NHS
Humber Teaching
NHS Foundation Trust

Trust Board Meeting 29 May 2024
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 29 May 2024, via Microsoft Teams

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence – Karen Phillips	CF	Note	verbal
2.	Declarations of Interest	CF	Note	√
3.	Minutes of the Meeting held on 27 March 2024	CF	Approve	√
4.	Action Log and Matters Arising	CF	Discuss	√
5.	Patient Story – "Spotlight on Being a Member of The Humber Youth Action Group"	KF	Note	√
6.	Chair's Report	CF	Note	√
7.	Chief Executives Report	MM	Note/Ratify	√
8.	Publications and Highlights Report	MM	Note	√
	Building a Shared Purpose and Vision			
9.	Electronic Patient Record (EPR) Major Projects Strategic Update	LP	Assurance	√
	Investing in People and Culture			
10.	Refreshed Research Strategy 2024-2026 -Cathryn Hart, Assistant Director Research & Development attending	KF	Ratify	√
11.	Staff Survey Presentation to Board (IQVIA to attend)	VM	Discuss	√
12.	Equality Delivery System 2 (EDS2) Report	VM	Approve	√
13.	Charitable Funds Update	PB	Assurance	√
14.	24/25 Board Assurance Plan	PB	Assurance	√

	Developing Leadership Behaviours			
15.	Integrated Care Board (ICB) Objectives 24/25	MM	Note	√
	Embedding Improvement into Management Systems and Processes			
16.	Finance Report	PB	Discuss	√
17.	Performance Report	PB	Discuss	√
18.	Risk Register Update - Oliver Sims, Corporate Risk & Compliance manager attending	HG	Approve	√
19.	Board Assurance Framework Update – Oliver Sims, Corporate Risk & Compliance manager attending	MM	Discuss	√
20.	Report on the Use of the Trust Seal	MM	Note	√
21.	Review of Standing Orders, Scheme of Delegation and Standing Financial Instructions	SJ/PB	Approve	√
22.	Annual Declarations Report	SJ/PB	Discuss	√
23.	Going Concern – Annual Statement 2023/24	PB	Approve	√
	Patient Safety			
24.	Freedom to Speak Up Guardian's Annual Report 2023/24 - Alison Flack, Freedom to Speak Up Guardian attending	MM	Approve	√
25.	Freedom to Speak Up Strategy 2024-2027 - Alison Flack, Freedom to Speak Up Guardian attending	MM	Approve	√
26.	Emergency Preparedness, Resilience and Response (EPRR) Annual Report	LP	Approve	√
	Assurance Committee Reports			
27.	Board and Committee Effectiveness Reviews 2023/24	SJ	Approve	√
28.	Mental Health Legislation Committee Assurance Report	MS	Assurance	√

29.	Audit Committee Assurance Report	SMcKE	Assurance	√
30.	Workforce & Organisational Development Committee Assurance Report	DR	Assurance	√
31.	Charitable Funds Assurance Report*	SMcKE	Assurance	√
32.	June Board Strategic Development Agenda	CF	Note	√
33.	Items to Escalate including to the High Level Risk Register & for Communication	CF	Note	verbal
34.	Any Other Urgent Business	CF	Note	verbal
35.	Review of Meeting – Being Humber	CF	Note	verbal
36.	**Exclusion of Members of the Public from the Part II Meeting**			
37.	**Date, Time and Venue of Next Meeting** Wednesday 31 July 2024, 9.30am via Microsoft Teams			

*Presented to Board as Corporate Trustee

NHS
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Agenda Item 2

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Declarations of Interest
Author/s:	Caroline Flint 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: • Removal of the Directorships for Priyanka Perera related to Child Dynamix Trading Ltd and Child Dynamix • Addition of declaration for Phillip Earnshaw related to Smawthorne Community Project

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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	

Caring, Learning
& Growing Together

	Mental Health Legislation Committee		Operational Delivery Group	
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail) Monthly Board report	✓ 29.5.24

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)	• Chair of Yorkshire & Humber Clinical Research Network • IMAS partner • Humber and North Yorkshire ICB Board Member • Non-Executive Director DHU Healthcare (a Social Enterprise organisation)
Mr Peter Beckwith, Director of Finance (Voting Member)	• Son is a Student at Hull York Medical School
Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	• No interests declared
Dr Kwame Opoku-Fofie, Medical Director (Voting member)	• Director of Bluewaters Healthcare Limited • Spouse Mrs Marian Opoku-Fofie 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
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	• Husband works for HMRC
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 Mike Smith, Non-Executive Director (Voting Member)	• Director Magna Trust • Director, Magna Enterprises Ltd • Associate Hospital Manager RDaSH • Trustee - The Rotherham Minster Development Trust
Mr Francis Patton, Non-Executive Director (Voting Member)	• Non-Executive Chair, The Cask Marque Trust • Treasurer, All Party Parliamentary Beer Group • Managing Director, Patton Consultancy • Non Executive Director of SIBA and Chair of SIBA Commercial, The Society of Independent Brewers • Trustee Director, the Baxi Partnership Limited

	• Trustee Director, the Baxendale Employment Ownership Trustees Limited • Trustee Director the Spirit Pension Trust
Mr Dean Royles, Non-Executive Director (Voting Member)	• Director Dean Royles Ltd • Trustee Health People Managers Association (HPMA) • Owner Dean Royles Ltd • Advisory Board of Sheffield Business School • Associate for KPMG • Chair of NHS Professionals Strategic Advisory Board • Non-Executive Director Sheffield Teaching Hospitals NHS Trust
Mr Stuart McKinnon-Evans, Non-Executive Director (Voting Member)	• Wife is employed by Carers' Resource, which may supply services to the NHS in West and North Yorkshire.
Dr Phillip Earnshaw, Non-Executive Director (Voting Member)	• Director of Conexus GP Federation • Owner of Phillip Earnshaw Ltd • Ex- partner Health Care First Partnership • Trustee of Prince of Wales Hospice • Five Towns PCN Clinical Director • Board Member of Wakefield District Health & Care Partnership • Trustee Smawthorne Community Project is a local charity in Castleford
Mihinduklilasuriya Weerasingha Indrika Priyankari Marguerite Perera (Priyanka Perera) Associate Non-Executive Director (Non-Voting Member)	• Managing Director B.Cooke & Son Ltd, Hull
David Smith Associate Non-Executive Director (Non-Voting Member)	• Trustee at Hospice UK • Trustee at St Leonards Hospice, York

Humber Teaching NHS Foundation Trust

Item 3

Trust Board Meeting
Minutes of the Public Trust Board Meeting held on Wednesday 27 March 2024 via Microsoft Teams

Present:

Rt Hon Caroline Flint, Chair
Mrs Michele Moran, Chief Executive
Dr Phillip Earnshaw, Non-Executive Director
Mr Stuart McKinnon-Evans, Non-Executive Director
Mr Francis Patton, Non-Executive Director
Ms Priyanka Perera Associate Non-Executive Director
Mr Dean Royles, Non-Executive Director
Mr David Smith, Associate Non-Executive Director
Mr Mike Smith, Non-Executive Director
Mr Peter Beckwith, Director of Finance
Dr Kwame Fofie, Medical Director
Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals
Mrs Lynn Parkinson, Deputy Chief Executive/Chief Operating Officer

In Attendance:

Mrs Stella Jackson, Head of Corporate Affairs
Mrs Karen Phillips, Deputy Director of Workforce & Organisational Development
Mr John Duncan, Equality Diversity Inclusion (EDI) Lead and Eve Rose (for item 31/24)
Ms Alison Flack, Programme Director, (for item 40/24)
Mrs Jenny Jones, Trust Secretary (Minutes)

Apologies:

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

28/24	**Declarations of Interest** The declarations were noted. Any further changes to declarations should be notified to the Trust Secretary. The Chair requested that if any items on the agenda presented anyone with a potential conflict of interest, they declare their interest and remove themselves from the meeting for that item. The Chief Executive; Director of Finance; Mike Smith, Non-Executive Director; and Stuart McKinnon-Evans, Non-Executive Director have a standing declaration of interest regarding items relating to the Collaborative Committee.
29/24	**Minutes of the Meeting held 31 January 2024**

	The minutes of the meeting held on 31 January were agreed as a correct record.
30/24	**Matters Arising and Actions Log** There were no matters arising. The action log and work plan were noted.
31/24	**An Inclusion Story – Supporting Staff with Disabilities** John Duncan introduced the story explaining the inclusive management approach that had helped Eve to overcome her disability, which was complex and multifaceted, and had given her the confidence to excel in her role both practically and physically. He highlighted the work of the Occupational Health team that had reduced its response time to staff to 24 hours. The staff survey question score for making reasonable adjustments was 84% which was better than the comparator score of 79% and was an improvement on the Trust's 2022 results. Eve shared her journey and how she had overcome challenges with the help of people within the Trust. A number of adjustments had been made allowing her to fulfil her role and most recently, changes made had enabled her to complete the staff survey online. Mandatory training had been a struggle to complete, however this had also been achieved through working collaboratively with other staff. The Board was complimentary of everything that Eve had achieved and what she had gone through before coming to work at the Trust. Lynn Parkinson asked what more could be done to encourage staff with a disability to ask for support should they need it. Eve outlined the importance of work being undertaken to destigmatise. Eve offered to help by talking to staff groups to share her experiences and to outline the support available. The Chief Executive thanked Eve for sharing her story and suggested that John and Karen Phillips discuss with Eve how she could help other staff going forward. The Board thanked Eve for attending the meeting and sharing her story.
32/24	**Chair's Report** The Chair presented her report which was taken as read. The following areas were highlighted: • Ask the Board – the first session had received positive feedback from staff. • Dr Wendy Mitchell, a well renowned and respected research champion for the Trust passed away recently. Wendy was an inspirational woman and an advocate for raising awareness of Dementia. The Chair on behalf of the Board, extended her condolences to Wendy's family and friends. • Nominations for the HSJ awards • International Women's Day – this was well attended to celebrate inspirational women. • Visits had taken place since the last meeting. Some visits had been cancelled and were being rearranged. • The Governor/Board Development Day which was engaging and inclusive. A case study would be submitted to NHS Providers for the Governor Showcase Conference.

	Resolved: The report was noted.
33/24	**Chief Executive's Report** The report was taken as read and the following key points highlighted: • The Rainbow Alliance held an event recently with good feedback received • Updates from Directors included details of their visits • Work continued with the Veterans Forum. A recent meeting was well attended by partner organisations and promoted networking and relationship building. • The Trust has been nominated in the NHS Communicator Awards and the HSJ Awards • In June, Dr Lade Smith, CBE, the President of the Royal College of Psychiatrists, would be visiting the Trust • An excellent visit to the Tigers Trust charity had taken place recently which showcased the work they did across Hull and beyond, to make a difference to people's lives • A new Dean had been appointed to the Hull York Medical School (HYMS) To celebrate the life and work of Dr Wendy Mitchell, an award would be dedicated to her at the Trust's staff awards. Karen Phillips reported that NHS England recently launched its enhanced leave and pay policy in support of staff. The Trust had launched its policy last year and was asked to appear on BBC radio Humberside to promote the work that had been undertaken to support staff. Karen had been asked to join a webinar panel on how to support staff in parenthood. An update on the Multi-Agency Public Protection Arrangements (MAPPA) was included in the report. Lynn Parkinson informed the Board that Kate Munson, OBE, Head of Hull & East Riding Probation Delivery Unit, Yorkshire and the Humber Region, would be leaving her post at the start of April and Sally Adegbembo from another probation unit in the Yorkshire region would be her successor. Kate Yorke, Associate Director of Psychology and Trust MAPPA lead would be leaving the Trust in April and Helen Courtney, Clinical Lead for the Forensic Division would be replacing her as the Trust lead. The Board thanked them for their work with the organisation. Mike Smith noted the Emergency Preparedness Resilience and Response (EPRR) Arrangements Policy was presented for approval. Although there was no longer a requirement for a Non-Executive Director (NED) to be involved, he was interested to understand more about the changes to the policy. Lynn explained that the changes related to sub-contractors demonstrating they met the requirements in overall emergency planning. Stuart McKinnon-Evans asked if test exercises were completed. Lynn confirmed they did take place and were planned 12 months in advance. The Trust had participated in them during the last year. Some were organised through the Local Resilience Forum (LRF) and some were table top exercises. Planning and outcomes were debriefed and shared wider. Mike queried whether recent problems with grocery on-line shopping and payments would be taken on board. Lynn explained this would be through the LRF who reviewed incidents such as this on behalf of the Trust. Francis Patton noted there was media interest in veterans and mental health and

	suggested that the Board could receive an update on this area at a future Board. . He referred to the PROUD Alumini proposal in the report asking to hear more about this. Karen explained that the PROUD programme was launched in 2018 and a review of the content had taken place recently. An extensive leadership development programme was included as part of the scheme but did not include supporting relationships with leaders afterwards. The Leadership Conference would be a good opportunity to bring leaders together at an event with speakers and interesting topics. Board members were welcome to attend the event. An update was provided in the report on Humber Primary Care and the Care Quality Commission (CQC) inspection. Francis asked about arrangements for patients that were not confident with technology and alternative ways they could contact the practice. Phillip Earnshaw commented that in his experience, the online platform was unpopular with some patients and outlined the importance of the Trust offering alternative ways for patients to access the practice/appointments. In response, clarification was provided that patients could telephone the practice and there was a dedicated Engagement Lead for primary care focussing on all aspects of access. The Chief Executive suggested the Quality Committee review work being undertaken around access. The work undertaken on the Estates was noted by Stuart. He asked if the Trust would continue to bid for Salix funding in the future. Pete Beckwith confirmed this would be applied for if available. In 2024/25, resources had been set aside to address Green Plan initiatives. **Resolved**: The Board noted the report. An update on our approach to Veterans and mental health to come to a future Board **Action KF** The Quality Committee to review the access actions taken at Humber Primary Care **Action HG**
34/24	**Publications and Highlights Report** The report provided an update on recent publications and policy. **Resolved:** The report was noted.
35/24	**24/25 Annual Operational Plan Final Draft** The Annual Operational Plan outlined the Trust's operational priorities, challenges and drivers for 2024/25. It triangulated divisional planning, workforce planning and financial planning and was underpinned with a clinical/quality focus that ensured that all transformation detailed within it was evidence based. Pete Beckwith explained that the draft plan had been completed ahead of the Planning Guidance being issued. Comments from the Board would be used to inform the final plan. In the future, more time would be built into the timescales to allow further discussion at a Strategic Session. Francis Patton commented that the draft plan seemed fairly generic with limited information and limited metrics and asked if it was an NHSE template or our own documentation. He suggested that there was a set of strategic issues throughout the agenda that would all help inform and improve the plan could be included and

highlighted that the following information might be included:

- Areas of Delayed Transfers of Care, mental health review and how these fitted in with Kings Fund requirements and the shift from primary to community.
- How Integrated Care Board (ICB)/ Integrated Care System (ICS) plans may impact on the Trust
- Expansion of the executive summary to give more focus on the finance perspective.
- Detail of the exit rate for ICB coming out of 23/24 and the amount of money available and how the potential impact of this for the Trust would be managed going forward.
- Productivity needs to be included up front and information on how the plan linked to the overall strategic plan.
- Information at the front of the plan to be included regarding the priorities and anticipated achievements over the next 12 months.

Francis noted that the there were no key risks highlighted on the front sheet and that finance must be a risk particularly the potential future impact of finance from a central and ICB position.

Pete believed the Executive Summary could be improved. The exit rate was variable and the previous year this had stood at £240 million for the ICS. Grant Thornton had completed some work which would confirm this. No funding for growth was anticipated and increased demand for Trust services affected productivity. Non-recurrent initiatives that had been provided this year might not be available next year which would impact on waiting lists.

The Chief Executive acknowledged that some assumptions had been made regarding the Trust's financial position in relation to the system around effectiveness and new growth. More detail would be available when the national picture was clear.

Phillip Earnshaw commented there was no transition for community and primary care. Health inequalities needed more maturity and children and learning disability services information should incorporate measures.

Stuart McKinnon-Evans agreed with the comments made and acknowledged uncertainty existed around external factors and asked whether the Trust had a rolling plan. Pete confirmed there was a rolling plan. At the back of the document information was incorporated regarding commissioning intentions nationally and around Place. If any investment was made available a plan was in place regarding its use.

The Trust Chair noted there were some synergies between this plan and the performance data which would identify the areas of challenge.

Mike Smith asked about innovations in Forensic services to help patients (for example wood working, animal care etc). Lynn Parkinson explained the Trust employed dedicated educational advisors for patients and patients could take part in educational programmes if they chose to. There was also the Recovery College that patients could access. A gym was developed at service user request and the future intentions of the woodwork shop were being explored. The Trust Chair felt that more information on what was being done and the uptake was needed. This should include vocational,

	and activities undertaken to relieve boredom. Dean Royles acknowledged the difficulties of creating a plan in the absence of any national guidance. He suggested that an additional meeting/e mail exchange to sign off the plan when ready would be helpful as the Board needed to be clear about its role in signing off the plan. Francis proposed a discussion at the April Strategic Board meeting to give time for the plan to be amended and for further discussion to take place. The Trust Chair agreed and would revisit the agenda for the meeting. Other areas to consider were: How this would be reflected in discussion on performance and finance and how sites with wider issues were impacting on the Trust's decision making. **Resolved:** The report was noted. Comments made will feed into a future version which would be discussed at the April Strategic Development Board Meeting. The agenda to be reviewed **Action CF** Information on activities in Forensic and the update to be provided **Action LP**
36/24	**Leadership Competency Framework for Board Members** The report summarised the general principles and actions for Board members, arising from the recently published Leadership Competency Framework (LCF), which was aligned to the Fit and Proper Persons Test (FPPT). The report was taken as read. Karen Phillips reported that full implementation of the LCF was not possible for 2024 appraisals, due to a delay in the release of supporting documentation for Non-Executive Director appraisals, which was expected in Autum 2024. Preparations were underway to deliver the Chair appraisal in accordance with the framework for 2024. Principles would be followed for wider Board member appraisals for 2024 with an addendum created to support conversations, with full implementation in 2025. **Resolved:** The report was noted.

37/24	**National Staff Survey Results 2023**
	An overview of the National Staff Survey Results, following the national publication on 7 March 2024, was presented and taken as read. Highlights of the report were:
	
	• The Trust position was better that the national average across all People Promise theme areas and across all People Promise sub themes.
	• The Trust position was better than the average for its benchmark group (this consisted of 51 mental health and community Trusts) in all but one People Promise theme areas, where it was equal to the average (we are a team)
	• The Trust reported above sector and national scores for five key questions;
	
	  • I feel that my role makes a difference to patients / service users.
	  • Care of patients / service users is my organisation's top priority.
	  • My organisation acts on concerns raised by patients / service users.
	  • I would recommend my organisation as a place to work.
	  • If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

	Presentation of the results would be given at the May meeting by the IQVIA who undertook the survey on behalf of the Trust. The Executive team would consider the results for their respective areas and identify areas of improvement. All the questions in the survey were nationally set which could not be changed. Additions could be included from organisations. Dean Royles appreciated the update. There had been a positive collaborative change over a number of years to improve scores which he believed should be celebrated. However, there was always more that could be done. Significant had been undertaken by the Workforce team and across the Trust. Francis Patton agreed exceptional work had been undertaken over the last few years to reach this position. He referred to Promise 7 question and scores for other related questions which did not correlate and felt staff did not link these together. David Smith congratulated the Trust on its results. He noted the "experienced discrimination on the ground of sexual orientation" responses were in the bottom 20%. He felt this was due to wider society issues and people not falling into specific categories with different gender issues. The Trust Chair agreed categories were too generic at times. The Chief Executive thanked the team and everyone in the organisation for a good set of results. Momentum would be maintained, and areas identified for further action. A key area to progress was flexible staff working issues. The actions would be monitored through the Workforce and Organisational Development Committee. **Resolved:** The report was noted.
38/24	**Associate Hospital Managers (AHMs) Reappointment Reviews** The report was presented by Mike Smith. Under Section 23(6) of the MHA 1983 the Trust delegates its power of discharge to individuals authorised by the Board for that purpose. The re-appointees had been observed and fully appraised and Mike Smith recommended the reappointment of Mike Hood and Lyn Hood for three years, subject to the position of Hospital Manager not changing. Phil Earnshaw and Dean Royles had met with the department manager in relation to becoming AHMs. **Resolved:** The Board approved the re-appointment of the two AHMS.
39/24	**Patient Led Assessment of Care Environment (PLACE)** The results from the 2023 (PLACE) Assessment and a summary of actions being taken was provided to the Board. Scores for food were always lower due to the size of the units, however ward scores were positive. The score for Granville Court had reduced this year. Senior managers visited the site immediately after the score was revealed and believed that the refurbishment works that were due to take place (but not yet started) had been reflected in the environment scores. The Chief Executive visited last week and found things better than anticipated. Staff were disappointed with the results and believed the scoring should

	have been better. **Resolved:** The report was noted.
40/24	**Humber and North Yorkshire Integrated Care Board Collaborative Programme Update** Alison Flack presented the report which was taken as read. Areas drawn out from the report included: • Successful Trauma Informed Care conference held earlier this month • Youth Justice work with partners across the system • Reoffender rates reduced • Metrics for reporting in 24/25. • Out of area data used to be on the number of bed days, but is now based on the number of patients • Talking Therapies – more focus on outcomes and recovery • Key Lines of Enquiry from the national team are being worked through • Autism/ADHD assessment pathways – following a significantly increased level of demand for autism and ADHD assessments, the Autism/ADHD assessment pathways steering group was established to scope demand and approaches across the Integrated Care Board (ICB) 6 Places. • Collaborative strategic review – Outputs form the Carnal Farrar strategic review had been shared and had identified some key themes for collaborative development: Stuart McKinnon-Evans asked when data would be available regarding the Autism and ADHD assessment pathways. Alison explained this was the work that Carnal Farrar were involved in. Three options with different models were proposed and were being worked through. It was anticipated this would take 4 – 6 weeks before the next iteration was available for providers to consider. **Resolved:** The report was noted
41/24	**Finance Report** The report showed the financial position for the Trust as at the end of February 2024. The Trust achieved a break-even position at the end of Month 11 and was forecasting a break-even position at the end of the financial year. The cash balance at the end of Month 11 was strong and the Better Payment Practice Code performance was 93.1%. Phillip Earnshaw was pleased to see the improvement in the agency position but noted that consultant expenditure had increased. Kwame Fofie reported that progress had been made with recruitment which would come through in future figures to give a positive start to 24/25. **Resolved:** The Board noted the Finance report
42/24	**Performance Report** Pete Beckwith presented the report that showed the current levels of performance as at the end of February 2024. Hilary Gledhill referred to the safer staffing dashboard which showed January data. She reported that sickness levels and clinical supervision had improved. For this

	month, all units apart from one had met all targets. Occupied bed days were high, but quality indicators were being achieved. The Trust Chair asked if there was any correlation between flu and the uptake of the vaccination in the sickness data. Hilary would review this and respond outside the meeting. An update on waiting times was provided by Lynn Parkinson. An adverse situation was being seen in neurodiversity, the waiting time position for children's services and adult ADHD. This was being discussed at Integrated Care Board (ICB) level and through the mental health and learning disabilities collaborative. The additional investment was coming to an end and conversations continued around productivity. The Hull Memory Assessment position contributed to the overall picture. A detailed proposal had been given to commissioners to address this. The intention was to put more upfront resources into schools. The Trust Chair had visited recently and been told some of the issues related to young people being referred into the service and not attending appointments. Phillip Earnshaw commented that part of the problem was that GPs had no alternative outlets to refer them to and, therefore, used services such as this for referrals. A piece of work was underway around this issue and was due to be completed in the near future. An increase had been seen in out of area placements for PICU due to demand for female beds, which was also affecting the wider system. The situation was being managed. **Resolved:** The report was noted. Information to be provided on sickness and the uptake of the flu vaccination **Action KP**
43/24	**"Closed Cultures" Progress Report** The report provided an update on the further work being undertaken by the Trust regarding the early identification of closed cultures following the Panorama expose of Edenfield, an NHS medium secure unit in the North West in 2022. The information built on the previous updates and considered the recommendations made in the review into Greater Manchester Mental Health Foundation Trust, from the report published in January 2024. The report had been considered by the Quality Committee. **Resolved:** The report was noted.
44/24	**Trust Board Sub Committee Chairs and Non-Executive Director (NED) Champions Roles 24/25** The report outlined details of sub-committee chairs and NED champion roles from April 2024. No changes were proposed and a review would be undertaken in July when recruitment of new NEDs had taken place. **Resolved:** The report was noted.
45/24	**Quality Committee Assurance Report** Phillip Earnshaw presented the report from the meeting held earlier this month. A good presentation was received on sexual safety and the Mental Health Redesign Pre Consultation Business Case was received.

	Resolved: The report was noted
46/24	**Mental Health Legislation Committee Assurance Report** The assurance report was presented by Mike Smith and taken as read. The following key points were highlighted: • Two junior Doctors had volunteered to take on the re-audit of consent to treatment. A meeting had been held to discuss the terms of reference. • Delayed discharges from secure beds was a national problem. The Trust was doing everything possible to consider how to expedite discharge and all viable alternatives had been considered. **Resolved:** The assurance report was noted.
47/24	**Audit Committee Assurance Report** Stuart McKinnon-Evans presented the report which was taken as read. The February meeting was positive and updates received on: • Provider Sector Regime • Risk Management and the risk register • Internal audit progress. Excellent progress with audit recommendations • The internal audit plan for 24/25 **Resolved:** The Board noted the report.
48/24	**Charitable Funds Assurance Report** The report was presented to the Board as Corporate Trustee. The charity was in transition from an external provider to in-house provision. Three fundraising campaigns had been identified for the future. **Resolved:** The report was noted
49/24	**Collaborative Committee Assurance Report** The report was presented by Stuart McKinnon-Evans and taken as read. Three admissions to hospital had been prevented by the Eating Disorder team by providing intensive home treatment. **Resolved:** The report was noted
50/24	**Board Strategic Development Agenda** The agenda for the April meeting was presented for information. The meeting would primarily focus on Digital functions and time would be allocated to consider the Annual Operating Plan. **Resolved:** The agenda was noted.
51/24	**Items to Escalate including to the High-Level Risk Register and for Communication** No items were raised.
52/24	**Any Other Urgent Business**

	No other business was raised.
53/24	**Review of the Meeting – Being Humber** The meeting was held in the Being Humber style with full and engaging discussions.
54/24	**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.
55/24	**Date and Time of Next Meeting** Wednesday 29 May 2024, 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 2024 Board meeting and update report on earlier actions due for delivery in May 2024 *Rows greyed out indicate action closed and update provided here*						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
#	33/24(a)	Chief Executive's Report	An update on our approach to Veterans and mental health to come to a future Board	Medical Director	May 2024	Update included in Chief Executive report
27.3.24	33/24(b)	Chief Executive's Report	The Quality Committee to review the access actions taken at Humber Primary Care	Director of Nursing, Allied Health and Social Care Professionals	30 May Quality Committee	Item on the Quality Committee agenda
27.3.24	35/24(a)	24/25 Annual Operational Plan Final Draft	Comments made will feed into a future version which would be discussed at the April for Strategic Development Board Meeting. The agenda to be reviewed	Trust Chair	28.4.24	The draft AOP was reviewed at the 24 April Strategic Board Meeting. It was agreed the document provided assurance. The final Strategic AOP to go to May Board with the cover report highlighting the importance of it linking

						into the Trust's strategic objectives, ICB objectives and national priorities and where any gaps/pressure points existed in relation to delivery of these.
27.3.24	35/24(b)	24/25 Annual Operational Plan Final Draft	Information on activities in Forensic and the update to be provided	Chief Operating Officer	August 2024	This will be taken to the quality committee at the meeting in August.
27.3.24	42/24	Performance Report	Information to be provided on sickness and the uptake of the flu vaccination in the inpatient units	Associate Director of People and Organisational Development	April 2024	Information provided to Director of Nursing

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
26.10.22	200/22	Chief Executive's Report	Speech and Language Therapists, Ruth Edwards and Siobhan Ward to be invited to a future meeting	Chief Operating Officer	April 2023 revised to 27 Nov 2024	Patient/Staff story to be provided on Speech and Language
31.1.24	08/24	Social Values Report 2022-23	Communication plan to be shared with the Board	Chief Executive	27.3.24	Contained in Chief Executive's report

A copy of the full action log recording actions reported back to Board and confirmed as completed/closed is available from the Trust Secretary

NHS
Humber Teaching
NHS Foundation Trust

Board Public Workplan April 2024/March 2025 *(v1k)*

Chair of Board: ___Caroline Flint_____
Executive Lead: _____Michele Moran_____

Board Dates:- / Reports:	Strategic Headings	LEAD	29 May 2024	31 Jul 2024	25 Sep 2024	27 Nov 2024	29 Jan 2025	26 Mar 2025
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
Quarterly Items								
Finance & Investment Committee Assurance Report	Assur Comm	FP		x		x	x	
Charitable Funds Committee Assurance Report	Assur Comm	SMcKE	x		x	x		x
Workforce & Organisational Development Committee	Assur Comm	DR	x	x		x	x	
Quality Committee Assurance Report	Assur Comm	PE			x	x		x
Mental Health Legislation Committee Assurance Report	Assur Comm	MS	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	
Board Assurance Framework	Corporate	MM	x	x		x	x	
Risk Register	Corporate	HG	x	x		x	x	x
Humber and North Yorkshire Integrated Care System – Mental Health and Learning Disabilities Collaborative Programme Update Update	Corporate	MM		x		x		x
6 Monthly items								
Freedom to Speak Up Report	Corporate	MM	x			x		
MAPPA Strategic Management Board Report (inc in CE report)	Strategy	LP			x			x
Safer Staffing 6 Monthly Report	Corporate	HG		x			x	
Research & Development Report	Corporate	KF		x			x	
Annual Agenda Items								
Suicide and Self-harm Strategic Plan (next due 2025)	Strategy	KF			x			
Recovery (Enabling) Strategy Update (due 2026)	Strategy	LP		x				
Patient and Carer Experience Forward Plan (2023 to 2028 (due 2023)	Strategy	KF			x			
Presentation of Annual Community Survey	Corporate	KF		x				
Guardian of Safeworking Annual Report	Corporate	KF			x			
Patient & Carer Experience (incl Complaints and PALs) Annual Report	Corporate	KF			x			
Quality Accounts	Quality	HG	x					
Infection Control (Enabling) Plan	Strategy	HG			x			
Infection Prevention Control Annual Report	Quality	HG		x				

NHS
Humber Teaching
NHS Foundation Trust

Board Dates:- Reports:	Strategic Headings	LEAD	29 May 2024	31 Jul 2024	25 Sep 2024	27 Nov 2024	29 Jan 2025	26 Mar 2025
Safeguarding Annual Report	Quality	HG			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
Health Stars Strategy Annual Review	Assur Comm	KP	x					
Annual Operating Plan	Strategy	MM						x
Freedom to Speak Up Annual Report	Corporate	MM			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					
Annual Declarations Report	Corporate	SJ	x					
Charitable Funds Annual Accounts	Corporate	PB					x	
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			
Annual National Staff Survey Results	Corporate	KP						x
Board Terms of Reference Review (inc in Effectiveness review)	Corporate	CF	x					
Committee Chair Report	Corporate	CF		x				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			
Workplan for 2023/24: To agree	Corporate	CF/MM	x					
Edenfield Update	Corporate	HG			x			x
Compliance with the New Provider License	Corporate	SJ			x			
Staff Survey Presentation to Board	Corporate	KP	x					
Staff Survey Progress Report	Corporate	KP			x			
Review of the Constitution	Corporate	SJ		x				
EDS2 Report	Corporate	KP	x					
Electronic Patient Record (EPR) Major Projects Strategic Update	Corporate	PB	x	x	x	x	x	x
Adhoc/future Items								
Freedom to Speak Up Strategy 2024-2027	Inv in P & C	MM	x					
Review of Committee Membership and NED Champions	Corporate	CF		x				

Board Dates:- Reports:	Strategic Headings	LEAD	29 May 2024	31 Jul 2024	25 Sep 2024	27 Nov 2024	29 Jan 2025	26 Mar 2025
Research Strategy 2024-2026	Inv in P & C	KF	x					
Annual Operating Plan	Inv in P& C	PB	x					
Annual Review of Board Performance Report	Emb Imp into Man Syst &Proc	PB					x	
Finance & Investment Committee Effectiveness Review	Corporate	SJ		x				
Deleted /Removed Items								

NHS
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Agenda Item 5

Title & Date of Meeting:	Trust Board Public Meeting– Wednesday 29th May 2024
Title of Report:	Patient Story – "Spotlight on Being a Member of The Humber Youth Action Group"
Author/s:	Maisy – Humber Youth Action Group Member, Service User and Staff Member Felicity Hague - Engagement Assistant for Children's Services
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper:	Felicity will give an overview of the Humber Youth Action Group. Felicity will be followed by Maisy who will tell her story to the Trust Board to highlight what being a member of the Humber Youth Action Group has meant to her and; • What can be gained from joining Humber Youth Action Group • How becoming engaged with services and sharing experiences can lead to opportunities within the Trust.

Key Issues within the report:

Positive Assurances to Provide: • This account provides the positive experience of a person who has become involved in a variety of Trust activities including gaining employment in the Trust as a result of being a member of the Humber Youth Action Group.	**Key Actions Commissioned/Work Underway:** • N/A
Key Risks/Areas of Focus: • None	**Decisions Made:** • N/A

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	

Caring, Learning & Growing Together

	Finance & Investment Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail)	29.5.24

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

Agenda Item 6

<table>
<tr><td>Title & Date of Meeting:</td><td colspan="2">Trust Board Public Meeting – 29 May 2024</td></tr>
<tr><td>Title of Report:</td><td colspan="2">Chair's Report</td></tr>
<tr><td>Author/s:</td><td colspan="2">Rt Hon Caroline Flint
Trust Chair</td></tr>
<tr><td>Recommendation:</td><td colspan="2"><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 colspan="2">To provide updates on the Chair, Non-Executive and Governor activities since the last Board meeting.</td></tr>
<tr><td colspan="3">Key Issues within the report:</td></tr>
<tr><td colspan="2">Positive Assurances to Provide:
Update from the last Board Strategic Development meeting.
Governor Briefings and Council of Governor meeting
Participated in HNY ICB strategic meetings with Chairs and CEOS regarding system working and finance
Visits to Humber services
Freedom to Speak up Quarterly Catch Up
Complaints Quarterly Catch Up
Chair's and Chief Executive's Appraisals completed.</td><td>Key Actions Commissioned/Work Underway:

Outlined in the report.</td></tr>
<tr><td colspan="2">Key Risks/Areas of Focus:</td><td>Decisions Made:
N/A</td></tr>
</table>

Caring, Learning & Growing Together

• Funding and Service planning across Humber North Yorkshire ICS for 24/25	

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Board report	29.5.24

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 – 29 May 2024

Jenny Jones, Trust Secretary, Personal Assistant (PA) to myself and the Chief Executive and Board Support Unit (BSU) Manager retired last week, and I would like to take this opportunity to formally put on the record our thanks to Jenny for her service to Humber.

For me, Jenny has been a tremendous support and source of knowledge during the last two and half years as Chair. But I know many others of longer standing will miss her for the same reasons. They were able to express this at her leaving do last week and wish her the very best in her retirement.

Recruitment for Jenny's replacement has been successfully completed and we look forward to working with **Laura Roberts who joins Humber in July**. Laura will continue as PA to myself and Michele and BSU Manager whilst Stella Jackson Head of Corporate Affairs will assume the Trust Secretary responsibilities with BSU support.

Both the Chief Executive and I have individually undertaken our **2023/24 Appraisals** which will be reported to the Governors' ATC Committee for me and the Remuneration and Conditions for Michele. Thanks to Francis Patton who took part in both, and Marilyn Foster conducted mine with Francis.

1.Trust Compliance with the Fit and Proper Person Test Framework 2023/24

The Board is asked to note the paper appended to my Chair's Report which affirms that:

- 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.

2.Trust Board Strategic Development Meeting, 28 February 2024

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.

The Board focussed its attention on the following areas at the February meeting:

- **Rapid Review into Data on Mental Health Inpatient Settings Action Plan -** The Board was assured the recommendations arising from the Rapid Review had been or were being implemented.

- **Digital -** Lee Rickles (Chief Information Officer at the Trust) gave a progress update on the development of the Trust's Electronic Patient Record (EPR). Board members were assured about staff being able to retrieve data quickly from the new system; and the data migration process would be validated to ensure the consistency of data migration. Random record checks would be undertaken, and any reported failures would be investigated. **Rafael Sorribas,** the Chief Information Officer from Devon Partnerships Trust gave a presentation in which he outlined their implementation approach, the risks faced, the future optimisation tasks and lessons learned by the Trust. It was agreed Lynn Parkinson would **ensure EMT is informed of any training attendance issues and that the Trust's Disability Staff network should be invited to comment on any roll-out, implementation and training plans.**
  The Board **agreed** EPR updates should be a standing item on Board meeting agendas and during succession planning discussions, to a NED with a digital background being recruited to the Board [this would be reflected in the forthcoming NED recruitment campaign].

- **Data Literacy (Understanding Data) -** The Chief Information Officer provided a training refresh on structural process charts (SPC); Benchmarking; Power BI; Data solutions across the Humber and North Yorkshire Integrated Care System. It was agreed that that **EMT should consider the incorporation of analytical analysis narrative and that the SPCs could also incorporate information regarding the Trust's performance against the best in field and an aspirational target.**

- **Digital Transformation - Thorsten Engel, Partner from Deloitte's, gave a thought -provoking presentation regarding the art of the possible in relation to digital solutions in e health.** During the presentation, he shared examples of how artificial intelligence was being utilised for patient care across the world and being embedded into products to facilitate clinical checks and better care. He pointed out that there were many positive developments to aid both prevention and treatment interventions as well as reduce staff time spent on bureaucracy and mundane tasks.

- **Leadership Competency Framework (LCF), Fit and Proper Person Test (FPPT) and Equality, Diversity, Inclusion (EDI) Improvement Plan Triangulation Summary -** Karen Phillips outlined the general principles and actions for Board members. Concerns were raised about the FPPT process being resource intensive and possibly deter potential Non-Executive Director (NED) candidates. Also, the LCF appraisal form was too complicated and long. It was agreed the Trust should feedback to NHS England and NHS Providers.

- **Strategic Annual Operating Plan (AOP) – Referred from the March Board for further discussion it was agreed the plan should be linked into the Trust's Strategic objectives, ICB objectives and national priorities.** It was agreed the document provided assurance that the Trust

was triangulating the different objectives and priorities. T**he final report to May Board should highlight where any gaps/pressure points existed in relation to delivery of the various objectives and priorities, action being taken to address these and whether any of the Trust's priority areas or strategic objectives required review considering ICB objectives and national priorities.** Whilst the Trust was no longer required to seek Governor views regarding the plan, it was important that they were informed about the priorities and any gaps in meeting these.

- **Financial Update -** Michele Moran reported the Trust had **achieved a positive year-end financial position** and an email had been sent to Board members regarding this. The financial plan for 2024/25, which had been submitted to the ICB, was reflective of the Trust receiving the same level of Mental Health Investment Standard (MHIS) funding and System Development Funding (SDF) to that received the previous year. The Board **agreed** it would not sign off a plan which did not incorporate the anticipated level of MHIS and SDF funding.

- **Hull Health and Care Partnership Board -** agreed they should be invited to a future Strategic Board Development meeting.

2. Chair's Activities Round Up

I spoke on the theme of journeys at the Humber Easter Service at Hall Farm and enjoyed very much the chance to milk a cow!

Since the last Board I have also met with **Dr Gary Dyson Deputy Medical Director** to discuss primary care at Humber and more specifically in Bridlington.

I accompanied **HNY ICB Chair Sue Symington on a tour of Whitby Community Hospita**l where with Humber, HNY ICB and Place colleagues we had a good discussion about the potential for Whitby to host other provider services and be part of a wider coastal health strategy including Scarborough and Bridlington.

On the 7 May I represented the Trust at the final CEO's and Chairs briefing as part of the **NHS England Mental Health Act Quality Improvement programme** to improve th experience for people from ethnically diverse backgrounds, people with a learning disability and autistic people when detained under the Mental Health Act. The session was to pause, reflect and share learning from the pilot phase. Being black or autistic patients within mental health units was heard from individuals with lived experience supporting this project nationally. It would be useful for the Board as a whole to know more about the pilot in Humber's PICU what was found and how learning will be applied across Humber.

At time of writing, I am looking forward to chairing the morning session of **Humber's Research Conference 2024** and make the closing remarks on 22 May.

NHS NEYH organised a conference for Yorkshire and Humber NHS Trusts on the theme of "Inequalities and Poverty and the Impacts on Health" in Leeds. As well as me Sarah Clinch attended from Humber. It was a really interesting day

and a lot to share. As Chair of the Government's Independent Advisory **Committee on Fuel Poverty** I presented on fuel poverty in our region. The local authorities with the highest proportion of households that are fuel poor starts **with Kingston Upon Hull at 20.4%** followed by Bradford 19.8%; Doncaster 18.2% and Barnsley, Calderdale and Kirklees at 17%. In England, after the West Midlands, **Yorkshire and Humber have the highest proportion at 17%**

NHS HNY Integrated Care Board met with Chairs and CEOs to receive an update on the year end position for 2023/24 and the Financial Performance and Workforce Plan Position for 2024/25 and Medium-Term Stability. The ICB is committed to a "no deficit" culture and expect to produce a medium term sustainable and financial recovery plan over the summer.

3.Visits (in person and virtual)
My thanks to staff and patients who I have met on my recent visits and at events

- **Whitby Community Hospital (See above)**
- **Pine View Low Secure Forensic**
- **Perinatal Mental Health Service for Hull, East Riding, N&NE Lincolnshire**
- **Virtual Long Service Awards**
- **Catch up with David Napier who leads our Complaints Team.**
- **Quarterly meeting with Freedom to Speak Up Guardian Alison Flack**

External meetings included:
Humber and North Yorkshire (HNY) Provider Chairs
HNY ICB and NHS System Chairs and CEO's
NHS Confederation Mental Health Chairs Network
NHS Confederation Chairs' Group
East Riding Health and Well Being Board

NEDS/Governors Visits

- Millview Court 18 April - Stuart McKinnon-Evans & Ruth Marsden
- Millview Lodge 14 May - David Smith

Director/NED's Unannounced Visits

- Malton 9 April - Dean Royles
- Humber Centre 24 April - Phillip Earnshaw
- Granville Court 1 May - Stuart McKinnon-Evans Maister Lodge 16 May - Phillip Earnshaw

4. Governors

Council of Governors' Meeting (180424) was in person and well attended. It was the first for new governors including Superintendent Gary Foster our new Humberside Police Governor. There were questions to non-executive directors and executive directors on regular standing items on assurance, performance and finance. I gave a report on the NED Recruitment 2024 Campaign which is underway.

In addition, the Humber Services Spotlight by the Individual Placement and Support (IPS) Team Lead Les Motherby explained the employment support approach for people experiencing severe mental health issues. This was made more powerful by hearing from Emma who was supported back into paid work. The CoG also heard from Humberside Fire and Rescue Service's Governor Jon Henderson about their work with Humber and responding to calls where a person has or may have mental health issues. Comments about accessibility of CoG papers are being progressed taking into account the CoG Effectiveness Review 23/24 and further discussion at a Governor Briefing in May.

Governor Briefings 2024 are open to all governors and take place online 10 times a year with half the time for an informal catch up with me and the other half to brief on a specific service or topical issue relevant to governors. In April a bitesize briefing was provided on Humber's International Recruitment and how these staff are supported to undertake their work and personally with finding accommodation etc.

Appointment, Terms and Conditions Committee 230524 – at time of writing this is still due to take place but will be focussed on the Committee's Effectiveness Review, Agreeing content in Humber's Annual Report and the outcome of my appraisal which was undertaken by SID Francis Patton and ATC Chair Marilyn Foster.

Trust Chair Caroline Flint 170524

Humber Teaching NHS Foundation Trust

Agenda Item

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Trust Compliance with the Fit and Proper Person Test Framework 2023/24
Author/s:	Caroline Flint Trust Chair
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper:	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.

Key Issues within the report:	
Positive Assurances to Provide:	**Key Actions Commissioned/Work Underway:**

• 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.	• Some learning/areas for improvement have been identified regarding the completion of the annual checks and this will be addressed for the 2024/25 checks.
Key Risks/Areas of Focus: No matters to escalate	**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	
Charitable Funds Committee		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 2023/24

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 they have fit and proper directors in post, 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 their organisation 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 2023/24 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 the social media checks were undertaken in-house and DBS checks continue to be undertaken in-house in accordance with company policy. Learning from this process has been identified and will be improved for 2024/25.

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.

Humber Teaching NHS Foundation Trust

Agenda Item 7

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
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. Ratification of policies for: • Professional Boundaries Policy • Risk Management Policy • Use of Force Policy • Job Evaluation Policy • Supporting Transgender Patients and Service Users 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

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Report to Board	29.5.24

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

1.1 Policies for Approval

Trust Policies

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

Policy Name	Date Approved	Lead Director	Key Changes to the Policy
Professional Boundaries Policy	23/4/2024	Associate Director of People and OD	A number of changes have been made. The key differences are: • Change of name to the policy. • Information regarding professional boundaries with patients, carers and their families has been expanded. • Definition of a Personal Relationship included. • Information incorporated that we do not wholly prohibit personal relationships between colleagues in the workplace and to recognise this can be a positive factor although to make clear standards, expectations and obligations to ensure this does not impact day-to-day operations. • Social Media information expanded.
Risk Management Policy	23/4/2024	Director of Nursing, Allied Health and Social Care Professionals	This policy was ratified by the Board in March 2024. A further amendment has been approved by EMT regarding the inclusion of a section regarding: Emergency Preparedness, Resilience and Response (EPRR) Risks. The approved wording to be included is detailed below: Emergency Preparedness, Resilience and Response (EPRR) Risks Key risks facing the organisation regarding emergency preparedness, resilience and response are identified

			and captured under the Operations directorate risk register and reviewed on a quarterly basis by the Trust's Emergency Preparedness, Resilience and Response (EPRR) team taking into account any new or emerging risks highlighted by the National, Local or Community Risk Registers. Risks will be captured where threat or hazards are identified which may affect the ability of the Trust to deliver its functions. Actions to mitigate the assessed risks where required are agreed at the meeting and form part of the Trust's EPRR work programme. Progress against the actions and the current level of risk posed is regularly monitored. A monthly report to the Trust's Operational Delivery Group details the current open EPPRR risks facing the Trust, allowing for review of any current issues being faced and monitoring of identified mitigations, as well as further areas of action required. The report also highlights any new or closed risks within the reporting period and supports with the escalation of any significant risks within the Trust. Quarterly risk management reports to Trust Board include the total number of EPRR risks as well as a breakdown of risk ratings. Should any EPRR risk be graded at a current rating of 15+ (significant risk) it would be escalated to the Executive Management Team for review and considered for inclusion in the organisations' Trust-wide risk register. Identified EPRR risks will also be considered for inclusion on the Trust's Board Assurance Framework if they present significant risk to the achievement of one of the organisations strategic goals.
Use of Force Policy	9/4/2024	Chief Operating Officer	Information has been included regarding: • Informal patients with capacity to leave • Being trauma informed

			• Use of restrictive interventions with older people
Job Evaluation Policy	25/3/2024	Associate Director of People and OD	A number of amendments have been made to this policy to add clarity regarding different roles and responsibilities and documents for submission or to reflect current practice. Relevant information about the job evaluation system has been added.
Supporting Transgender Patients and Service Users Policy	25/3/2024	Medical Director	The policy has undergone a moderate refresh to clarify some previous wording, modernise outdated terminology or strengthen/ enhance the content. Additional definitions have also been added. The policy underwent a rigorous co-production and consultation process with members of the LGBT+ community, partner organisations who support the LGBT+ community, clinical and corporate staff) and has subsequently been awarded the Co-production Logo stamp.

1.2 Around the Trust

1.2.1 Leadership Visibility

Granville Court

I have done many visits this month, but it was fabulous (as always) to visit and spend quality time with our staff and service users at Granville court. It was good to talk about the proposed refurbishment, which is well supported by staff, families and service users.

1.2.2 Social Workers

Social workers have a crucial part to play in improving mental health services and mental health outcomes for citizens. They bring a distinctive social and rights-based perspective to their work. Their advanced relationship-based skills, and their focus on personalisation and recovery, can support people to make positive, self-directed change. Social workers are trained to work in partnership with people using services, their families and carers, to optimise involvement and collaborative solutions. Social workers also manage some of the most challenging and complex risks for individuals and society, and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the Approved Mental Health Professional (AMHP).

It has been an honour to spend some time with our Social Workers since my last report. Their commitment, work and support to our service users is vital. Integrated care is essential in the service user recovery journey.

1.2.3 NHS England

I have spoken with Amanda Pritchard the Chief Executive of the NHS, who was interested in our thoughts on the current NHSE strategy and their future strategy, alongside the current demands and challenges. It was a useful conversation, but as always I have come away with some national work to pursue.

1.2.4 NHS Parliamentary Awards

We have secured 9 nominations put forward by MPs on our behalf in the NHS Parliamentary Awards. There are a couple of projects which have been picked up by more than one MP which is great. The shortlists will be announced on 10th June. Please see below:

Project	Service	Category	Owner	Shortlisted
Felix Manders-Wilde	Mental Health Crisis Intervention Team (MHCIT)	Excellence in Education and Training	Jodie Wake	Emma Hardy
Recovery pathway	STaRS	Excellence in Mental Health Award	Toyah Pardoe	Dame Diana Johnson
RCRP	Mental Health Unplanned	Excellence in Mental Health Award	Adrian Elsworth	Emma Hardy
RCRP	Mental Health Unplanned	Excellence in Mental Health Award	Adrian Elsworth	Graham Stuart
YOURHealth Coach Project	YOURHealth	Health Equalities	Ryan Nicholls	Rt Hon Greg Knight
YOURHealth Coach Project	YOURHealth	Health Equalities	Ryan Nicholls	Emma Hardy
Patrick Naughton-Doe	PMLD	Health Equalities	Sarah Clinch	Dame Diana Johnson
ED Pathway	Mental Health Unplanned	The Excellence in Urgent and Emergency Care Award	Adrian Elsworth	Dame Diana Johnson
ED Pathway	Mental Health Unplanned	The Excellence in Urgent and Emergency Care Award	Adrian Elsworth	Graham Stuart

1.2.5 Speech and Language Therapy (SALT)

I have spoken with the SALT team. Staff from the Speech and Language Therapy team within the Community Team for Learning Disabilities have been working with the Maritime Museum in Hull to make their exhibitions more user friendly for people with learning disabilities. They are also bought a time capsule which our teams have input into, a ceremony was held in which the Lord Mayor buried the time capsule.

1.2.6 Police and Crime Commissioners and Newly Elected Councillors following Elections in May 2023

Police and Crime Commissioners in our area:

- Humberside - Jonathan Evison – Conservative

Newly Elected Mayor:

- York and North Yorkshire Combined Authority, David Skaith – Labour and Co-operative

Newly Elected councillors:

Hull Wards

- Avenue, Karen Wood - Labour
- Beverley and Newland, Michael Ross – Liberal Democrat
- Boothferry, Alison Collinson – Liberal Democrat
- Bricknell, Peter North - Labour
- Derringham, George Grozav – Labour
- Drypool, Scott Preston – Liberal Democrat
- Holderness, Linda Tock – Liberal Democrat
- Ings, Alan Gardiner - Labour
- Kingswood, Ted Dolman – Liberal Democrat
- Longhill and Bilton Grange, Julia Conner – Liberal Democrat
- Marfleet, Sharon Belcher - Labour
- Newington and Gipsyville, Tracey Dearing – Labour
- North Carr, Paul Harper – Labour
- Orchard Park, Rosie Nicola – Labour
- St Andrews and Docklands, Daren Hale – Labour
- Southcoates, Hester Bridges – Labour
- Sutton, Jonathan Cahill – Liberal Democrat
- University, Mark Collinson – Liberal Democrat
- West Carr, Tracey Neal – Liberal Democrat

East Riding

- Minster and Woodmansey, Tony Henderson - Liberal Democrat
- Tranby, Ross Harrison - Liberal Democrat

2 Around the Integrated Care System

2.1.1 Hull and NLAG

The board asked colleagues and stakeholders to vote in a poll to decide on a name for the group of hospitals. Over 2,300 people voted and the preferred name, of which the hospitals group is now known as, is the NHS Humber Health Partnership, which will be launching a set of group values later this month, followed by a group strategy in July.

3 Director Updates

3.1 Chief Operating Officer Update

3.1.1 Leadership Visibility

The Chief Operating Officer and Director of Nursing are continuing to undertake a series of visits to in patient units, unannounced and out of hours. Visits have included Townend

Court, STAR's, Mill View Court, Fitzwilliam Ward at Malton Hospital and Whitby Hospital. Current operational challenges were discussed, areas of transformational change work were considered and any barriers to making progress were picked up and addressed. Overall staff were motivated and were committed to service improvement.

3.1.2 Operational, Service Planning, Industrial Action and Covid Update

This update provides an overview of the operational, service planning, industrial action and covid position across our clinical services and the arrangements and continuing work in place in the Trust and with partner organisations to manage these concurrent pressures.

The Trust has continued to be prepared for industrial action so that there is minimal disruption to patient care and service provision. The Emergency Preparedness Resilience and Response (EPRR) Team coordinate the completion of assessment checklists developed to support the trusts preparations for any action. This planning continues to consider the potential and planned strike action by other services and sectors. The Integrated Care System EPRR team is currently working with organisations to prepare for possible industrial action by GP's. Our emergency planning arrangements have and will continue to be stood up to coordinate and implement our plan to manage the impact of any further strike action. Silver command will continue to meet regularly during any action and report to gold command via sitrep reports. Our preparation work has so far been effective and fortunately we have seen no significant adverse impact on our services.

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 arrangement came into effect in December with the introduction of national, regional and system coordination centres in line with the OPEL Framework 2023/24. In preparation for this, coordinated work was undertaken by organisations to review the action cards associated with each level in the OPEL framework to ensure that the actions taken to prevent escalation were robust. Triggers are now in place that stand up daily executive director level response when necessary.

Our winter plan for 2023/24 has now been stood down and a full review of the Trusts and the systems winter plan for 2023/24 has commenced and will be complete at the end of Q1 which will then lead to the commencement of planning for winter 2024/25, this plan will be presented to the board in September 2024.

Operational service pressures have been stable in the Trust in April and early May. The highest pressures were seen in our community services in Scarborough and Ryedale due to continued high demand and the ongoing pressures seen by the acute hospital. Pressures have also been experienced in Primary Care due to the ongoing increased demand. The Trusts overall operational pressures in the last two months has remained reduced to (OPEL) 2 (moderate pressure). Localised pressures have also been experienced in our learning disability inpatient service at Townend Court due to staff absence and the complexity of patients, plans are in place to mitigate this, it is a short-term challenge and recruitment has been undertaken.

Child and Adolescent Mental Health (CAMHS) services are continuing to experience high demand, it remains at a plateau in April and May for core services but with ongoing increase in referrals for Neurodiversity services. Presenting needs continue to be of high levels of acuity and complexity. High demand for young people experiencing complex

eating disorders has plateaued and a new eating disorder community treatment service has been operationalised by the service to support this. Focus continues on reducing waiting times in these services, particularly in relation to autism and attention deficit hyperactivity disorder diagnosis. Occupancy and patient flow in our CAMHS inpatient beds continues to improve, whilst delayed transfers of care have reduced in the last two months.

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 overall daily bed occupancy has been between 75.2 – 86.0%. Work has been undertaken to reduce the use of older peoples functional out of area bed use with plans developed to expand the use of the Older Peoples Acute Community Service (intensive community support) and to consider the use of step up/step down community-based beds. A change to the configuration of the older people's beds at Maister Court and Millview Lodge has increased the availability of male beds. Out of area placements for our Psychiatric Intensive Care Unit (PICU) has risen during April and May, demand for these beds has been high and the unit has been 100% occupied. Patient need has also led to the requirement for female only environments and therefore this has impacted the need to use out of area beds for patient safety and quality of care reasons. Scheduled estate works are taking place currently to significantly improve the PICU seclusion suite which is also temporarily impacting on patient flow. Focussed work is taking place to address all aspects of adult acute care inpatient flow.

Delayed transfers of care (DTOC) 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. The escalation measures have however had a positive impact on achieving discharge for some of our longest delayed patients, however the number of patients delayed has increased in April.

System pressures have been overall slightly reduced in the Humber areas more recently for both health and social care., pressures have remained high in York and North Yorkshire. Whilst Acute hospital partners in all parts of our area have reported pressures at OPEL 4 for short periods during the last two months, periods of de-escalation to OPEL 3 (and occasionally OPEL 2) are occurring more frequently. Local authorities and the Ambulance services have also experienced some improvement for periods in pressures. The combined impact of these ongoing pressures has however seen system pressures remain at overall OPEL 3. 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 the recent industrial action.

Ongoing work has been taking place by our recruitment team to increase the number of staff available to us on our bank, recruitment campaigns focussed on specific clinical areas have had success and bank fill rates remain improved. Continuing effort is taking place to reduce the number of health care assistant (HCA) vacancies to decrease reliance on agency use and a rolling advert and recruitment process is in place. A detailed plan is in place to eliminate the use of all HCA agency staff by June and all off framework agency staff by July 2024.

The Trust has continued to see low numbers of cases of **Covid-19** positive inpatients, however there was a small number of cases during April and early May.

When combined with non-covid related sickness the overall staff absence position is currently at 6.42% and is slightly reduced from the position reported in March.

The Trust continues to effectively manage the impact of high system pressures and industrial action within its ongoing arrangements. Reducing delayed transfers of care/patients with no criteria to reside (NCTR) and further 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 are currently pursuing 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. The key programmes are set out below:

- Neurodiversity Service Recovery and Transformation
- Quality Transformation for Adult Learning Disability Services
- The development of a Children's and LD bespoke website
- The Transformation of Townend Court
- Implementation of the CLEAR project in CAMHS
- Primary Care Improvement Programme
- Phase 2 of the Virtual Ward project -Finalising Digital Technology solutions locally and at regional Digital Delivery Groups.
- Phase 2 of the One Community Transformation – Specialist Services
- Continuation of E-Rostering extension
- The roll out of SNoMED reporting
- Recruitment / Agency reduction spend
- Increased recording of Protected Characteristics
- Becoming a Trauma Informed Organisation
- Utilisation of Medic on Duty within Health Roster
- Electronic Job Planning for Allied Health Professionals
- Provision of Mental Health Services to HMP Full Sutton and Millsike
- Estates Building Plan -Ouse and Derwent Refurbishment
- Forensics Long Term Estates Plan
- Review and updating of ICB service specifications in Mental Health and Children's Divisions
- The continuation of the Older Peoples Mental Health community and inpatient transformation
- Adult Mental Health out of area bed use reduction and acute care pathway improvement.
- Adult mental health crisis and home based treatment improvement and CLEAR programme.

3.1.3 Children and Young People's Eating Disorder Intensive Treatment Team (EDITT)

New funding was received in June 2023 from NHS England to expand eating disorder services to support children and young people. This funding was made available in response to the significant national rise in demand of children presenting with complex eating disorders following the pandemic. The new Trust service became operational in December 2023 and aims to avoid CAMHS inpatient admissions and where avoidance cannot be achieved, reduce the length of stay in a CAMHS inpatient bed. It does this by increasing the options for young people and their families/ carers by offering a more intensive community/ home based service for those who require this as well as aligning closely with Inspire for those who require short term admission or supported step down from CAMHS inpatient services. This service aspires to offer a bespoke package of care with differing levels of support being available based on individual clinical need. The key aims are summarised below:

- To work in partnership with CAMHS in-patient and the acute hospital teams to help facilitate and support home leave and safe, early discharge in Hull, East Yorkshire North East Lincolnshire and North Lincolnshire.
- To provide intensive home-based meal support to young people and their families who are at risk of requiring an inpatient admission or are at risk of physical deterioration, which may require an acute admission because of their eating disorder.
- To empower parents and carers to manage their child's eating disorder and learn new skills to support them.
- To support young people and families to remain in their community, stabilise and improve physical health and restore more normal eating patterns.
- To avoid or reduce the need for Nasogastric (NG) feeding, restrictive practice and/ or admission to CAMHS inpatient services where possible.

Early feedback from the families and patients who have used the service is positive. The team are collating a range of outcome data which will demonstrate the number of hospital admissions avoided and clinical recovery outcomes of an intensive home treatment model when compared with a traditional inpatient stay.

3.2 Director of Nursing, Allied Health and Social Care Professionals

3.2.1 Leadership Visibility

Over the last couple of months, the Director of Nursing, Allied Health & Social Care Professionals has visited Granville Court where all staff spoke very proudly of their work and how much they loved working there. Staff were excited about the planned works to modernise the build and showed us information for residents and their families about the changes which was easy to read and appropriate. Positive interaction between the staff and the residents was observed.

A visit has also been made to Townend Court to meet the clinical team to discuss some of the current pressures on the unit due to vacancies and further work in place to ensure high quality care and support for staff remains a key focus.

The Director of Nursing and the Chief Operating Officer continue with their unannounced and out of hours site visits, visiting Townend Court, STARS, and Inspire in recent weeks. Staff are welcoming and keen to talk about their work environments.

3.2.2 Fuller Enquiry

Over the course of 15 years, Fuller committed sexual offences against at least 100 deceased women and girls in the mortuaries of the Kent and Sussex Hospital and the Tunbridge Wells Hospital. His victims ranged in age from nine to 100.

In February 2021, the Board of Maidstone and Tunbridge Wells NHS Trust commissioned an internal investigation, independently chaired by Sir Jonathan Michael, to consider how the mortuary offences committed by David Fuller, an electrical maintenance supervisor, could take place without detection, what lessons the Trust could learn, and to address the most likely questions of the victims' families and key stakeholders.

The Inquiry held interviews with over 200 witnesses and reviewed more than 3,700 documents. Based on the evidence heard and reviewed by the Inquiry team, the report makes 17 recommendations with the aim of preventing any similar atrocities happening again in the Trust.

In light of the offences carried out by Fuller and the recent media coverage regarding Legacy Funeral Directors in Hull we are revisiting our care of the deceased guidance for staff to ensure all safeguards are in place when passing the care of the deceased from our care to a funeral director to ensure all safeguards are in place. Our Professional Lead for Palliative Care and End of Life is leading this work.

3.2.3 Culture of Care Standards for Mental Health Inpatient Services Including those for People with a Learning Disability and Autistic People.

The culture of care standards for mental health inpatient care were released in April 2024. The guidance aims to support all providers to realise the culture of care within inpatient settings everyone wants to experience including people who need this care and their families, and the staff who provide this care. The standards have been co-produced and apply to all NHS-funded mental health inpatient service types, including those for people with a learning disability and autistic people, as well as specialised mental health inpatient services such as mother and baby units, secure services, and children and young people's mental health inpatient services.

The vision for inpatient care:

'The purpose of inpatient care is for people to be consistently able to access a choice of therapeutic support, and to be and feel safe. Inpatient care must be trauma informed, autism informed and culturally competent`.

To support the vision there are 12 overarching core commitments, each of which has a set of associated standards. Work to improve the culture of care on inpatient wards, creating the conditions where patients and staff can flourish should focus on these core commitments.

1. Lived experience: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight
2. Safety: People on our wards feel safe and cared for
3. Relationships: High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe
4. Staff support: We support all staff so that they can be present alongside people in their distress.
5. Equality: We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes

6. Avoiding harm: We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs
7. Needs led: We respect people's own understanding of their distress
8. Choice: Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care
9. Environment: Our inpatient spaces reflect the value we place on our people
10. Things to do on the ward: We have a wide range of patient requested activities every day
11. Therapeutic support: We offer people a range of therapy and support that gives them hope things can get better
12. Transparency: We have open and honest conversations with patients and each other, and name the difficult things

Humber Teaching NHS Trust has been successful in a bid to receive support to roll out this work across 4 of our inpatient units, (Westlands, Avondale, Townend Court and Swale Ward). As part of this we have received funding to support roll out and support from the Royal College of Psychiatrists. Work is in its early stages. The Executive Lead for the programme for the Trust is Hilary Gledhill, Director of Nursing, AHP and Social Care Professionals and senior management lead is Paul Johnson, Clinical Director.

EMT have agreed this important work will form one of our quality priorities in our Quality Accounts for 2024/25 with progress updates provided to EMT and the Quality Committee.

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

3.3.1 Leadership Visibility

Since April and May the Associate Director of People and OD has visited and observed clinical training and leadership development programmes to engage with staff and better understand experience and quality of training.

3.3.2 Baby Loss National Webinar

In March 2024 NHS England launched a National Baby Loss Policy Framework. This framework provides support to individuals who suffer from pregnancy or baby loss in the first 24 weeks by providing them with 10 days paid leave. The framework also offers the partner of someone who has suffered pregnancy or baby loss five days paid leave. An individual who suffers pregnancy or baby loss after 24 weeks will be entitled to full maternity leave and pay.

Within our Trust Leave Policy and Your Leave Plus programme of work, that was launched in 2023 we have already adopted these changes. As a Trust we provide paid leave for individuals who experience pregnancy or baby loss and premature birth which mirrors the newly launched National framework.

Our Associate Director of People and OD was a panel member for a national webinar with Tommy's on 'How to Implement a Pregnancy Loss Policy in your NHS Trust' and was able to share the sector leading work the Trust launched last year. Through our partnership with Tommy's, we have access to their Pregnancy and Parenting at Work Portal. This Portal provides a large breadth of training, which all Humber NHS staff can access, to help improve support for employees through all different pregnancy journeys: 'Fertility in the

Workplace' 'Supporting an Employee Through Pregnancy and Baby Loss or Premature Birth at Work' 'Pregnancy and Parenting at Work'

3.3.3 Respect Campaign Update

Our staff survey data tells us that staff from ethnically diverse backgrounds, and staff with a disability or long-term condition, have a worse experience working for the Trust than those from white or non-disabled backgrounds.

The above findings are supported by anecdotal feedback on workplace experience from our staff networks (including our LGBTQ+ staff network), and whilst the Trust positions well against national figures and shows improvement year on year, there is an acknowledgement that more can be done as part of our journey to widen participation, create a compassionate and inclusive culture and ensure a positive and safe workplace culture.

The Trust has put in place many initiatives to reinforce that discriminatory behaviour is not acceptable and to support staff to speak up, including;

- Freedom to Speak Up Guardians in place.
- Reviewed and updated the grievance, bullying and harassment and disciplinary policy and procedure.
- The Trust behavioural standards were recently updated with the equality and diversity elements strengthened.
- Three staff networks in place, all with an EMT Sponsor.
- Bullying and harassment awareness training added to the core training offer, delivered internally by the Trust's leadership and management trainer.
- Requirement for all involved in recruiting staff to have participated in recruitment and selection training, which specifically addresses unconscious bias and discrimination.

Whether from patients, service users, managers or colleagues, bullying, harassment and/ or discrimination is not acceptable.

Since the launch of the Respect campaign, we have seen an expected increase in referrals for bullying, harassment and discrimination. This gives colleagues in the People and OD team and those across the organisation the opportunity to address these concerns in a fair and consistent manner.

3.3.4 Recruitment Statistics

Our recruitment team received some great figures from their TRAC benchmarking data which covered the period of 1st October 2023 – 31st December 2023:

Employment check Total Lapse Time (speed) which took 19 days on average and **ranked top 15 out of 190 trusts** which is 3 days quicker than the last quarter.

Conditional to starting letter sent (speed) took 30 days on average and **ranked 69 out of 190 trusts** which is 3.9 days quicker than last quarter.

The 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.

3.3.5 Leadership Competency Framework/ Fit and Proper Persons Test/ EDI Improvement Plan

The mid to latter part of 2023 saw NHS England publish a number of key frameworks, shaped by the Messenger Review – 'Leadership for a collaborative and inclusive future' (July 2022) and the 2019 Tom Kark KC review of the fit and proper person test.

These frameworks, namely the EDI Improvement Plan (published in June 2023), the refreshed Fit and Proper Persons Test (FPPT) framework (published in September 2023) and the aligned Leadership Competency Framework (LCF) (published in March 2024), set out collective responsibilities for Boards that;

1. Assesses core elements of competence, which all directors should be able to meet in order to perform at their best (LCF, March 24).
2. Sets out new checks and balances required by NHS organisations to ensure board members are fit and proper to be NHS directors (FPPT, September 23).
3. Sets out targeted actions for Boards to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce (EDI Improvement Plan, June 2023).

The Board has been regularly informed and assured of the Trust's progress against specific actions and has given consideration to specific recommendations and shaped the preferred course of action in order to meet the expectations of each framework.

3.3.6 Statutory and Mandatory Training Review

The Trust continues to maintain high levels of compliance with statutory and mandatory training. EMT and the Workforce & OD Committee recently reviewed a deep dive into statutory and mandatory training to ensure sufficient plans are in place to maintain this position and address any areas of concerns.

Overall statutory/mandatory training compliance is 94.96% as at January 2024, against an 85% Trust target.

Statutory/Mandatory training compliance has risen by 1.77% compared to January 2023.

3.3.7 Annual Leave in Electronic Service Record (ESR)

Annual leave is now live in ESR from 1st April 2024. For all staff and managers, including those who use Health Roster, ESR will now calculate individuals' entitlements, including bank holidays and other additional days.

For managers and colleagues not using a live roster, this will also provide an online booking and approval system through the ESR Portal, replacing the various calculation trackers and spreadsheets in use previously.

3.4 Medical Director Updates

3.4.1 Leadership Viability

Executor Director/ Non-Executor Director visits unannounced visits			
Dates	**Unit/ward**	**Board Members**	**Remarks**
4 April 2024	**PICU, Mirada House**	**David Smith & Kwame Fofie**	Positive visit. Upbeat and engaged team. Learned more about interplay of MH

			and MoJ. Assurance gained.
24 April 2024	**Humber Centre**	**Dr Phillip Earnshaw & Kwame Fofie**	We visited Ouse ward which is in line for refurbishment. We interacted with 4 male patients who were overall happy with things. Overall thankful to senior member of staff who made time to show us around.
16 May 2024	**Maister Lodge and Court**	**Dr Phillip Earnshaw & Kwame Fofie**	We had the opportunity to speak and go round the ward with the medics and ward manager. We were impressed by the passion of the team and the quality of patient care.

3.4.2 Pharmacy

Non-Medical Prescribing Awareness Week

Non-Medical Prescribing Awareness Week took place on 15-19 April 2024, with several online sessions covering the following themes:

- Pre-application presentation for staff considering the next step, i.e. to apply for the V300 prescribing course.
- Introduction to the NMP Awareness week
- Giving recognition NMPs in the Trust and the hard work they do to achieve the qualification and to continue expanding their scope of prescribing.
- The new Annual NMP Declaration Form for the Trust – understanding the importance of recording qualification and ensuring that all NMP are working to Trust policies and are covered vicariously.
- The launch of our new Non-Medical Prescribers (NMP) Intranet page. This provides up-to-date information and links to all aspects of V300 prescribing – from education to becoming an Assessor. Participants were asked to give feedback so that the website can always be kept relevant and useful for all prescribers.
- The NMP policy and the importance of having a policy for prescribers to protect them and to assure the Trust. Giving clear indications of responsibility and accountability in the Trust.
- DPPs (Designated Prescribing Practitioners) and Supervisors. Without having experienced assessors and supervisors, we cannot train new NMPs. Looking at the process and future plans to increase support for this group of prescribers.

The sessions had generated a lot of insightful discussions and interest around different elements of prescribing. The plan is to organise an NMP Awareness Week every year. This may be further developed into a full NMP conference in the future.

3.4.3 Medical Education

- HYMS Annual Monitoring Visit took place on Tuesday 30th April 2024. Feedback

was excellent, no concerns raised, and they were satisfied with the governance arrangements. HYMS recognised all of the positive work and innovations from Humber including the four HYMS Excellence Awards nominations:

  - Dr Sathya Vishwanath, HYMS Team Lead
  - Dr Renato Merolli, Associate Director of Clinical Studies
  - Sarah Chew, Medical Education Undergraduate Nurse Lead
  - Jane Lloyd, Undergraduate Programme Lead

- Career discussions being held by the Executive Medical Director, Higher Training Tutor, and Head of Medical Education & Medical Directorate Business, with 6 Higher Trainees on 10th May 2024. This prospective consultant recruitment exercise should prove beneficial in filling some consultant vacancies in 2024/25.
- Junior Doctor led event held on the 17th April 2024, well planned and delivered by trainees.
- New trainee induction held.

Medical Appraisal & Revalidation

- Appraisal training session held 19th April 2024 for new Trust doctors – well received.
- Responsible Officer (RO) Decision Making Panel held 15th April 2024, revalidation of 2 consultants agreed.

3.4.4 Quality Improvement

- The QI Annual Report is due to go to QPAS in June 2024.
- QI Week is 17-21 June and planning for this is underway.

3.4.5 Veterans Service

OpCourage – Who are we?

- Mental health support for veterans A specialist service for ex-armed forces; veterans; families/carers and service personnel who are approaching discharge, to support and recognise the early signs of mental health problems.
- If you are experiencing mental health difficulties related to your time in, and transition from the military, these services can provide a range of treatments and support regardless of when you left the armed forces. This includes recognising the early signs of mental health issues and providing access to early treatment and support, as well as treatment for complex mental health difficulties and psychological trauma. OpCourage North is not a crisis service however we do work with local services to support people during periods of crisis. Patients can also be helped with employment, finance, reduction in substance misuse or other addictive behaviours, housing, and social support.

What do we offer?

- A range of specialist support and treatment for members of the armed forces community, which includes:

- Helping to recognise and treat early signs of mental health problems, as well as more advanced mental health conditions and psychological trauma.
- Providing support and treatment for co-occurring mental health and substance use
- Liaising with charities and local organisations to support wider health and wellbeing, such as help with housing, relationships, finances and employment.
- Referring to other NHS services where needed
- Recognising that family may also need help and care and supporting them to access this.

Who are we for?

To access our service you must –

- Be resident in England.
- Have served in the UK armed forces for a full day (or be a family member/carer who is experiencing difficulties relating to time and experiences of Military service)
- Be registered with a GP practice in England or be willing to register with a GP – We will support people to access this where needed.
- Be able to provide your military service number or another form of acceptable proof of eligibility.

For armed forces personnel approaching discharge.

Armed forces personnel approaching discharge can now get treatment and support at NHS veterans' mental health services across England and thereafter into their civilian life, whether this is months or years later.

If you are experiencing mental health issues, these services can provide a range of treatment and support in close liaison with Defence Medical Services (DMS). This includes recognising the early signs of mental health issues and providing access to early treatment and support, as well as treatment for complex mental health difficulties and psychological trauma.

Patients can also be helped with employment, finance, reduction in substance misuse or other addictive behaviours, housing, and social support.

To access these services whilst you are still in the armed forces, you must meet the following criteria:

- be a resident in England

- have an identified or diagnosed mental health illness / disorder

- have a discharge date from the Ministry of Defence (MOD) or be found to be unfit for continued military service by their medical board

- have been identified by the Departments of Community Mental Health as requiring follow on psychiatric care on discharge from the MOD

- have had their pre-release medical and been identified by their DMS GP as requiring mental health transition support

- have had a pre-release medical before they self-refer

Once we receive your referral, you will be offered an initial assessment within two weeks and where appropriate a first clinical appointment two weeks thereafter.

How to get in touch –

- Tel: 0300 373 33 32
- Email: opcourageNORTH@cntw.nhs.uk

Further information –

- Website - Op Courage: Veterans Mental Health and Wellbeing service - CNTW083 - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Patient information leaflet - Op-Courage-North-Infomation-for-patients-Dec-2023-V3.pdf (cntw.nhs.uk)
- Information for referrers - OpCourage-Information-for-referrers-A4-July-2023.pdf (cntw.nhs.uk)

3.5 Director of Finance Updates

3.5.1 Leadership Visibility

Since April the Director of Finance has visited Mill View with governors and Pine View to observe the current capital works taking place at the unit.

3.5.2 Cyber Security Updates

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 2024: 54 (*Incl 11 in April*)
- High Priority CareCERT notices Issued during 2024: 6 (*Incl 2 in April*)

There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during March or April 2024.

3.5.3 Digital Updates

Data Lake

The new data lake is now commissioned in the cloud and being configured to support the reporting for the new Electronic Patient Record.
Staff will continue to use Power BI as the main reporting viewer, which will start to be based on data from the new data lake.

The IT team have been working on a replacement to the current VPN solution, to both make it easier for staff to use and meet new NHS Cyber Security requirements.
The replacement VPN system, called Always On, will automatically connect your laptop to the VPN whenever it has an internet connection using certificates so there will no longer be a need to click and run the "Humber VPN" and enter your username and password. T
The new VPN is currently being tested by members of the IT Team and will be rolled out to several early adopters. Testing will continue until the end of May and subject to their being no issues, will start to roll out in early June to the rest of the trust to meet the end of June deadline.

Interweave

Interweave have completed the real time record creation using large language models and cognitive Artificial Intelligence with Google and Deloitte. The initial finding is positive, but further development to progress to the next stage capability.

EPR Future State Workshops

13 Future state process workshops have taken place with operational team to validate the new ways of work based upon the Electronic Patient Record

3.5.4 Estates and Hotel Services Updates

Hotel Services

- Trial of the new Electronic menu ordering system is due to commence in the Humber Centre. This will assist with the Trust's compliance with the new healthcare food and drink standards.
- A new Dietican is due to join the team in June (International recruite from USA)
- PLACE lite reviews have been completed with notable improvements in the scores at Granville Court, the results will be presented to the Trusts Health and Safety Group
- A New range of cleaning products are being introduced which will reduce the Trusts Carbon Footprint.

Estates

- Electric vehicle fleet delivery is imminent, on arrival this will need to be livered up, vehicle and tool trackers fitted. We are also including advertising for 'Working at Humber' as per requests from comms, projects and recruitment. EV chargers at Willerby Hill for the new EV fleet will go live from 7 June.
- The roll out of water circulating temperature monitoring tags is progressing with installation complete at Sunshine House, Inspire and ERCH, with a further programme across inpatient sites in the first instance. Early results are proving really positive, results will provide live and ongoing detailed insight, to assist with ongoing water compliance assurance.
- External Lighting is being added to Building Management Systems to improve functionality and allow for control to be undertaken remotely.
- Addressable LED emergency lighting has been installed in Mary Seacole and College House and also forms part of the Pineview and Humber Centre projects.

- Trust HQ Demolition is progressing and will complete later in the calendar year – works on site have been paused due to nesting birds of prey in the building.
- The refurbishment works at Pineview are due to complete at the end of May 2024, an application to alter the reception area and form a new self service staff area has been supported by the Estates Strategy and Capital Delivery Group.

3.5.5 Health Inequalities Delivery Plan Update

In April 2024, the Health Inequalities Operational Group agreed a delivery plan for the coming year covering:

- Communications and Knowledge Transfer – building on the successful launch of the health inequalities intranet pages by delivering a programme of webinars and communications to increase staff awareness of health inequalities.
- Data analysis – working with clinical and operational teams to develop action plans in response to data published in the annual report on health inequalities in access to mental health services, use of the Mental Health Act and restrictive interventions. Development of a self-service health inequalities dashboard for use by teams across the Trust.
- Supporting teams to address health inequalities - running reflective workshops to help teams identify potential inequalities of access, outcomes and experience within their services.
- Integrating health inequalities into Trust strategies and policies – ensuring that the Trust's new Access Policy and associated SOPs take health inequalities into account. Exploring options for expanding the Trust's Equality Impact Assessment to incorporate wider inequalities such as poverty, inclusion health groups and digital exclusion. Supporting the implementation of health inequalities related aspects of the Physical Health Strategy. Maintaining alignment with the Recovery Strategy and Trauma Informed Care programme.
- Ensuring that approaches to health inequalities are embedded in clinical practice – incorporating health inequalities into the implementation of Person Centred Planning and the Culture of Care standards for mental health inpatient services. Incorporating content on health inequalities in revised service specifications for CAMHS, Children's Therapies and Adult and Older Adult mental health.
- Workplace culture and training – promoting uptake of health inequalities training on ESR. Incorporating health inequalities content into Trust leadership training.
- System working to address the wider determinants of health – reviewing the impact of housing issues on service users, patients and Trust services. Mapping Trust involvement in health inequalities related system initiatives.

4 Communications Update

Quarterly Communications Update

- **Service Support**

Division	**Campaigns/Projects this month**
Mental Health (Planned/Unplanned)	• CLEAR project (CAMHS) • PRW Rebrand • Person Centred Care Planning
Community & Primary Care	• GP practice website

	redevelopment • Call handling - bringing the out of hours service in-house • Primary Care Addition Service x 2new services
Children's and Learning Disabilities	• Divisional website development • Granville Court Build Programme • MHST conference • I-Thrive conference
Forensic	• New AHP role recruitment

- **Granville Court - Build Programme**

We are working with estates and the service to provide communication for staff and families ahead of the redevelopment programme.

Dedicated internal and external website pages include frequently asked questions and video content to ensure that there is a single source of up-to-date information for both audiences. The intranet page for staff has had 433 visits since launch demonstrating It is being well used by this audience.

- **General Practice Website Developments**

Following patient engagement, new homepages are live for all practices. The work has been awarded the co-production stamp demonstrating our inclusion of patient voice in the project. Over 80 patients were involved in the redesign.

We will continually review site analytics to ensure the homepages deliver on their goal of making the website easier to navigate, with patients being able to get to the information they need quick and efficiently.

- **I-Thrive Conference**

Our dedicated communications lead for Mental Health Schools Teams managed the communications and supported the planning of the i-Thrive Together Conference on 23rd April. It engaging over 150 education staff at a key time as our MHSTs prepare to move into wave 11 of the Mental Health Support Team roll out.

Theme 1: Promoting people, communities, and social values

- **Social values report**

We have produced this year's report in line with the Annual Report to demonstrate our commitment to social values. It will be launched at a Summer Showcase, a marketplace event on the 4th July. People whose stories we have shared will be invited to attend the event.

The 2022/23 Social Values report was launched in January. It was promoted on our website, stakeholder newsletter, via stakeholder internal communications and partner external newsletters. The report has been viewed online over 200 times since launch.

- **Brand Updates**

The brand platform continues to support a well communicated visual identity, performing well and above target of growing visits by 20%. We held a Brand Workshop and a 'Catch Up with Comms' session over the period reaching over 50 staff, driving traffic to the site.

Recent updates include new Trust photography (Health Visitors), additional guidance on the Accessible Information Standard, and access to a bank of mental health stock photography courtesy of the Mental Health Trust.

Social media

- **National Campaigns**

Our social media channels continue to be used to support national and system messages. While this content does not see the levels of engagement that stories about our members of staff does it provides a key public health function.

Across the period over 50 posts have been shared to support national messaging on:

- Rebrand to NHS Talking Therapies
- Using the NHS App as a point of contact over Easter
- The launch of the 111 mental health option across the UK

- **Staff Stories**

The best-performing content across our channels continues to be surrounding our Humbelievable Teams. Featured stories on our 0-19 Service taking part in a Royal Foundation for Early Childhood, enjoying an engagement rate of over 10% - 10x the industry 'good' standard.

Also included was the news of the Trust's best-ever Staff Survey results, which achieved a 5% engagement rate (higher than average) and carried a recruitment sub-message.

Media coverage

- **Pre-Election Period**

NHS England imposed restrictions on proactive media due to the Local Elections on 2 May 24 were in place over the reported period, impacting the number of positive stories landed over the period.

March - April	April - May
• 15 stories covered in press – 11 Positive and 4 Neutral • 2 negative	• 4 stories covered in press – 4 Positive and 0 Neutral • 0 negative

Top Three	Top Story
1. Royal Foundation for Centre of Early Childhood (Telegraph, Sky News, Nursing Times) 2. YourLeave Plus – miscarriage leave (BBC online, Nursing Times, Hull Daily Mail) 3. Whitby GP Out of Hours changes (BBC online, Scarborough News, Whitby Gazette)	1. Maternal Mental Health Week – Toria's Story (Hull Daily Mail)

Service Change Document – New Process

Following a negative media coverage of the change of out of hours provision in Whitby we have tightened the process for notifying the team about planned service change.

By engaging directly with services early in the process will ensure proactive and well managed communications are in place. This has been shared with PMO and through divisional ODG's.

Alarm Baby Distress Scale & Royal Foundation Centre for Early Childhood

The highlight of media coverage over the period was the Royal Foundation Centre for Early Childhood (RFCEC) meeting with our Health Visitors following the release of the results of the trial they were involved in on the Alarm Baby Distress Scale (ADBB). The RFCEC were extremely positive about the media coverage that the visit received engagement included;

- Instagram reel, featuring Rachael Ramage, one of our Health Visitors, received more than 2.5k 'likes'
- RFCED video viewed 20,000 times online.
- The 'X' (formerly Twitter) post seen 138,000 times and retweeted 286,000 times, including by the Prince and Princess of Wales' account which have more than 15million followers.

The media attending on the day was Sky News and Telegraph and coverage included;

- Sky News – televised video interview and report. Also online in news pages.
- The Telegraph – featured online in news and also in print with the story noted on the front page of the hard copy newspaper.
- Nursing Times
- Children & Young People Now

- **Events**

Anita Green, Events & Communications Officer has been appointed to the Charity

Manager role. We have successfully recruited to her role with a start date to be agreed in July.

Events supported over the period include;

- Mental Health Small Grants Celebration Event
- Unintentional Injuries and Safer Sleep Conference
- PACE and QI Celebration Event

Upcoming events:

- CEO Challenge – 4th July
- Summer Showcase – 4th July
- Staff Summer Fun Day – August (TBC)

100k Your Way

The 100k Your Way, our online staff walking challenge, has proved to a success again this year with over 500 staff registered, 97 individuals and 85 in teams. So far we have walked over 41,000KM and are on track to beat last year's total.

The updated website includes several new features included showing the percentage of distance walked by each team and the ability to add photographs.

Staff taking place are also fundraising for Health Stars for the first time this year, raising £540 to date.

- **Awareness Days**

We work with services to support an agreed calendar of awareness days.

March	April	May
11-17 Safer Sleep week 18-24 Neurodiversity Celebration Week 18-22 Social Work Week 25 Holi 31 Transgender day of visibility 31 Easter Sunday	Stress Awareness Month 10 Ramadan 18 Administrative Professionals Day 22 Stephen Lawrence Day 22-26 World Immunisation Week 29-4 Maternal Mental Health Week 29-3 Experience of Care Week	100k You Way National Walking Month 5 World Hand Hygiene Day 12 International Nurses Day

- Over 100 people attended, watched live or have watched through the intranet the Easter Service
- A joint letter from Michele Moran and Hilary Gledhill was send on Internal Nurses Day to thank all our Nurses, they also received pin badges and a wellness calendar

which have been well received from our nursing staff. 248 colleagues downloaded the 'Kindness Calendar'.
- 87 colleagues took part in staff sessions during Stress Awareness Month with a focus on practicing mindfulness and getting a good night's sleep.
- For Maternal Mental Health week We had 113 engagements on our social media posts with this story "This team saved my life and my relationship with my baby and I'll be eternally grateful." (humber.nhs.uk) gaining 52 of those interactions which has proven to be one of our most successful awareness days posts we've had.

Theme 2: Enhancing prevention, wellbeing and recovery

- **Stakeholder Newsletter (Humber Happenings)**

The Humber Happenings stakeholder newsletter continues to be successful with over 2200 subscribers.

The newsletter has exceeded the target set of increasing sign ups by 30% p/a. Total subscribers on have increased by 67% with a 32.87% open rate.

Sharing the newsletter on LinkedIn also continues to see great engagement, maintaining over 1200 monthly article views.

- **Electronic Patient Record Project**

The EPR benefits campaign launched on 29 April. This was launched through a one-off email to all staff, and visuals such as a unique desktop background and launch page on the homepage of the intranet. This campaign will be spread over a long period of time, as further benefits work will be developed over the coming months.

The next phase of the campaign centred around EPR champions and divisional contacts will launch by the end of May.

Theme 3: Developing an effective and empowered workforce

- **Humbelievable**

The 23/24 campaign concluded in April, having driven over 35,000 visits to the Join Humber website – the best-performing year ever for the campaign.

The Humbelievable workplan for 24/25 has been signed off by the Recruitment Task and finish group, with work starting immediately. This includes plans to exploit search traffic in both September and March – a key learning from the 23/24 New Year, New Job campaign – alongside New Year, New Job. Output for the year has been restructured around these key timings and messages so that no output sits in isolation and can be supported by a larger campaign across the three key periods of activity.

The Humber Jobs email bulletin now has 700 subscribers following a dedicated digital marketing campaign.

- **People Strategy**

Our new People Strategy document was successfully launched to colleagues in March. The policy has been downloaded over 350 times from the intranet, with the supporting video, that showed colleagues discussing what it is like working at our Trust being viewed over 250 times.

- **Palliative and End of Life Care**

We worked with Professional Lead for Palliative & End of Life Care, to create new online resource centre for colleagues caring for people at the end of life launched as part of Dying Matters Awareness Week.

It includes information about training opportunities, quick access to commonly used forms and documents and key contact information.

- **Intranet Staff Engagement Project**

Specialist internal communications research organisation, H&H have recently completed several drop-in sessions for staff across our divisions and large area of our Trust geography. Sessions have been held at Mill View Court, Trust HQ, The Humber Centre, both of our Humber Primary Care GP sites in Bridlington and Whitby hospital.

H&H are currently compiling this information before moving onto the next stage of the project which will include small focus groups to give more detailed feedback on the first stage findings. The research outcome report will be shared with EMT to guide future development plans for this key communications platform.

Theme 5: Innovating for quality and patient safety

NHS Communicate Awards – Highly Commended
We were delighted to be highly commended in the Health & Wellbeing campaign category for last year's 28 Days of Wellbeing and 100K Your Way programmes. The awards celebrates the best of NHS Communications across the country.

HSJ Digital Awards – Two shortlisted
We are celebrating nominations for;

- Optimising Clinical Pathways through Digital, Hybrid Neurodiversity Assessments

- Digital Clinical Safety Award, Yorkshire & Humber Shared Care Record

NHS Parliamentary Awards
We celebrated having eight submissions picked up by at least one MP, the most we have ever submitted. Shortlists are announced on 10 June 2024. The projects and individuals highlighted in the submissions are:

- Recovery pathway
- Specialist Perinatal
- Right Care Right Person
- YOURHealth Coach Project
- Patrick Naughton-Doe - Patrick is a Profound and Multiple Learning Disability doctor and was put forward by Tess Owens (Partnerships & Strategy Officer) for his lead in the advocacy, design, and development of a specialist doctor service for patients with PMLD.
- Felix Manders-Wilde - Felix is a Specialist Nurse who was put forward for the award by Jodie Wake (Registered Nurse Apprentice) for his support and mentorship throughout her journey from HCA to a Registered Nurse Associate, as well her Trainee Nursing Associate Course.
- Phlebotomy Clinic
- ED Pathway

Theme 6: Optimising an efficient and sustainable organisation

- **Interweave**

We supported the Yorkshire and Humber Care Record with their Shared Care Record Summit in Birmingham,16-17 April. In addition to assisting with the organisation and preparation of the event, Loren attended in person to visible coverage on our social media and other external channels.

The Summit was attended by 300 people, 413 people joined via our YouTube live steam and social media engagement over this period of time was high with an engagement rate of 6.46%, over 7,350 impressions and reaching over 9,400 people.

- **InPhase**

InPhase went live on 1 April 2024. The communications plan and internal campaign outlined important information and updates to staff who previously used Upstream. This cohort have now moved to the new system, which will support them with things like clinical audits. Training has been provided using videos and post go-live communications support will continue to be provided as required.

In addition to this, we continue to support the team with the development of an Interweave Communications Strategy, which will help guide our goals set in the Communications plan for 2024-25 which was launched within the last month.

- **Bridgit Care**

We are supporting the Trust's strategy and partnerships and digital teams with devising a business case for the continued use of Bridgit Care within the Trust. This is a service that supports our patients who are carers, bridging the gap between health and social care organisations, such as us, and various voluntary and community sector carer organisations locally.

Measures of Success

Theme 1: Promoting people, communities, and social values			
KPI	**Measure of success by 2025**	**Benchmark**	**This period**
Positive Media Stories published	Positive vs negative coverage maintained at 5:1	5 stories covered by media per month	13 positive stories covered by media 1 negative stories covered by media
Visits to Brand Portal	Up 20% to 696 sessions	415	1358

Facebook engagement rate	2%	2.69%	4.94%
Twitter engagement rate	2%	4%	4.15%
LinkedIn follower growth	+ 4.3%	Target 2872 followers	314 new followers – 4,915 total

Theme 2: Enhancing prevention, wellbeing and recovery			
KPI	**Measure of success by 2025**	**Benchmark**	**This month**
Stakeholder newsletter open rate	20%	35.71%	32.87%
Increase subscribers	Increase by 30% p/a	88	197 – 67% increase

Theme 3: Developing an effective and empowered workforce			
KPI	**Measure of success by 2025**	**Benchmark**	**This month**
Intranet bounce rate reduced	< 50%	57.36%	56.5%
Intranet sessions maintain at current level	77,101 sessions p/m	77,101	96,659
Global click through rate (CTR) increase	7%	10.2%	8.5%
Staff engagement event programme	Engage 10% of staff in each event (2023/24) 20% (24/25)	First staff engagement event attracted 10% of staff (360)	506 (14%)

Theme 5: Innovating for quality and patient safety		
KPI	**Measure of success**	**Progress to date**
Awards nominations	4 national/2 local shortlists	Awaiting results on shortlistings

	annually	

Theme 6: Optimising an efficient and sustainable organisation			
KPI	**Measure of success by 2025**	**Benchmark**	**This month**
Reduce homepage bounce rate	Below 50%	66.45%	66.4%
Increase average page visits/views per session	+ 2 per visitor	1.94	1.3
Increase average session duration	+ one minute	1m 32s	1m 36s

5 Health Stars Update

Legacy Wishes

At the point of transfer from Smile Foundation back into the Trust there were 37 live wishes, all legacy wishes have now been either fulfilled or closed.

Three live wishes are currently being developed into more significant 'dreams' schemes, details of which are below

Dream	Name/ Description	Funding requirements	Contact	Next steps
New waiting area at Inspire	'Worth the Wait' Help us create a new reception and waiting area for children and young people accessing mental health and NHS therapies.	Project Target - £30,000 Funds available £15,000 CAMHS3 £2000 grant funding (Finn FP Charitable Trust)	Bethia Dennis Karen Warwick	Estates are progressing to get final costs to confirm full appeal details.
Sensory Room – ERCH	'Make Sense' Creating a new sensory room to provide a safe and supportive space for neurodivergent children at East Riding Community Hospital	£19,077.60 Funding is available – ERCH 1/ERCH 2	Michelle Field Sally Ward	Estates managing. Update required to understand when to draw down funds. Whilst funded it can be used as an example of a successful 'appeal' for the website.
Dementia	'Donate for Dementia' or	Project target - £30,000	Rishi Soukraj Rachel Laud	Estates are progressing to

Dream	Name/ Description	Funding requirements	Contact	Next steps
friendly day room Poss name	'The Fitzwilliam Appeal' Together we can create a haven of comfort, dignity, and connection for those navigating the challenging journey of dementia.	£971 in M1. Malton Lions and Rotary have indicated interest in funding.		get final costs to confirm full appeal details. Charity team to visit Malton for an update.

New Wish Process

Prior to transition Smile had invested grant funding from NHS Charities together in a new online 'Circle of Wishes' online platform. This platform was developed in collaboration for joint use with the Health Tree Foundation, the charity of North Lincolnshire and Goole Hospital NHS Foundation Trust

This development was reviewed by the transitional group and deemed not fit for purpose without significant investment to allow it to deliver the functionality and automation required.

A review of options identified a solution using MS forms to run an approvals process. This software application is being utilised to create a new process which will take a wish maker step by step through a robust process including finance, medical devices, IPC, Health and Safety and Charity Manager approvals before requiring final sign off by the Fund Guardian.

The form will live in a new Staff Zone on the relaunched charity website. It will also include guidance on what constitutes a 'wish' and walks them through completing the application.

It is envisaged the new wish process will go live early June, and currently trial wishes are currently testing the process.

Branding has been developed for the new wish process, and this is summarised below:

Governance arrangements
As part of the work to bring the management of charitable funds back in-house a review of charity governance arrangements has been undertaken.

This has included a review of internal controls using the Charities commission internal controls checklist. There are no high-risk areas or areas requiring immediate attention, however improvements can be made, and an action plan has been developed to be implemented over the next 12 months.

Internal Governance Arrangements
EMT have supported the internal governance arrangement proposed whereby the charity will sit within the communications department under the leadership of the Deputy Director of Communions and Charitable Funds with executive lead remaining the Trusts Director of Finance.

In addition to the leadership roles above, the following resource will support the in house management arrangements:

Role	**Main Duties**
Charity Management (B6) 30 hours (Anita Green)	Ensure that the Charity is well managed and that there are clear plans and processes that reflect charity best practice; allowing the Charity to deliver its full potential. The Charity Manager will also line manage the existing role of Events & Communications Officer as they will provide support for fundraising events.
Communications Support (5) 20 hours (Helen Waites)	Support the delivery of the fundraising plan through the development and management of effective marketing campaigns. Day to day management of communications including website updates, newsletters, social media management, event support, case studies and impact reporting.
Financial Support (Jessica Spicer)	Existing Resource has been identified within the financial services structure to support with the financial administration and reporting
Administrative Support (Nicola Furley)	Existing Resource has been identified within the financial services structure to support with the general administration and reporting
Governance Support (Band 7)	Non-Recurrent support has been secured via the bank to assist with establishing governance process's, procedures, etc.

Internally a Charitable Funds Operational Group (reporting into EMT) has been established, this group will ensure the day to day operation of the Trusts charity are operating as intended.

The role of the Group includes the development and review of governance arrangements for the charity, the risk register, support communications plans and have oversight of wishes in the system to ensure they can be progressed in a timely manner.

EMT have supported the current Charitable Funds Committee remains in place, and that a stocktake/review is takes place later in the 2024 calendar year.

Scheme of Delegation Review

To streamline the wish process the Charitable Funds Committee supported the proposal to separated charitable funds requests between wishes and dreams and support this with adjustments to the scheme of delegations

- **'Wishes'** (under £5000) will be submitted via the online MS forms process. These will be approved by the Charity Manager and Fund Guardian. The process will also include assurance that service managers are aware of the wish. Fund Guardians are currently Divisional General Managers and the Executive Director of Finance for 'The Big Thank You'.

- All **'Dreams' (over £5000)** will be worked up as a full business case for the Charitable Funds Committee. This will include all values of charitable funding requests. The Fund Guardian is part of this process.

The following table summarises the changes to the scheme of delegation. The proposed changes will form part of the annual review of the Standing Financial Instructions and Scheme of Delegation, which is due to Trust Board in May 2024.

Current	Proposed
Up to £1,000 Authorisation from Health Stars Fundraising Manager and Fund Guardian £1,000 - £4,999 Further authorisation from Director of Finance and Service Lead £5,000 - £25,000 Further authorisation from Charitable Funds Committee £25,000 and above To be noted by HTFT Board via assurance report	**Wishes - Up to £5000** Authorisation from Health Stars Charity Manager and Fund Guardian **Dreams - Over £5,000** Charitable Funds Committee

Marketing & Communications

Communications Priorities April – May

During the first two months in house we developed the enabling assets and messaging to support the relaunch of the charity to staff, stakeholders and the public.

New marketing messaging

To reposition the charity in the hearts and minds of our supporters work we have created a compelling narrative that brings to life who we are and what we do.

The new messaging includes;

'What we do' – where we have impact

We have reviewed past wishes to summarise of how charitable funds has an impact across our services. These themes will be used across our marketing messaging to demonstrate what we fund to the public and to give clarity to staff when applying for charitable funds.

Our Impact Pillars

Enhanced equipment	**Enhanced environment**	**Patient and visitor experience**
Funding equipment that NHS budgets do not cover. This could be an item that is not considered essential but will help our staff to provide the best possible treatment or the most cutting-edge version of an essential piece of equipment.	Making our buildings more attractive and therapeutic. Donations help us go beyond plain walls and basic decoration improve the experience for people who use our buildings and services.	Providing the little extras that make a visit or stay in our services that little bit brighter. We help ease the burden on families, offer comfort through treatment and reduce boredom
Supporting our Staff Making a donation is a brilliant way to say 'thank you' and support our incredible NHS team. Whether they cared for you as a patient or looked after a loved one, we know that they have a positive impact every day and we want them to know what a difference it makes**.**	**Healthier Communities** We are committed to reducing health inequalities and creating healthier futures for people in Hull, East Yorkshire and North Yorkshire .	

'Who You Support' - summarising our services

Health Stars does not have the benefit of being a hospital charity. These charities are easy to understand for the public and patients and funds are often raised following successful treatment or cure or in memory of a loved one.

Whilst our services are currently arranged into four divisions this is not understood by the general public and should not restrict how we describe ourselves. When considering the marketing of the charity we have grouped our services into five categories.

These categories have been chosen to maximise funding and public and stakeholder engagement. This has been supported by the divisions.

Mental Health and Wellbeing	**Children, Young People and Families**	**Neurodiversity** We support	**Learning Disabilities**	**Healthy Communities**

We support people to live happier and more fulfilling lives. We help people to get help early and support their mental wellbeing, provide treatment, support, rehabilitation and recovery, as well help in an emergency.	We help give children the best start in life. We promote good health, emotional wellbeing and help prevent illness, helping young people to reach their full potential and enjoy life.	people to thrive in their everyday lives. We provide screening, signposting and support services that work together with individuals to understand what support is needed and how to help.	We help people with a learning disability live a happy and fulfilling life. We provide assessment, treatment and support to help them live as independent a life as possible.	We improve the health and wellbeing of your local community. We care for people close to home, focusing on preventing illness, making diagnoses, treating conditions and offering urgent medical help.

Website relaunch

The Health Stars website was redesigned in 2023. Despite an improved design, the content and navigation are not fit for purpose as a charity website. The narrative is heavily weighted towards granting staff wishes with limited reference to fundraising.

A new website has been written which repositions the charity and it focused on donations, telling charity stories and communicating who we support and what we fund.

It also includes a dedicated 'Staff Zone' to support staff giving and applications for charitable funds. From this section staff can access the new one-step application form to access charitable funding for all requests under £5000. This is supported by new online and print guides – 'A Step by Step Guide to Making a Wish' and 'Accessing Charitable Funding: A Guide for Staff'.

The funded by remaining NHS Charities together funding which funded the initial redesign. The site will be re-launched on 20th May.

Case Studies

Telling stories is the best way to bring to life the impact of charitable work. When people can connect with real-life narratives of individuals or communities positively affected by our efforts, they are more likely to feel motivated to contribute. Storytelling also provides concrete examples of the tangible results enhancing transparency and trust, especially with our staff.

We are working through the backlog of past wishes and previous Health Stars case studies to populate the new website and inform future marketing. This includes creating a number of examples of what certain amounts of funding can provide e.g. A donation of £100 can provide x

Launch Marketing Plan

Health Stars has been soft launched to staff through a new internal newsletter, it introduced the team and invited test wishes.

This will be followed by the reopening of wishes and the launch of the new Health Stars website end May/early June.

Pennies from Heaven, our payroll giving scheme and the charity lottery will be relaunched along with the website to grow our support to these regular opportunities to give.

Dedicated marketing campaigns in May (Pennies from Heaven) and June (Lottery) will follow to focus on each scheme and the benefits

Michele Moran
Chief Executive

Humber Teaching NHS Foundation Trust

Agenda Item 8

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
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:	To inform and update the Trust Board on recent key publications and policy since the January Board (detailed below): • Doctors leaving the NHS • Regulation of Physician Associates and Anaesthesia Associates • Care Quality Commission: Assessing the Well-Led Question Guidance • Care Quality Commission Annual Community Mental Health Survey • Waiting times for mental health services for children and young people • NHS Missing out on savings • Tackling health inequalities

Key Issues within the report:

Positive Assurances to Provide: • n/a	**Key Actions Commissioned/Work Underway:** • n/a
Matters of Concern or Key Risks: • n/a	**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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Board	

Monitoring and assurance framework summary:

Caring, Learning & Growing Together

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 since the previous Board.

1. British Medical Association – doctors leaving the NHS

A recent report by the British Medical Association (BMA) estimated 15,000 to 23,000 doctors were estimated to have left the NHS prematurely in England between September 2022 and September 2023. The BMA report went on to highlight steps which could be taken to retain doctors including: fair pay and working conditions, improved diversity and inclusion and time for learning and development.

Further details are available via this link: Staggering cost of losing doctors from the NHS revealed in BMA report - BMA media centre - BMA

NHS England has also published a report outlining steps which can be taken to improve the working lives of doctors in training. These steps fall under three categories: increasing choice and flexibility (better rota management and deployment); reducing duplicative inductions and pay errors (streamline and improve HR support); and create a sense of value and belonging for the doctors.

The letter is available via this link: NHS England » Improving the working lives of doctors in training

Lead: Medical Director:

In response to official letter from NHS England and concerns from BMA, we have started a joint meeting between Medical Workforce Team and Medical Education to improve the working lives of postgraduate doctors in training and retention. There is a bigger piece of work from NHS England such as best practice guide and reducing the burden of StatMand. In the short term there are actions we can take now as employers to improve the working lives of doctors in training. These include:

- Increase choice and flexibility: better rota management and deployment,
- Reduce duplicative inductions and pay errors: streamline and improve HR support,
- Create a sense of value and belonging for our doctors.

Workforce committee will be given regular updates of the process in Humber.

2. Regulation of Physician Associates (PAs) and Anaesthesia Associates (AAs)

The General Medical Council has announced that PAs and AAs will start to be regulated from December this year. This will help ensure that they can work safely and be held to account if serious concerns are raised.

Story link: PA and AA regulation: information for employers - GMC (gmc-uk.org)

Lead: Medical Director:

In December 2024, the GMC will start regulating physician associates (PAs) and anaesthesia associates (AAs). The GMC have developed proposed rules, standards and guidance setting out how they will regulate these professions.

The GMC have also developed draft principles that will inform the content of decision-making guidance that will apply to doctors as well as to PAs and AAs from December 2024. There is currently a consultation about those rules, standards and guidance and those principles (26 May 2024). It is not about who should regulate PAs and AAs, as this has now been written into law. We continue to monitor the updates from the GMC as we are exploring the employment of PAs in the trust.

3. Care Quality Commission: Assessing the Well-Led Question Guidance

In April 2024, the CQC published guidance which outlines how it will assess whether a provider trust is well-led. The guidance was jointly developed by the CQC and NHS England and is intended to help trusts to understand what good leadership looks like. The guidance includes expectations around system working, freedom to speak up and continuous improvement.

This guidance, alongside the Single Assessment Framework, replaces the previous inspection framework for NHS trusts and foundation trusts.

Link: Guidance for NHS trusts and foundation trusts: assessing the well-led key question - Care Quality Commission (cqc.org.uk).

Lead: Chief Executive/Director of Nursing, Allied Health and Social Care Professionals:

The guidance is a useful document as it brings together all best practice national standards/guidance that underpin each of the key lines of enquiry helping Trusts to understand what good leadership looks like.

The areas covered are:

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Freedom to Speak up
- Workforce , equality , diversity and inclusion
- Governance, management and sustainability
- Partnerships and communities
- Learning a, improvement and innovation
- Environmental sustainability.

The Director of Nursing is contacting the leads for the areas in scope requesting they review the requirements and underpinning standards and notify her of any further work that is required to strengthen our compliance. The outcome from this work will be overseen by EMT.

4. Care Quality Commission Annual Community Mental Health Survey

NHS Providers has produced a briefing on the Care Quality Commission (CQC) annual community mental health survey for 2023, published on 18 April 2024. This survey gathers feedback from people using NHS community mental health services in England, focusing on their experiences of care. The briefing summarises the survey key findings, areas identified by the CQC for improvement, and sets out NHS Providers' view.

Link: ndb-cqc-community-mental-health-survey_april24.pdf (nhsproviders.org)

Lead: Chief Operating Officer:

Considerable work has been undertaken by our Mental Health Division to respond to the findings of this survey. A robust plan is in place with appropriate oversight in the relevant forums in the Trust. Our plan builds on the findings from previous years and has co-production with service users and carers integral to the work.

5. Waiting times for mental health services for children and young people

The Monitoring the Mental Health Act in 2022/2023 report highlights that nearly half a million children and young people were waiting to access or undergo mental health treatment in November 2023. The CQC has reported that according to the latest statistics from NHS England, this number increased by almost 20,000 by January of this year. These children are having to wait an average of 40 days from referral to treatment. Many children who are receiving care have been placed in the wrong settings, such as adult wards or general children's wards, adding to their distress.

Lead: Chief Operating Officer:

Considerable work has been undertaken by our Childrens and Learning Disability Division to improve all waiting times. Our access to core CAMHS has seen waiting times reduce during the last 12 month. Access to our inpatients beds has also improved, particularly with Inspire now able to accept young people requiring treatment and support with severe eating disorders, this has reduced significantly the number of children being treated in the wrong setting i.e. general children's wards. Challenge and focus continues to support children requiring access to diagnosis for neurodiversity.

6. NHS Missing out on Savings

The Public Accounts Committee (PAC) has warned that NHS Supply Chain, which was created to save the NHS money through pooling hospitals' purchasing power, has failed to persuade NHS trusts to use it to make billions in purchases.

NHS Supply Chain was created with the intention that the NHS could utilise its collective buying power to get the lowest prices for its purchases. The PAC's report finds that the organisation has not so far demonstrated it is achieving this intention.

Full report: NHS missing out on tens of millions in procurement savings, PAC report warns - Committees - UK Parliament

Lead: Director of Finance:

Updates from the report will be shared with the Finance Committee through the Committee's Insight report.

7. Tackling Health Inequalities

NHS Providers has launched a comprehensive guide for NHS trust board members to tackle health inequalities, *Reducing health inequalities: A guide for NHS trust board members*. The practical resource, designed to help NHS trust board members drive down unjust differences in health

outcomes in their local communities, can serve as a roadmap, enabling them to champion health equity and create positive change.

The guide covers a wide range of topics, from operational and clinical service delivery to the role of NHS trusts as anchor institutions and employers of NHS staff. It also provides a vision of what effective action on health inequalities entails, and suggests objectives for board members to implement within their trusts. Explore the full guide.

Lead: Medical Director:

Response to Reducing Health Inequalities: A Guide for NHS trust board members.

In May 2024, the Health Inequalities Operational Delivery Group completed the Health Inequalities Self-Assessment Tool which forms part of 'the guide for NHS trust board members to tackle health inequalities, Reducing health inequalities: A guide for NHS trust board members.'

The scoring from the self-assessment report is as follows:

Theme	Score	Percentage Complete	Maturity Level
1 - Building public health capacity & capability	2	25%	Developing
2 - Data, insight, evidence and evaluation	7	50%	Maturing
3 - Strategic leadership & accountability	10	56%	Maturing
4 - System partnerships	8	80%	Thriving

The process identified the following strengths and gaps:

Strengths:
- Commitment to reducing health inequalities within the Trust Strategy and a named board-level Exec Lead for HI
- Engagement with communities to inform work on health inequalities.
- Clear governance structure for the Trust's health inequalities work, through the Health Inequalities Operational Group
- Programmes in place to improve access to employment to underrepresented groups in your organisation.
- Delivery of quality improvement work related to health inequalities.

Partially achieved actions which have already been identified as areas of focus for the HI delivery plan for 2024/25:
- Increasing uptake of staff training on health inequalities
- Acting on performance data broken down by ethnicity and deprivation (to be published in the upcoming Trust Annual Report, follow up workshops scheduled with clinical and operational teams)
- Continuing to review care pathways and clinical practice consider the extent to which they enable equitable access, experience, and outcomes.
- Continuing to work with system partners to identify opportunities to invest in services that will prevent and mitigate healthcare inequalities and realise longer term benefits.

Gaps
- Structured Trust Board training and/or development health inequalities

- Public health expertise within the Trust
- BI capacity to use existing population health data (e.g. population demographics and index of multiple deprivation) in our analysis of trust-level data in a systematic and Trust-wide way.

Humber Teaching NHS Foundation Trust

Agenda Item 9

Title & Date of Meeting:	Trust Board Public Meeting 29th May 2024
Title of Report:	Electronic Patient Record (EPR) Programme Update – May 2024
Author/s:	Lynn Parkinson, Deputy Chief Executive & Chief Operating Officer Lee Rickles, CIO Peter Beckwith, Director of Finance
Recommendation:	

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

Purpose of Paper:	The purpose of this paper is to provide the Trust Board with an update on the EPR programme.

Key Issues within the report:

Positive Assurances to Provide:

- SystmOne data migration unit has been built and being used for testing.
- The Robotic Process Automation proof of concept has been completed.
- 23/24 spend was within budget as planned.
- The first four data migration staff have been recruited.

Key Actions Commissioned/Work Underway:

- Agree the use of Robotic Process Automation and manual data migration for the second and third go-live.
- Completion of the future state process.
- Creation of the online and classroom training materials.
- Each division is now creating their own detailed training plan which will take place 2 to 6 weeks before each go live.

Key Risks/Areas of Focus:

- The dependency of the EPR implementation on dialog+, clinical documentation review and MaST (Management and Supervision Tool).
- Focus on data migration, reporting and the impact of operational pressures.

Decisions Made:

- The first go-live based on the Forensic division will be manual.
- Agreed the approach to class room and online training

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	✓
Charitable Funds Committee		Collaborative Committee	
		DDG, IGG, EPR programme Board, IMB	✓

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	

Electronic Patient Record (EPR) Programme Update – May 2024

1 Introduction and Purpose

The purpose of this paper is to provide the Trust Board with an update on the Electronic Patient Record (EPR) Programme.

2 What the new EPR provides

The Trusts future EPR is based upon a set of requirements developed with operational and corporate services, this is summarised below:

Functional Requirements and Principles	• Patient Administration • Clinical Functionality • Departmental Functionality • Electronic Prescribing and Medicines Administration (EPMA) • Order Communications & Results Reporting • Integration and interoperability • Reporting and Business Intelligence
Non-Functional Requirements	• Information Governance • Data Migration & Data Quality • Contract & SLA Management • Application Support and Development

3 Contract

A change control notice (CCN) has been raised with TPP to remove their data migration and include the RPA and manual data migration. TPP have been formally requested to respond to the CCN so the implementation plan and a reduction in cost can be applied to the contract. Although the CCN process is not yet concluded, it is not impacting the implementation of the EPR.

4 Funding

Based on the approved Investment Agreement, NHS England have released following funding to the Trust in 23/24. We are expecting to receive the 24/25 funding in Q3.

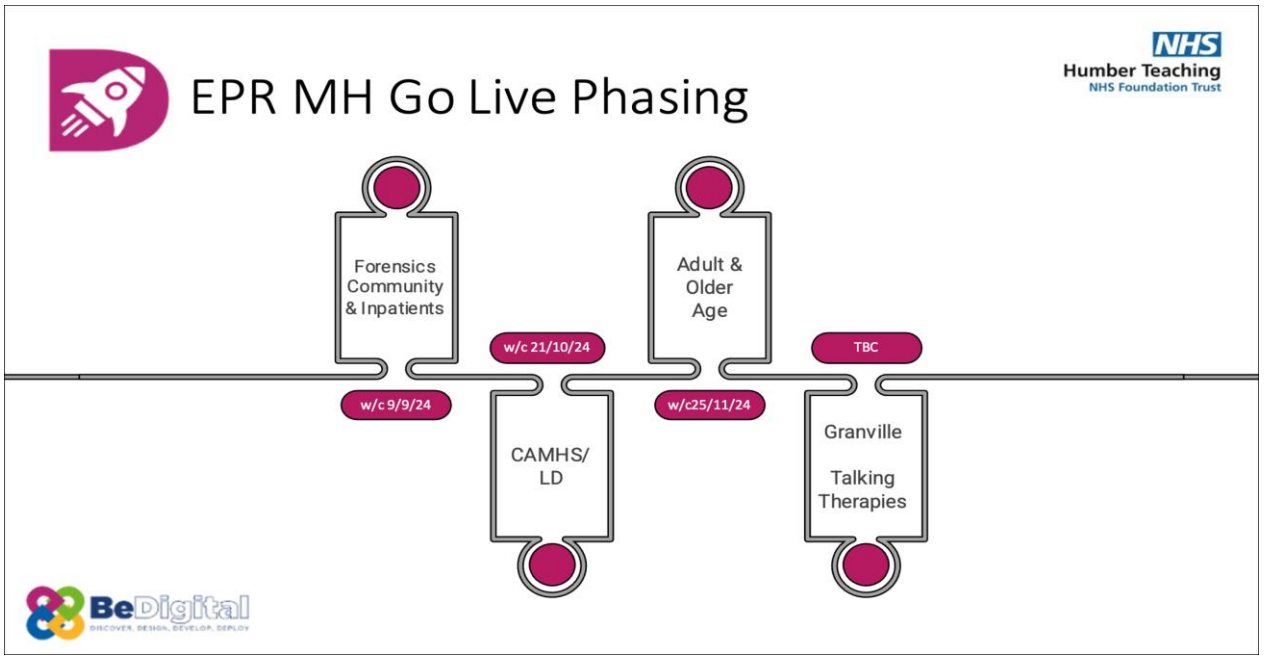
Capital spent in 23/24	£ 2.193M as budgeted
Capital budget 24/25	£ 1.388M to be received in Q3 FY 24/25
Revenue budget	£0.635M at Q1 24/25 and £0.518M to be received in quarter 3 24/25 so a total of £1.142M

5 Programme Update

The EPR Programme plan is attached at appendix A. The following section provide an update for each workstream.

5.1 Go-live

The phasing for going live from Lorenzo to SystmOne is shown below. Granville Court which is moving from paper and Talking Therapies moving from PCMIS (a bespoke digital case management system) do not have dates, but they are expected to move onto SystmOne early 25/26.



5.2 Business Change

13 future states design workshops have taken place which were focused on the inpatient and community functionality for clinical and administrative staff. The feedback from the workshops is being included in the new process, this will be reviewed by the clinical assurance group (chaired by the medical director) and then taken to the EPR Programme Board for approval There are a few support and corporate service process workshops which are required and these have been planned and are being progressed. These are expected to have small variation to the main processes.

5.3 Training

The training videos are being created and will be completed once the future state processes have been approved. The video will be provided within the learning management system on ESR. This will assist in the tracking of compliance to training as we require 90% of staff to be trained before we approve the move to going live. The materials will include comparisons between Lorenzo and SystmOne to help with the transition. Training will be based upon role so only the video required will be provided to the members of staff. A training room is being set-up to provide class room-based training for the expected small number of staff for whom online training is not the optimal approach. Opportunity will also be taken to provide staff with access to demonstration

versions of SytmOne in clinical and team timeout sessions to aid training and familiarisation.

Each division is now developing their own detailed training plan for training which will take place 2 to 6 weeks before each go live, these plans will be reviewed by the EPR programme board in June.

5.4 Data Migration

Due to TPP (SystmOne supplier) not being able to support a full data migration for a big bang go-live until 2025 we re-scoped our approach to be phased and use Robotic Process Automation (RPA) to carry out most of the data migration. Very recent planned testing has been completed for a data migration and the RPA process has not achieved the expected level of success. It has shown that the RPA processes that can be achieved are generally the simple ones, but they are high volume. This will mean staff will be required to support a manual data migration. Staff have already been recruited to support the first go-live phase with the Forensic division taking place on 9th September 2024. The outcome of this testing has been escalated to EMT and they and the EPR programme board are currently considering the risk assessment, the mitigation actions and finalising the options to address this, this will be finalised in early June.

An archive system is being built to hold the history of all the records from Lorenzo, which will be accessible from SystmOne. Lorenzo will not be decommissioned until 6 months after the last go-live and we have received a full data repatriation from the supplier of Lorenzo.

5.5 Configuration and build

We have configured the SystmOne data migration unit and used it to test the RPA data migration process and future state processes.

5.6 Testing & Assurance

A complete set of document and data tables have been provided from Lorenzo to test the data migration process. Testing has been focused on the RPA process which are included in section 3.1. Power BI dash boards are in place to identify current data migration based upon the phased go-live. Further dash boards are being developed to provide a command centre view of the testing, data migration, go-live and post go-live support.

6 Risk

The project team have reviewed all current risks to update them and/or added new ones where necessary. Several risks on the register have been closed as we have received the Frontline Digitisation funding for the EPR.

Risks currently rated high relate to operational resources being released for training and resourcing the project team via the additional resource from EPR funding. The position regarding operational resources is improving and is satisfactory for the first go live phase, Forensic Services. Focus is on addressing some deficits in the mental health division capacity, however this is expected to be resolved in June.

The current data migration risk is being mitigated by the RPA proof of concept which is highlighted in section 5.4.

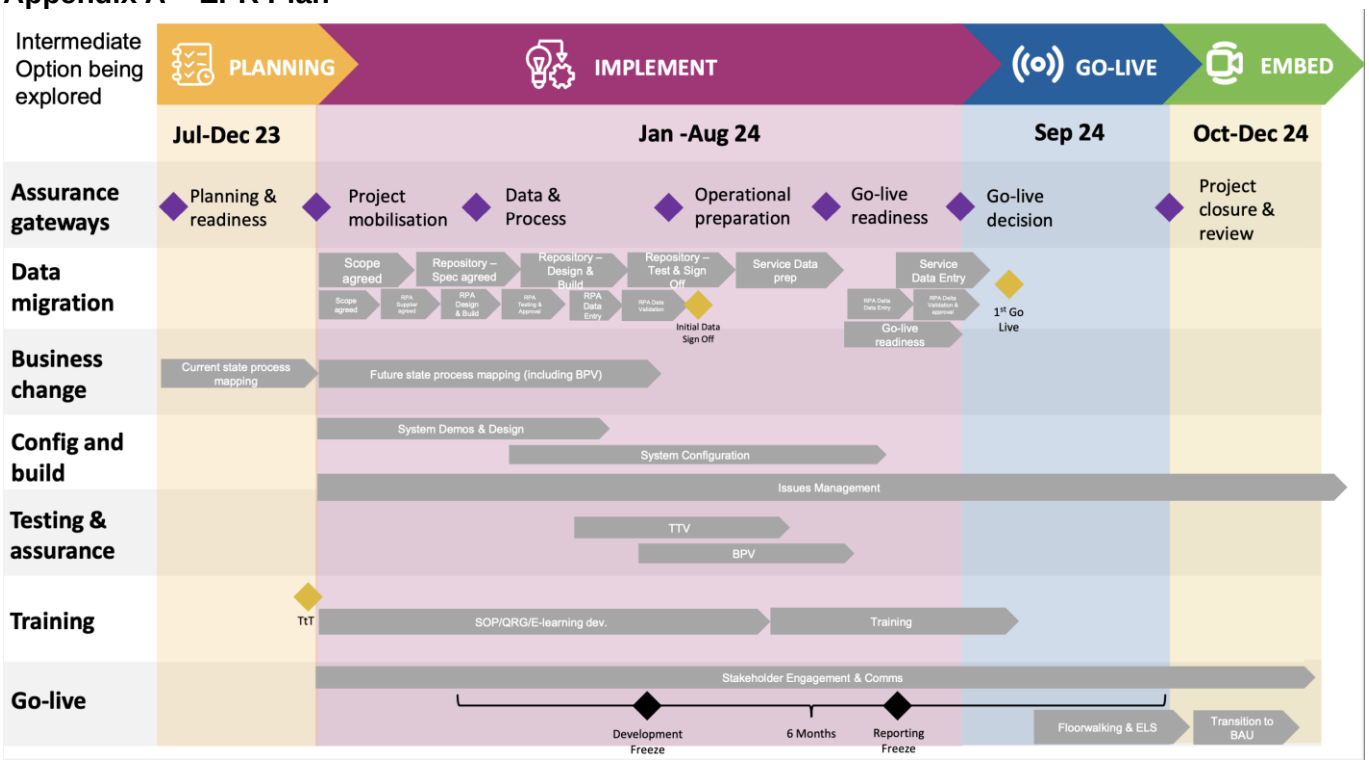
The dependence of the EPR on other projects has also increased as a risk. Currently the use of diaglog+, new clinical documentation project and the MaST (Management and Supervision Tool) system are either dependencies for the EPR or its resources. A recommendation will be presented to the EPR programme board and Digital and Data Group for approval in June to address and mitigate this risk,

7 Conclusion

Overall, good progress is being made to implement the new EPR. The RPA proof of concept has provided a valuable assessment of what is possible and has allowed enough time to complete a full data migration for an RPA/Manual or just manual approach. Future state processes are nearing completion so the training material can be finalised. We have a robust budget to support operational teams being released for training and to be part of the EPR team.

The risks will continue to be managed to ensure the implementation of the EPR meets all its assurance gateways and the Trust are confident to go-live.

Appendix A – EPR Plan



NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 10

Title & Date of Meeting:	Trust Board Public Meeting - 29 May 2024
Title of Report:	Refreshed Research Strategy 2024-26
Author/s:	Cathryn Hart, Assistant Director Research & Development
Recommendation:	

To approve		To discuss	
To note		To ratify	√
For assurance			

Purpose of Paper:	Refreshed Research Strategy 2024-26 for ratifying (This has been reviewed by QPaS Dec 2023 and approved by EMT Dec 2023 and Quality Committee Mar 2024.)

Key Issues within the report:

Positive Assurances to Provide:

- This refreshed research strategy has been reviewed by QPaS and approved by EMT and the Quality Committee. There were no changes requested by any of those groups/committees.
- This research strategy has been refreshed from the previous version considering changes in national policy, in the way research is delivered and in how we collaborate regionally and nationally. Also following a period that incorporated a global pandemic, where the importance of research was so clearly demonstrated in the worldwide fight against COVID-19. However, fundamentally the focus of this refreshed research strategy remains unchanged; to build on our current progress and continue our journey to achieving an outstanding reputation for research.
- Having reviewed many other Trust research strategies regionally and nationally as part of this refresh, it is clear that our strategy is

Key Actions Commissioned/Work Underway:

- As part of the refresh of this strategy, we ran eight roadshows in Spring 2023 with staff and people in our communities, across various areas in our Trust patch. This feedback confirmed that our three existing research strategy priorities are still relevant and also identified some of the key areas to consider in order to achieve these, for example, communication methods, research accessibility and staff capacity.

still very relevant and in line with the national direction.	
Key Risks/Areas of Focus: • The strategy was due for refresh 2023 and has been delayed due to not being able to do the consultation at our research conference in autumn 2022 as it moved to virtual at last minute. We then didn't get to do the consultation at our face to face roadshows until May 2023, and had also been hoping the ICB research strategy would be published in 2023 but this is now not expected until later in 2024.	**Decisions Made *(main changes):*** Much of the strategy remains unchanged. The main changes to the sections in this refreshed strategy are: *1.0 Exec summary* – added text summarising the refresh. *2.0 Background* – updated text around CQC, key policies and Yorkshire and Humber Clinical Research Network (CRN). *3.0 Aim* – added reference to patient and carer experience, quality improvement and health inequalities groups. Updated the charts in figures 1-3 and associated text. Updated the chart for Trust goals. Updated the paragraph about the Integrated Care System. *4.0 Mission, Vison & Values* – updated the Trust Vision and Values diagram. *5.0 Priorities & Objectives* – added text about consultation via roadshows. Adapted a few objectives in the tables relating to the 3 research priorities, *6.0 Looking Beyond* – adapted text around playing on our strengths, bringing in commercial research income, collaboration, and research integral to clinical roles. *8.0 Implementation & Monitoring* – updated text to reflect current national benchmark for success. *Appendix 1* – updated references to key documents steering research in the NHS. *Appendix 2* – updated examples of progress achieved to reflect 2020-23.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	Mar 2024	Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	11/12/23
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) - QPaS	01/12/23

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

(Refreshed) Research Strategy 2024-2026

Changing lives through research and ambition

Caring, Learning
& Growing Together

Document Configuration	
Date Nov 2023	***Version: 1.0***
Author Name / Job Title	Cathryn Hart, Assistant Director Research and Development
Directorate Name	Medical Directorate
Clinical / Executive Sponsor	Medical Director
Reporting Committee	Quality Committee
Trust Board Ratification	tbc
Review Date	Dec 2026
Distribution Channels	Committee Paper / Intranet / Website / Research Events
Key Internal Documents	Trust Strategy 2022-27
Key External Documents	The Future of Clinical Research Delivery: 2022 to 2025 implementation plan (Jun 2022) Royal College of Physicians/NIHR position statement: Making research everybody's business (Oct 2022) Allied Health Professions Strategy for England (Jun 2022) Chief Nursing Officer for England's Strategic Plan for Research (Nov 2021) The NHS Long Term Plan (Jan 2019) UK Policy Framework for Health and Social Care Research (2017) Health and Social Care Act (2012) NHS Constitution for England (2011)

Contents

Foreword

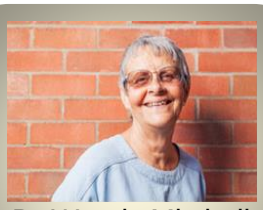
A message from our Chief Executive and Patient Research Champion

Michele Moran
Chief Executive

A high performing organisation recognises the importance of investing in research; enabling our staff to learn and grow and our community to participate in healthcare improvement. There is evidence that people do better in organisations that do research and therefore we see research as a core part of the service we provide for our community.

We are committed to working with key partners to increase opportunities for people to help shape the future of our health services and treatments, through taking part in research. Our communities are our experts by experience, and it is important that we provide opportunities for people from as many different services as possible to be included.

Overall, we hope that the growth and delivery of research at Humber Teaching NHS Foundation Trust will contribute to the evidence base for better health, increased opportunities for our community to shape services and improvements in the quality of care locally.



Dr Wendy Mitchell
Former Patient
Research Champion*

When you're given a diagnosis, whatever that condition might be, you might feel like your life is falling apart, feel worthless and of no use to anyone anymore. Participation in research can offer people hope for future generations but more so, give them back that sense of being valued once again that any diagnosis can strip away from you.

There is currently no cure for dementia and without willing volunteers to test new theories there will continue to be no cure or knowledge of how best to live and care for those no longer able to care for themselves with dementia. Social and technological research is equally as important as clinical drug trials for any condition.

We have to normalise involvement in research, but to do this we must have the backing of all healthcare professionals and for them to talk about research would help make it normal. Promoting research doesn't have to eat into anyone's budget. The NHS can't move forward without research and research can't move forward without willing volunteers. We need hope and research gives us that hope. Without research we can't change the future!

(Wendy, who was an inspiration to so many, sadly passed away Feb 2024, having battled* young onset dementia*)*

1.0 Executive Summary

Research is central to ensuring services are effective and that new treatments and ways of delivering care continue to be identified that enable recovery and prevention, reduce disease burden, improve quality and increase productivity.

We have refreshed this research strategy considering changes in national policy, in the way research is delivered and in how we collaborate regionally and nationally. Also following a period that incorporated a global pandemic, where the importance of research was so clearly demonstrated in the worldwide fight against COVID-19. However, fundamentally the focus of our refreshed research strategy remains unchanged; to build on our current progress and continue our journey to achieving an outstanding reputation for research. Having reviewed many other Trust research strategies regionally and nationally as part of this refresh, it is clear that our strategy is still very relevant and in line with the national direction.

In this strategy for 2024 to 2026 we have three research priorities, which in turn are aligned to our overall Trust Strategy 2022-27 goals. For each of the three priorities listed below, associated objectives have been identified, as well as indicators for what success is expected to look like.

Priority 1

Research embedded as a core component of clinical services

Priority 2

Enhanced community involvement and awareness

Priority 3

Growing our strategic research presence and impact

These were developed through extensive consultation with staff at various levels within the organisation, our governors, board, patients, service users, carers, and external stakeholders.

Whilst continuing to work on these priorities over the next three years, we will also be continuing to attract more new research funding and to develop more new partnerships with renowned clinical research professionals and innovators. Given the hybrid ways of working that have emerged in response to the COVID-19 pandemic, successful partnerships can be virtual and do not necessarily require a physical hub.

2.0 *Background*

There is good evidence that trusts who participate in research have improved health outcomes and healthcare processes.[1] [2] [3] Being research-active also makes the organisation a more attractive employer and increases its prestige, as well as bringing in extra income.

Research became specific in CQC Well Led inspections for trusts in Oct 2018; the first time research activity has been formally recognised as a key component of best patient care. In July 2022 the CQC launched a new single assessment framework which forms the basis for assessments of quality in providers and integrated care systems. Research remains part of this in the well led domain under the 'Learning, Improvement and Innovation'.

Key policies recognise the importance of research in the NHS and drive the research agenda nationally. The Department of Health and Social Care (DHSC) views research as a core responsibility for all NHS Trusts in England, the importance of research is enshrined in the NHS Constitution (2011), 'The Future of Clinical Research Delivery: 2022 to 2025 implementation plan' makes an explicit commitment to promote and embed research, as does the Chief Nursing Officer for England's Strategic Plan for Research (2021), the Allied Health Professions Strategy for England (2022) and the RCP/NIHR Joint Position Statement (2022), NICE guidance (2018) states we must tell people about research they could take part in and the NHS Long Term Plan (2019) recognises the importance of innovation via research (see *Appendix 1*).

The UK Policy Framework for Health and Social Care Research (2017) sets out the principles of good practice in the management and conduct of health and social care research across the UK. The status of this document is statutory guidance to which local authorities and NHS trusts in England must have regard. Its purpose is to ensure that the public will feel safe when they take part in research, whilst enabling the development of innovations which will help to improve the quality of health and care in the UK. The Framework helps bodies that commission care to fulfil their legal duty under the Health and Social Care Act 2012 to promote the conduct of research.

There is an expectation by DHSC that all NHS Trusts will participate in the successful delivery of research studies that are recognised by the research arm of

[1] Hanney S et al. 2013. Engagement in research: an innovative three-stage review of the benefits for health-care performance. *Health Services and Delivery Research* 1(8).
[2] Ozdemir BA et al. 2015. Research Activity and the Association with Mortality. *PLoS ONE* 10(2): e0118253. doi:10.1371/journal.pone.0118253.
[3] Downing A et al. 2017. High hospital research participation and improved colorectal cancer survival outcomes: a population-based study. *Gut* 66:89-96.

the NHS, namely the National Institute for Health and Care Research (NIHR). These studies are known as NIHR '*Portfolio'* studies.

The Yorkshire and Humber Clinical Research Network (CRN) (changed to Regional Research Delivery Network (RRDN) from Oct 2024) provides support and funding for research according to key performance indicators set by the NIHR. As a partner organisation the Trust has a formal agreement with the CRN/RRDN, with specified obligations with regard to supporting the delivery of *Portfolio* research locally and achievement of high-level objectives such as those relating to 'recruitment to time and target'...

Development funding awards for testing local innovation, new services or practice, such as those provided by local commissioners, do not usually qualify for the NIHR *Portfolio*, but are nonetheless important and for the Trust may lead on to the application of larger competitive grant awards in the future, which would subsequently qualify for *Portfolio* status. Research projects carried out as part of post-graduate qualifications tend to be classed as '*Non-Portfolio'* but nonetheless are also important in the development of research-experienced clinicians.

All research involving the NHS in England must have Health Research Authority (HRA) approval as it may involve greater risk, burden or intrusion for participants than standard clinical practice. Research activity and its governance are distinct from other data collection activities such as clinical audit and local service evaluation which have their own internal governance systems.

This research strategy embodies the above policies and guidance and seeks to increase our research offer to our community, enhance our services and improve patient safety; ***changing lives through research and ambition***.

As an organisation we recognise that our staff are our greatest asset and we are committed to developing a culture whereby research is embedded as a core part of clinical services, enhancing our offer to those who access our services, but also making Humber Teaching NHS Foundation Trust an excellent place for staff to work, learn and innovate.

3.0 The Aim of the Research Strategy

The main purpose of research is to make a positive difference to the quality of healthcare the NHS provides now and in the future. Our aim is therefore for research to be embedded as a core component of our clinical services since it is a key enabler to delivering high quality services as well as recruiting and retaining the best clinical staff. Research also links in with and positively impacts on the work of our Patient and Carer Experience, Quality Improvement and Health Inequalities groups; the pursuit of improved health and wellbeing of all our communities.

The three priorities and associated objectives identified in this research strategy seek to build upon our existing strengths, to continue what we are doing well so that we carry on growing and improving year on year, acknowledging that there are certain things we have to do (business as usual) to retain our core NIHR funding via our partnership with the CRN/RRDN, and to fulfil key regional and national research performance indicators. Importantly it will also focus on building capacity, developing new opportunities and innovation prospects, potential new partnerships, attracting key research innovators and increasing funding from external sources.

At the core of this strategy is building on our success trajectory. We doubled the number of participants in NIHR portfolio studies between 2013-14 and 2020-21 (see *Figure 1)* and doubled the number of studies between 2013-14 and 2022-23 (see *Figure 2)*. There was a dip in numbers of people participating in studies during 2021-22 and 2022-23 but this rose again in 2023-24.

Figure 1: Doubled the number of participants 2013-14 to 2020-21

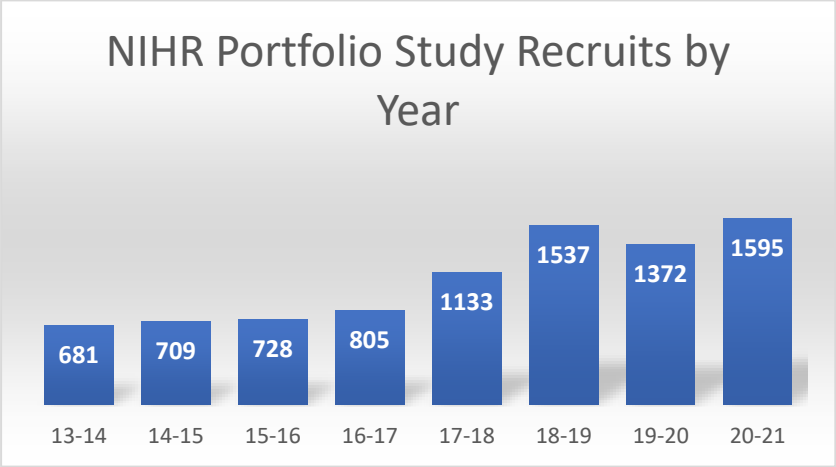
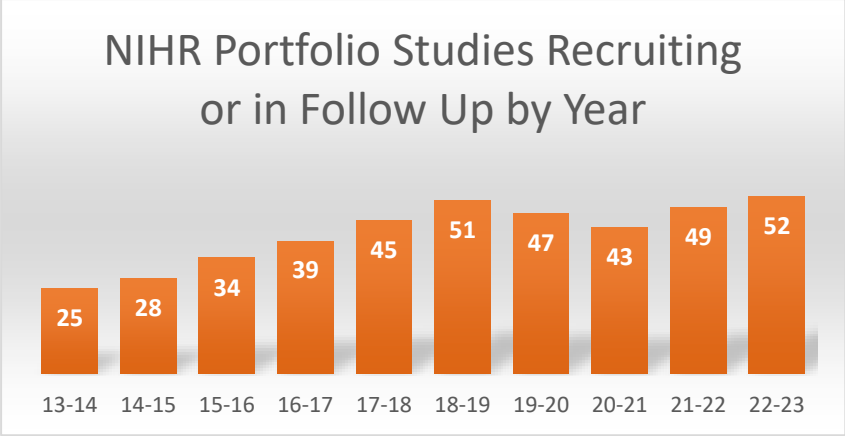
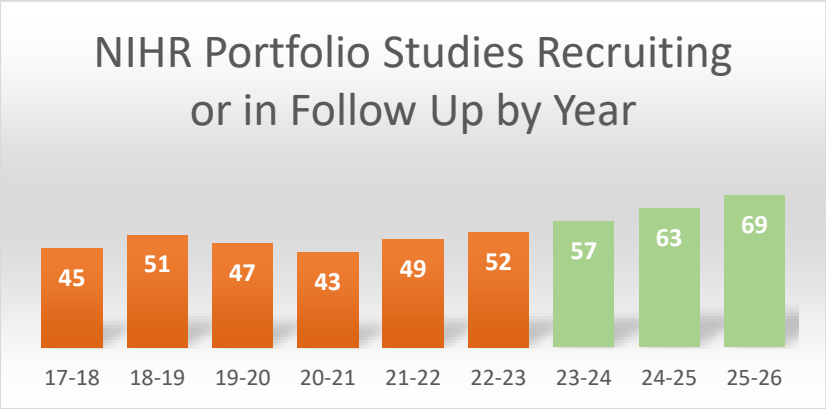


Figure 2: Doubled the number of studies 2013-14 to 2022-23



Our aspiration is to continue increasing our breadth and number of studies, such that more specialties are included in research across our Trust year on year, with *figure 3* illustrating what a ten per cent increase in studies each year would look like, We also aim to recruit to time and target in 80% of our NIHR Portfolios studies; a new national High Level Objective (HLO) introduced in 2023-24.

Figure 3: Increased numbers of studies up to 2025-26



Research has the potential to impact on all goals within the Trust's Strategy 2022-2027. Therefore, to implement this strategy we have aligned our priorities to the organisation's six goals.

The introduction of Integrated Care Systems (ICS) across England, including our local Humber and North Yorkshire (HNY) Health Care Partnership, provides new opportunities for us to work more closely with partner organisations across our 'places' and to increase opportunities for our communities to engage in research and to potentially benefit. A new virtual hub, the 'Innovation, Research and Improvement System' (IRIS) for HNY ICS, was officially launched in November 2023. Its vision includes creating a system-wide supporting structure and culture which allows research to become core business and ensures the health and social care grand challenges of 'start well' and 'die well' are addressed; areas of research that our Trust also has strengths in. The IRIS Research Strategy is expected to be published in 2024 and will also be important to us as a partner. .

We are a leading provider of integrated healthcare services across Hull, the East Riding of Yorkshire, Whitby, Scarborough, and Ryedale. Our wide range of health and social care services are delivered to a population of 765,000 people, of all ages, across an area of over 4,700 square kilometres and approximately 80 sites. Therefore, it is essential that this research strategy takes into account the unique challenges that each service brings. All of our staff, services and community can potentially be involved in research and therefore this research strategy applies Trust-wide.

4.0 Our Mission, Vision and Values

This Research Strategy describes how Humber Teaching NHS Foundation Trust will ensure that we embed a culture of research that supports the delivery of high quality, safe, effective care across all of the services we provide. The strategy has been designed to support the delivery of the Trust's vision and values which include:

Our 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

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 as a provider of high-quality services and being a great place to work.

5.0 Priorities and Objectives

When identifying the three key research priorities and associated objectives to focus on when we first published this research strategy in 2020, it was essential that we listened to what our community felt these should include. In doing so various groups were consulted, including service users, patients, carers, families, staff, Trust Governors and Board, commissioners, voluntary organisations and academic partners. This consultation also included a round table session with 170 people from 26 organisations that attended the 2019 Trust research conference. As part of the refresh of this strategy, we ran eight roadshows in Spring 2023 with staff and people in our communities, across various areas in our Trust patch. This feedback confirmed that our three existing research strategy priorities are still relevant and also identified some of the key areas to consider in order to achieve these, for example, communication methods, research accessibility and staff capacity.

These three priorities are aligned to our Trust strategic goals as outlined below:

Research Strategy Priorities	Linked to Trust Strategic Goals	
Priority 1 *Research embedded as a core component of clinical services*		Innovating for quality and patient safety
		Developing an effective and empowered workforce
Priority 2 *Enhanced community involvement and awareness*		Enhancing prevention, wellbeing and recovery
		Promoting People, Communities and Social Values
Priority 3 *Growing our strategic research presence and impact*		Fostering integration, partnerships and alliances
		Optimising an efficient and sustainable organisation

This strategy builds on from the achievements of our research strategy prior to its current refresh, against which significant progress was made on the objectives set out within it and an array of notable successes, impacts and examples of research translating into practice (see *Appendix* 2).

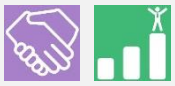
Below the paper sets out the objectives associated with the three strategic research priorities (*what we will achieve)* and also what success is expected to look like (*how will we know we have achieved it).* These have been slightly adapted as part of this refresh, but many remain unchanged as are still relevant for 2024-26 and fit well with national policies cited in section 2.0.

	Priority 1: **Research embedded as a core component of clinical services**
What will we achieve?	**How will we know we have achieved it?**
1. A culture of engagement and involvement in research throughout the organisation (not viewed as exclusive or specialist) 2. Workforce with capacity and capability for research 3. Research awareness in all teams 4. Ability/readiness to open studies in all service areas 5. Clinical staff developing research careers locally – 'growing our own'	✓ Research signposting in clinical documents/areas (including link to national 'Be Part of Research' website) ✓ Increased numbers of staff signposting people to studies ✓ Increased numbers of participants recruited into studies year on year ✓ Increased numbers of studies running in the Trust year on year ✓ Increased numbers of local people registered with the 'Join Dementia Research' (JDR) service year on year and taking part in studies included on the JDR register ✓ Studies in clinical specialties not previously participating in research, or where activity has been minimal ✓ Diversifying our research workforce and supporting nursing and Allied Health Professions (AHP) staff on academic research programmes ✓ Research regularly on the agenda of multi-disciplinary team meetings ✓ Research included in relevant staff supervision/appraisals ✓ All GP practices 'Research Ready' ✓ Research learning events for staff ✓ Protected time for research, including research training and developing research applications ✓ Research 'Community of Practice/Incubator'; regular sessions attended by e.g. grant experts, methodology experts, R&D staff, research active clinicians as well as a forum for those new to research where ideas can germinate and may foster cross collaboration ✓ Staff engaged in all relevant CRN/RRDN Specialty Groups ✓ Research-funded staff embedded in key areas and staff Research Champions in all areas

	✓ Increased numbers of early career researchers, Principal and Chief Investigators year on year ✓ Clinical research posts, e.g. NIHR fellowships, junior doctor academic trainees, joint clinical academic posts with universities and research doctorates ✓ Research targeted to enhance services/interventions in areas identified as a priority for the Trust and/or commissioners ✓ Targeted investment and support in teams identified as 'research hubs' ✓ Research highlighted in CQC report ✓ Research integrated into student clinical placements

	Priority 2: **Enhanced community involvement and awareness**
What will we achieve?	**How will we know we have achieved it?**
1. Partnership working with patients, service users, carers, families and groups representing them, to optimise participation in research 2. Volunteers influencing research development and delivery locally 3. Changed perception of research (demystified) across our community 4. Opportunities for everyone to take part in research studies, including 'harder to reach' groups 5. Raised awareness of social value of research 6. Learning from research shared with our community	✓ More patients, service users, carers and families co-producing research each year ✓ Increase numbers of Patient Research Champions and involve them in more research activities ✓ More local groups and voluntary organisations, including Patient and Carer Experience Forum, involved in raising awareness of and signposting people to research ✓ Actively engaged with Yorkshire & Humber Ethnic Minority Research Inclusion group and people experiencing health inequalities ✓ Involvement in research studies in non-NHS settings, e.g. schools and care homes ✓ Trust Members and Governors regularly provided with information about research ✓ Positive feedback in annual Participant Research Experience Survey, and other media ✓ Bridlington residents engaged in research through increased GP practice involvement and engagement of key community groups ✓ Research opportunities increased in health and social care by utilising technology and existing data systems ✓ Market Weighton residents engaged in more research as part of the 'Dementia Friendly'

	community project and through increased GP practice involvement ✓ Research results shared with study participants ✓ Patient stories about impact of research shared with staff, stakeholders and wider community; encouraging translation of research into practice ✓ Research results shared and awareness raised via annual research conference and other local research learning events



Priority 3: Growing our strategic research presence and impact

What will we achieve?	How will we know we have achieved it?
1. Effective relationships and collaborations with external partners 2. Reputation as a research capable organisation across multiple specialties 3. Recognised as a Trust that delivers high quality research to time and target 4. Income generation - financial sustainability for research 5. Trust more attractive to staff due to its research profile	✓ At least two research grant applications per year submitted with partners where Trust staff included as applicant(s) ✓ New partnerships with commercial, academic, provider and charitable organisations ✓ Trust as a site for studies led by at least one research sponsor each year that has not previously worked with us ✓ Increased marketing to external research partners, including commercial ✓ Partnership working with Yorkshire and Humber Applied Research Collaboration (ARC) and Health Innovation Yorkshire and Humber; aiding translation of research into practice ✓ Joint research staff appointments with local Universities, including professors, formally linked to the Trust ✓ Research involving ICS partner organisations and/or ICS priorities ✓ Primary Care Networks (PCNs) actively engaged in research with the Trust ✓ Deliver a balanced financial position, with goal of delivering a surplus ✓ At least one funded research grant application per year where Trust is a partner/host ✓ Qualification for more than the minimum £25k DHSC Research Capability Funding ✓ Commercial research study opened ✓ Increased share of CRN/RRDN funding ✓ Increased use of research in marketing

	material for the Trust (e.g. for attracting staff, tendering for services) ✓ Research performance targets met ✓ 'Recruitment to time and target' for 80% of studies ✓ High quality, research active staff recruited into Trust or with honorary contracts ✓ Diversifying research funding streams; ensure ongoing financial stability and funding via (i) charitable; (ii) commercial sources and (iii) national grant applications. This will reduce the dependence on NIHR RRDN funding. This will be supported by robust financial policies and standard operating procedures to enable transparency in our research practices. ✓ Alternative modes of funding local research accessed, e.g. charitable funds

6.0 Looking Beyond 2026

As well as working on the three priorities detailed above, it is important that we look beyond these and focus on future ambitions. We should be doing more NIHR Portfolio research which is locally led and playing on our existing strengths in key areas, for example, CAMHS, especially in nature-based research, addictions, perinatal and infant mental health, dementia and digital technology. Our longer term ambition must be to bring in much more external research income, including that of commercial/industry research, and develop a national reputation as a centre of excellence in our key areas. Given the way working practices have changed because of the pandemic and collaboration has become much easier from a distance, this would not need to be a tangible centre, but would have strong regional links to universities and other key stakeholders, alongside national and international collaborators.

This would enable collaborative, cutting edge, interdisciplinary research, impacting on people at every stage in life, from preconception through to old age, transforming patient care, reducing health inequalities, and improving quality of life. Through the development of new partnerships and significantly increased research income, the Trust has the potential to be a key player involved at the forefront of research and innovation highlighted as local and national priority and of having a workforce where research is integral to clinical roles and included in career pathways.

7.0 Research Roles and Responsibilities

In order to support research in the Trust the Research and Development Unit, led by the Assistant Director Research and Development, provides:

- Research governance advice and support
- Research feasibility advice and support
- Conducting specific tasks to 'assess, arrange and confirm local capacity and capability' to deliver each new study, as part of the national Health Research Authority (HRA) study approval process.
- Contractual review and oversight for research studies
- Management of research funding
- Performance management of research and troubleshooting
- Research information management and reporting
- Development of research infrastructure, capacity and capability e.g. Principal Investigator mentoring
- Research partnership building
- Promotion of research internally and externally
- Signposting
- Consenting of research participants and data collection for NIHR Portfolio studies

The Medical Director is the Executive Lead with responsibility for research.

8.0 Implementation and Monitoring

The Assistant Director Research and Development will lead the implementation of the Research Strategy, with Executive Lead support from the Medical Director ensuring the objectives are achieved. Delivery against the Strategy will be formally monitored through the Quality Committee with six-monthly assurance reports to the Trust Board.

Monthly research performance against the annual recruitment target will be monitored by the Board via the Integrated Performance Tracker. A review of research performance will also be included in the Trust Quality Account each year.

The NIHR will continue to monitor the Trust's success in delivering research via national benchmarks, for example, the percentage of open to recruitment studies which are predicted to achieve their recruitment target, and local CRN/RRDN

performance indicators monitored remotely on an ongoing daily basis. The CRN/RRDN will also monitor progress through annual review meetings with the Trust.

Although this Strategy will be driven by the Research and Development Unit; it is inclusive and requires commitment and input from the whole organisation, not only from those who have research included as a significant part of their job role or in their job description, but by everyone.

Appendix 1: Key Documents steering research in the NHS

*'Patients benefit enormously from research and innovation, with breakthroughs enabling prevention of ill-health, earlier diagnosis, more effective treatments, better outcomes and faster recovery…. We will work to increase the number of people registering to participate in health research to one million by 2023/24….We will invest in spreading innovation between organisations.… Performance on adopting proven innovations and on research including in mental health services will become part of core NHS performance metrics and assessment systems, as well as benchmarking data.' (*NHS Long Term Plan, Jan 2019*)*

'*Tell people living with dementia (at all stages of the condition) about research studies they could participate in.'* (NICE Guideline NG97, Jun 2018)

'A sustainable and supported research workforce to ensure that healthcare staff of all backgrounds and roles are given the right support to deliver research as an essential part of care. Clinical research embedded in the NHS so that research is increasingly seen as an essential part of healthcare to generate evidence about effective diagnosis, treatment and prevention.' (The Future of Clinical Research Delivery: 2022 to 2025 implementation plan', DHSC Jun 2022)

'Create a people-centred research environment that empowers nurses to lead, participate in and deliver research, where research is fully embedded in practice and professional decision-making, for public benefit….to create an environment where research is woven into the fabric of our profession'. (Chief Nursing Officer for England's Strategic Plan for Research, Nov 2021)

*'Research is key to ensuring safe evidence-based practice to support patients and patient pathways. It is also important to strengthening the evidence base, to inform service design, clinical reasoning and shared decision-making with the people and communities we work alongside.' (*Allied Health Professions (AHP) Strategy for England: AHPs Deliver, Jun 2022)

'*It is also important to recognise the central role that clinical research plays in a wider research ecosystem… making research part of everyday practice for all clinicians. Ultimately, the events of recent years have shown clearly that research needs to be normalised as core business in the NHS, especially in the most difficult of times, as research for all.'* (Royal College of Physicians/NIHR position statement: Making research everybody's business, Oct 2022)

'Research activity should go to populations who need it, and we would like to encourage the best researchers, wherever they are based, to undertake clinical and public health research in the areas of England with greatest health needs.' (Letter dated 06/02/17 from Professor Chris Whitty, DHSC Chief Scientific Adviser, to NIHR Boards, Medical Schools and University Hospitals)

'Research is a core part of the NHS. Research enables the NHS to improve the current and future health of the people it serves. The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them'. (NHS Constitution, 2011)

'NHS foundation trusts will be required to provide certain essential NHS services including research.' (DoH document on NHS foundation trusts - Ref 6191, Jan 2006)

Appendix 2: Examples of progress achieved through delivery of Research Strategy during 2020 to 2023

- Co-produced animation 'My Research Journey' (3 minutes long) to help de-mystify research and encourage more people to take part. Also produced in various languages.

Humber Teaching NHS Foundation Trust - My Research Journey (English Subtitles) - YouTube

- Quotes from collaborators:

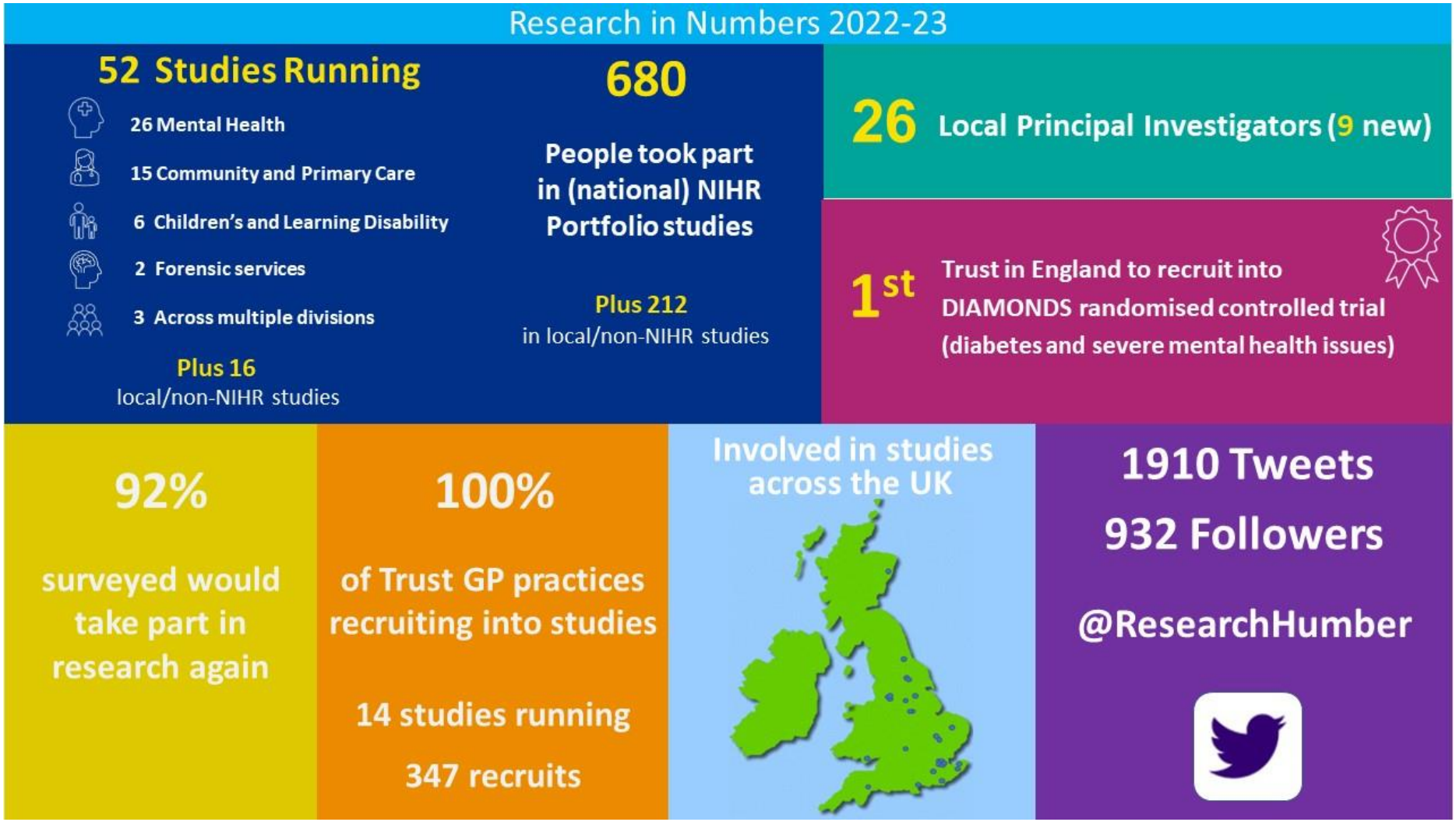
'What an amazing triumph, not only has the study achieved target but recruitment is complete several months before our permitted extension date. We really appreciate your zeal and determination to overcome the difficulties. So many studies have been severely hampered or have indeed failed due to the challenges and limitations of the COVID pandemic but you have been resilient. So be proud of yourselves! We are certainly very proud of you all.' (University College London)

'I just want to take this opportunity to say what a pleasure it's been to work with you on the study. You and the research team have been wonderful to work with and we're delighted that Humber agreed to work with us. We know how hard you have worked and it's testament to the team's dedication that Humber recruited 33 participants!!' (University of York)

'I have really enjoyed working with the mental health teams supporting people in the Humber region. I have been really impressed by the thoughtfulness and energy put into their work and to support research studies like mine.' (University of Oxford)

- Well-led Review:

*'The Trust is ambitious in its research portfolio, has some good examples of how it encourages and celebrates improvement and innovation'. (*Grant Thornton Well-Led Review, April 2022)


Research in Numbers 2022-23
52 Studies Running
26 Mental Health
15 Community and Primary Care
6 Children's and Learning Disability
2 Forensic services
3 Across multiple divisions
Plus 16
local/non-NIHR studies
680
People took part in (national) NIHR Portfolio studies
Plus 212
in local/non-NIHR studies
26 Local Principal Investigators (9 new)
1st Trust in England to recruit into DIAMONDS randomised controlled trial (diabetes and severe mental health issues)
92%
surveyed would take part in research again
100%
of Trust GP practices recruiting into studies
14 studies running
347 recruits
Involved in studies across the UK
1910 Tweets
932 Followers
@ResearchHumber

Impact of Research 2022-23

Changed Lives

'I was pretty well down .. I couldn't seem to experience anything positive ... the study has taught me not to give up.'

Shared Learning

450 delegates from 100+ organisations Registered for our 2022 Conference

'It has motivated me to get involved'

'Gave me areas to think about in my work with people who are struggling with their mental health'

Equality, Diversity and Inclusion

Co-produced research animation available in various languages

Partner in Hull Research Ready Communities and working closely with regional Ethnic Minority Research Inclusion Group

Generated income

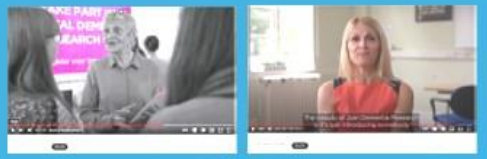
£660K research funding into the Trust

Enhanced Clinical Skills

6 staff trained in new interventions as part of research

43% of studies included novel interventions people would not have had access to otherwise

National Join Dementia Research video features Trust Research Champion & Assistant Director Research



Join dementia research

Contributed to evidence

17 publications included authors from our Trust

9 more publications related to research involving the Trust

Caring, Learning
& Growing Together

Humber Teaching NHS Foundation Trust

Agenda Item 11

Title & Date of Meeting:	Trust Board Public Meeting– Wednesday 29th May 2024
Title of Report:	National Staff Survey Results 2023 – IQVIA Presentation
Author/s:	Karen Phillips – Associate Director of People & OD
Recommendation:	

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

Purpose of Paper:	Charlie Bosher from IQVIA (survey administrator for the Trust) will be attending to deliver the Trust National Staff Survey 2023 results.

Key Issues within the report:

Positive Assurances to Provide:

The Trust positions better than the national average across all People Promise theme areas.

The Trust positions better than the national average in all People Promise sub themes.

The Trust positions better than the average for our benchmark group (51 MH and community Trusts) in all but one People Promise theme area, where we are equal to the average (we are a team)

The Trust positions better than the average for our benchmark group (51 MH and community Trusts) in all People Promise sub themes except two (Compassionate leadership & Line management) and equal to the average in one (motivation)

Key Actions Commissioned/Work Underway:

Equality, Diversity and Inclusion

- Respect Campaign with 'Report It' posters to target bullying, harassment and discrimination towards staff by managers and other colleagues. Posters target racism, homophobia, disability discrimination and sexual harassment.
- Task and Finish Group established to develop a coherent, clinically led process for addressing abuse from patients towards staff based upon their protected characteristics.
- Roll out of the Access to Work Programme led by Estates and Occ Health addressing reasonable adjustments and access to buildings for staff with a disability/long term condition.
- Move forward action plan from LGBT Foundation towards our Rainbow Badge Accreditation to address areas of risk around sexual orientation, gender expression and identity.

The Trust is the most improved provider of its kind in the country for the question asking staff it they would recommend their organisation as a place to work. Improvement in the number of staff who agree/strongly agree that they 'would recommend their organisation as a place to work" which has risen from 49% in 2019 to 67% in 2023, making the Trust the most improved in the country for Trusts of its kind and second most improved in the NHS over that time period. The Trust reports above sector and national scores for five key questions; ○ I feel that my role makes a difference to patients / service users. ○ Care of patients / service users is my organisation's top priority. ○ My organisation acts on concerns raised by patients / service users. ○ I would recommend my organisation as a place to work. ○ If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	• Implementation of Equality in Action - Breaking barriers for women's advancement - a gender equality initiative. • Implementation of the Act Against Racism Charter– Royal College of Psychiatrists • 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 planned following a recent gap analysis **Wider Actions** • The Trust has been recognised as an exemplar Trust and has received funding for a 12 month fixed term role that will focus on improving retention with focus on the People Promise theme areas in the NSS.
Key Risks/Areas of Focus: 1. Note that a last minute complication at a national level with the results for the People Promise theme 'We are Safe and Healthy' means	**Decisions Made:** • N/A

this theme is currently unreported. 2. Note that the presentation refers to the IQVIA sector comparison of 28 Trusts and not the national position. The presentation does however compare Trust year on year figures. **3. Specific Areas of focus from the survey** ○ People Promise 7 – Sub score 2 – Line Management ○ People Promise 1 - Sub score 2 – Compassionate Leadership 16c06 Experienced discrimination on grounds of age. Bottom 20% of sector, Org 29.1%, Sector 20.5%. 16c04 Experienced discrimination on grounds of sexual orientation. Bottom 20% of sector, Org 8.5%, Sector 5.8%. The last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it. Below the sector score and reduced against 2022 figure ○ **WRES Areas of Focus** Ind5: q14a - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?	

Ind8: q16b - In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues? ○ **WDES Areas of Focus** Ind5: q14a - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public? Ind8: q16b - In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	14/05/24
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Board	29/05/24

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

Agenda Item 12

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	NHS Equality Delivery System (EDS22)
Author/s:	John Duncan - EDI Partner Mandy Dawley - Assistant Director of Patient and Carer Experience
Recommendation:	

To approve	x	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	This paper sets out the Trusts Equality Delivery System (EDS22) submission for 2024, which provides evidence towards the Trust meeting its EDI objectives for patients and the workforce.

Key Issues within the report:

- EDS Reporting Template
- Domain 1: Commissioned or Provided Services
- Domain 2: Workforce Health and Wellbeing
- Domain 3: Inclusive Leadership
- Action Plan

Positive Assurances to Provide:

- Humber Youth Action Group (HYAG) continues to grow with 40 members.
- Launch of the Youth Recovery and Wellbeing College
- Re-accredited as Veteran Aware. We were originally accredited in May 2020 where we met standards laid down by the Veterans Covenant Healthcare Alliance (VCHA
- WDES data puts the Trust 29th out of 212 NHS Trusts (Top 14%)
- Trust is better than national averages for 18 of 19 metrics in the national WRES and WDES figures.
- Trusts Gender Pay Gap is better than national average

Key Actions Commissioned/Work Underway:

- Patient and Carer Experience Five Year Forward plan (2023 to 2028)
- Patient and Carer Experience (PACE) forums Armed Forces Community Navigator (AFCN)
- Experts by Experience (EbE) initiative
- Young Peoples Co-production and Participation toolkit for Staff
- Humber NHS cadets programme launched in November
- Patient and Carer Experience Annual Report (including Complaints and Feedback).
- Actions arising from WRES/WDES/Gender Pay Gap Report
- Rainbow Badge Accreditation
- Respect Campaign
- No Excuse for Abuse Task and Finish Group
- NHSE EDI Improvement Plan
-

Key Risks/Areas of Focus:

- NHS England EDI Improvement Plan
- Progress against Workforce Equality

Decisions Made:

- N/A

Objectives 2023/24	

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	14/05/24
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Board	29/05/24

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	

Classification: Official

Publication approval reference: PAR1262

NHS Equality Delivery System 2022

EDS Reporting Template

Version 1, 15 August 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	**Humber Teaching NHS Foundation Trust**	**Organisation Board Sponsor/Lead**
		Karen Phillips –Associate Director Workforce and OD
Name of Integrated Care System	Humber and North Yorkshire	

EDS Lead	John Duncan/Mandy Dawley		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	18/05/23 05/01/24 24/01/24		**Individual organisation**	
			Partnership* (two or more organisations)	
			Integrated Care System-wide*	Peel Project Humber and North Yorkshire Health and Care Partnership Hull City Heath Care Partnership East Riding of Yorkshire Council Health Watch Hull (and East Riding) PACE Forums

Date completed	April 2024	**Month and year published**	May 2024

Date authorised		**Revision date**	

Completed actions from previous year	
Action/activity	**Related equality objectives**
• The Trust continues to use Reachdeck (formerly called Browsealoud) accessibility tool on the website. • An online Friends and Family Test survey is now available on the Trust website and can be converted into many languages using the websites Reachdeck toolbar. To support the online form, information on how to access the online form is available on the website in seven of the Trust's most popular languages. • Trust Strategy produced and available in Easy Read. • Patient and Carer Experience forums and events taking place virtually via MS Teams and face to face. • Additional iPad's have been purchased to help our Learning Disabilities patients access Microsoft Teams meetings. Patients are now able to attend virtual meetings with support from the Engagement Lead for Learning Disabilities and Autism. Workshops and other feedback sessions have realised an increase in engagement since the iPad's have been introduced. • The Trust continues to use Microsoft Teams when engaging with the public. Patient and Carer Experience forums and the Humber Youth Action Group are using this platform which is proving to encourage accessible participation across all age ranges. • Children's and Young Peoples services are using Canva to create marketing resources and social media assets. • MS Forms have been introduced across all services to create surveys to support the gathering of information and experiences to help shape and improve our services and the care we deliver. • Several services are using the Bridgit Care App to support patients, services users and carers (including young people and their families), to access support, care plans and information. • ChatHealth – The East Riding 0-19 Service has introduced ChatHealth. ChatHealth is a confidential text messaging platform for young people aged 11-19 (up to 25 for those with special educational needs and disabilities) to access specialist school nursing support and easily accessible information. • Parentline – Both the Hull and East Riding 0-19 service are launching Parentline which is a confidential text messaging system for parents and carers and will provide families with an accessible way to access specialist health visiting advice and support, as well as reliable information. This is especially valuable to more vulnerable parents who may wish to remain anonymous when seeking advice and support.	**Patient and Carer's Objectives:** • To increase the voice of individuals from all backgrounds by offering more flexibility and different approaches when engaging with the Trust. • To improve digital inclusion methods to support individual needs. • To further develop systems and processes to encourage young people to actively engage with the Trust. • To continue to strengthen data collection processes to better understand the demographics of the people accessing our services.

• Learning Disability services have health action plans, positive behaviour support plans and accessible plans in paper format and electronic format. • Learning Disability services have the 'My Health Guide' on tablets for Learning Disability patients to allow them to share their own information. • The Carers Champion training is accessible for all Trust staff via ESR. The training helps identify unpaid carers, raise awareness in our services, families or community and helps individuals to signpost a carer to the support available from local carers support organisations. • Talking Mats have been introduced in the Trust's Learning Disability Services. They come in two formats (digital and physical) and include a range of images and tiles to describe most situations that may be encountered in everyday life. It is anticipated that by providing an alternative and effective means of communication will improve the way in which our service users can express their needs from both a medical and a social perspective. • The Trust gave away goody bags at Hull Pride 2022 to everyone who completed a short survey to share their views on how they would like to be engaged with the Trust during the next five years. Responses helped to inform the Trust's Patient and Carer Experience Five Year Forward Plan (2023 to 2028). • The Trust's Humber Youth Action Group continues to grow from strength to strength enabling young people to shape and co-produce services as well as provide an opportunity for individuals to learn about the Trust and develop new skills and knowledge. • In November 2022 the Trust launched a clinical template for collecting demographical data including protected characteristics and health inequalities. The template has been designed to improve the quality of demographical data reported into the Trust's clinical systems (SystmOne and Lorenzo). It is anticipated that this additional template will support staff to ask more qualitative questions about an individual's protected characteristics and/or health inequalities. By asking additional questions will provide the Trust with more robust demographical data about our patients and service users which will help to inform the Trust on who our patients and service users are. This will help the organisation to engage and involve our wider community in Trust activities (e.g. forums and quality improvement initiatives).	
• Recruitment deep dive report developed (see link below), that examines shortlisting and appointment against all protected characteristics, with biannual reporting for assurance moving forward. This report provides insight and targeted recruitment actions for divisions and taken into areas by HRBPs, with bespoke actions agreed in areas. A new EDI bulletin has been developed to ensure the EDI lead and HRBPs can collaborate on actions for divisions. • We have successfully been accredited by the LGBT Foundation for the NHS Rainbow Badge Scheme, with initial stage recognition and have been provided with an action plan that will inform our EDI workstreams moving forward. We are ambitious to progress to bronze accreditation, and the	**Workforce Objectives:** • Analysis of applications to work for the Trust show that males, and disabled people are underrepresented compared to the communities we serve. Targeted recruitment and advertising actions to be

improvement action plan provided by the LGBT Foundation will be actioned in collaboration with the Trust LGBTQ+ staff network, and our divisional areas. • Our Respect campaign was launched in the November, with a range of 'Report It' posters in the workplace, with the aim of developing a positive and safe workplace culture. This campaigns focus is on developing a safe culture to report 'staff to staff' incidents of bullying, harassment or discrimination, towards all people, but with particular emphasis on reaching underrepresented groups, namely but not limited to, the LGBTQ+ community, those with a disability or long-term condition and colleagues from ethnically diverse backgrounds. In addition, we developed a 'Report It' intranet page as a resource hub, hosting all relevant information, contact details and policies. • As part of the Trust's membership of Stonewell's Diversity Champion Scheme, the Trust will be using their proud employer jobs portal to advertise a number of band 7 and above job roles to the LGBTQ+ community, a review will be undertaken when job roles have been filled. Since December the EDI Lead reviews a selection of job roles advertised on NHS Jobs on a monthly basis for language, quality and accuracy of information. Meetings are established between EDI Lead and HRBPs to regularly review adverts for band 7 and above roles, and measure what new channels for advertising have been exploited such as Pink Jobs, and Stonewall's Proud Employer portal. • The Humber High Potential Development Scheme 2024 is in progress with plans in place to ensure the offer is been shared with staff networks, global email and MS Teams EDI channels. Planned promotion through internal networks such as the Leadership Forum are planned. Similar activities will take place when the Leadership and Senior Leadership programmes open to new cohorts. A mentoring offer, including reverse mentoring, has been developed and work is underway to fully embed the scheme. • WRES and WDES reports are shared with the relevant networks, however there is still work to do to bring the raw data to networks earlier in the timeline to contribute to analysis and action planning based upon the WDES/WRES metrics for 23/24 data. • Bullying and Harassment training for managers has been written and planned for an internal delivery model. It provides practical steps and conscientious guidance to help prevent, identify, and confidently confront bullying and harassment at work. It will provide leaders and managers with information, knowledge and understanding of Bullying & Harassment for staff in the workplace. Following the Trust's policy on Bullying and Harassment. • Diversity data is represented through the ESR portal with a full data quality process in place since 2021 and led by the Strategic HR team. In early 2020 unspecified entries for equality data was as high as 27% across the organisation, this has now been greatly reduced and in December 2023, we had 25 Permanent staff with unspecified entries and this was reduced to 6, a reduction of 76%. • 'Being Humber' standards are interwoven into the new people strategy, into our leadership development programmes, values-based recruitment and the Respect campaign. Work is currently being undertaken with the OD team to link the Trust Behavioural Standards framework to inclusive	established to attract those underrepresented to the Trust • To achieve the NHS Rainbow Badge Accreditation at bronze level. • Embed the Respect campaign as business as usual. • ED&I Workforce Lead, in collaboration with HRBPs, to review advertising strategy for band 7 – VSM • Use available communications channels to showcase success stories and promote the Humber High Potential Development Scheme, the Leadership and Senior Leadership programmes, and NHSI targeted development to our ethnically diverse, Disabled/LTC and LGBTQ+ staff. • Through our governance structures, support and empower our Race Equality, LGBTQ+ and Disability Staff Networks to work with ethnically diverse and Disabled/LTC staff on the development of the WRES/WDES action plan, and development opportunities • Continue to deliver Trust bullying and harassment awareness training for managers • Continue to drive the process to reduce the number of 'unspecified' entries in staff records.

language guidance provided in support for teams. The first collaborative training event with OD and EDI took place on 19th January. • We are supporting the Humber and North Yorkshire Health and Care Partnership's coaching network, which is for anyone working or volunteering in health and social care across Humber, North Yorkshire and West Yorkshire. We have promoted the Health and Care Women Leaders Network led by the NHS Confederation. Communications channels included Trust Global email, WOD MS Teams, Equality Network MS Teams, Trust Local email and the managers Newsletter. • Whilst processes have been agreed for competitive rounds for 24/25 awards, there is an indication that LCEA processes will cease under new pay award arrangements for consultants. As such equal distribution was applied for 23/24. • We currently have 19 trained female mentors, alongside a comprehensive Mentoring Hub (humber.nhs.uk). Currently we have 3 female mentees undergoing the mentor programme. Work is ongoing to ensure widen participation and embedding of the scheme. • Progress has been made with a template developed to add succession planning as an element of workforce planning. HRBP's will work with divisions as a part of these plans.	• Ensure high visibility of the Trust Behavioural Standards framework. • Deliver and monitor female participation in Career Confidence Coaching sessions • Ongoing analysis of recruitment EDI data • Embed and monitor the newly launched mentoring programme to take an intersectional approach to identifying collaborative actions

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	• Single Point of Access – Inpatient & Community Forensic Services. • Single Point of Contact for Community Services in North Yorkshire. • Front Door, Single Point of Access – Children's. • Supporting 111 Option 2 for Mental Health calls. • Introducing Youth Recovery College & Wellbeing College.	**Achieving activity**	Service Managers.
	1B: Individual patients (service users) health needs are met	• ED Streaming now operational. • The Humber Centre now has an enhanced vocational and educational offer. • PMLD Doctor provision for Hull. • Addictions Service – Inclusion Health Team.	**Achieving activity**	Service Managers.
	1C: When patients (service users) use the service, they are free from harm	• Daily Safety Huddles (Corporate and Divisional) demonstrate that 99% of patients receive harm free care. • Patient Safety Investigations under the new Patient Safety Incident Response Framework fully implemented, which provides robust mechanisms for learning and improvement and links to quality improvement methodology. • Patient Safety Incident Response Plan and Policies which have been co-produced with PACE and patient safety partners so ensure	**Excelling activity**	Patient Safety Team

		our reflective of what is important to the people who are using the services. • The introduction of the 'Involving patient and families' working group to ensure the voice of the patient is heard in relation to patient safety and areas of improvement and development. • Think family approach underpins safeguarding and patient safety. • Two Patient Safety Partners and two Patient Safety Specialist in post in line with the National Patient Safety Strategy • Thematic review of our patient safety incident over the past three years which has led to the development of our patient safety priorities and key quality improvement initiatives to improve patient safety and reduce harm. • Annual Peer Reviews embedded across all the divisions resulting in the development of quality improvement actions plans to drive improvement and improve safety. • Strengthened processes for Learning the Lessons and Learning from Excellence • Introduction of the cultures dashboard. • Leadership visibility and announced and unannounced visits to areas of frontline practice. • Patient Safety Syllabus Level 1, Oliver McGowan training (Compliance 93.87%) and Freedom to Speak up mandatory for all staff. • Safeguarding level 1 (compliance 99.36%) and MCA level 1 mandatory training (compliance 97.8%) • Staff survey results improving year on year which demonstrates healthy workforce who deliver compassionate care to people who use services.		

		• Weekly Pressure Ulcer Review and Learning Group and demonstrates the vast majority of pressure ulcers do not occur in our care. • Quarterly Falls Working Group. • Clinical supervision compliance monitoring • Clinical risk training to ensure staff understand, assess and plan for risk appropriately with patients. • Safer staffing establishment reviews in line with NQB and NHSI requirements. • Robust governance and assurance processes • Complaints and Feedback routinely reviewed and thematic deep dives undertaken, with improvement plans put into place to action areas raised. • Friends and Family Test and national service user feedback • Infection prevention and control 5-year plan 2023-2028. Good levels of hand hygiene and PPE adherence. Very low outbreaks of communicable diseases and these are COVID related and good evidence of containment and management. IPC training compliance 97%. zero cases of Trust apportioned MRSA, MSSA or *E. coli* bloodstream infections or Clostridioides difficile infections • Safeguarding plan 2023-2026 in place • White ribbon accreditation • Safeguarding adult and children's policies are in place alongside mental capacity policies, all of which put the individual at the heart of safeguarding processes. • Safeguarding oversight of individuals in inpatient services who are in seclusion or long term segregation.		

		• Service visits and monthly safeguarding meetings in secure services, attendance at clinical network and governance meetings • Safeguarding oversight of all patient safety incidents reported across the Trust. • Safeguarding investigations and reviews carried out on behalf of Local Authorities • Signed up to Sexual Safety Charter and Steering group in place to take forward further areas of focus to continue to ensure patients and staff are safe • Reducing restrictive interventions in line with the Use of Force Act in place and data routinely monitored and all periods of prone restraint reviewed via the Clinical Risk Management Group. • Peer review process in place and involves the Patient Safety Specialists and Patient Safety Partners who visit clinical areas to review against standards of care. • Freedom to speak up processes in place. • All newly qualified staff supported through preceptorship academy and inducted into safe cultures and speaking out about closed / unsafe cultures. • Mandatory training in place with excellent compliance rates of 94.71%, we are second in the country for training compliance. • Greatix, sharing and learning from excellence		
	1D: Patients (service users) report positive experiences of the service	• **Friends and Family Test** – website has ReachDeck software which includes; text-to-speech, reading and translation support to the website. Provides instant access to assistive features and helps to reduce barriers between our digital content and our diverse online audiences. FFT online form to assist collecting feedback from	**Excelling activity**	Assistant Director of Patient and Carer Experience/Patient and Carer Experience Team

		our ethic diverse communities. https://www.humber.nhs.uk/Services/friends-and-family-test.htm • **National Community Mental Health Service User Survey** – The Community Mental Health Service User Survey working group meets on a regular basis to identify and implement actions, to address areas where improvements can be made. A robust governance process is in place to support the delivery of the action plan. • **National GP Survey** – The Primary Care Improvement Programme has been established to co-ordinate several improvement projects to address feedback received. • **Scale, Spread and Embed national project** - The Trust's three GP practices participate in this initiative. An algorithm has been built into the Trust's FFT Dashboard (for the pilot teams – 3 GP practices) where thematic analysis of the FFT feedback responses (positive and negative) are shared. • **Patient, Service User and Carer stories** are shared at Trust Board and Council of Governor meetings. • **Patient and Carer Experience forums**, visit the Trust's website for further information: https://www.humber.nhs.uk/Services/patient-and-carer-experience.htm • **Patient and Carer Experience Annual Report (2022/23) including Complaints and Feedback**		

		showcases how patients, service users and carers report on their positive experiences of our services and informs on the variety of initiatives taking place across services: https://www.humber.nhs.uk/Services/patient-and-carer-experience.htm • The Trust has recently produced it's next **Patient and Carer Experience Five Year Forward Plan (2023 to 2028)** which informs how it will listen, support and work together with our patients, service users and carers over the next five years: https://www.humber.nhs.uk/Services/patient-and-carer-experience.htm • A Good Experience initiative - this is a project from the Humber and North Yorkshire Integrated Care System (ICS), that will give an agreed and expected standard of communication for everyone accessing any services from organisations within the ICS and will also support staff from all organisations within the ICS.		
Domain 1: Commissioned or provided services overall rating			10	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Staff Survey Outcomes reflect progress with workplace health and wellbeing. • New People Strategy 2024-2028 places a lens on organisational wellness • Physical Health and Wellbeing MOT inc. Blood Glucose, Cholesterol, Blood Pressure, Body Composition and Emotional Wellbeing assessment • Weight loss, smoking cessation support through Health and Wellbeing services. • Talking Therapies accessible to employees • Employee Physiotherapy Service • Free flu/covid vaccination • Health and wellbeing programme of events to support physical health. • Mental Health First Aiders • Counselling support offered through Occupational Health Services. • Access to Employee Assistance Programme. • Policies related to enhanced leave and flexible working in place to support overall wellbeing and flexibility.	**Achieving activity**	Health and Wellbeing team/ Occ Health team

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Key findings from the Trust Workforce Race Equality Standard (WRES) submission for 2023 finds; 1. The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months is 21.2%. Notably this is a reduction of 9.2% on the previous year, as well as being significantly better than the national figure of 30.4%. 2. The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months is 25.8%, a similar figure to the previous year but this is better the national figure of 27.7%. 3. The percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months is 16.7%, which is an improvement on the previous year and only 0.1% above the national figure of 16.6%. WDES key findings from the Workforce Disability Standard (WDES) finds; 1. The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from managers in last 12 months is 11.7% (down on the previous year 13.8%). This is nearly double the comparative figure for staff without a disability which is 6.4%. However, the Trust figure is the lowest it has been for five years, continuing a year on year improving trend and is better than the national figure (16.4%).	**Developing activity**	EDI Lead/ Workforce and OD Operational team

		2. The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from other colleagues in last 12 months is 22.6% this compares to 10.9% of staff without a disability, and is better than the national figure of 25%. 3. The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from patients/service users in last 12 months is 32.2% (compared to 21.1% non-disabled staff), which is showing a 2.2% decline since 2022 but reports a position 0.9% better than the national average. • Staff Survey shows a reduction in B&H • Trust has signed up to the Act Against Racism Charter led by Executive Medical Director. • Respect Campaign, supported by anti-B&H posters and digital resources to develop a safe culture to report incidents • Equality, Diversity & Human Rights training is a mandatory course for all staff • In house Bullying and Harassment Awareness Training for Managers • Trust has implemented the NHS England EDI Improvement Plan		
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Support services on offer include: Staff counselling service via Occupational Health, an Employee Assistance Programme (EAP), an Employee Psychology Service (EPS) and NHS psychological support	**Achieving activity**	Occupational Health/Workforce Operational team

	2D: Staff recommend the organisation as a place to work and receive treatment	62.8% of staff would recommend the Trust as place to work, which matches the national average, and is a year-on-year improvement from 2018 when the figure was 47.6%. 65.3% of staff would recommend the Trust as place to receive treatment, which is 4.9% above the national average, and is an improvement from 2018 when the figure was 60.4%.	**Achieving activity**	Workforce Experience team (Staff Survey) Divisions (actions)
Domain 2: Workforce health and well-being overall rating			7	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Medical Director has oversight of the Act Against Racism Charter led by The Royal College of Psychiatrists and the Executive Medical Director has oversight. • Associate Director of People & OD has oversight of the WRES/WDES/Gender Pay Gap/Staff Survey and People Strategy • The Trust has an EDI Steering Group led by the Associate Director of People & OD, and its membership is drawn from across the divisions, this group reports to the Workforce and Organisational Development Committee • Three executive leads act as sponsors for the Trust's Staff Networks, providing strategic support and high-level escalation to EMT • The Executive Management Team receives a quarterly EDI report to provide assurance as to meeting our EDI aims. • Governance is assured through QPaS, W&OD Committee, as well as Divisional ODG meetings, where aspects of EDI for staff or patients are routinely discussed including reports such as WDES/WRES/Gender Pay Gap/PACE Annual Report/Staff Survey and EDI Annual Report	**Achieving activity**	Executive leads

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• All new policies, procedures and projects undertake an Equality Impact Assessment (EqIA) to identify any areas of concern to the Board. • A new Health Inequalities Working Group reports directly to the Executive Management Team • The Executive Management Team receives a quarterly EDI report to provide assurance as to meeting our EDI aims • The Trust is undertaking the Patient and carer race equality framework (PCREF) which will report to the Executive Management Team	**Excelling**	EDI Lead/ Strategic Partnerships Manager/ Assistant Director of Patient and Carer Experience and Co-production
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• The Trust has implemented the Patient Safety Incident Response Framework (PSIRF), with reports going to EMT, to maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. • The Trust has implemented a new People Strategy overseen by the Associate Director of People & OD • The Workforce Information team provide an award-winning Workforce Scorecard and People Insight Report that provides a comprehensive overview of workforce performance for all divisions • Areas are subjected to Accountability Reviews with monitoring in place via EMT	**Excelling**	Associate Director of People & OD /Executive medical Director/Patient Safety Lead
Domain 3: Inclusive leadership overall rating			8	
Third-party involvement in Domain 3 rating and review				

Trade Union Rep(s):	**Independent Evaluator(s)/Peer Reviewer(s):**
Staff Side Reps	Miriam Sykes CHCP

EDS Organisation Rating (overall rating):

Achieving

Organisation name(s):

Humber Teaching NHS Foundation Trust

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
John Duncan/Mandy Dawley	Annual
EDS Sponsor	**Authorisation date**
Karen Phillips Associate Director of People & OD	24/01/24

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Improving quality of information. Improve access within Primary Care.	Reviewing and improving consistency of Mental Health Patient Brochures ENGAGE Consult IN Primary Care and Cloud-based telephony system	September 2024 March/April 2024
	1B: Individual patients (service users) health needs are met	Improve the physical health offer within Forensic and Mental Health inpatients. To provide an alternative to admission for Children and Young People with an eating disorder.	Recruit to a Dietetics post. To fully mobilise the service, including recruiting to all vacant posts.	April 2024 April 2024

	1C: When patients (service users) use the service, they are free from harm	To ensure we continue to strengthen the voice of the patient, families, and carers. Strengthen our processes for learning from excellence to ensure good practice and learning is shared system wide.	Further develop the role of the patient safety partners and recruit additional partners to work with and alongside the divisional engagement leads. Explore how we better capture learning from excellence, and embed learning the lessons events	
	1D: Patients (service users) report positive experiences of the service	Quality Improvement Quality Improvement Strengthen Inclusivity Engagement and Involvement	To develop and roll out a new style FFT Dashboard together with a QI approach to address feedback received. To increase the number of 'You Said, We Did' examples on the Trust website To further enhance our faith offer to ensure inclusivity for our patients, service users and staff. To continue to build and sustain relationships with our diverse communities.	August 2024 March 2024 March 2025 March 2025

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Quality Improvement	• Develop integrated referral pathways between Occupational Health and Wellbeing team • Implementation of evidence-based initiatives (asymptomatic testing) • Seek feedback on wellbeing activities and Period Dignity Scheme and use this to shape future action • Develop 2024/25 workplan	June 2024 June 2024 June 2024 April 2024
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Bullying and Harassment • Support for staff	• Monitor and review the effectiveness of the Respect Campaign, embedding principles into the business. • Deliver paper to EMT to regarding support to staff who receive abuse from patients. • Develop managers flowchart to support staff who have received abuse from patients. • Progress against the WRES/WDES action plan • Progress action plan from the LGBT Foundation regarding the Rainbow badge accreditation scheme	Quarterly June 24 June 24 June 24 August 24
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Improving support to staff subjected to abuse from patients	• Task and finish group to develop clinically led process to ensure managers are providing consistent and effective support to staff who have been subjected to abuse from patients by bringing together existing reporting and support mechanisms	July 24

	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff Survey Outcomes	• Tailored divisional action to work in their areas to address staff perception of the Trust as a place to work and receive treatment	Workforce Experience team, HRBPs, Operational areas

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• NHS England EDI Improvement Plan • Executive Sponsorship of Staff Networks	• Chief executives, chairs and board members to have specific and measurable EDI objectives to which they will be individually and collectively accountable. • Board development session to discuss options, best practice and implementation of above action	June 24 Complete
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Quarterly Board EDI Assurance Report • Health Inequalities reporting to Board. • Reporting against Act Against Racism Charter – Royal College of Psychiatrists	• Board will regularly review the impact of equality and health inequalities and the associated risks through regular review and development sessions. • Board will regularly have the opportunity to challenge the progress and support EDI initiatives and actions	Quarterly Quarterly Quarterly
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• Ongoing Accountability reviews • Quarterly Board EDI Assurance Report • EDI Annual Report, WRES/WDES and Gender Pay Gap reporting	• Through regular reporting, the Board will be assured that levers are in place to manage performance and monitor progress with staff and patients, and have the opportunity to understand and challenge areas of risk	Quarterly Quarterly Annually

		• Patient and Carer Experience five year forward plan (2023-2028) • Patient and Carer Experience Annual Report (inc. Complaints and Feedback)		Quarterly Annually

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting– 29th May 2024
Title of Report:	Charitable Funds Update
Author/s:	Peter Beckwith, Director of Finance Rachel Kirby, Deputy Director of Communications and Charitable Funds
Recommendation:	

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

Purpose of Paper:	The purpose of this paper is to update the Trust Board (as corporate Trustee of the Charity) on progress with the charity since the transfer in house.

Key Issues within the report:

Positive Assurances to Provide:

- All Legacy Wishes have now been closed
- Governance arrangements for the charity have been reviewed against the charity commission internal controls checklist
- Positive Staff engagement in the work to date

Key Actions Commissioned/Work Underway:

- Review of wider governance arrangements planned for later in the year
- New Wishes platform due to go live end of May/early June
- Website Relaunched and new Branding developed
- Communications Plan developed

Key Risks/Areas of Focus:

- None

Decisions Made:

- The Trust Board are asked to note the current updates in relation to the charity following the transfer back in house.

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Trust Board	✔

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*

Caring, Learning
& Growing Together

√ *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	

1. Introduction and Purpose

The purpose of this paper is to update the Trust Board (as corporate Trustee of the Charity) on progress with the charity since the transfer in house

2. Background

The Trust Board (as corporate trustee) agreed to a proposal to bring the charity back in house in November 2023. The contract with Hey Smile Foundation terminated on the 31st March 2024.

The decision was based on continued poor performance against KPI's as well as a desire to bring clinical and corporate teams closer to our charitable objectives.

To ensure a safe transfer in house, a charitable funds transition group was established, this group met during bi -weekly during January to March providing assurance and escalation to EMT where appropriate.

3 Local Governance and Oversight

3.1 Charitable Funds Group

To ensure the day to day operations of the Charity are successful and operating as intended, a charitable funds group has been established, this group meets monthly and will provide assurance reports to EMT.

The Charitable Funds Group will review governance arrangements for the charity, the risk register, support communications plans and have oversight of wishes in the system to ensure they can be progressed in a timely manner.

3.2 Internal Controls Checklist

The Charitable Funds Group has reviewed the charities internal controls using the Charities commission internal controls checklist. This has identified there are no high-risk areas or areas requiring immediate attention, however improvements can be made, and an action plan has been developed to be implemented over the next 12 months

3.3 Charity Management

The charity will sit within the communications department under the leadership of the Deputy Director of Communions and Charitable Funds with executive lead remaining the Trust's Director of Finance.

In addition to the leadership roles above, the following resource will support the in house management arrangements:

Role	Main Duties
Charity Management (B6) 30 hours (Anita Green)	Ensure that the Charity is well managed and that there are clear plans and processes that reflect charity best practice; allowing the Charity to deliver its full potential. The Charity Manager will also line manage the existing role of Events & Communications Officer as they will provide support for fundraising events.

Role	Main Duties
Communications Support (5) 20 hours (Helen Waites)	Support the delivery of the fundraising plan through the development and management of effective marketing campaigns. Day to day management of communications including website updates, newsletters, social media management, event support, case studies and impact reporting.
Financial Support (Jessica Spicer)	Existing Resource has been identified within the financial services structure to support with the financial administration and reporting
Administrative Support (Nicola Furley)	Existing Resource has been identified within the financial services structure to support with the general administration and reporting

3.4 Trust Board Oversight (As Corporate Trustee)

Given the transfer in house the proposal in the first instance is that the governance arrangements for the charity remain in situ with the charitable funds committee continuing to meet on a quarterly basis with assurance reports to Trust Board.

A review of this arrangement is planned for later in the calendar year.

4 Wishes Update

4.1 Legacy Wishes

At the point of transfer from Smile Foundation back into the Trust there were 37 live wishes, all legacy wishes have now been either fulfilled or closed.

3 live wishes are currently being developed into more significant 'dreams' schemes, details of which are below

Dream	Name/ Description	Next steps
New waiting area at Inspire	**'Worth the Wait'** Help us create a new reception and waiting area for children and young people accessing mental health and NHS therapies.	Estates are progressing to get final costs to confirm full appeal details.
Sensory Room – ERCH	**'Make Sense'** Creating a new sensory room to provide a safe and supportive space for neurodivergent children at East Riding Community Hospital	Estates managing. Update required to understand when to draw down funds. (*Whilst funded it can be used as an example of a successful 'appeal' for the website*).
Dementia friendly day room	**'Donate for Dementia' or** **'The Fitzwilliam Appeal'** Together we can create a haven of comfort, dignity, and connection for those navigating the challenging journey of dementia.	Estates are progressing to get final costs to confirm full appeal details. Charity team to visit Malton for an update.

4.2 New Wish Process

As part of the transitional work the charity team have reviewed options to streamline the wish system, and a new process has been developed using MS Forms Software. The new process will take wish makers step by step through a robust process including finance, medical devices, IPC, Health and Safety and Charity Manager approvals before requiring final sign off by the Fund Guardian.

The form will live in a new Staff Zone on the relaunched charity website. It will also include guidance on what constitutes a 'wish' and walks them through completing the application.

It is envisaged the new wish process will go live towards the end of May/early June , and currently trial wishes are being progressed to test the process.

4.3 Dreams and Wishes

To streamline the wish process the Charitable Funds Group have considered and supported the following proposal where requests are separated between wishes and dreams**.**

- **'Wishes'** will be submitted via the online MS forms process. These will be approved by the Charity Manager and Fund Guardian. The process will also include assurance that service managers are aware of the wish. Fund Guardians are currently Divisional General Managers and the Executive Director of Finance for 'The Big Thank You'.

- All **'Dreams'** will be worked up as a full business case for the Charitable Funds Committee. This will include all values of charitable funding requests. The Fund Guardian is part of this process.

4.4 Branding

Branding has been developed for the new wish process, and this is summarised below:

Logo Family

5 Communications Update

5.1 Website Relaunch

A new website has been written which repositions the charity and is focused on donations, telling charity stories and communicating who we support and what we fund.

It also includes a dedicated 'Staff Zone' to support staff giving and applications for charitable funds. From this section staff can access the new one-step application form to access charitable funding for all requests under £5000. This is supported by new online and print guides – 'A Step by Step Guide to Making a Wish' and 'Accessing Charitable Funding: A Guide for Staff'.

The site will be re-launched on 20th May.

5.2 Marketing Plan

There will be a soft launch of Health Stars on w/c 6th May to allow us to test the new wishes process. This will also give us the opportunity to troubleshoot any issues prior to relaunch.

This will be followed by the reopening of wishes and the launch of the new Health Stars website end May/early June.

Due to the 100K Your Way staff health and wellbeing event also launching on 1st May and running throughout the month we will build up the communications throughout the month before talking more loudly throughout June.

Pennies from Heaven, our payroll giving scheme and the charity lottery will be relaunched along with the website to grow our support to these regular opportunities to give. Dedicated marketing will follow to focus on each scheme and the benefits for staff.

5.3 New Marketing Message

To reposition the charity in the hearts and minds of our supporters we need to create a compelling narrative that brings to life who we are and what we do.

As a complex organisation operating across a wide range of services and unique geography this work will ensure we are able to engage potential fundraisers and donors with our core purpose.

'What we do' – where we have impact

We have reviewed past wishes to summarise of how charitable funds has an impact across our services. These themes will be used across our marketing messaging to demonstrate what we fund to the public and to give clarity to staff when applying for charitable funds.

Known as out impact pillars, these are summarised in the table below.

Enhanced Equipment	Enhanced Environment	Patient and Visitor Experience	Supporting Out Staff	Healthier Communities
Funding equipment that NHS budgets do not cover. This could be an item that is not considered essential but will help our staff to provide the best possible treatment or the most cutting-edge version of an essential piece of equipment	Making our buildings more attractive and therapeutic. Donations help us go beyond plain walls and basic decoration improve the experience for people who use our buildings and services.	Providing the little extras that make a visit or stay in our services that little bit brighter. We help ease the burden on families, offer comfort through treatment and reduce boredom	Making a donation is a brilliant way to say 'thank you' and support our incredible NHS team. Whether they cared for you as a patient or looked after a loved one, we know that they have a positive impact every day and we want them to know what a difference it makes.	We are committed to reducing health inequalities and creating healthier futures for people in Hull, East Yorkshire and North Yorkshire

Who You Support' - summarising our services

Health Stars does not have the benefit of being a hospital charity. Due to the nature of our services and our estate, we have to work harder to help potential donors understand our purpose and how their support can have a real and lasting impact.

When considering the marketing of the charity we have grouped our services into five categories. These categories have been chosen to maximise funding and public and stakeholder engagement (This has been supported by the divisions).

Mental Health And Wellbeing	Children, Young People and Families	Neurodiversity	Learning Disabilities	Healthy Communities
We support people to live happier and more fulfilling lives. We help people to get help early and support their mental wellbeing, provide treatment, support, rehabilitation and recovery, as well help in an emergency.	We help give children the best start in life. We promote good health, emotional wellbeing and help prevent illness, helping young people to reach their full potential and enjoy life.	We support people to thrive in their everyday lives. We provide screening, signposting and support services that work together with individuals to understand what support is needed and how to help.	We help people with a learning disability live a happy and fulfilling life. We provide assessment, treatment and support to help them live as independent a life as possible.	We improve the health and wellbeing of your local community. We care for people close to home, focusing on preventing illness, making diagnoses, treating conditions and offering urgent medical help.

6 Recommendation

The Trust Board are asked to note the current updates in relation to the charity following the transfer back in house.

Humber Teaching NHS Foundation Trust

Agenda Item 14

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	24/25 Board Assurance Plan
Author/s:	Peter Beckwith, Director of Finance Jon Duckles, Head of Partnerships and Strategy
Recommendation:	

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

Purpose of Paper:	The purpose of this paper is to provide the Board with assurance against each priority area as described in the NHS England 24/25 Priorities and Operational Planning Guidance. The paper also outlines gaps in assurance/negative assurance where these have been identified.

Key Issues within the report:

Positive Assurances to Provide: • This paper has been refined as part of the service planning and operational planning process with extensive input from divisional and corporate colleagues. • This approach was approved by EMT following the discussion at the Trust Strategic Board.	**Key Actions Commissioned/Work Underway:** • All gaps in assurance are being actively managed in collaboration with system partners. • This document will be used to update the Trusts Board Assurance Framework.
Key Risks/Areas of Focus: • Key risks and areas of focus are identified within the document.	**Decisions Made:** • Not applicable

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	7/5/24
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		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	

Board Assurance Plan 2024/25

NHS
Humber Teaching
NHS Foundation Trust

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
Quality and Patient Safety	Implement the Patient Safety Incident Response Framework (PSIRF).	**Innovating for quality and patient safety**	PSIRF currently being embedded into Trust patient safety incident response policies and plans. Plan to improve the engagement of patients and their families in response to incidents. Plan in place to recruit patient safety partners who will ensure that the patient/service user's voice is heard.	
Primary and Community Services	Improve community services waiting times, with a focus on reducing waiting lists.	**Enhancing prevention, wellbeing and recovery**	The Trust is working with ICB colleagues to manage and find solutions to the demand that CYP and adult neurodiversity referrals are placing on the Trust and how these may be safely managed utilising independent providers and shared care arrangements. Service specification reviews for Children's Therapy Services to ensure that service specifications reflect the services that our workforce is being asked to deliver. Waiting lists in Dietetics are reducing due to recent investment. Core CAMHS are almost <18 week compliant. Within S&R Community Services (as of April 24) there are 192 patients waiting longer than 18 weeks across all services (down from 228 in March 24). Most services are maintaining their waiting lists; the key outlier is physiotherapy with (105 >18 weeks in March 24). However, significant capacity and demand analysis and a pathway review has been undertaken to improve this position.	CYP and Adult ADHD and CYP Autism waiting lists are currently outstripping demand due to significant rise in referrals. Due to the size of the current ADHD medication waiting lists for CYP the current children's and adult services are not able to start anyone on medication as the services are at capacity. The current waiting lists are on pause. Long waiting lists in Paediatric Speech and Language Therapy services due to increase in demand post Covid. Reviewing the model of referral in to Contact Point CAMHS due to increased demand.

Board Assurance Plan 2024/25

NHS
Humber Teaching
NHS Foundation Trust

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
	Continue to improve the experience of access to primary care, including supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.	**Enhancing prevention, wellbeing and recovery**	The Trust are delivering the PCN DES in line with National Guidance: - Installation of an improved telephony infrastructure across all three practices. - Promotion of the NHS App supported by digital volunteers in practices increasing App utilisation, improved digital access to appointments, care navigation and Total Triage. - Working with PCN colleagues to ensure that ARRS roles deliver additional capacity within practices via the PCN. - Ongoing provision of extended access appointments over and above PCN target. These measures are expected to be reflected in improved FFT and patient satisfaction results.	
Mental Health	Improve patient flow and work towards eliminating inappropriate out of area placements.	**Enhancing prevention, wellbeing and recovery**	We will continue to work with ICB colleagues and provider collaboratives to improve bed base to reduce the need for out of area placements. Support improvements in the quality and safety of all-age inpatient care, by finalising and publishing system 3-year plans to localise and realign inpatient care in line with the mental health inpatient commissioning framework by June 2024. Working with social care providers to reduce delayed transfers of care which in turn should reduce OOA placements.	There are system challenges around patient flow and a lack of places to discharge patients is leading to a bottleneck which is increasing out of are placements due to reduced flow. There is a potential gap around assurance that out of area beds are delivered by providers that are CQC compliant.

Board Assurance Plan 2024/25

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019).	**Enhancing prevention, wellbeing and recovery**	The Trust continues to deliver the CMHT transformation. The Trust will deliver person centred care planning programme by December 2024. Service specification reviews will ensure that service specifications reflect the services that our workforce is being asked to deliver. We will continue to work with acute colleagues to ensure people with a mental health issue who attend ED are managed by the ED streaming service. The Trust will continue working with VCSE & other agencies to increase awareness and referrals into perinatal services. We are continuing to develop our early intervention and prevention model in children's services for emotional mental health and wellbeing. We are working to establish a pre assessment pathway for Paediatric Speech and Language Therapy to address quality of waits. Eating Disorder Intensive Treatment (EDIT) Team supporting admission avoidance for children young	Significant local system gap in funding for Eating Disorder Services. This is a priority for Hull and East Riding Place however the funding to deliver this is unavailable. Long waiting lists in Paediatric Speech and Language Therapy services due to increase in demand post Covid.

Board Assurance Plan 2024/25

Humber Teaching NHS Foundation Trust

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery.	**Enhancing prevention, wellbeing and recovery**	We continue to review access and recovery data by ethnicity and deprivation decile. The Trust has consistantly delivered over 700 patients a month who complete 2+ contacts at discharge. The Trust have consistantly delivered above the 48% reliable recovery objective over the last year and is demonstrating an increase against 23/24 figures. The Trust also demonstrates a 67% reliable improvement rate over the last year and is demonstrating an increase against 23/24 figures. We will continue to develop Recovery College Embedding the recovery strategy throughout the Trust. The Trust continues to work work with the ICB & Public Health to achieve 6 week and 18-week access targets.	
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025.	**Enhancing prevention, wellbeing and recovery** **Promoting people, communities and social values**	Where appropriate Humber services are supporting primary care in helping to deliver on this target. Our three practices are also working within their PCNs to enable delivery for their practice populations.	Much of this work is delivered by Primary Care.
	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025.	**Enhancing prevention, wellbeing and recovery**	We continue to work with ICB colleagues to reduce the wait for memory assessment, including timely access to diagnostics. We are working to increase the dementia diagnosis rate to 66.1% across Hull and East Riding. The Trust is working with ICB, Local Authority and VCSE to review and redraft service specs for older people's services. The wider system is exploring solutions to issues with diagnostic imaging and reporting and the Trust are involved in these conversations.	Diagnostic imaging and reporting capacity from the Acute Trust continues to be a challenge and is having a negative impact on delivery of a timely diagnosis.

Board Assurance Plan 2024/25

NHS
Humber Teaching
NHS Foundation Trust

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025.	**Enhancing prevention, wellbeing and recovery**	Where appropriate, Trust services are supporting primary care in helping to deliver on this target. Our three practices are also working within their PCNs to enable delivery for their practice populations. Bridlington PCN achieved 93% delivery and Harthill PCN achived 72% however there were a large number of patints who declined the service within Harthill PCN.	
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population.	**Enhancing prevention, wellbeing and recovery**	Adult LD services are in the process of agreeing and developing a Home-Based Treatment Team (HBT), which would sit within the management structure of the Intensive Support Team (IST). The HBT Team would provide specialist support into a person's home to either prevent admission to the Assessment and Treatment Unit (A&TU), or to support earlier discharge from the A&TU. Forensics Services have reviewed Length of Stay (LoS) of LD patients in secure services. Average LoS has reduced by approx. 12 months from baseline, but remains higher than average for LD patients. The Learning Disability Forensic Outreach and Liaison Service (LDFOLS) continue to support discharge.	The Trust are working with partners to deliver a solution to better support patients with an LD closer to their own home however funding is a significant barrier. A permanent psychiatrist role which would support LDFOLS has been advertised within the community forensics team, but there has been little interest in the position.
Prevention and Health Inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children. and young people	**Promoting people, communities and social values**	The Trust's delivery plan for health inequalities for 2024/25 focuses on: - Communications and knowledge transfer. - Data analysis. - Team Support/New project development. - Integrating health inequalities into Trust strategies and policies. - Training and awareness training for staff. - Ensuring that approaches to health inequalities are embedded in clinical practice.	

Board Assurance Plan 2024/25

Humber Teaching NHS Foundation Trust

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions.	**Developing an effective and empowered workforce**	People strategy with strategic priorities and targets ratified in January 2024 and launched in March 2024. Associated people strategy delivery plan in place to shape operational actions. The Trust positions better than the national average across all People Promise theme areas. The Trust positions better than the national average in all People Promise sub themes. Improvement in the number of staff who agree/strongly agree that they 'would recommend their organisation as a place to work" which has risen from 49% in 2019 to 67% in 2023, making the Trust the most improved in the country for Trusts of its kind and second most improved in the NHS over that time period.	Specific Areas of focus from the 2023 NSS: - Experienced discrimination on grounds of age. Bottom 20% of sector, Org 29.1%, Sector 20.5%. - Experienced discrimination on grounds of sexual orientation. Bottom 20% of sector, Org 8.5%, Sector 5.8%. - The last time I experienced harassment, bullying or abuse at work, myself or a colleague reported it. Below the sector score and reduced against 2022 figure. WRES and WDES Areas of Focus: - In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public? - In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?
	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors.	**Developing an effective and empowered workforce**	Flexibility in rotas: - Higher Trainees self-roster for their on-call duties. - Core trainees have the ability to swap their on-call duties. Reducing duplicative inductions: - An induction relating to their Psychiatry placement is the induction doctor's attend. Payroll errors: - A salary starter form has been produced, detailing all elements of a doctor's salary to ensure payroll errors are at a minimum.	

Board Assurance Plan 2024/25

NHS
Humber Teaching
NHS Foundation Trust

NHS Operational Priorities and Planning Guidance Area	NHS Operational Priorities and Planning Guidance Objective	Linked to Strategic Goal	Positive Assurance	Gaps in Assurance/Negative Assurance
	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan.	**Developing an effective and empowered workforce**	The breadth of the apprenticeship standards we offer has increased dramatically, the start of 2024 shows 32 different apprenticeship standards currently being undertaken across the Trust and this is continually expanding. This means we have a more qualified workforce across all of our departments. On average we have 130 staff undertaking an apprenticeship at any one time from level 2 (GCSE) to level 7 (masters) apprenticeships. We have staff that have completed a level 2, 3, then level 6, and are now fully qualified registered staff.	- We could be greater aligned to workforce planning for the clinically registered apprenticeships, embedding apprentices into our Trust preventing them to go elsewhere on completion of their apprenticeship. There is no formal agreement to support them to stay. - Off the job hours and placements cause managers staffing issues when they are already short staffed. - Work Experience placements are secured in departments that are willing to support students, these aren't currently linked to the long term strategy of staffing shortages.
Use of resources	Deliver a balanced net system financial position for 2024/25.	**Optimising an efficient and sustainable organisation**	We have confidence that we can deliver a BRS of 1.5% annually. We will continue to deliver efficiencies through the delivery of productivity and efficiency programme and the use of technology e.g. New EPR, e-rostering.	Wider ICS Financial Position (Deficit Plan £50m) Level of unidentified efficiencies across the ICS (£55m). ICS Stretch Income target (£25m)
	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25.	**Optimising an efficient and sustainable organisation**	We will deliver a reduction in bank and agency of 28% (£2.218m). We will end the use of "off framework" agency usage before July 2024.	

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 15

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Humber & North Yorkshire (HNY) Integrated Care Board (ICB) Objectives 2024/25
Author/s:	Michele Moran Chief Executive
Recommendation:	

To approve		To discuss	
To note	√	To ratify	
For assurance			

Purpose of Paper:	To present the ICB Objectives for 2024/25 to the Board

Key Issues within the report:

Positive Assurances to Provide: • The actions for driving delivery of objectives for Leading for Excellence, Prevention, Sustainability and Voice at the Heart were presented.	**Key Actions Commissioned/Work Underway:** • Developing the detail to achieve the objectives
Key Risks/Areas of Focus: • Financial means to develop the objectives	**Decisions Made:** • ICB April 2024 meeting

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) - Board	29.5.24

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

Caring, Learning
& Growing Together

	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 and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

ICB Objectives 24/25

Stephen Eames

Humber and North Yorkshire Health and Care Partnership

Leading for Excellence

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Actions for driving delivery of objectives

- Embed at pace our Innovation, Research, Improvement System (IRIS) to support our commitment to be a transformational ICS.
- Drive digital innovation at pace to ensure that the ICS is at the leading-edge by scaling up digital solutions to deliver our vision system priorities, and system wide operations.
- Ensure rapid progress in the use of data to provide high quality business intelligence and to support real time decision making.
- Take every opportunity to shift resources from acute services to community, primary and social care settings.
- Sustain a high-performance culture in the ICB and ensure a high-quality leadership cadre.
- Model our vision and values (including the values in the new Leadership framework for Board members) and message to our staff, our partners, and the wider community.
- Personally champion the delivery of the HNY ICB Equality, Diversity and Inclusion improvement plan 2024/5
- Practice excellent people interventions including high personal visibility, brilliant communications, high expectations of individuals and effective rigorous performance appraisal.
- Ensure that ICB/ICP governance arrangements are of the highest standard and are focused on safety of service users, oversight of risk, avoiding unnecessary bureaucracy and enabling clear decision making

Leading for Prevention

Actions for driving delivery of objectives

- Measurably improve outcomes for patients and communities by transforming and improving services
- Deliver a population health and inequalities programme in 24/25 that measurably moves towards the long-term aim of improving the life chances and quality of life for people who live in HNY.
- Act as an Anchor network to exploit the collective potential of the System, including partner organisations, wider public service, the Further Education sector, and local business to address health and wider inequalities in the most deprived communities in Humber and North Yorkshire.
- Deliver plans for 24/25 that specifically improve Cancer, Coronary Vascular Disease, Mental Health and Elderly Frail Services.
- Deliver plans for 24/25 that continue to reduce smoking through the ongoing development of the HNY Centre of Excellence for Tobacco control.
- Deliver phase 1 of the plan to deliver a generational change in the health and wellbeing of children who live in HNY

Humber and North Yorkshire Health and Care Partnership

Leading for Sustainability

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Actions for driving delivery of objectives

- Create a blueprint for future service provision and associated organisational form by September 2024 for implementation from April 2025
- Deliver a quality financial and productivity programme in 24/25, based on the Grant Thornton review, that delivers measurable quality improvements, financial balance and increased productivity including reducing the overall pay bill of the ICB and the wider NHS in HNY
- Deliver financial and efficiency plans of 4.2%, applying the principle of no deficits; whilst making investment decisions which will enable the ICS to achieve its ambitions.
- Accelerate the workforce breakthrough programme including measurable improvements 24/25, 25/ 26, 26/27 in all workstreams.
- Implement world class systems for nurturing and growing leadership potential across the ICS including effective succession planning, both in the ICB and across our partnership.
- Rapidly embed the accountabilities and delegated authority of provider collaboratives and places to ensure the ICS operating model delivers system and organisational goals and plans.
- Ensure significant improvements in ICB productivity in 24/25 by effective application of flexible working policies and use of technology.

Humber and North Yorkshire Health and Care Partnership

Voice at the Heart

NHS Humber and North Yorkshire Integrated Care Board (ICB)

Actions for driving delivery of objectives

- Lead and manage effectively upwards (into NHSE and DHSC), outwards (Our 4+1 regional model) and horizontally across our 28 partner organisations and partners the voluntary, education and business sectors.
- Establish leading edge approaches to understanding the views of the people we serve and seek to co-produce plans and actions that respond effectively to their needs.
- Develop programmes of engagement that promote health ensuring that over time health really is everyone's business, particularly in those areas where health inequality is life limiting.

Humber Teaching NHS Foundation Trust

Agenda Item 16

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Finance Report April 2024
Author/s:	Name: Peter Beckwith Title: Director of Finance
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper:	This report is being brought to the Trust Board to provide the financial position for the Trust as at the 30th April 2024 (Month 1). The report provides assurance regarding financial performance, key financial targets and objectives.

Key Issues within the report:

Positive Assurances to Provide:	**Key Actions Commissioned/Work Underway:**
• At Month 1 a financial position consistent with the Trust plan has been recorded • Cash balance at the end of April was £22.976m.	• Work on year end accounts is ongoing.
Key Risks/Areas of Focus: • None.	**Decisions Made:** • The Trust Board are asked to note the Finance report for April 2024, and comment accordingly.

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	29.5.24

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 2024

1. Introduction

This report is being circulated to the Trust Board to present the financial position for the Trust as at the 30th April 2024 (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 current version of the Trust plan with the Integrated Care Board is a deficit Budget of £0.933m for the 2024/25 financial year.

The Trust has uploaded a budget consistent with the ICS financial planning position which reflects the £0.933m.

A monthly profile has been reflected in the Trust Budget.

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 and the main focus going forward will be to forecast the outturn position.

3. Pay Award

The current financial position reflects pay award funding of 2% which is consistent with the plan submission and the planning guidance.

4. Agency

An agency expenditure target has been set for 2024/25 at £5.583m this represents a reduction in expenditure of 28% from 2023/24

Table 1: Agency Target Spend by Staff Group

	2023-24 Actual £	2024/25 Target £
CHILDRENS AND LD	1,961,569	1,403,788
COMMUNITY & PRIMARY CARE	408,291	292,192
MENTAL HEALTH	4,760,670	3,406,951
FORENSIC SERVICES	350,933	251,143
CORPORATE	319,888	228,926
Total	**7,801,351**	**5,583,000**

Off framework Agency Expenditure in April was £14k. There is a recognition that Off Framework Agency expenditure should be eliminated from 30 June 2024.

5. Cash

As at the end of April 2024 the Trust held the following cash balances:

Table 2:
Cash Balance

Cash Balances	£000s
Cash with GBS	22,848
Nat West Commercial Account	96
Petty cash	33
Total	**22,976**

The cash balance is influenced by a number of different factors including the lead provider collaborative, non recurrent funding and timing of capital expenditure.

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 £
NON NHS		
Total bills paid	2,451	8,326
Total bills paid within target	2,279	7,316
Percentage of bills paid within target	**93.0%**	**87.9%**
NHS		
Total bills paid	129	3,161
Total bills paid within target	107	2,922
Percentage of bills paid within target	**82.9%**	**92.4%**
TOTAL		
Total bills paid	2,580	11,487
Total bills paid within target	2,386	10,238
Percentage of bills paid within target	**92.5%**	**89.1%**

7. Recommendations

The Trust Board are asked to note the Finance report for April 2024, and comment accordingly.

Humber Teaching NHS Foundation Trust

Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting– 29th May 2024
Title of Report:	Trust Performance Report – April 2024
Author/s:	Name: Peter Beckwith/Richard Voakes Title: Director of Finance/Business Intelligence Lead
Recommendation:	To approve: ☐ To discuss: ☐ To note: ☑ To ratify: ☐ For assurance: ☐
Purpose of Paper:	This purpose of this report is to inform on the current levels of performance as at the end of February 2024. 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.

Key Issues within the report:

Positive Assurances to Provide:

- Mandatory Training – the Trust maintained a strong position against the Trust target of 85%, reporting current compliance at 94.6%
- The overall trust vacance position is current at the lowest reported level of 6.3%, with Nursing Vacancies maintaining a below target position. Consultant vacancies remain above target but report the lowest position in months.

Key Actions Commissioned/Work Underway:

- Targeted work continues in all services that are challenged by meeting over 52 week and 18 week waiting time standards to recover and achieve sustainable improvement. This work is underpinned by capacity and demand analysis which is refreshed on a regular basis. A recent audit demonstrated that the operational approach in place to address waiting times gave “significant assurance”.
- Dialogue continues with the ICB to agree a way forward on waiting times for 2024/25 and beyond. This continues to be an area of national challenge, but it does not receive priority for Mental Health Investment Standard (MHIS) funding. ODG and EMT oversee the position and work to reduce waiting times.
- A proposal has been developed to further transform the older adult acute care pathway and this is being taken forward in the Mental Health. LD and autism ICS collaborative. If supported this should see older adult out of area placements eliminated.

	• PICU flow is currently being targeted through improvement methodology to recover the out of area position, this is also being affected by patients who are being transferred from prison whose discharge is subsequently being delayed by Ministry of Justice restrictions.
Key Risks/Areas of Focus: • Waiting times for both children's and adult neurodiversity services continues to be the most significant area of pressure and challenge. In all these areas demand exceeds commissioned capacity. Additional non-recurrent investment that the Trust was able to commit in 2023/24 has now ceased as it could not be achieved in the financial plan for 2024/25, meaning that the waiting times will deteriorate again in these services. • Clinical Supervision - The lower-than-target compliance this month is in part as a result of lower compliance in Community and Primary Care (84%) and Childrens and Learning Disability Division (74%). The target is (85%) with high compliance in maintained in Mental Health planned (96%) and unplanned (88%) Forensic (92%) and Corporate (98%). • Out of area placements for adult mental health beds and our Psychiatric Intensive Care Unit (PICU) has risen during April. Demand for these beds has been high and the PICU unit has been 100% occupied. Patient need has also led to the requirement for female only environments and therefore this has impacted the need to use out of area beds for patient safety and quality of care reasons. Scheduled estate works are taking place currently to significantly improve the PICU seclusion suite which is also temporarily impacting on patient flow. Focussed work is taking place to address all aspects of adult and older adult acute care inpatient flow	**Decisions Made:** • None (report is to note)

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	29.5.24

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	

Financial Year 2024-25

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.

Chief Executive: Michele Moran

Prepared by: Business Intelligence Team

Reporting Month:

Apr-24

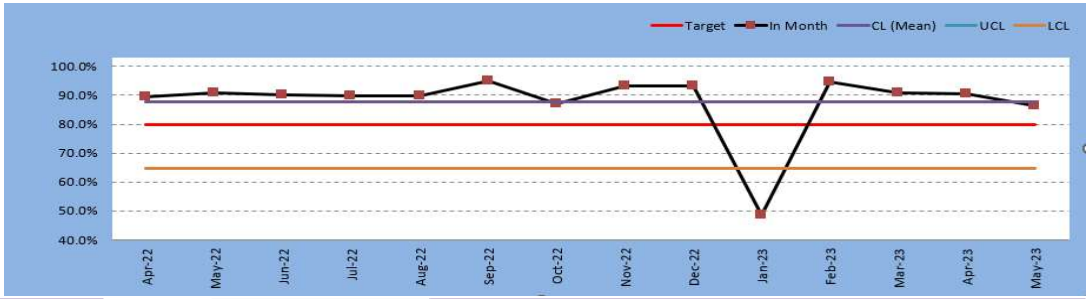
Humber Teaching NHS Foundation Trust

Trust Performance Report

Humber Teaching NHS Foundation Trust

For the period ending:	April 2024

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

NHS Humber Teaching NHS Foundation Trust

For the period ending: **April 2024**

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
Goal 2	NHSER Talking Therapies - Moving to Recovery	Recovery Rates for patients who were at caseness at start of therapeutic intervention

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending:	April 2024

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 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

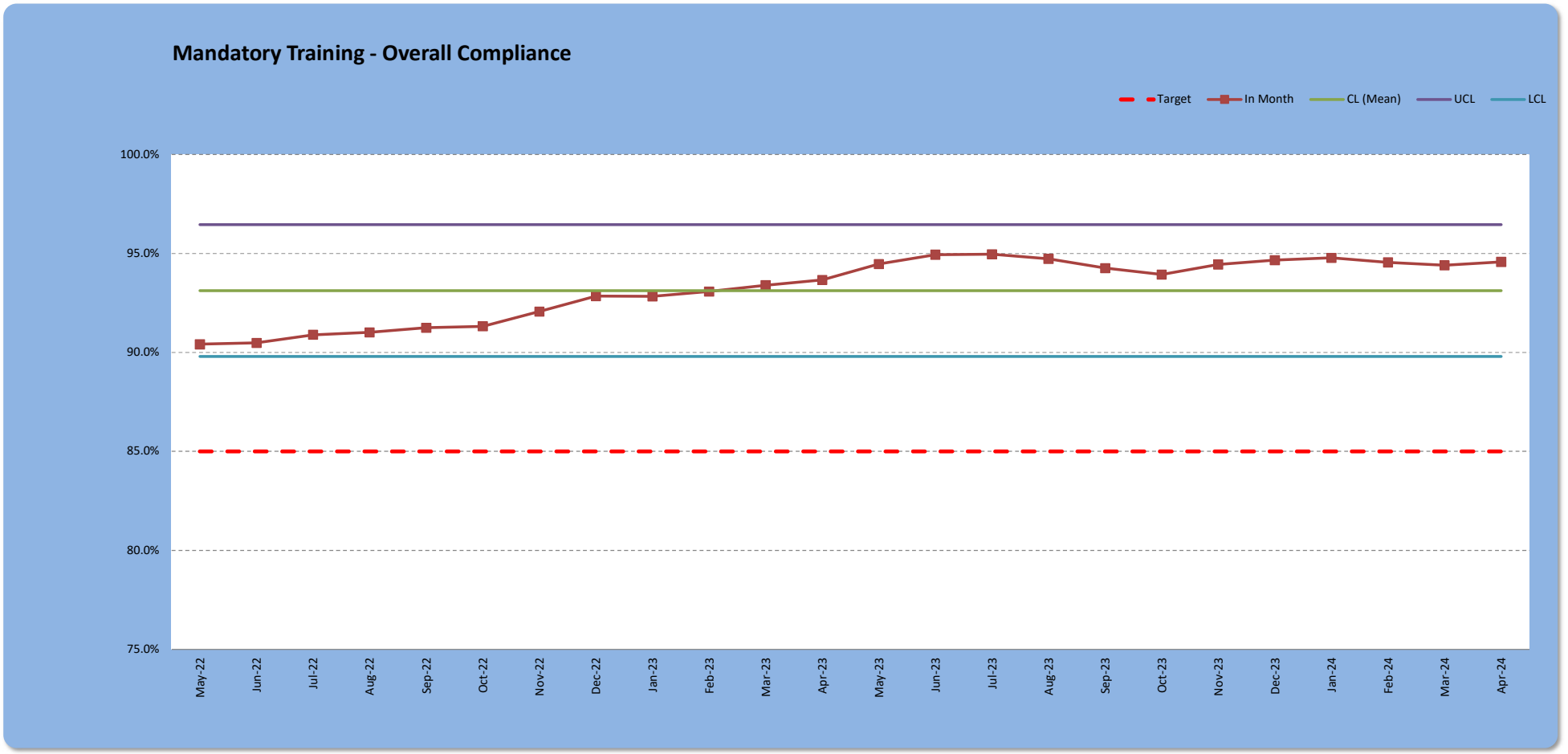
PI RETURN FORM 2024-25

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
85%	80%	94.6%

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

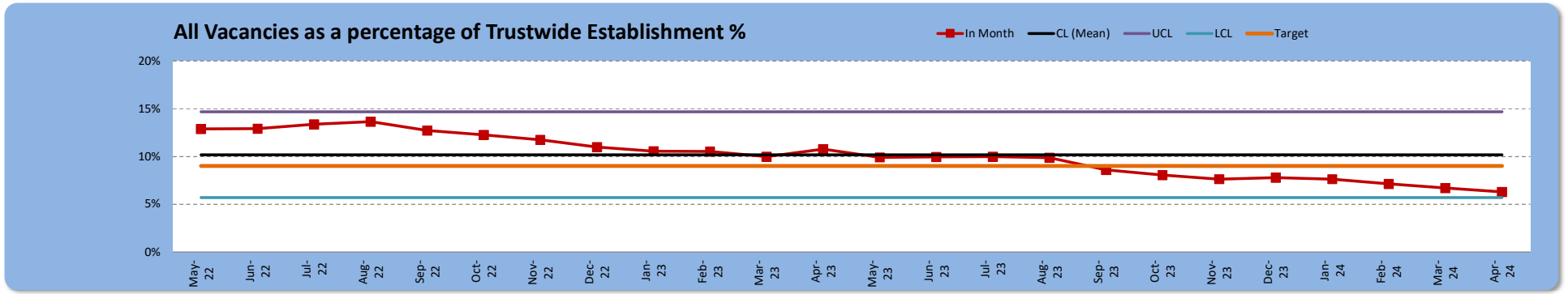
PI RETURN FORM 2024-25

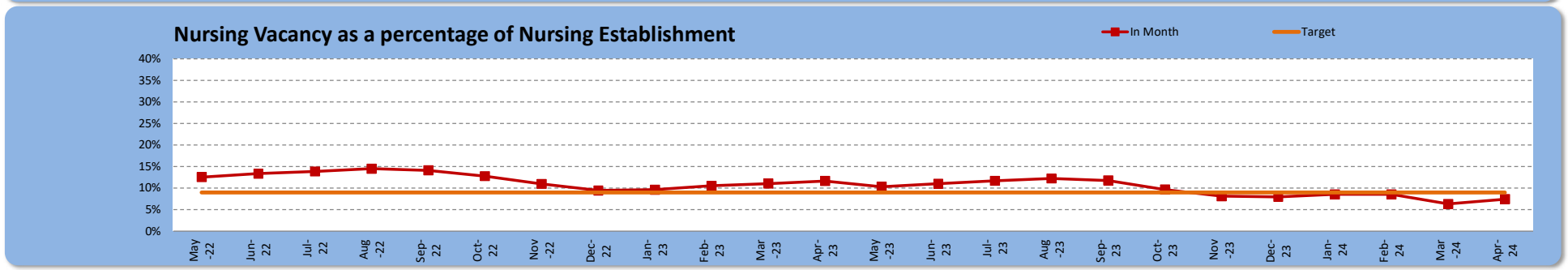
Goal 1 : Innovating Quality and Patient Safety

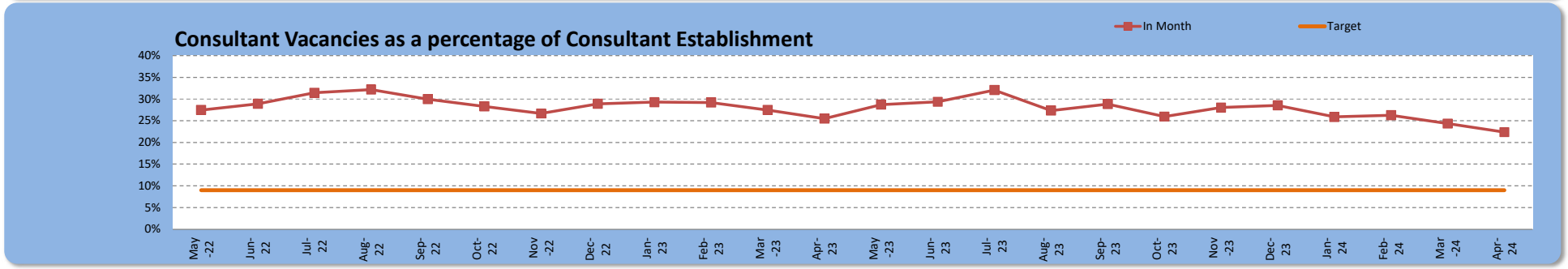
For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
N/A	N/A	6.3%

Indicator Title	Description/Rationale	Executive Lead	KPI Type
Vacancies (WTE)	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.	Karen Phillips	WL 2 VAC







Please refer to the accompanying front sheet/report for any relevant commentary

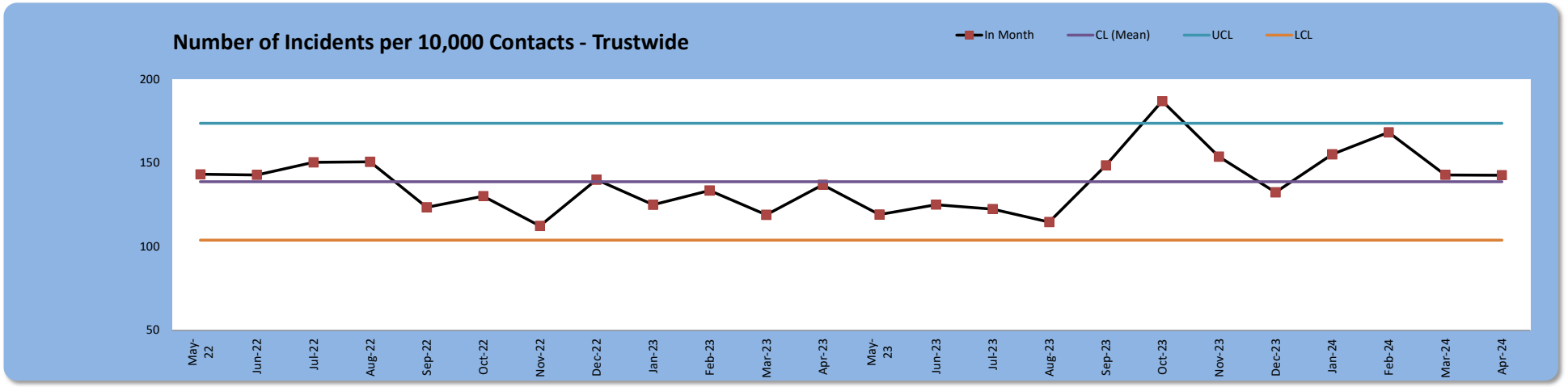
PI RETURN FORM 2024-25

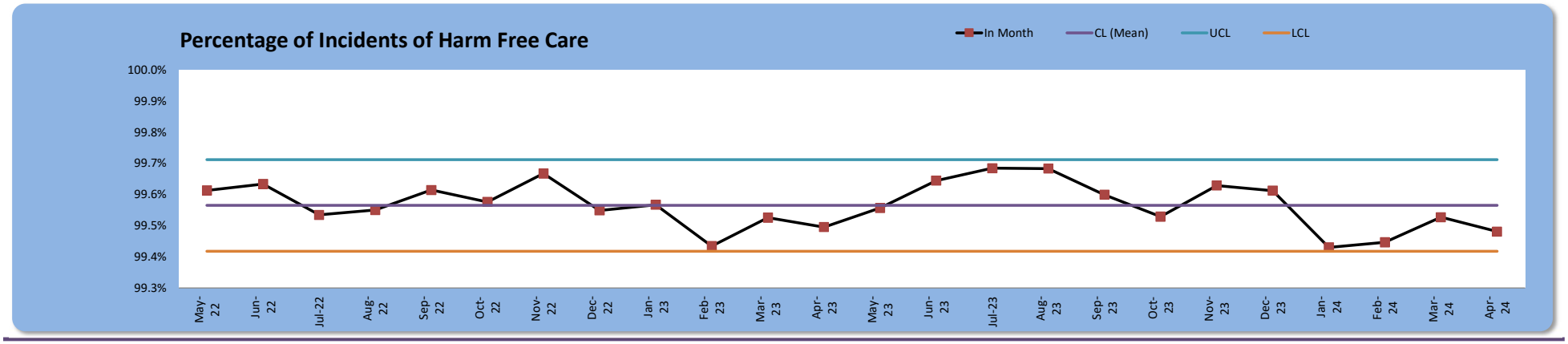
Goal 1 : Innovating Quality and Patient Safety

For the period ending: **April 2024**

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 Hilary Gledhill	IA_TW





Please refer to the accompanying front sheet/report for any relevant commentary

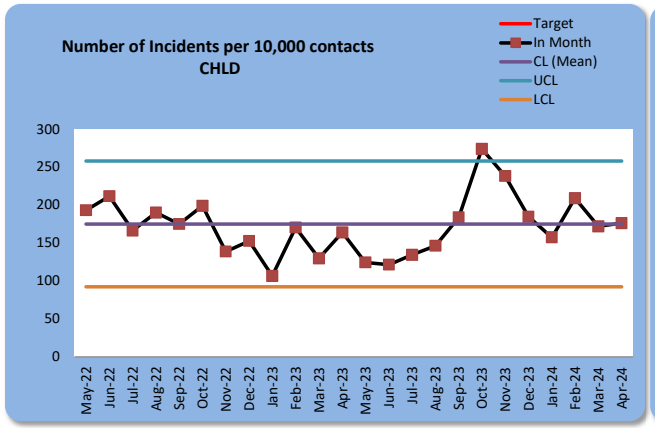
PI RETURN FORM 2024-25

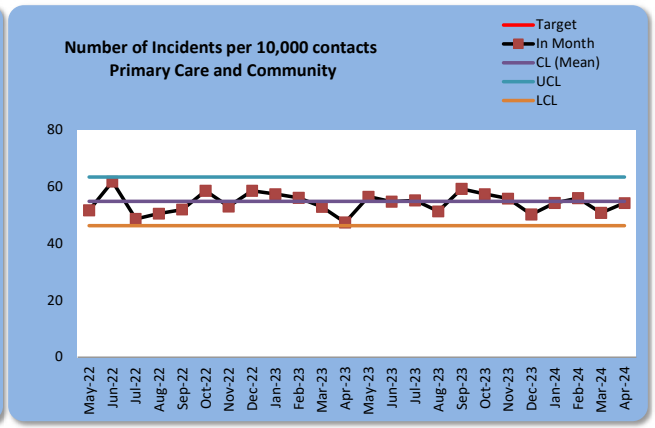
Goal 1 : Innovating Quality and Patient Safety

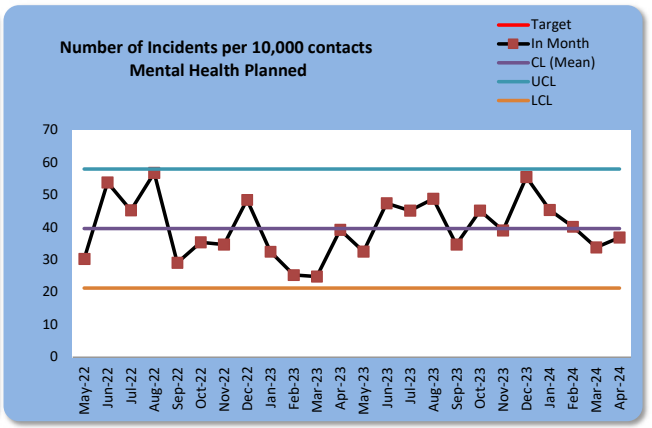
For the period ending: **April 2024**

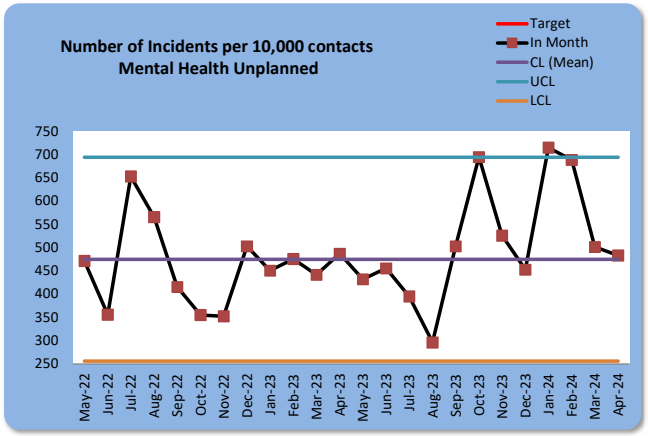
Target:	Amber:	Trustwide current month stands at:
0	0	143

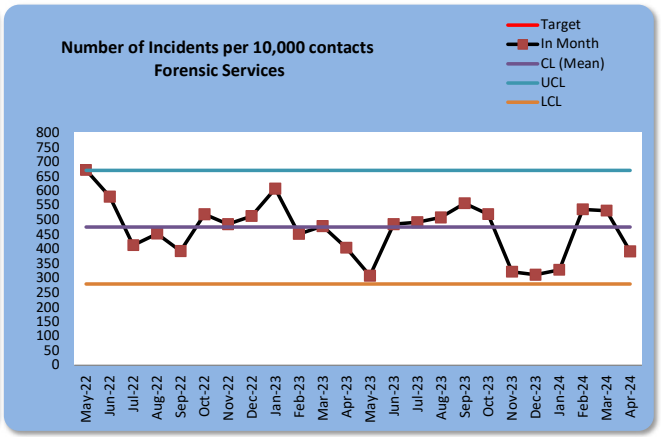
Indicator Title	Description/Rationale	Executive Lead	KPI Type
Incidents	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Hilary Gledhill	IA_TW











Current Month per Division

Children and Learning Disability	176
Primary Care and Community	54
Mental Health Planned	37
Mental Health Unplanned	483
Forensic Services	391

Incident Analysis

	Mar-24	Apr-24
Never Events	0	0
% of Harm Free Care	99.5%	99.5%
% of Incidents reported in Severe Harm or Death	0.8%	1.3%

Please refer to the accompanying front sheet/report for any relevant commentary

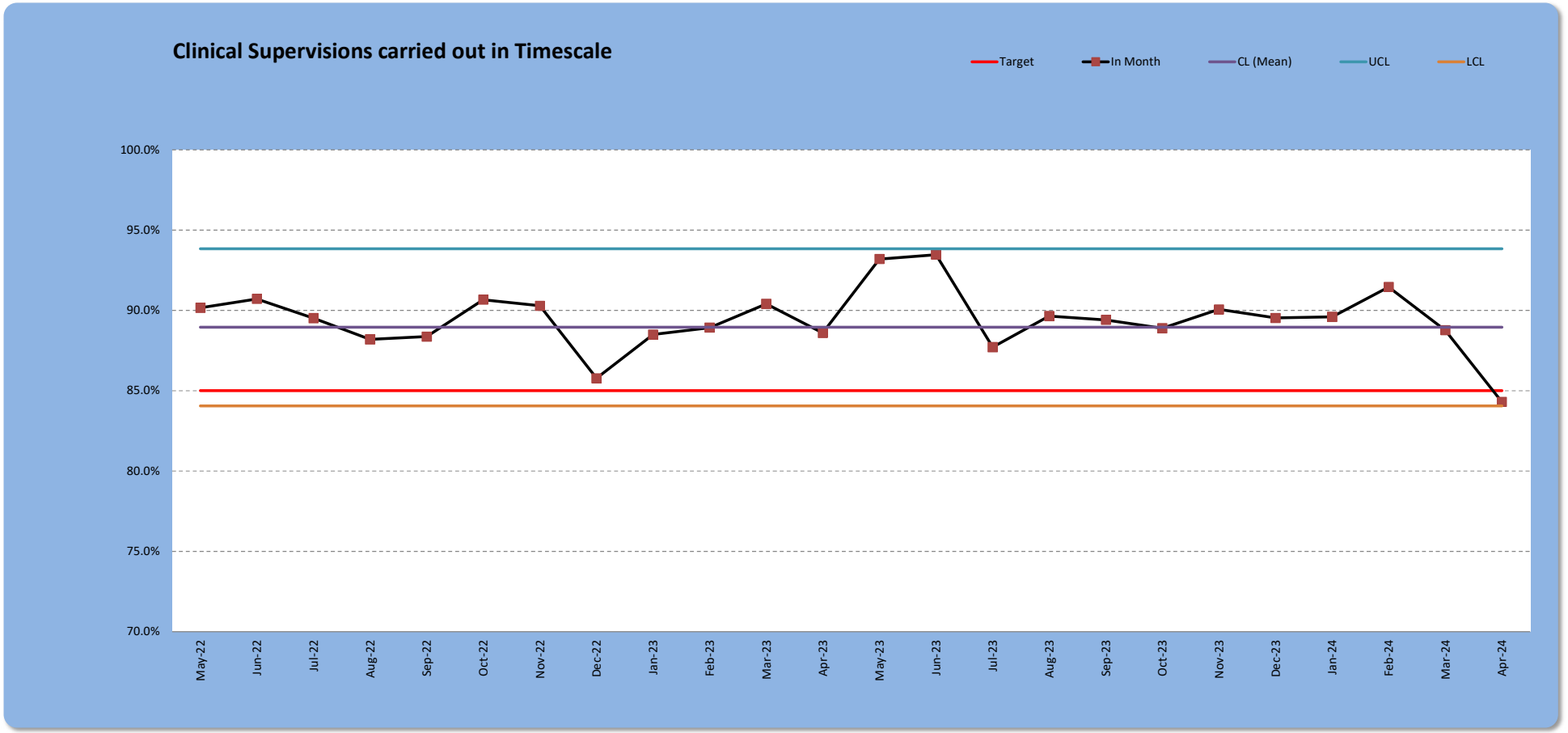
PI RETURN FORM 2024-25

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
85%	80%	84.3%

Indicator Title	Description/Rationale	Executive Lead	KPI Type
Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	Hilary Gledhill	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: 2023-24

Reporting Month: Mar-24

NHS Humber Teaching NHS Foundation Trust

Shown one month in arrears

Units						Bank/Agency Hours				Average Safer Staffing Fill Rates				High Level Indicators												
										Day		Night		QUALITY INDICATORS (Year to Date)											Indicator Totals	
Speciality	Ward	Speciality	WTE	OBDs (including leave)	CHPPD Hours (Nurse)	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-24	Mar-24
Adult MH	Avondale	Adult MH Assessment	28.4	73%	12.2	23.9%	↓	7.5%	↓	95%	105%	97%	114%	0	24	4	0	93.3%	90.7%	83.3%	81.3%	4.1%	4.0	1	0
	New Bridges	Adult MH Treatment (M)	39.6	94%	7.8	16.6%	↓	0.0%	↑	83%	104%	74%	120%	2	47	2	0	84.6%	98.7%	95.2%	95.5%	6.4%	-1.6	4	3
	Westlands	Adult MH Treatment (F)	38.1	88%	10.8	40.5%	↓	5.0%	↑	88%	72%	98%	138%	4	57	4	3	No Data	88.5%	73.3%	76.2%	12.5%	1.2	1	2
	Mill View Court	Adult MH Treatment	28.7	86%	8.9	12.5%	↓	12.6%	↓	102%	94%	91%	118%	3	34	1	1	93.3%	94.1%	86.7%	75.0%	7.2%	2.0	0	1
	STARS	Adult MH Rehabilitation	40.0	99%	23.4	33.5%	↓	0.3%	↓	65%	161%	95%	100%	2	4	0	0	92.7%	94.7%	73.3%	86.7%	5.6%	1.4	4	3
	PICU	Adult MH Acute Intensive	30.2	103%	18.5	40.1%	↓	10.4%	↑	92%	112%	100%	122%	1	127	1	0	89.7%	95.1%	100.0%	93.8%	3.4%	4.7	1	1
OP MH	Maister Lodge	Older People Dementia Treatment	34.4	81%	15.8	20.8%	↑	0.9%	↓	93%	114%	98%	129%	0	48	2	0	97.5%	91.7%	84.6%	79.2%	5.1%	-0.8	1	0
	Mill View Lodge	Older People Treatment	30.0	99%	13.6	18.6%	↓	7.2%	↓	85%	69%	100%	102%	2	24	0	0	93.8%	96.4%	78.6%	88.9%	3.6%	4.0	2	2
	Maister Court	Older People Treatment	14.5	100%	16.3	39.0%	↑	4.8%	↓	86%	97%	100%	100%	1	10	0	0	No Data	94.7%	71.4%	88.9%	0.0%	0.8	1	1
	Pine View	Forensic Low Secure	32.0	76%	10.4	28.6%	↑	0.0%	→	108%	80%	52%	110%	0	2	1	15	100.0%	96.6%	81.8%	88.9%	11.3%	0.2	2	2
	Derwent	Forensic Medium Secure	23.9	81%	18.9	50.6%	↑	0.0%	→	89%	90%	98%	138%	2	4	1	0	95.7%	94.7%	90.0%	92.9%	3.0%	0.0	1	0
	Ouse	Forensic Medium Secure	23.0	71%	9.3	14.8%	↓	0.0%	→	98%	86%	95%	97%	1	5	0	2	95.7%	93.7%	81.8%	80.0%	11.5%	-0.4	1	1
	Swale	Personality Disorder Medium Secure	27.5	73%	10.2	39.1%	↓	0.0%	→	62%	100%	84%	86%	8	4	3	12	73.1%	92.2%	72.7%	76.5%	2.2%	2.0	2	2
	Ullswater	Learning Disability Medium Secure	29.2	67%	16.7	33.8%	↑	0.0%	→	92%	143%	100%	142%	17	17	0	9	100.0%	95.8%	90.0%	90.0%	11.9%	-0.1	0	1
Child & LD	Townend Court	Learning Disability	37.0	30%	41.1	45.2%	↓	0.4%	↓	68%	98%	101%	99%	10	332	4	0	100.0%	92.7%	81.8%	79.2%	14.0%	4.0	2	2
	Inspire	CAMHS	12.0	77%	24.2	24.4%	↑	12.7%	↓	96%	116%	101%	125%	1	24	2	0	55.6%	86.1%	83.3%	60.0%	12.5%	-2.0	3	3
	Granville Court	Learning Disability Nursing Care	56.3	87%	16.2	36.7%	↓	0.8%	↓	108%	99%	100%	109%	3	3	0	0	84.3%	94.8%	66.7%	95.2%	13.4%	0.2	1	1
CH	Whitby Hospital	Physical Health Community Hospital	44.8	91%	8.4	2.9%	↓	0.0%	→	94%	81%	102%	100%	1	1	0	0	92.5%	94.1%	85.0%	90.9%	4.1%	-1.0	0	0
	Malton Hospital	Physical Health Community Hospital	33.6	94%	7.0	15.7%	↓	0.0%	→	92%	89%	116%	85%	0	0	2	0	100.0%	88.8%	100.0%	94.4%	1.5%	0.3	2	1

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

	Staffing and Quality Indicators
Contract Period:	2023-24
Reporting Month:	Mar-24

Humber Teaching NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : Mar

There has been an improvement in overall sickness rates with 10 units flagging red compared to 12 in February . TEC sickness rate is down to 14% from 21.6 % in February.

There are no units with 5 red flags.

All units have achieved their CHPPD target except for Newbridge's which is slightly below target, impacted by high OBD. Malton achieved CHPPD target in February .

Mandatory training (all) is above 85% for all units. Compliance with ILS/BLS has been consistently strong, with only Inspire flagging red for BLS. This has been raised with the unit manager, matron and resuscitation officer.

Clinical supervision remains in a strong position with the majority of units above 85%. Swale are slightly under target and this has been addressed with the team leader and Modern matron.

Pine View's registered fill rates on night is below target and indicative that they are sometimes working with one RN instead of 2. This is being covered in part by additional unregistered nursing staff being rostered onto the shift. The shortfalls have been raised with the Humber Centre leadership team and are being addressed. Swale have had additional pressures due to RNs in work who are unable to have direct patient contact at present; new starters; one nurse who has pre agreed long term leave; 1 nurse undertaking DMI training. This has impacted on RN fill rates on days and clinical supervision compliance. This has been resolved from mid April.

Townend Court are below target for RN fill rates on days however due to low OBDs their CHPPD remains strong.

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
<=5.9	>=6.9	Malton
<=7	>=8	New Bridges, Westlands, Mill View Court, Swale, Whitby
<=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	Towend Court

Registered Nurse Vacancy Rates (Rolling 12 months)

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
13.40%	13.60%	14.10%	14.21%	13.85%	13.67%	13.50%	12.10%	11.04%	11.25%	11.00%	9.56%

Slips/Trips and Falls (Rolling 3 months)

	Jan-24	Feb-24	Mar-24
Maister Lodge	2	9	3
Millview Lodge	3	2	2
Malton IPU	4	5	1
Whitby IPU	2	3	3

Malton Sickness % is provided from ESR as they are not on Health Roster

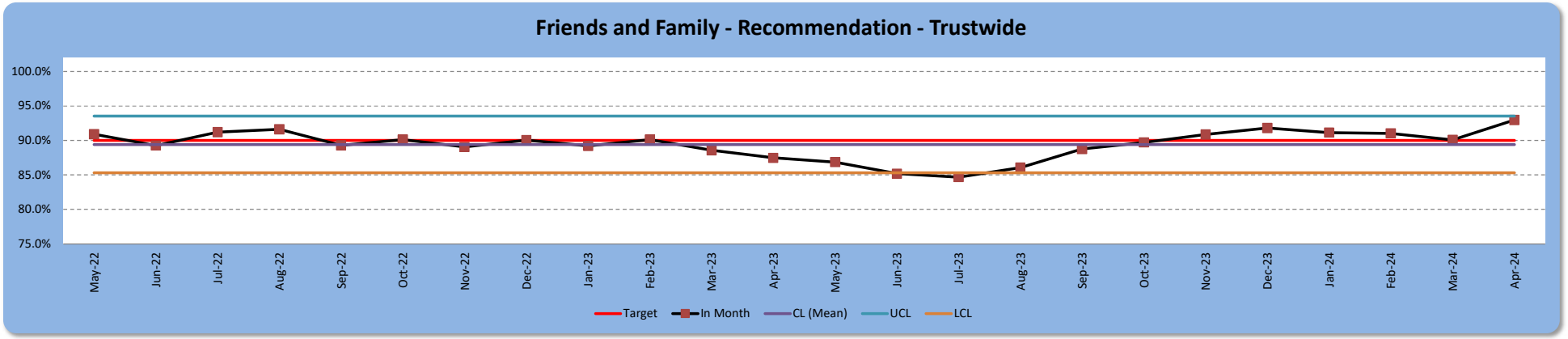
PI RETURN FORM 2024-25

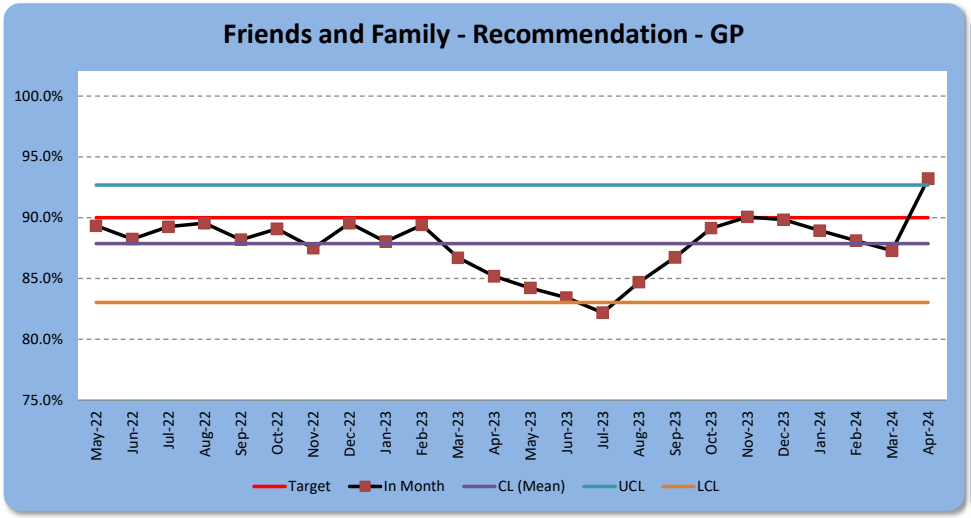
Goal 1 : Innovating Quality and Patient Safety

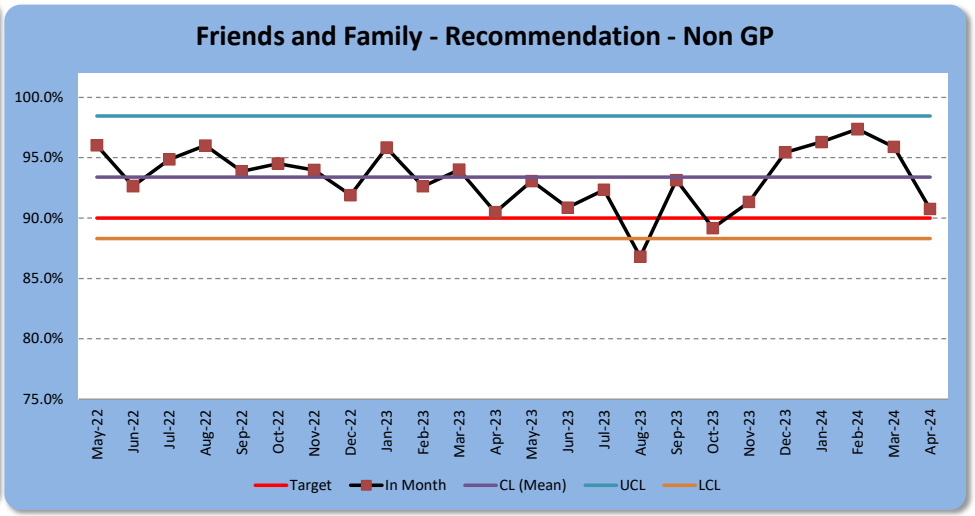
Target:	Amber:	Current month stands at:
90%	80%	93.0%

For the period ending: **April 2024**

Indicator Title	Description/Rationale		KPI Type
Friends and Family Test	Results of the overall surveys completed where patients would recommend the Trust 's services to their family and friends	Executive Lead Kwame Fofie	FFT %







Please refer to the accompanying front sheet/report for any relevant commentary

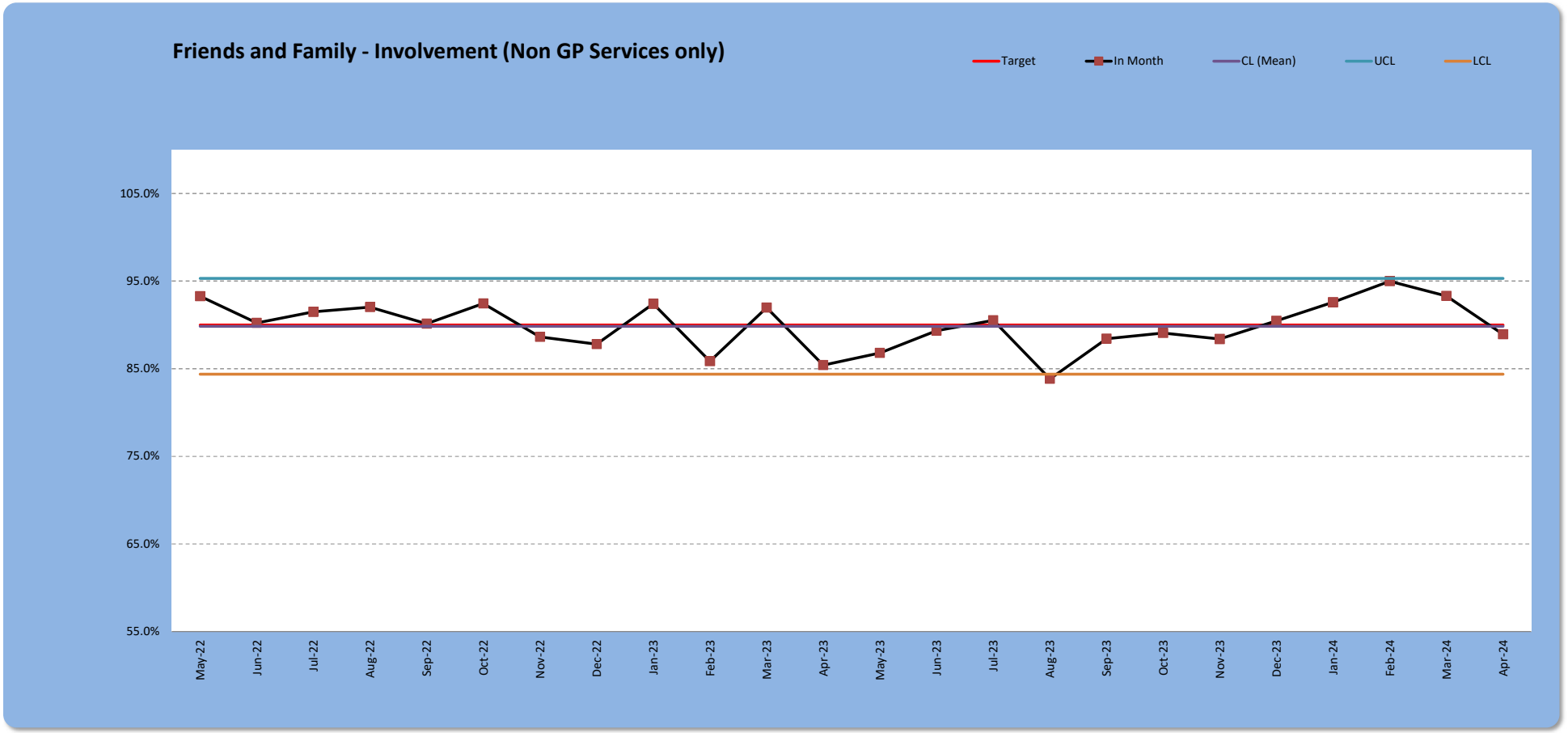
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
90%	80%	88.9%

Indicator Title	Description/Rationale	Executive Lead	KPI Type
Friends and Family Test	Results of the overall surveys completed where patients felt they were involved in their care	Kwame Fofie	CA 3c %



Please refer to the accompanying front sheet/report for any relevant commentary

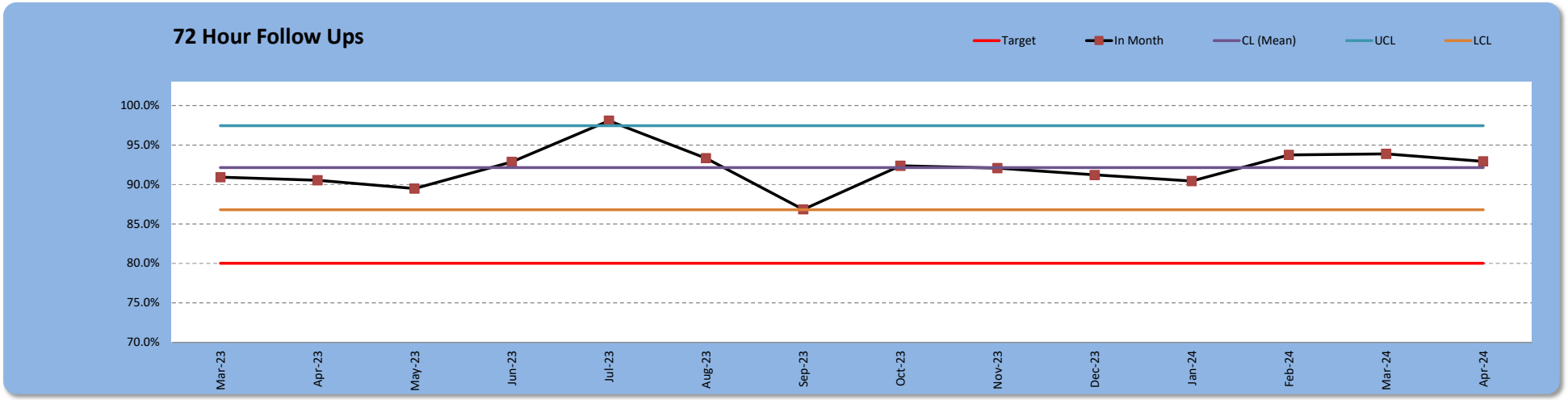
PI RETURN FORM 2024-25

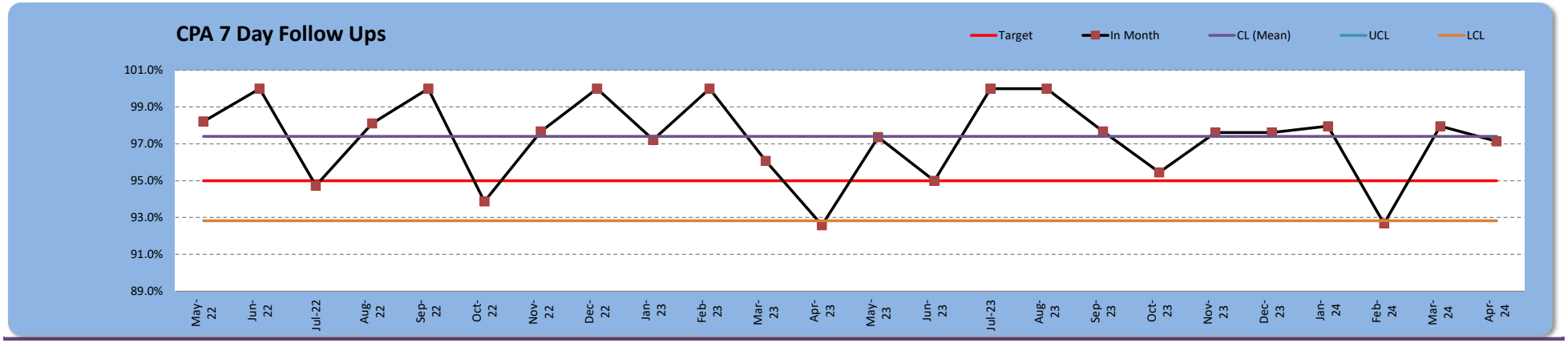
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

Target:	Amber:	Current month for 72 hour stands at:
80%	60%	92.9%

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

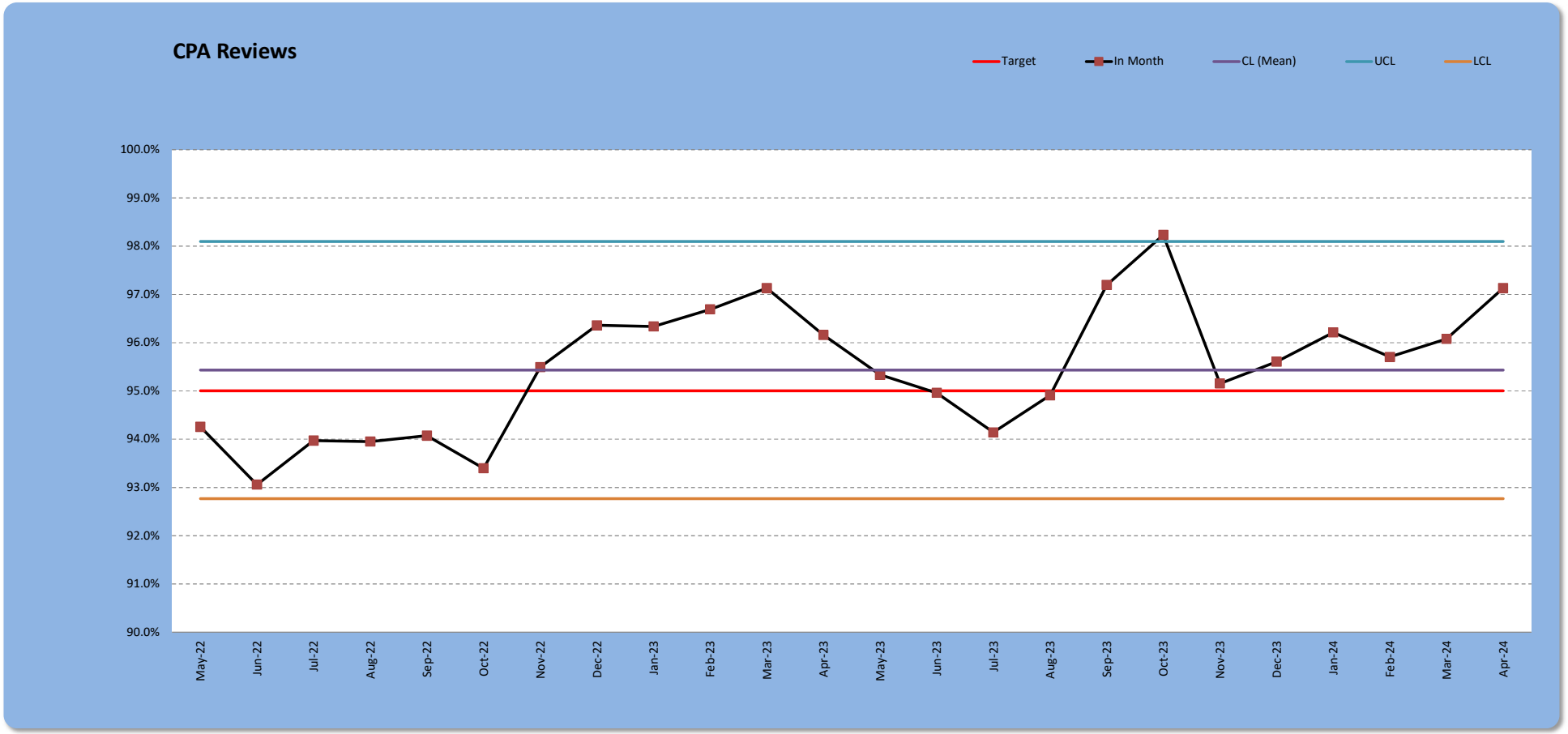
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
95%	85%	97.1%

Indicator Title	Description/Rationale	Executive Lead	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	Lynn Parkinson	OP 7



Please refer to the accompanying front sheet/report for any relevant commentary

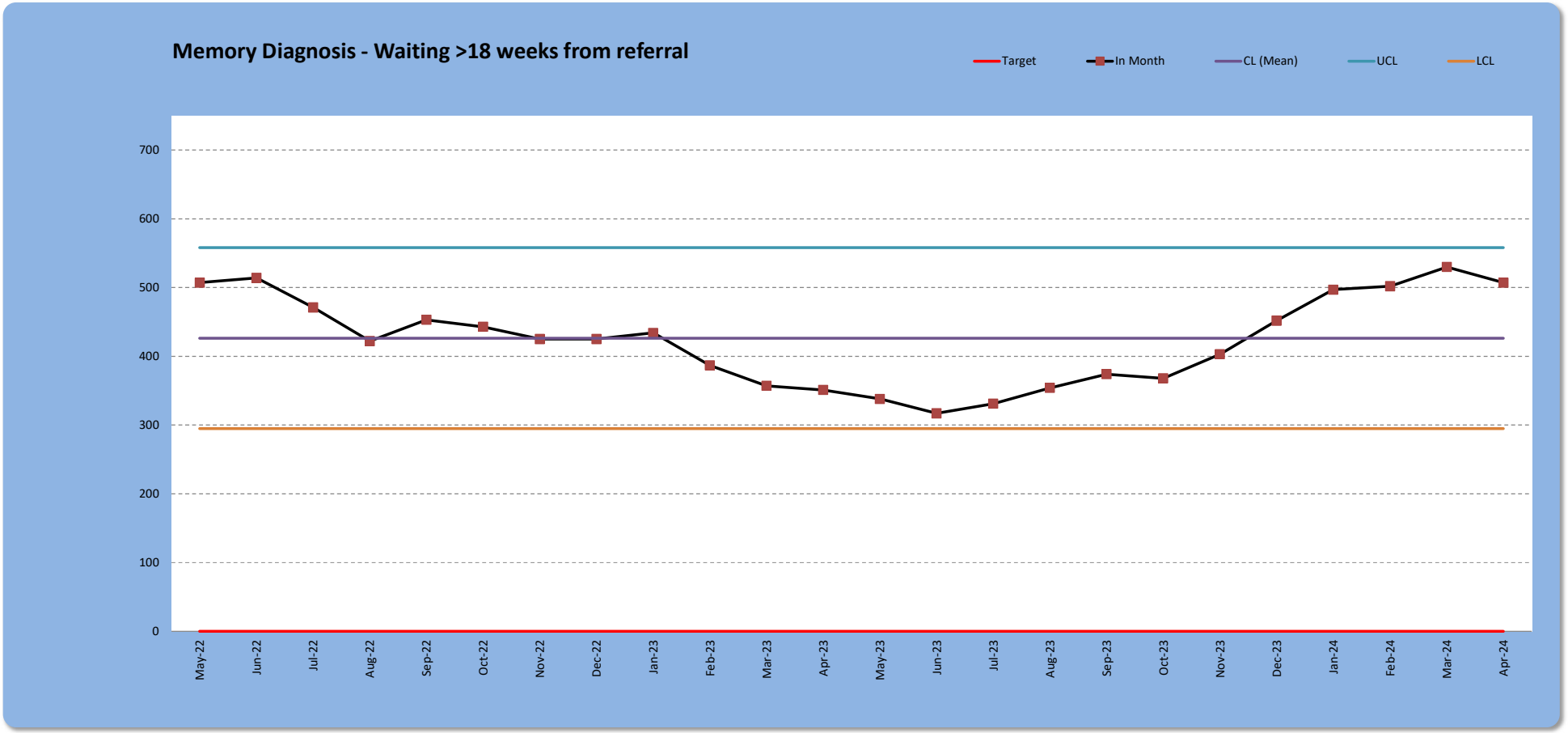
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
n/a	n/a	507

Indicator Title	Description/Rationale		KPI Type
Memory Service - Assessment/Diagnosis Waiting List	Referral to Assessment/Diagnosis Waiting Times (Incomplete Pathways) : The number of patients referred to the Memory Service are awaiting greater than 18 weeks for assessment and/or feedback of diagnosis.	Executive Lead Lynn Parkinson	MemAssWL



Please refer to the accompanying front sheet/report for any relevant commentary

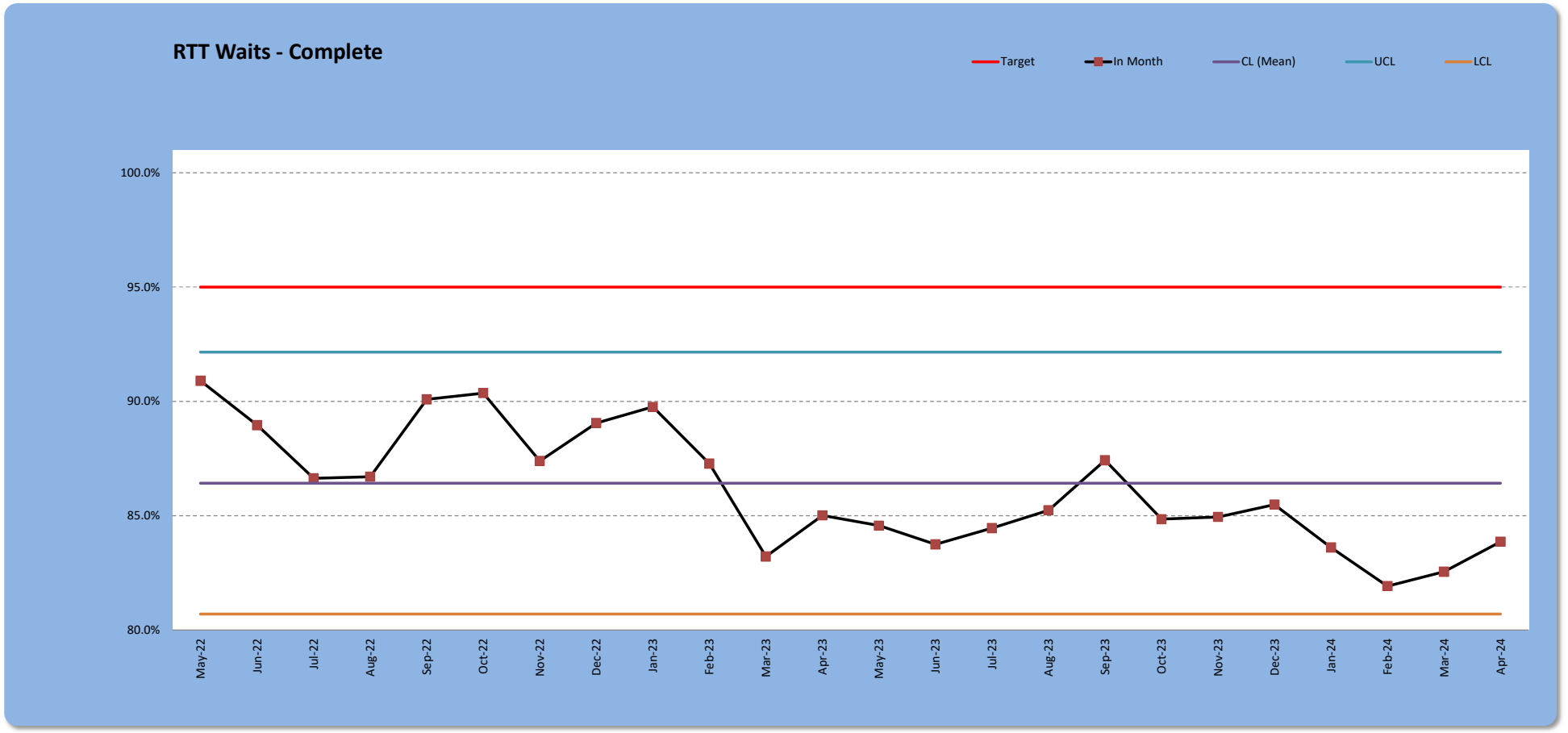
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
95%	85%	83.9%

For the period ending: **April 2024**

Indicator Title	Description/Rationale		KPI Type
RTT Experienced Waiting Times (Completed Pathways)	Referral to Treatment Experienced Waiting Times (Completed Pathways) : Based on patients who have commenced treatment during the reporting period and seen within 18 weeks	Executive Lead Lynn Parkinson	OP 20



Please refer to the accompanying front sheet/report for any relevant commentary

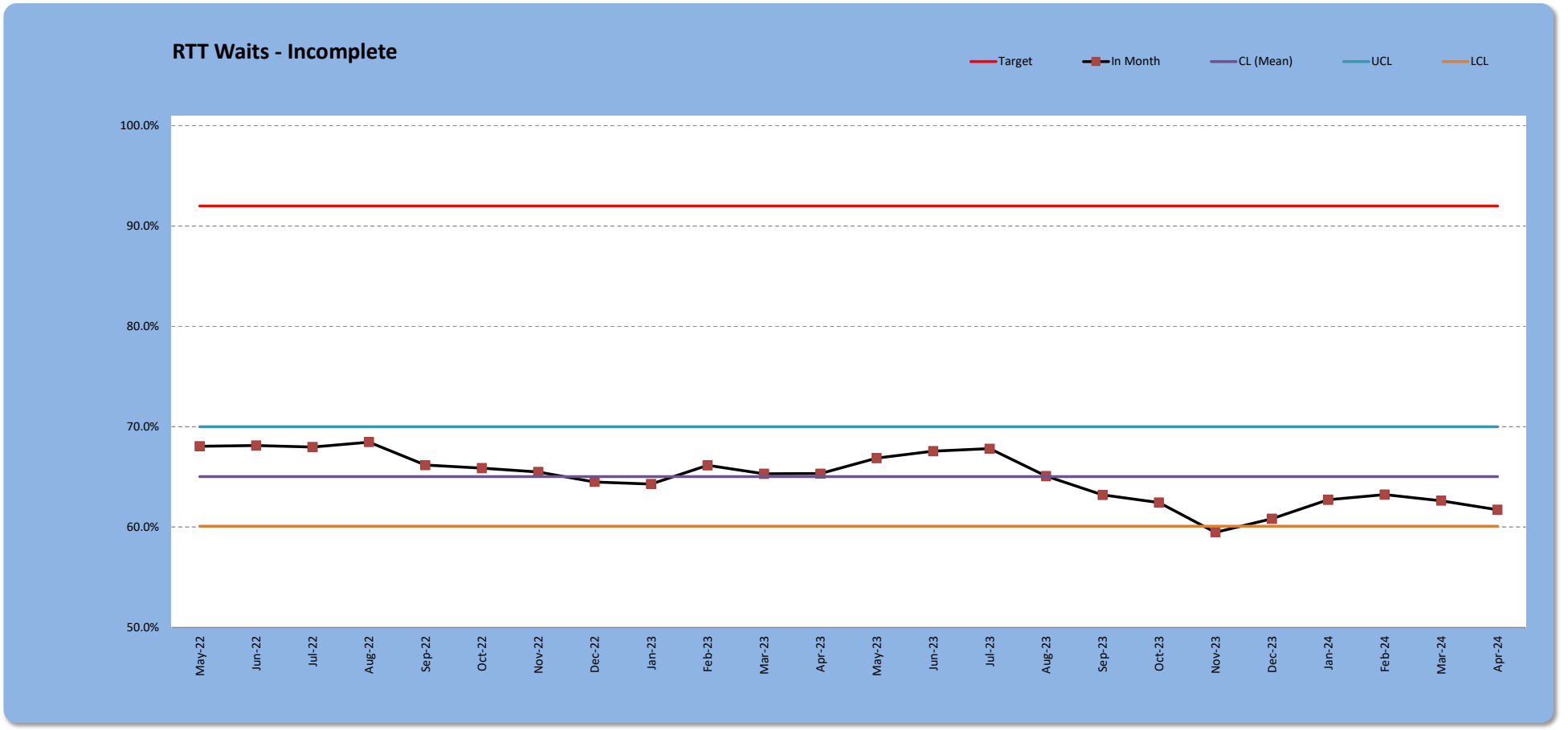
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
92%	85%	61.7%

For the period ending: **April 2024**

Indicator Title	Description/Rationale		KPI Type
RTT Waiting Times (Incomplete Pathways)	Referral to Treatment Waiting Times (Incomplete Pathways) : Proportion of patients who have had to wait less than 18 weeks for either assessment and or treatment.	Executive Lead Lynn Parkinson	OP 21



Please refer to the accompanying front sheet/report for any relevant commentary

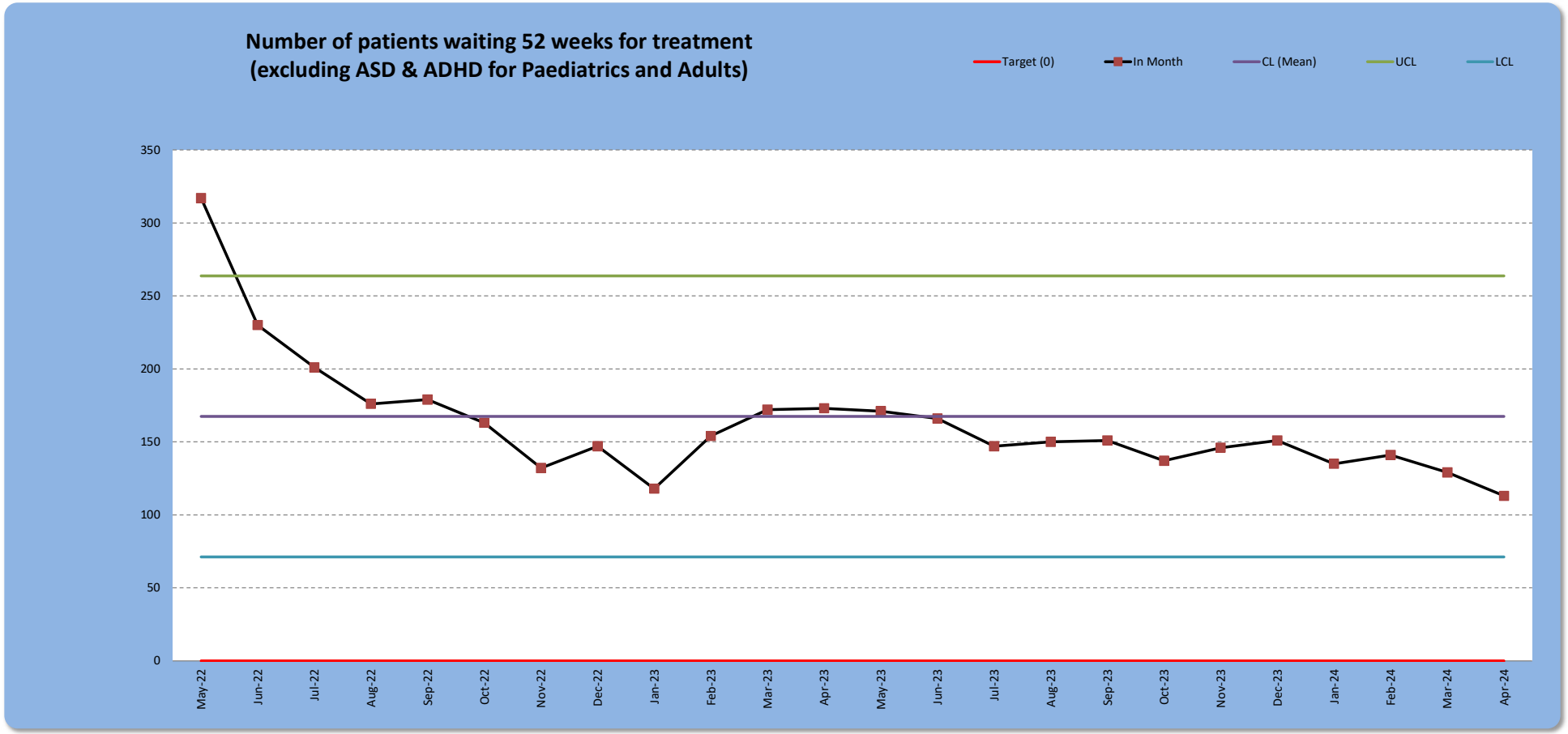
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	113

For the period ending: **April 2024**

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

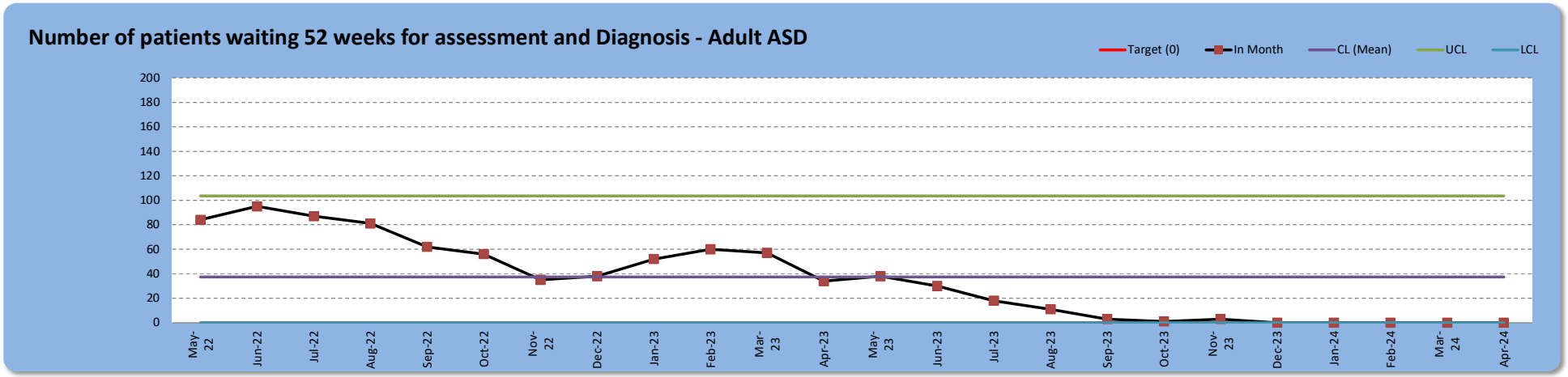
PI RETURN FORM 2024-25

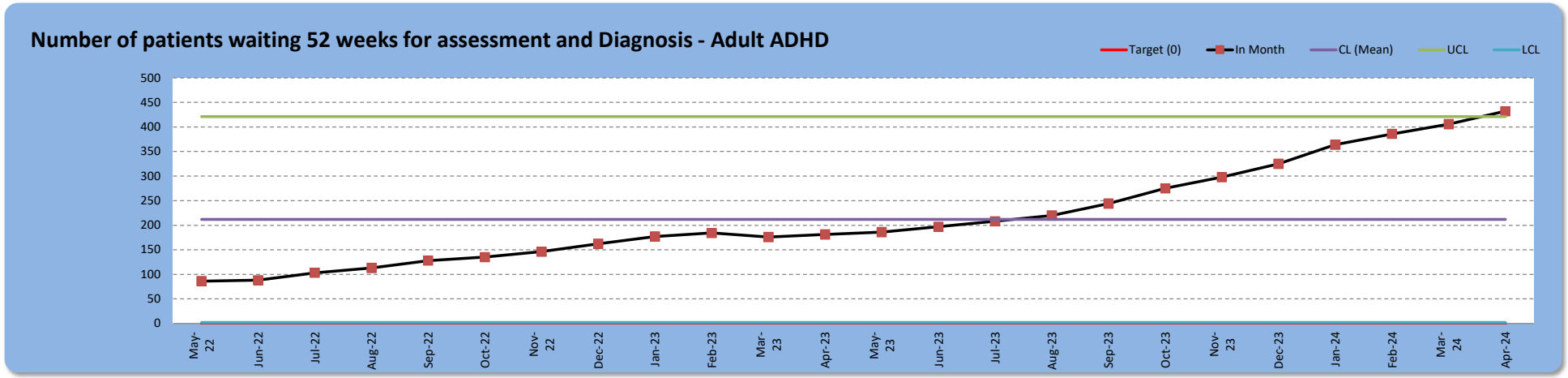
Target:	Amber:	Current month stands at:
0	0	432

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

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

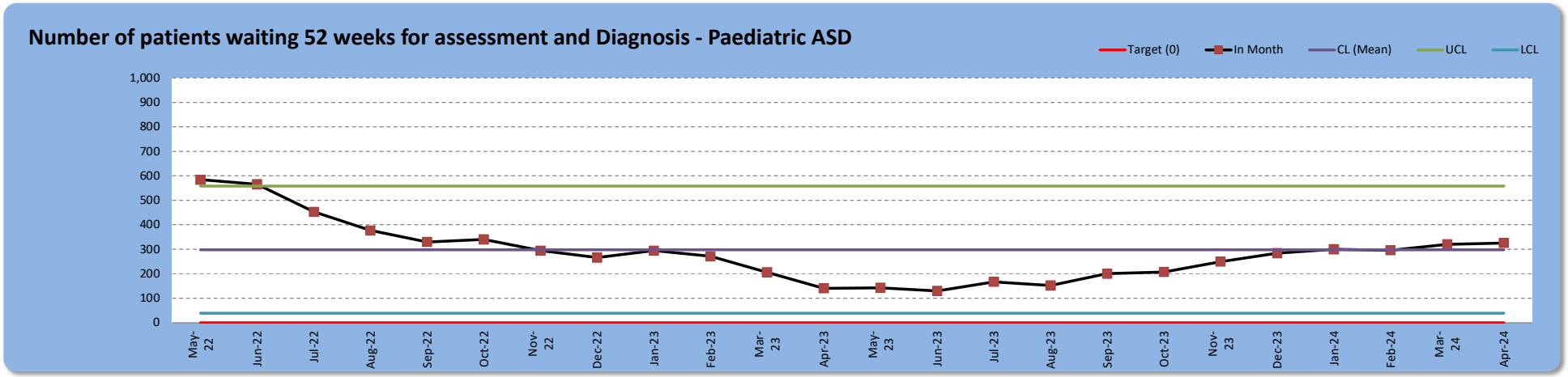
PI RETURN FORM 2024-25

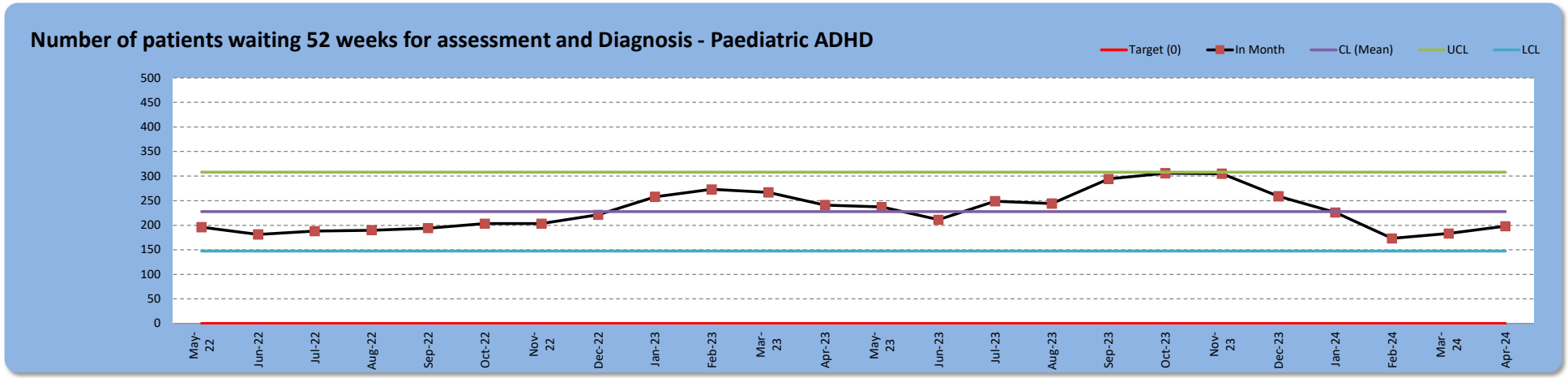
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	524

For the period ending: **April 2024**

Indicator Title	Description/Rationale	Executive Lead	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	Lynn Parkinson	OP 22s





Please refer to the accompanying front sheet/report for any relevant commentary

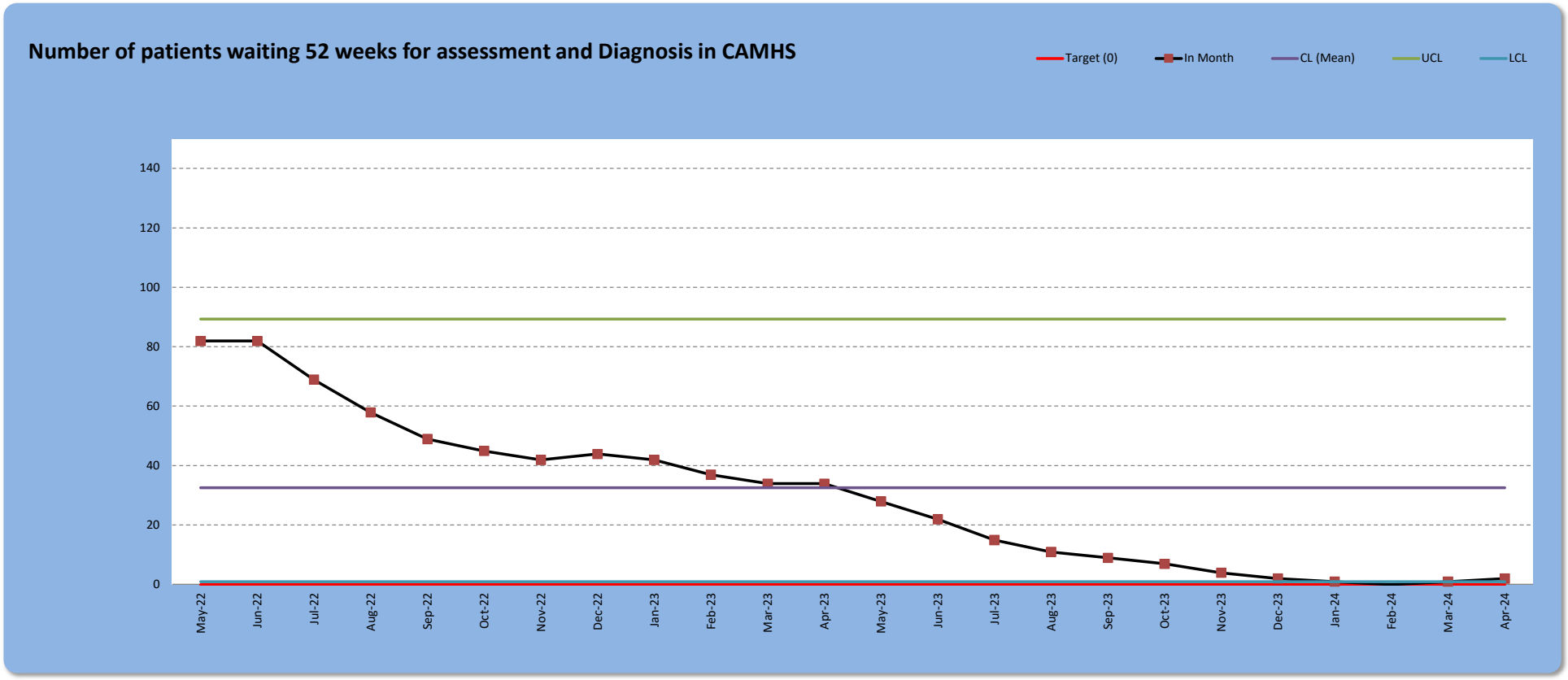
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	2

For the period ending: **April 2024**

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

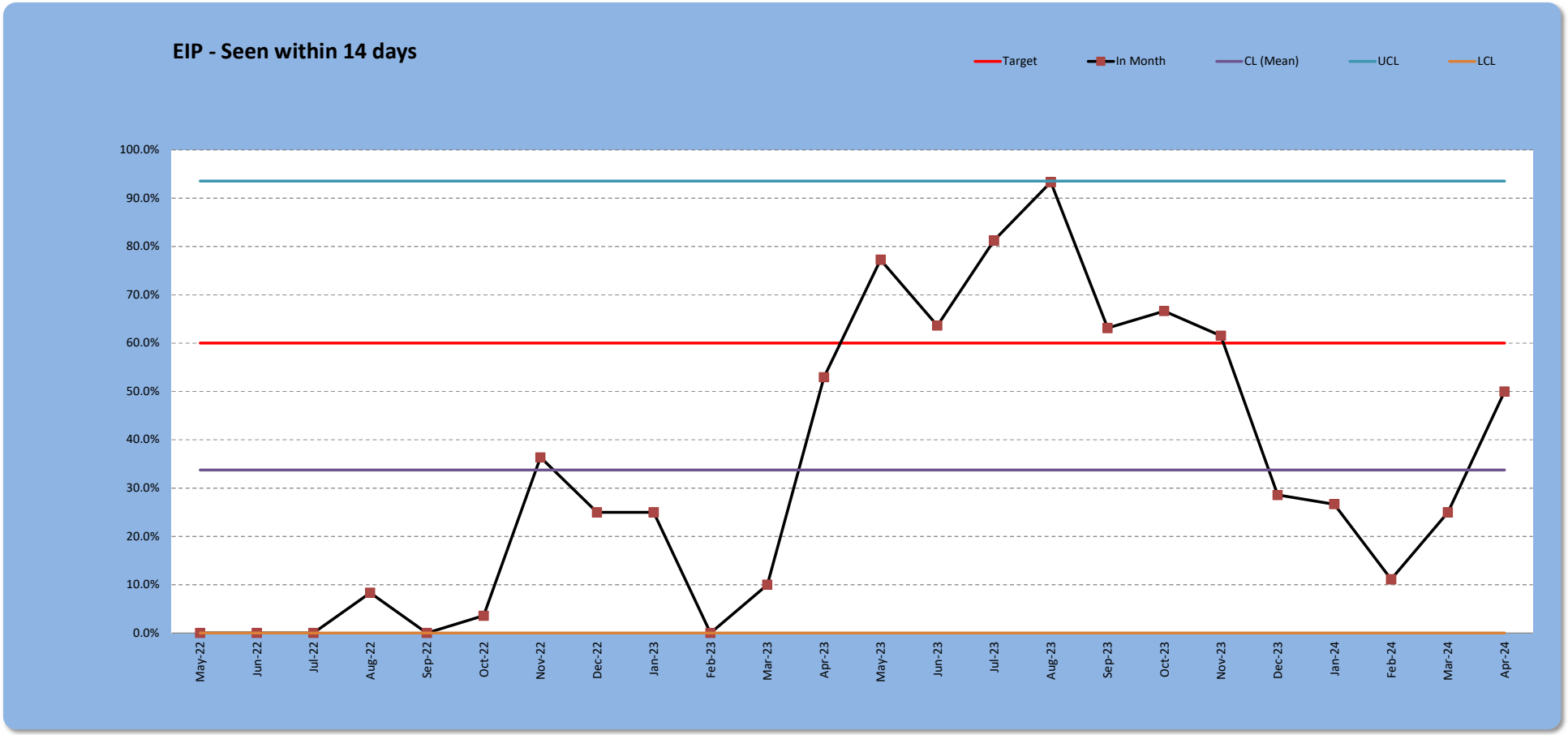
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
60%	55%	50.0%

For the period ending: **April 2024**

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

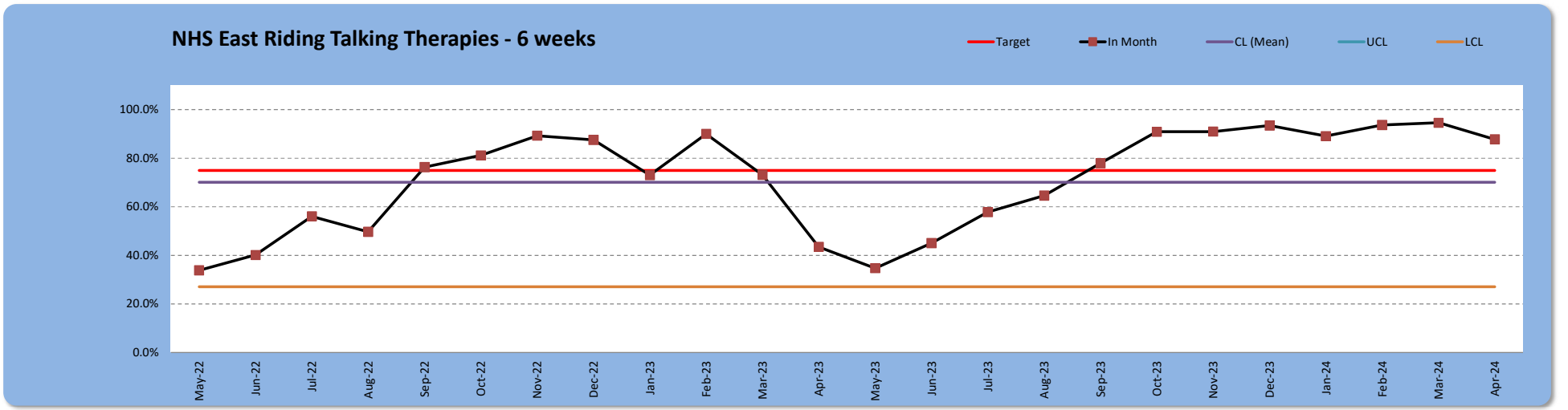
PI RETURN FORM 2024-25

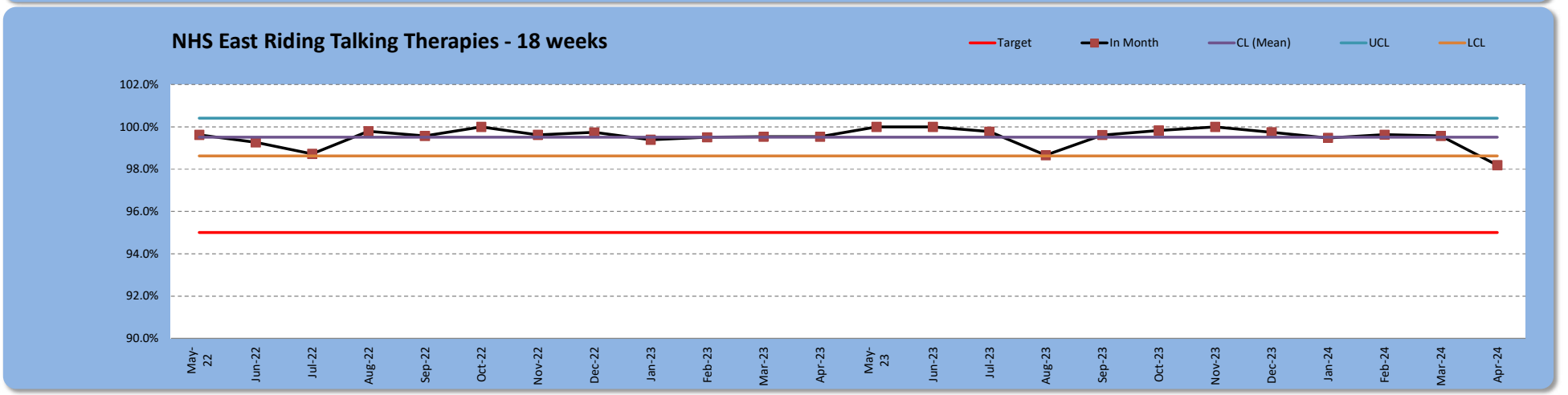
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

Target:	Amber:	Current month 6 weeks stands at:	Target:	Amber:	Current month 18 weeks stands at:
75%	70%	87.8%	95%	85%	98.2%

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

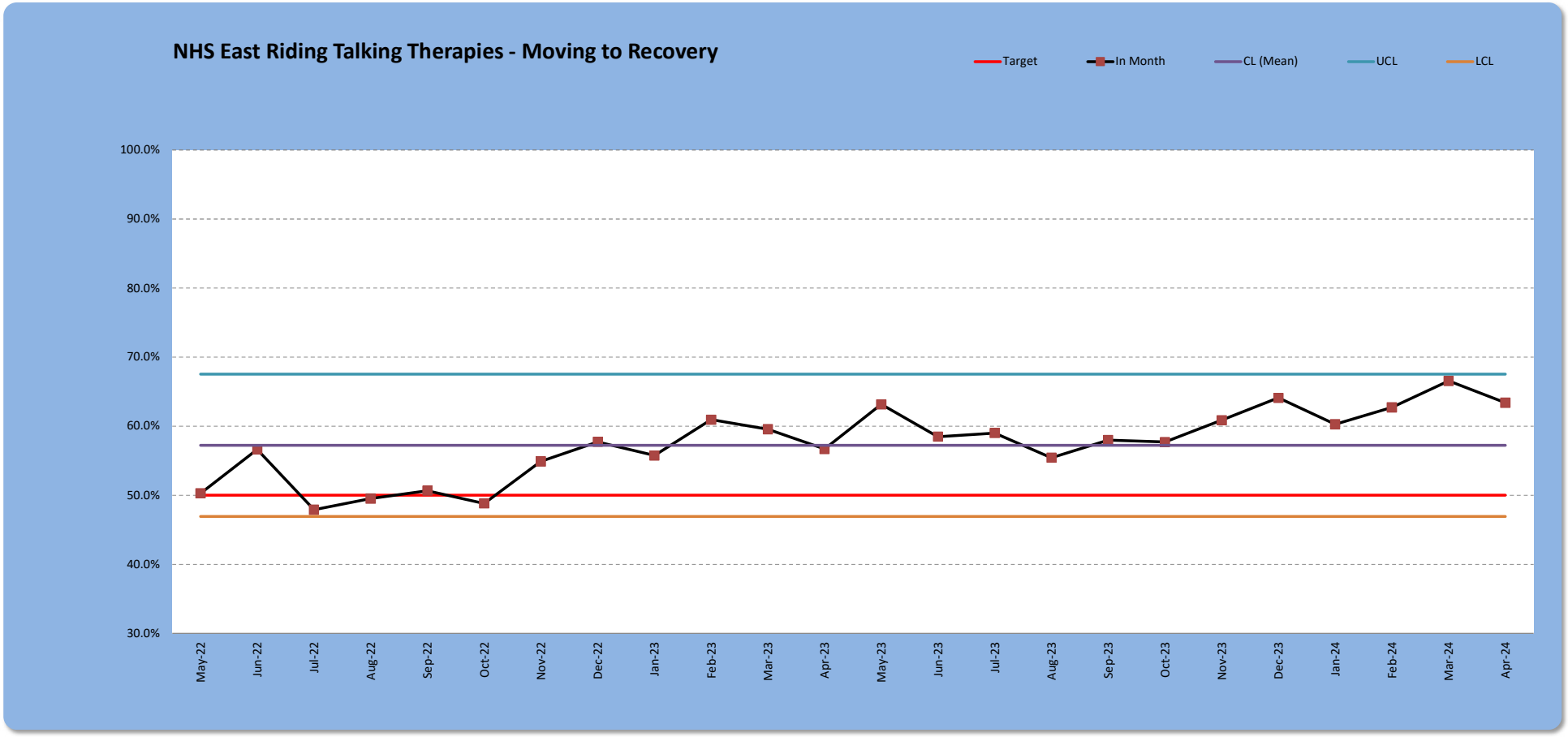
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:
50%	45%	63.4%

Indicator Title	Description/Rationale	Executive Lead	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)	Lynn Parkinson	OP 11



Please refer to the accompanying front sheet/report for any relevant commentary

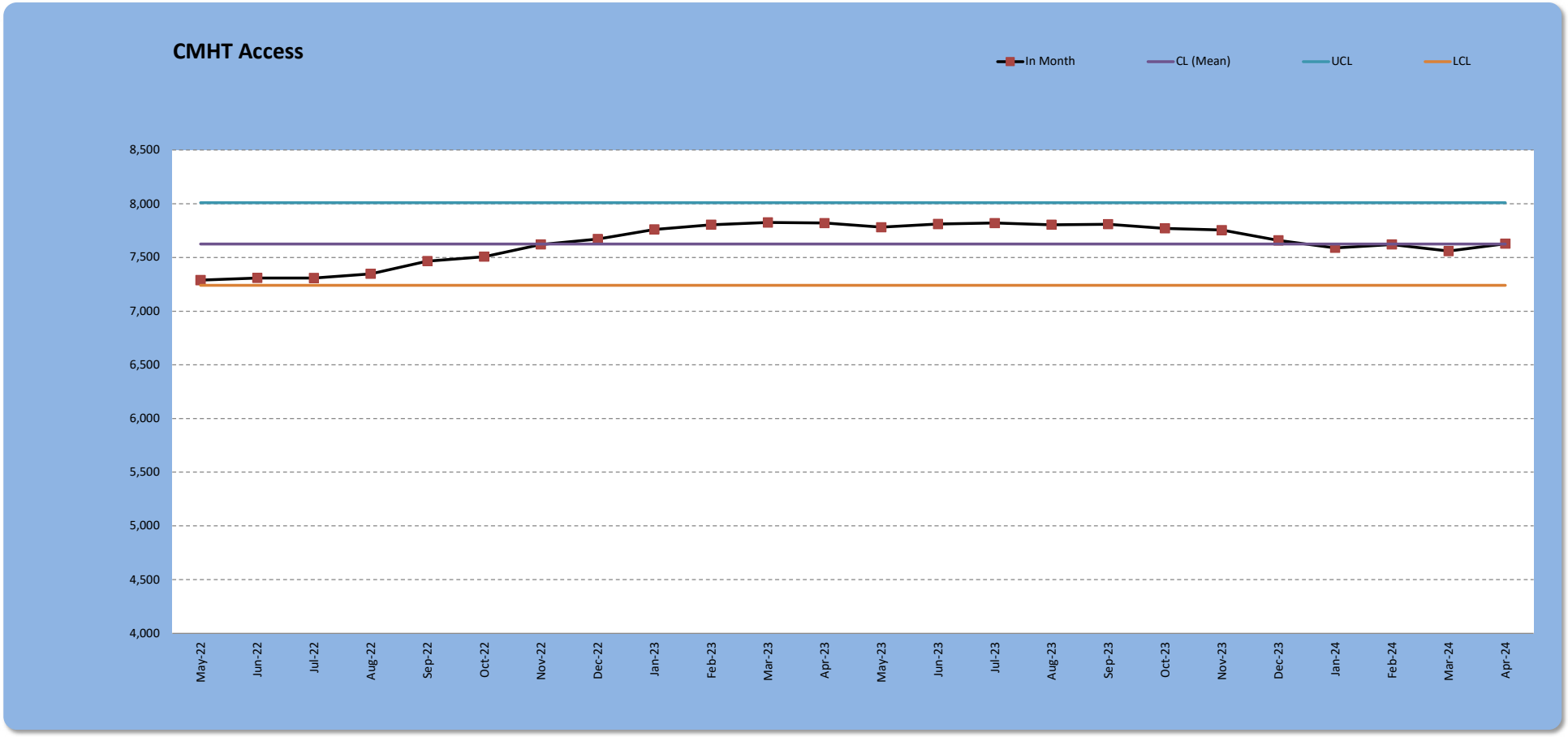
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
TBC	TBC	7627

For the period ending: **April 2024**

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

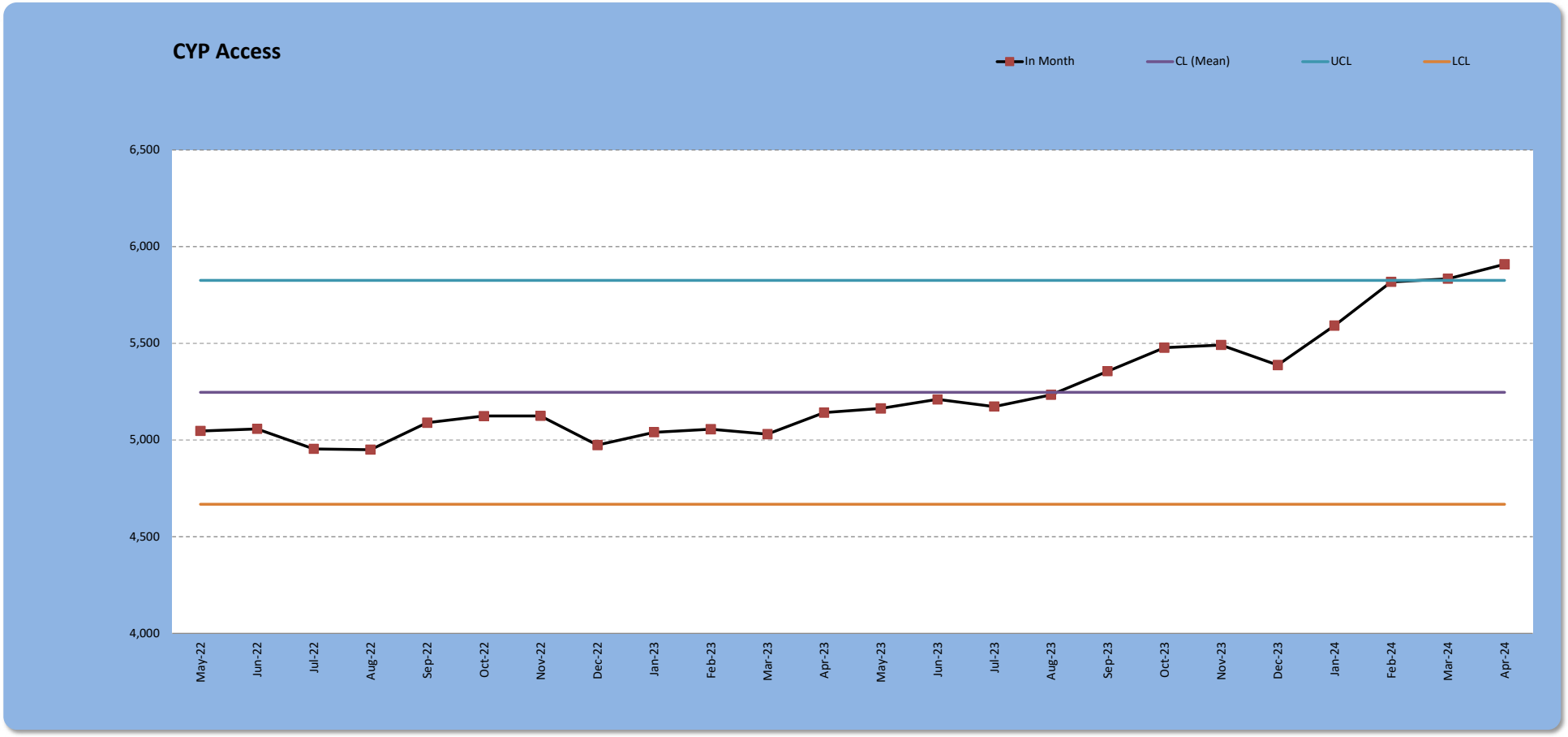
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
TBC	TBC	5909

For the period ending: **April 2024**

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

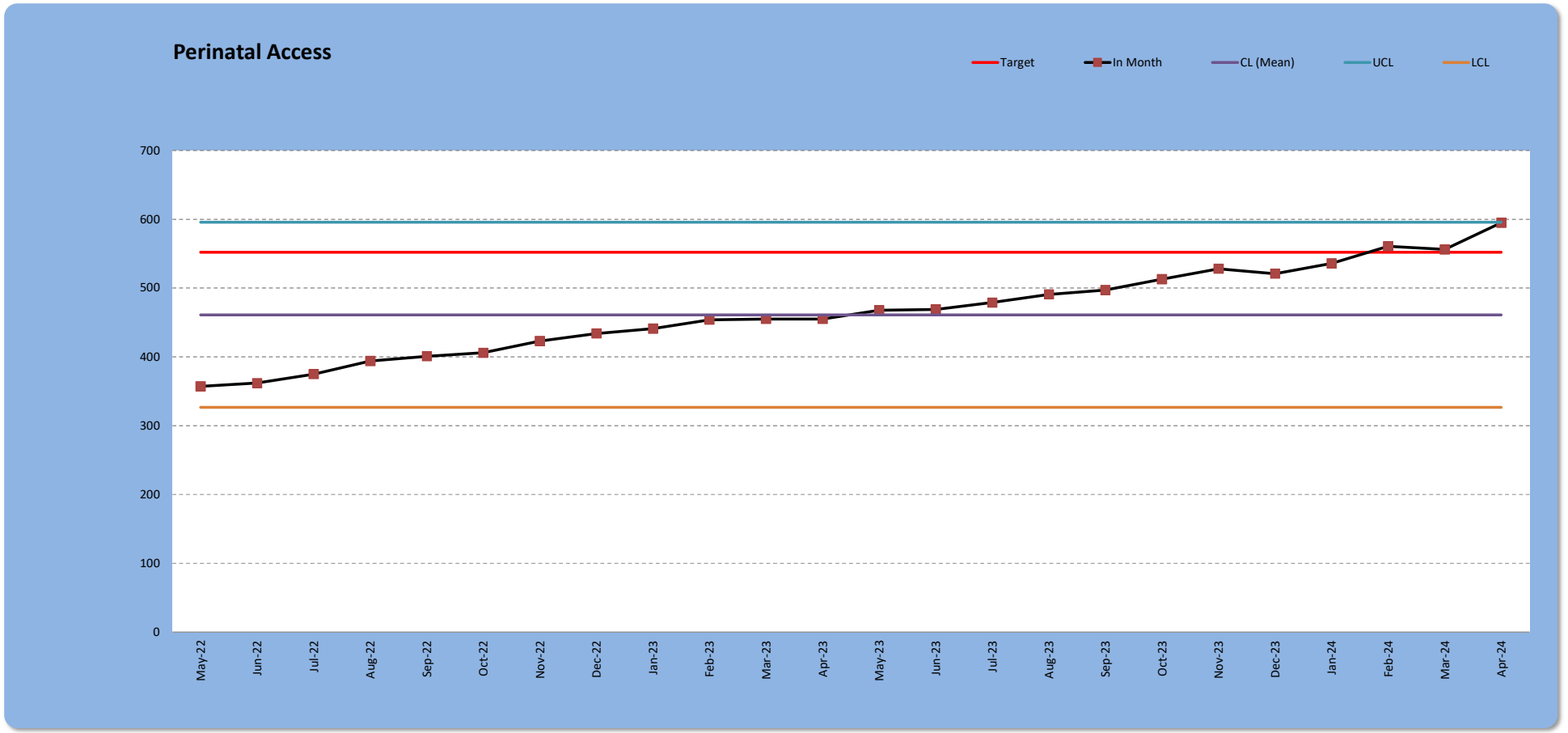
PI RETURN FORM 2024-25

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
TBC	TBC	595

For the period ending: **April 2024**

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 and East Riding only)*	Executive Lead Lynn Parkinson	MHS91.1



Please refer to the accompanying front sheet/report for any relevant commentary

PI RETURN FORM 2024-25

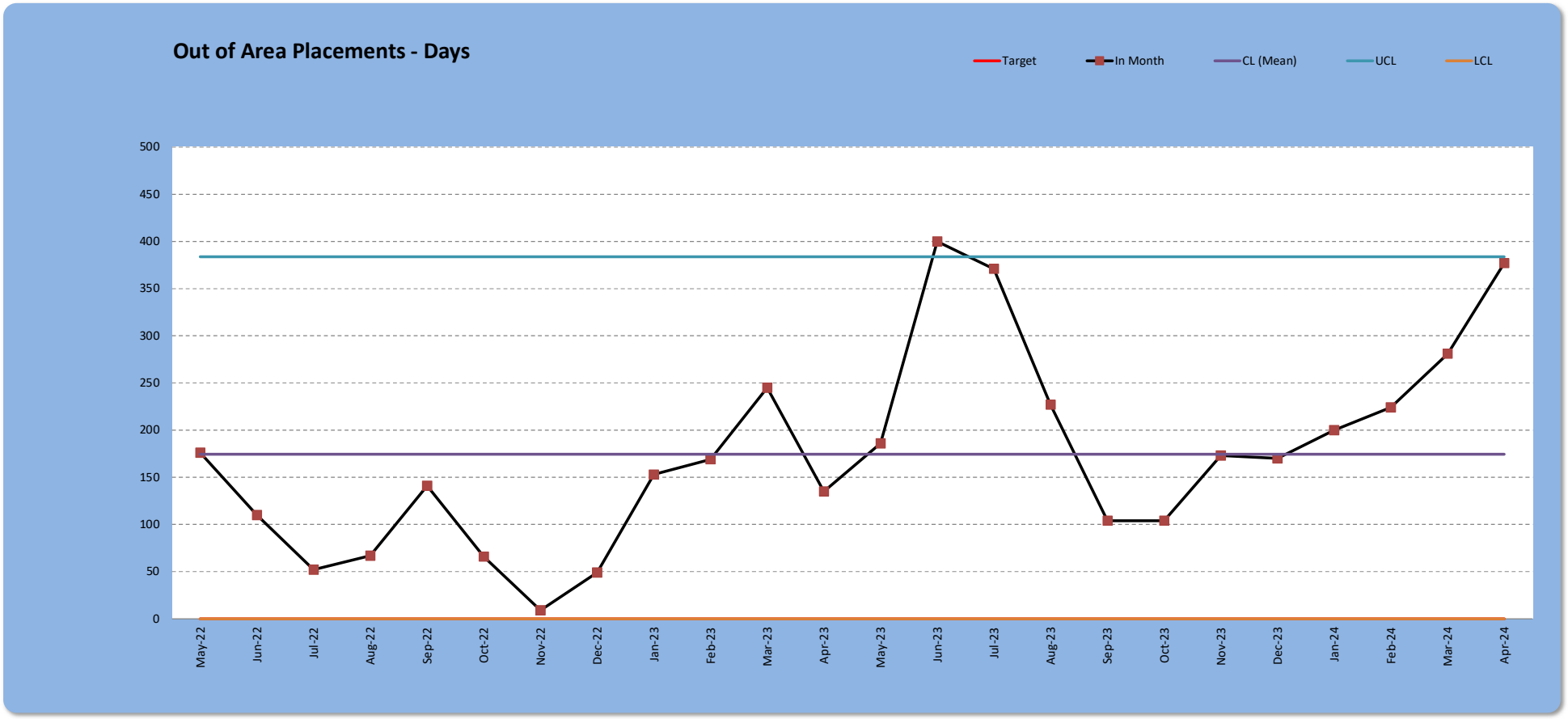
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **April 2024**

Target:	Amber:	Patients OoA within month:
0	0	23

Split:	# days	# patients
Adult	106	10
OP	110	6
PICU	161	7

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 2024-25

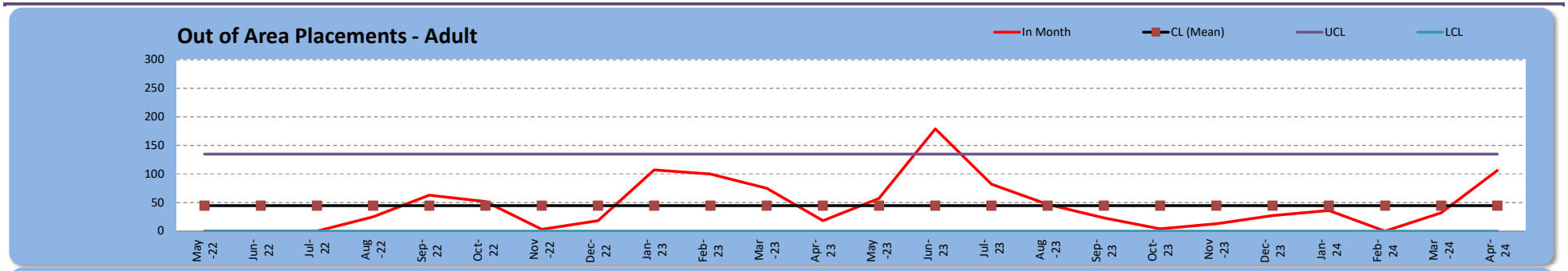
Goal 3 : Fostering Integration, Partnership and Alliances

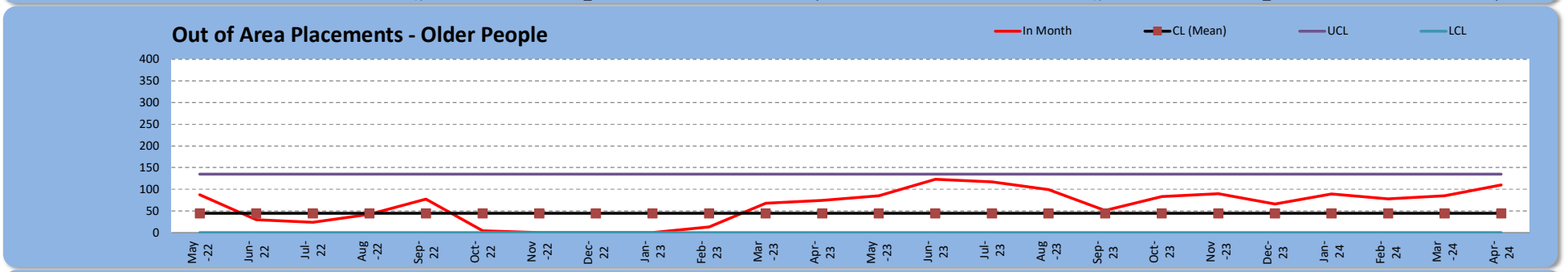
For the period ending: **April 2024**

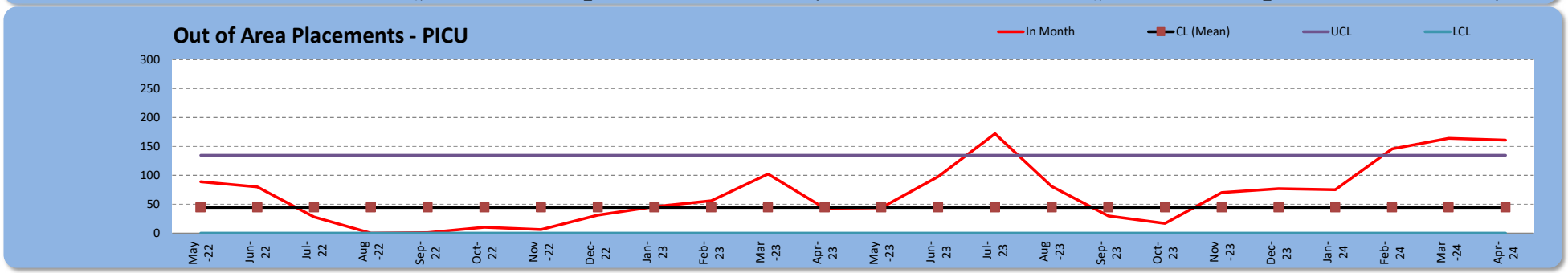
Split for Current month:

Apr-24	
106	Adult
110	OP
161	PICU
377	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

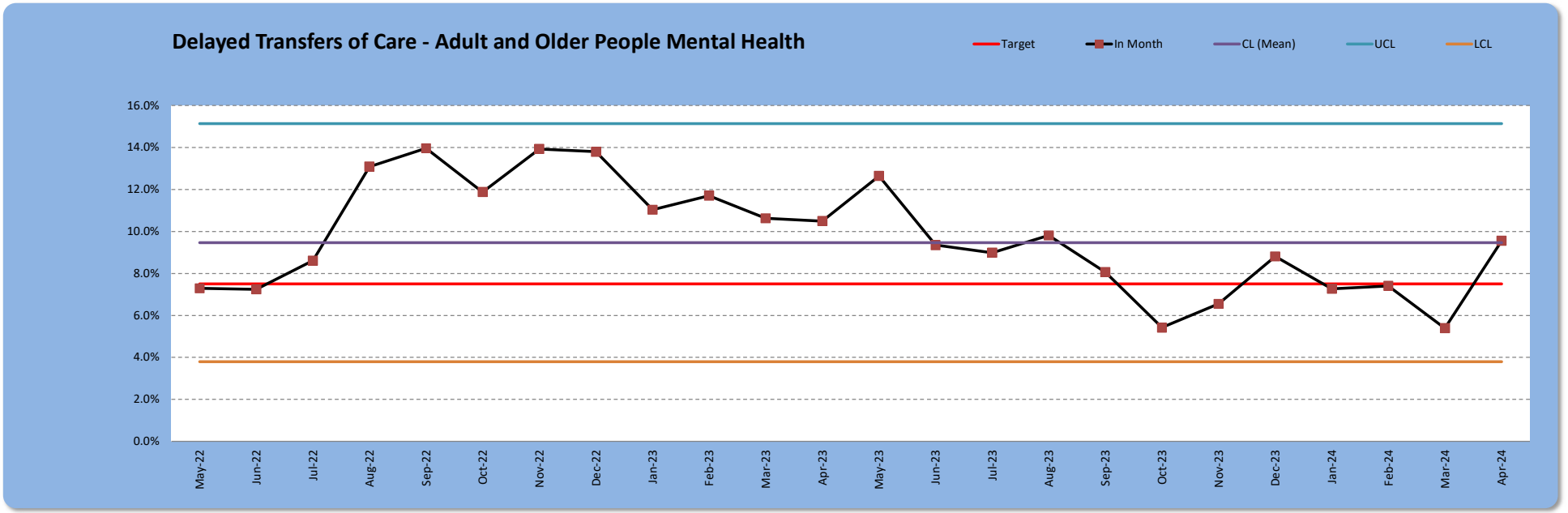
PI RETURN FORM 2024-25

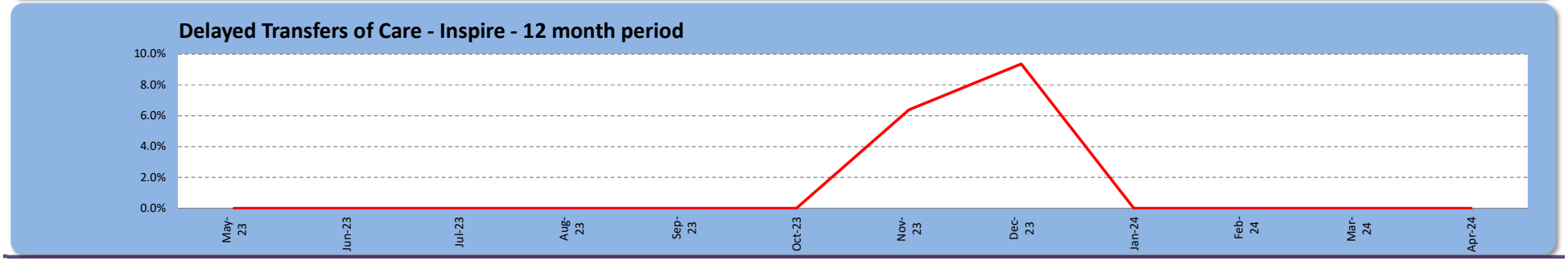
Goal 3 : Fostering Integration, Partnership and Alliances

Target:	Amber:	Current month stands at:
7.5%	7.0%	9.6%

For the period ending: **April 2024**

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

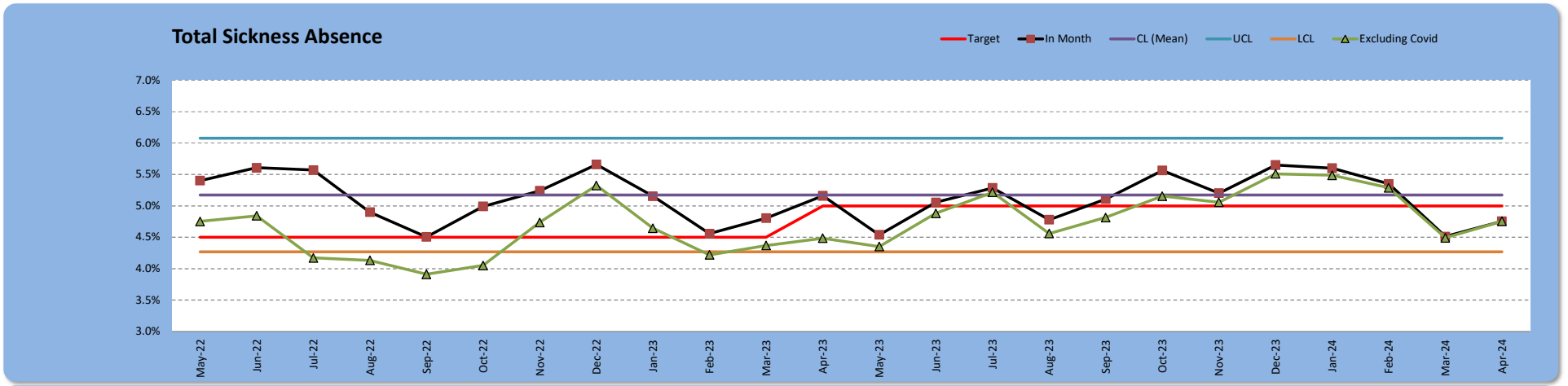
PI RETURN FORM 2024-25

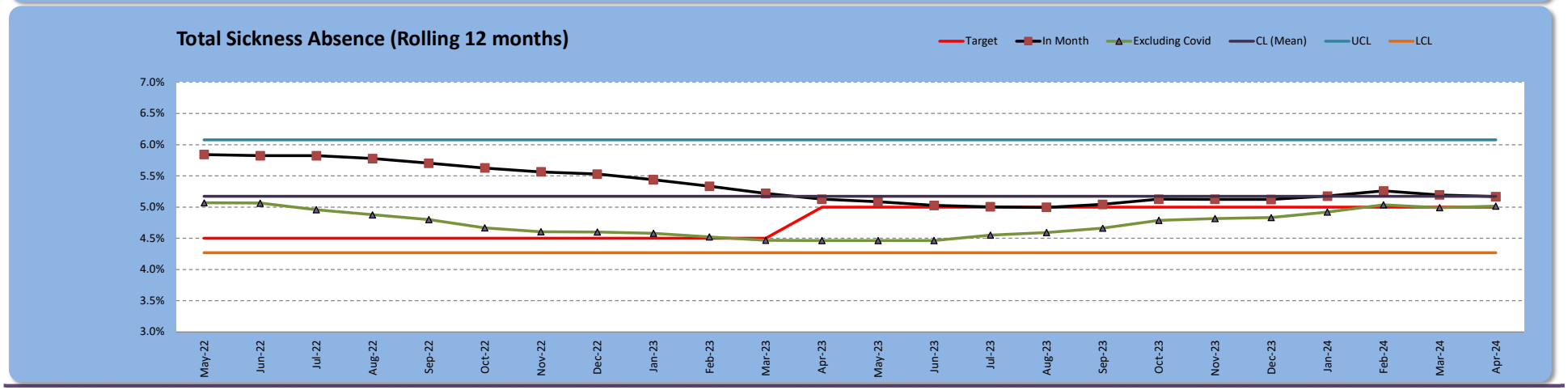
Goal 4 : Developing an Effective and Empowered Workforce

Target:	Amber:	Current month stands at:
5.0%	5.2%	4.8%

For the period ending: **April 2024**

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

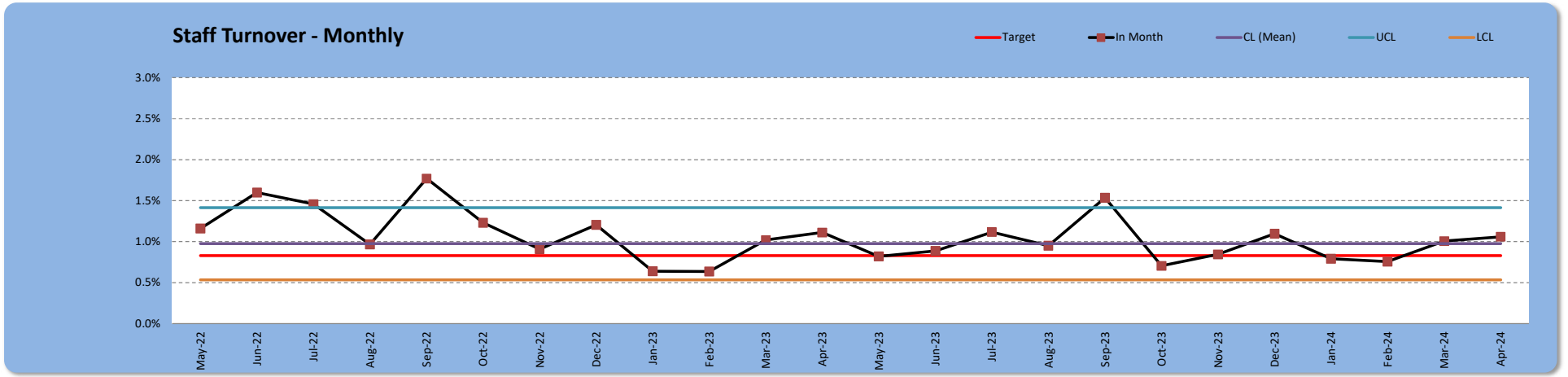
PI RETURN FORM 2024-25

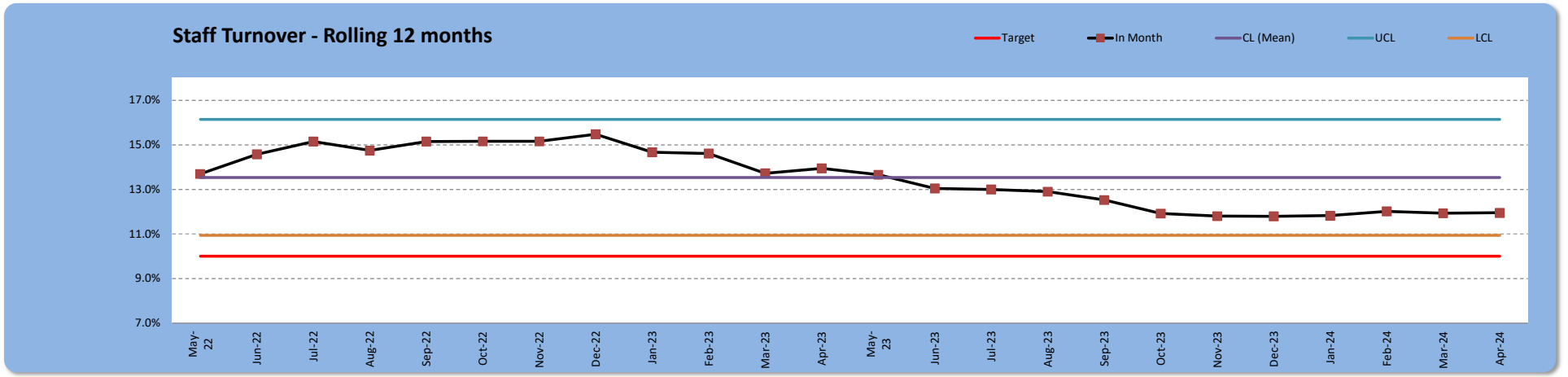
Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **April 2024**

Target:	Amber:	Current month stands at:	Target:	Amber:	Rolling figure stands at:
0.8%	0.7%	1.1%	10%	9%	12%

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

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
Director of Workforce and Organisational Development:	Steve McGowan
Medical Director:	Kwame Fofie
Director of Nursing:	Hilary Gledhill

Caring, Learning
& Growing Together

Issue Date: 14/05/2024

Financial Year 2024-25

NHS Humber Teaching NHS Foundation Trust

Mental Health Long Term Plan Metrics

This document provides a high level summary of the performance against the Mental Health Long Term Plan 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.

Chief Executive: Michele Moran

Prepared by: Business Intelligence Team

Reporting Month:
Apr-24

Mental Health Targets Dashboard

NHS England
Humber Teaching NHS Foundation Trust
2024/25
10 May 2024

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target / Threshold/FIO	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
1	Overall Access to **Core Community Mental Health Services for Adults and Older Adults** with Severe Mental Illnesses **Rolling 12months**	7018	7940	7953	7929	7932	7894	7872	7779	7706	7735	7680	7586	7628
2	Access to **Children and Young People's** Mental Health Services **Rolling 12months**	6855	5163	5210	5173	5234	5356	5478	5493	5389	5593	5819	5837	5909
3	Women Accessing Specialist Community **Perinatal Mental Health Services** **Rolling 12months (ALL 4 PLACE AREAS)**	865	644	654	666	672	691	709	701	716	742	740	756	765
4	Inappropriate adult acute mental health **Out of Area Placement (OAP)** bed days **Rolling 3 months**	360	566	721	957	998	702	435	381	447	543	594	705	882
5d	NHS **Talking Therapies** - Access (Target/Plan)	FIO	500	500	500	500	500	467	467	467	480	480	480	500
5n	NHS **Talking Therapies** - Access (Actual)	FIO	421	451	448	522	517	581	599	398	576	536	463	607
5	NHS **Talking Therapies** - Access (Fiscal Year Performance)	100%	85%	87%	87%	91%	93%	97%	101%	99%	101%	102%	102%	121%
6	Mental Health **Delayed Transfers of Care** Rate	≤7.5%	12.6%	9.3%	9.0%	9.8%	8.1%	5.4%	6.5%	8.8%	7.3%	7.4%	5.4%	9.6%
7	Physical Health **Delayed Transfers of Care** Rate *(aka Fit to Reside)*	≤7.5%	18.8%	26.0%	20.8%	17.6%	17.8%	15.7%	26.1%	13.8%	21.0%	15.3%	22.6%	17.8%

Mental Health Targets Dashboard

NHS England
Humber Teaching NHS Foundation Trust
2024/25
10 May 2024

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target / Threshold/FIO	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
8a	Proportion of new referrals to **community crisis service** with first face-to-face contact within 4 hours **(very urgent)** **Includes both CYP and Adults**	NULL	0.0%	No cases	75.0%	40.0%	100.0%	No cases	57.1%	66.7%	0.0%	100.0%	81.8%	73.1%
8adenom	Proportion of new referrals to **community crisis service** with first face-to-face contact within 4 hours (very urgent) **Denominator** **Includes both CYP and Adults**	NULL	1	0	4	5	1	0	7	3	3	5	11	26
8aNumer	Proportion of new referrals to community crisis service with first face-to-face contact within 4 hours (very urgent) **Numerator** **Includes both CYP and Adults**	NULL	0	0	3	2	1	0	4	2	0	5	9	19
8b	Proportion of new referrals to **community crisis service** with first face-to-face contact within 24 hours **(urgent)** **Includes both CYP and Adults**	NULL	74.4%	78.7%	85.2%	81.1%	71.4%	67.3%	72.3%	60.4%	51.2%	90.9%	82.0%	75.5%
8bdenom	Proportion of new referrals to **community crisis service** with first face-to-face contact within 24 hours **(urgent)** **Denominator** **Includes both CYP and Adults**	NULL	43	47	54	53	49	49	47	48	43	44	50	53
8bnumer	Proportion of new referrals to community crisis service with first face-to-face contact within 24 hours **(urgent)** **Numerator** **Includes both CYP and Adults**	NULL	32	37	46	43	35	33	34	29	22	40	41	40
8c	Proportion of new referrals to **Liaison Psychiatry Service (LPS)** from A&E with face-to-face contact within 1 hour	NULL	93.4%	92.5%	92.9%	93.6%	95.1%	95.8%	91.0%	88.2%	89.0%	93.4%	90.6%	89.8%
8cDenom	Proportion of new referrals to **Liaison Psychiatry Service (LPS)** from A&E with face-to-face contact within 1 hour **Denominator**	NULL	303	292	296	329	304	263	277	272	282	286	299	266
8cNumerator	Proportion of new referrals to **Liaison Psychiatry Service (LPS)** from A&E with face-to-face contact within 1 hour **Denominator**	NULL	283	270	275	308	289	252	252	240	251	267	271	239

Mental Health Targets Dashboard

NHS England
Humber Teaching NHS Foundation Trust
2024/25
10 May 2024

Humber Teaching NHS Foundation Trust

Entry	Indicator Definition	Target / Threshold/FIO	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
9a	**Virtual Wards** - Number of Beds Available	FIO	10	10	10	10	10	10	15	15	15	15	15	15
9b	**Virtual Wards** - Number of Beds Days Available	FIO	310	300	310	310	300	310	450	465	465	435	465	450
9c	**Virtual Wards** - Number of Beds Days Occupied	FIO	14	130	146	66	121	167	181	205	221	211	95	127
9	**Virtual Wards** - Number of Bed Occupancy	FIO	5%	43%	47%	21%	40%	54%	40%	44%	48%	49%	20%	28%

Mental Health
Long Term Plan Targets
Dashboard - PLACE data

NHS Improvement

Humber Teaching NHS Foundation Trust

2023/24

10 May 2024

NHS
Humber Teaching
NHS Foundation Trust

Entry	Indicator Definition	Target / Threshold/FIO	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
1a	Overall Access to **Core Community Mental Health Services for Adults and Older Adults** with Severe Mental Illnesses Rolling 12months **(HULL PLACE ONLY)**	3123	3106	3092	3101	3130	3119	3137	3115	3117	3174	3175	3117	3138
1b	Overall Access to **Core Community Mental Health Services for Adults and Older Adults** with Severe Mental Illnesses Rolling 12months **(East Riding PLACE ONLY)**	3895	4556	4598	4580	4589	4587	4558	4513	4465	4448	4407	4371	4398
2a	Access to **Children and Young People's** Mental Health Services Rolling 12months **(HULL PLACE ONLY)**	3991	2854	2854	2849	2866	2890	2943	2929	2873	2964	3069	3073	3078
2b	Access to **Children and Young People's** Mental Health Services Rolling 12months **(East Riding PLACE ONLY)**	2864	2148	2182	2149	2192	2282	2340	2362	2320	2431	2550	2569	2632
3a	Women Accessing Specialist Community **Perinatal Mental Health Services** Rolling 12months (HULL PLACE ONLY)	238	276	267	268	266	264	271	260	265	274	265	269	273
3b	Women Accessing Specialist Community **Perinatal Mental Health Services** Rolling 12months (EAST RIDING PLACE ONLY)	173	179	187	189	193	204	208	205	213	222	222	228	225
3c	Women Accessing Specialist Community **Perinatal Mental Health Services** Rolling 12months (NORTH EAST LINCS PLACE ONLY)	173	170	165	165	170	175	165	165	176	175	182	188	191
3d	Women Accessing Specialist Community **Perinatal Mental Health Services** Rolling 12months (NORTH LINCS PLACE ONLY)	281	11	24	33	37	46	52	58	60	65	69	75	83
4a	Inappropriate adult acute mental health **Out of Area Placement (OAP)** bed days Rolling 3 months **(HULL PLACE ONLY)**	202	361	406	493	543	430	292	199	220	213	278	350	444
4b	Inappropriate adult acute mental health **Out of Area Placement (OAP)** bed days Rolling 3 months**(EAST RIDING PLACE ONLY)**	158	102	204	361	349	248	127	161	175	244	180	177	206

Humber Teaching NHS Foundation Trust

Executive Team:

Chief Executive:	Michele Moran
Chair:	Caroline Flint
Chief Operating Officer:	Lynn Parkinson
Director of Finance:	Peter Beckwith
Director of Workforce and Organisational Development:	Steve McGowan
Medical Director:	Kwame Fofie
Director of Nursing:	Hilary Gledhill

Caring, Learning & Growing Together

Issue Date: 10/05/2024

Humber Teaching NHS Foundation Trust

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Risk Register Update
Author/s:	Executive Lead: Hilary Gledhill, Director of Nursing, Allied Health & Social Care Professionals. Oliver Sims Corporate Risk and Incident Manager
Recommendation:	

To approve	X	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	The report provides the Board with an update on the Trust-wide risk register (15+ risks) including the detail of any additional or closed risks since last reported to Trust Board in January 2024.

Key Issues within the report:

Positive Assurances to Provide:

MH88 – Insufficient AMHP resource to deliver responsive service (increased demand on AMHP service has gone up by a significant level in 2023, along with significant increase in s136 work reflecting the national picture) which means we fail to meet statutory duties under the mental health act, this is a reputational risk as we may not adhere to legal requirements and there may be further risk of harm as response to urgent need is delayed.

Development opportunities are being introduced to increase AMHP posts for the trust rota including recruiting non-social workers, creating trainee roles, reviewing commitment of current AMHPs within the Hub, support staff on the assisted year of practice, develop an Action Plan to support recruitment and retention overall. Local incentives are being monitored to determine market competition.

WF38 – As a result of the current level of consultant vacancies, agency solutions are being used to ensure that services are kept safe which has financial impact for the Trust and may also affect our ability to maintain an effective and engaged workforce.

Ongoing retention work within the Trust across hard to recruit roles and Trust staff retention plan in place. Recruitment plan in place for consultant vacancies

Key Actions Commissioned/Work Underway:

- Work has been undertaken within the Trust to consider applicable system risks, and a planned review of the current risks held on the Humber and North Yorkshire Integrated Care Board risk register was undertaken by the Executive Management Team at their planned timeout in March 2024 to identify cross-organisational risks for inclusion on the Trust risk register.

- Details of the scoped system-informed risks have been included in body of the report.

which is monitored by the Executive Management Team and the Workforce and OD Committee. Workforce planning process overarching plan in place for 2023/24 financial year and additional investment in recruitment, marketing, and communications in place. **LDC82 – Due to local demands significantly exceeding what is commissioned in relation to ADHD intention, there is insufficient medical staffing to assess, and review needs of this service user group. This has resulted in a lengthy waiting list for young people diagnosed with ADHD being considered for intervention. While these young people are sent waiting list letters and can access ad hoc support via our duty system, regular reviews are not viable given existing staffing levels. This is likely to have impact on their functioning such as educational attainment based on diagnosis received.** There is ongoing work within the service to the address the increasing levels of demand in terms of ADHD medication review. Increased use of skill-mix is being explored within waiting list review activity and more oversight of demand through weekly huddles and monitoring arrangements is in place. Further discussion is required at system-level to determine longer-term arrangements to manage to the sustained increase in demand. **LDC87 – Due to size of the CTLD Speech and Language dysphagia waiting list; individuals not receiving the treatment they have been assessed as needing in a timely manner. Leading to the risk of increased distress in individuals and families, and an increased risk of poor physical health.** Mitigations are in place around staffing within the service to support the work around the waiting list. Further staff within the service have now undertaken relevant training to support ongoing management of these patients. Triaging system in place to ensure that most urgent cases are being highlighted and that clients with significant clinical are being seen within appropriate timescales. Further vacancies within the team and additional training requirements to be addressed. **OPS17 – Failure to effectively address waiting times within the Trust's Neurodiversity services (Adult and Childrens) which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.** Recovery plans remain in place to reduce waiting times and achieve 52-week compliance (or below where that is applicable). Data demonstrates that progress is now being made in reducing over 52-	

week wating times, particularly in the children's autism service which previously had the highest number of patients waiting over 52 weeks.

Key Risks/Areas of Focus:

- No matters of concerns to highlight or key risks further to those included in the Trust wide risk register to escalate.

Decisions Made:

- There are currently **8** risks held on the Trust-wide Risk Register. The current risks held on the Trust-wide risk register are summarised below:

Risk Description	Current Rating	Movement from prev. quarter
MH88 – Insufficient AMHP resource to deliver responsive service which means we fail to meet statutory duties under the mental health act, this is a reputational risk as we may not adhere to legal requirements and there may be further risk of harm as response to urgent need is delayed.	16	⇔
WF38 – As a result of the current level of consultant vacancies, agency solutions are being used to ensure that services are kept safe which has financial impact for the Trust and may also affect our ability to maintain an effective and engaged workforce.	16	⇔
LDC82 – Increased demand for ADHD medication due to recovery work on the ADHD waiting list resulting in inadequate medical staffing capacity to manage all ADHD service demand.	16	⇔
LDC87 – Due to size of the CTLD Speech and Language dysphagia waiting list; individuals not receiving the treatment they have been assessed as needing in a timely manner. Leading to the risk of increased distress in individuals and families, and an increased risk of poor physical health.	16	**New Risk**
FII236 – Due to the lack of available of capital nationally, the Trust may be unable to redesign its mental health inpatient services which may impact Trust delivery of safe and effective services as there will be 5-6 sites that cannot be further developed due to building and regulatory constraints.	16	**New Risk**
OPS17 – Failure to effectively address waiting times within the Trust's Neurodiversity services (Adult and Childrens) which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.	16	**New Risk**
WF47 – Regional workforce reduction schemes and any subsequent local requirement to deliver the same, is likely to impact on Trust ability to recruit into future roles therefore impacting quality of care and compliance.	16	**New Risk**

	FII238 - As a result of difficulties within the ICS to meet challenging financial targets for 2024/25, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	**15**	**New Risk**

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

	Date		Date
Audit Committee	05/2024	Remuneration & Nominations Committee	
Quality Committee	02/2024	Workforce & Organisational Development Committee	04/2024
Finance & Investment Committee		Executive Management Team	05/2024
Mental Health Legislation Committee		Operational Delivery Group	04/2024
Charitable Funds Committee		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	

Risk Register Update

1. Trust-wide Risk Register

There are currently **7** risks reflected on the Trust-wide risk register which records all risks currently scored at a rating of 15 or above and is reflected in ***Table 1*** below:

Table 1 - Trust-wide Risk Register (current risk rating 15+)

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	Movement from prev. quarter
MH88	Insufficient AMHP resource to deliver responsive service (increased demand on AMHP service has gone up by a significant level in 2023, along with significant increase in s136 work reflecting the national picture) which means we fail to meet statutory duties under the mental health act, this is a reputational risk as we may not adhere to legal requirements and there may be further risk of harm as response to urgent need is delayed. Sufficient AMHP resource to deliver responsive service which means we fail to meet statutory duties under the mental health act, this is a reputational risk as we may not adhere to legal requirements and there may be further risk of harm as response to urgent need is delayed.	**20**	**16**	**4**	⟺
WF38	As a result of the current level of consultant vacancies, agency solutions are being used to ensure that services are kept safe which has financial impact for the Trust and may also affect our ability to maintain an effective and engaged workforce.	**20**	**16**	**8**	⟺
LDC82	Due to local demands significantly exceeding what is commissioned in relation to ADHD intention, there is insufficient medical staffing to assess, and review needs of this service user group. This has resulted in a lengthy waiting list for young people diagnosed with ADHD being considered for intervention. While these young people are sent waiting list letters and can access ad hoc support via our duty system, regular reviews are not viable given existing staffing levels. This is likely to have impact on their functioning such as educational attainment based on diagnosis received.	**20**	**16**	**8**	⟺
LDC87	Due to size of the CTLD Speech and Language dysphagia waiting list; individuals not receiving the treatment they have been assessed as needing in a timely manner. Leading to the risk of increased distress in individuals and families, and an increased risk of poor physical health.	**20**	**16**	**4**	⟺
FII236	Due to the lack of available of capital nationally, the Trust may be unable to redesign its mental health inpatient services which may impact Trust delivery of safe and effective services as there will be 5-6 sites that cannot be further developed due to building and regulatory constraints.	**20**	**16**	**8**	**New Risk**
OPS17	Failure to effectively address waiting times within the Trust's Neurodiversity services (Adult and Childrens) which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.	**20**	**16**	**8**	**New Risk**
WF47	Regional workforce reduction schemes and any subsequent local requirement to deliver the same, is likely to impact on Trust ability to recruit into future roles therefore impacting quality of care and	**20**	**16**	**8**	**New Risk**

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	Movement from prev. quarter
	compliance.				
FII238	As a result of difficulties within the ICS to meet challenging financial targets for 2024/25, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery. **Initial and current ratings remain unchanged to reflect that the Trust is currently limited in terms of current internal controls for this particular risk. Contractual discussions with commissioners are ongoing and the Trust is taking all necessary action to ensure receipt of appropriate funding.**	15	15	5	New Risk

2. Closed/ De-escalated Trust-wide Risks

There is **1** risk previously held on the Trust-wide risk register which has been closed / de-escalated since last reported to Trust Board in January 2024.

Table 2 - Trust-wide Risk Register Closed / De-escalated Risks

Risk ID	Description of Risk	Risk Status / Update
OPS11	Failure to address waiting times and meet early intervention targets which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.	Risk reviewed by Trust Chief Operating Officer and split into separate new risk register entries to capture specific service areas facing highest level of risk and risk around >52 week waits. The newly scoped risk has been reviewed by the Executive Management Team and is included as part of the Trust-wide risk register.

3. Trust Risks (Informed by system risks)

Table 3 – Trust system-informed risks

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
WF46	Regional failure to deliver or capitalise on priority workforce transformation initiatives and a failure to place an equitable lens on Mental Health and Community workforce, may lead to static or worsening workforce recruitment and retention challenges system-wide, impacting the Trust at a local level.	16	8	4
WF47	Regional workforce reduction schemes and any subsequent local requirement to deliver the same, is likely to impact on Trust ability to recruit into future roles therefore impacting quality of care and compliance.	20	16	8
FII236	Due to the lack of available of capital nationally, the Trust may be unable to redesign its mental health inpatient services which may impact Trust delivery of safe and effective services as there will be 5-6 sites that cannot be further developed due to building and regulatory constraints.	20	16	8

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
FII238	As a result of difficulties within the ICS to meet challenging financial targets for 2024/25, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery. **Initial and current ratings remain unchanged to reflect that the Trust is currently limited in terms of current internal controls for this particular risk. Contractual discussions with commissioners are ongoing and the Trust is taking all necessary action to ensure receipt of appropriate funding.**	15	15	5

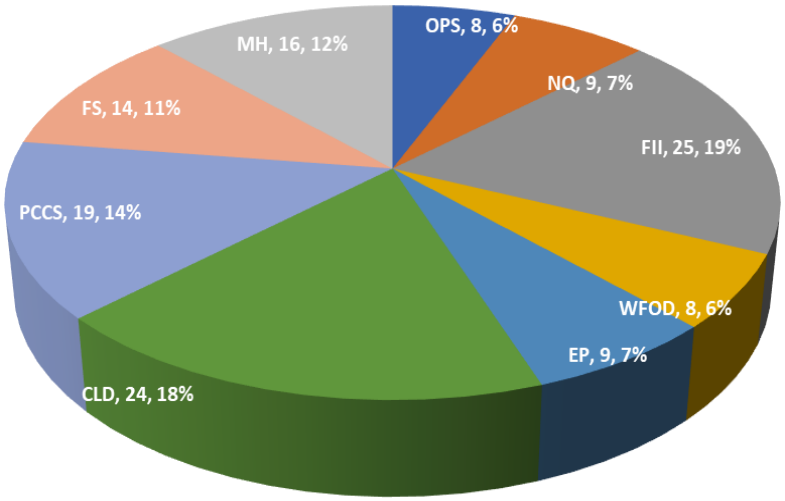
4. Wider Risk Register

There are currently **132** risks held across the Trust's risk registers. The current position represents an overall decrease of **8** risks from the **124** reported to Trust Board in January 2024. The table below shows the current number of risks at each risk rating:

Table 3 - Total Risks by Current Risk level

Current Risk Level	Number of Risks – January 2024	Number of Risk – May 2024
20	0	0
16	4	7
15	0	1
12	29	33
10	2	3
9	34	33
8	21	22
6	27	27
5	2	2
4	5	5
3	0	0
2	0	0
Total Risks	**124**	**132**

Chart 1 – Total Risks by Division/ Directorate



Key:

OPS – Operations Directorate
NQ – Nursing & Quality
FII – Finance, Infrastructure & Informatics Directorate
WFOD – Workforce & OD Directorate
EP - Emergency Preparedness, Resilience & Response
PCCS – Primary Care and Community Services
CLD – Children's and Learning Disabilities
FS – Forensic Services
MH – Mental Health Services

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Date Reviewed	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
1	MH88	Insufficient AMHP resource to deliver responsive service (increased demand on AMHP service has gone up by a significant level in 2023, along with significant increase in s136 work reflecting the national picture) which means we fail to meet statutory duties under the mental health act, this is a reputational risk as we may not adhere to legal requirements and there may be further risk of harm as response to urgent need is delayed.	Objectives	Almost Certain	Severe	20	Significant	1. Escalations to divisional leads. 2. Affected shifts out in advance to bank and overtime to other staff to back fill if short notice. 3. Agreed R&R payments and associated agreement for AMHPs ensuring set shifts are committed and request for release of Community AMHPs (Spoke) at weekly Division Sit Rep. 4. Review of AMHP operating model, business paper due at 19.12.23 Trust ODG. 5. Introduction of AMHP Hub to provide better oversight and continuity. This improves governance and practice of AMHPs. 6. AMHPS attend MHCIT daily MDT where resource allows.	1. Datix reviews 2. Daily meetings and handovers. 3. AMHP professional meeting with LA reviewing ongoing activity 4. Workforce pressure report monthly - to Trust and HCC Divisional leads 5. Complaint reviews	1.Service pressure elsewhere in Division reduces ability to release 'spoke' AMHPs. 2.Spoke' AMHPs are recruited to meet a specific service/division need not to respond to statutory demand 3.current long term sickness and retirement 4.Resilience of current AMHP provision to be reviewed, current resource is insufficient to meet demand(AMHP service business paper) -	1.AMHP Lead utilised to cover service 2.Need for AMHP Service dashboard to show activity and demand 3.AMPH service is a system wide resource requiring multi Divisional response, line of accountability and escalation needs improvement.	Likely	Severe	16	Significant	1. Ongoing recruitment to vacant AMHP posts (31/03/2025) 2. Working with business planning to set out options for ODG/EMT to consider for additional funding (30/08/2024) 3. Development of Trainee AMHP role and introduction of development opportunities (31/03/2025) 4. Recruitment of non-social worker AMHP posts (31/03/2025)	14/05/2024	Kirsten Bingham	Lynn Parkinson	ODG / EMT	Trust Board	Rare	Severe	4	Moderate
2	WF38	As a result of the current level of consultant vacancies, agency solutions are being used to ensure that services are kept safe which has financial impact for the Trust, and may also affect our ability to maintain an effective and engaged workforce.	Objectives	Almost Certain	Severe	20	Significant	1. Recruitment plan for Consultants in place (progress against which reported to EMT and Workforce and OD Committee). 2. 'Humbelievable' recruitment branding set up. 3. GMC sponsored International recruitment programme in place for Speciality Doctors (who may train to become Consultants). 4. Workforce planning process and overarching plan delivered for 23/24 5. Trust Workforce planning process in place for the past 4 years. 6. Additional investment in recruitment, marketing and communications targeted at Consultant recruitment 7. Talent Acquisition specialist role in place untl March 2024 working on consultant posts with some success to date 8. Rolling adverts out for consultant posts 9. Medical Workforce Plan approved 10. All medical vacancies are covered with agency workers. 11. Humber representatives attended the ICB ANCIPs recruitment event in India in January 2024, with 5 vacant consultant posts identified to be filled by SAS Drs / Two substantive appointments January 2024	1. Workforce and OD Committee (insight reports). 2. Divisional Business Meetings. 3. EMT 4. Trust Board 5. ODG 6. DATIX reports	1. Not all vacancies currently advertised (One vacancy is not currently advertised -Avondale). 2. Commencement of remaining international recruit.	1. Consultant vacancy rate March 2024 – 24.32%. 2. 9 vacancies - March 2024	Likely	Severe	16	Significant	1. Onboarding of the recruited specialty doctors from India (30/06/2024)	14/05/2024	Kwame Fofie	Kwame Fofie	Directorate Business Meeting / Executive Management Team	Trust Board	Unlikely	Severe	8	High
3	LDC82	Due to local demands significantly exceeding what is commissioned in relation to ADHD intention, there is insufficient medical staffing to assess, and review needs of this service user group. This has resulted in a lengthy waiting list for young people diagnosed with ADHD being considered for intervention. While these young people are sent waiting list letters and can access ad hoc support via our duty system, regular reviews are not viable given existing staffing levels. This is likely to have impact on their functioning such as educational attainment based on diagnosis received.	Objectives	Almost Certain	Severe	20	Significant	All young people receive waiting list letter once waiting time exceeds 12 weeks, and every 12 weeks exceeding this and the duty support service offer is detailed in this letter as is CAMHS and Early help. Any families or young people that access support via the duty service offer will be reviewed by the ADHD intervention lead to assess current risks and needs. Based on these reviews, the lead will review with partner agencies to optimise any appropriate signposting and consider expediting on the consultant waiting list. Staffing is now in place to maximum financial capacity including Non-medical prescriber now in post and working with team lead and consultant to try and optimise capacity through skill mixing. Substantive consultant now in post and due to liaise with intervention team to determine best way to utilise/pool skills to meet need. ADHD interventions Nurse, admin lead and Operational Manager hold Waiting list monitoring is in place to check the increasing demands and escalate this to Trust ODG and commissioners. Urgent appointments can be offered with a nurse if required.	Track number of long waiters on the ADHD intervention waiting list. Wil move to weekly reporting of waiting list once access plans more clearly established. Duty rota in place - details of how far in advance this is completed. ADHD intervention lead offering consultant slots every week - details to follow re: how many slots are offered per week and percentage allocated. ICB and SEND board are aware- a business case for non pharma logical intervention team and a capacity and a capacity and demand paper for pharmacological intervention has also been written.	Services do not have the financial resources to maintain this high-level demand for ADHD medication.	1. April 2024 - Childrens ADHD number of patient waiting assessment >52 weeks - 183. Paediatric ADHD Treatment number of patient waiting >52 weeks - 3.	Likely	Severe	16	Significant	1. Meeting to be arranged with ICB to discuss a long-term plan which meets new demands (30/06/2024) 2. Service to complete ADHD intervention gap paper and this is being reviewed by EMT (30/06/2024) 3. Service Manager to discuss with Neurodiversity Psychiatrist and intervention team on how to support non pharmacology intervention to ADHD (30/06/2024)	14/05/2024	General Managers	Lynn Parkinson	Directorate Business Meeting / Executive Management Team	Trust Board	Unlikely	Severe	8	High

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Date Reviewed	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
4	LDC87	Due to size of the CTLD Speech and Language dysphagia waiting list; individuals not receiving the treatment they have been assessed as needing in a timely manner. Leading to the risk of increased distress in individuals and families, and an increased risk of poor physical health.	Objectives	Almost Certain	Severe	20	Significant	1.Band 6 now completed dysphagia training 2.Band 6 dysphagia trained therapist has returned from long term sickness. 3.Band 7 SLT lead returned from maternity leave. 4.Band 5 SLT has begun dysphagia training however will not be qualified for 6-9 months. 5.One SLT currently doing adhoc bank hours. 6.Band 5 vacancies recruited into - commencing in July and September. 7. Dysphagia competencies now in place for Band 4 Associate Practitioners. 8. Continued use of triaging system to ensure most clinically urgent cases are highlighted. Current increase in Priority 1 and Priority 2 referrals as well as current waiters increasing in priority. This impacts on Priority 3 waiters. Triage process ensures that clients with significant clinical risk are seen within an appropriate timeframe.	1.LD clinical network - WHAT DOING - 2.Speech and Language Therapy Team Meetings 3.Long and Multiple waiters meetings 4.CTLD MDT meetings 5.Monitoring of waiting list 6.Complaints	1.Vacancies in the team however band 5 therapists when recruited often require dysphagia training which takes 9-12 months to complete.	1. April 2024: Hull Dysphagia 48 clients waiting. Longest wait 90 weeks. East Riding Dysphagia 23 waiting. Longest wait 65 weeks	Almost Certain	Severe	16	Significant	1.Ongoing recruitment to vacant service posts (31/03/2025)	14/05/2024	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High
5	FII236	Due to the lack of available of capital nationally, the Trust may be unable to redesign its mental health inpatient services which may impact Trust delivery of safe and effective services as there will be 5-6 sites that cannot be further developed due to building and regulatory constraints.	Objectives	Almost Certain	Severe	20	Significant	1. The Trust is utlising annual capital allocation with ringfenced budget for inpatient Estates improvement. 2. 2023-24 scheme for improvement of bathrooms in inpatient setting. 3. Trust maintains existing states are far as is possible through ongoing maintence and capital investment.	1. Estate Strategy and Capital Delivery Group 2. EMT 3. Service Planning and Transformation Group 4. Major Schemes Project Board	1. Operationl plans are annual, which do not allow for long term capital planning. 2. Increase in backlog maintenance as Trust estate deteriorating over time due to age and not meeting performance requirements toward net zero targets. 3. Inability to change suitability of existing buildings to accomodate improvements such as en-suite bathroom facilities.	1. Trust was not successful in application for new hospitals scheme. 2. RAAC issues nationally further affecting availability of centralised funding. 3. Trust compliance with Health Technical Memoranda and Health Building Notes.	Likely	Severe	16	Significant	1. Longer term strategies for services to be recognised (31/03/2025) 2. Finance Director exploring alternative funding options (31/03/2025)	14/05/2024	Rob Atkinson	Peter Beckwith	ODG / EMT	Trust Board	Unlikely	Severe	High	8
6	OPS17	Failure to effectively address waiting times within the Trust's Neurodiversity services (Adult and Childrens) which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.	Objectives	Almost Certain	Severe	20	Significant	1. Work underway with Divisions to address three areas of challenge 2. Local Targets and KPIs. 3. Close contact being maintained with individual service users affected by ongoing issues. 4. Waiting Times Procedure in place 5. Waiting times review is key element of Divisional performance and accountability reviews. 6. Review completed of all services with high levels of waiting times and service-level recovery plans developed. 7. Capacity and Demand review includes a focus on productivity and development of plans detailing Recovery requirements 8. Planning round and discussions taking into acut waiting times position.	1. Reports to demonstrate waiting list performance to Trust Board, Quality Committee and Operational Delivery Group. 2. Quality impact on key identified areas monitored via Quality Committee. 3. Weekly divisional meetings with Performance & Access Mgr around waiting list performance. 4. Introduction of Monthly Performance & Productivity Group chaired by COO. 5. Capacity and Demand planning has either taken place or is scheduled to take place in all long waiting areas and improvement trajectories developed or proposals developed for improvement.	1. Opportunities to revise pathways to increase productivity or reduce demand into services. 2. Confirmation on levels of funding available to support demand.	1. Adult ADHD number of patient waiting >52 weeks - 237 June 2023 patients increased to 432 April 2024 2 .Children's ASD number of patient waiting >52 weeks 589 in Q4 21/22 to 326 April 2024 3. Childrens ADHD number of patient waiting assessment >52 weeks 361 in Q4 22/23 to 198 April 2024 4. Operational planning guidance does not provide instructions in relation to neuro services.	Almost Certain	Moderate	15	Significant	1. Neuro diversity services work at ICB level to determine how processes can be standardised / streamline to reduce system pressures (30/06/2024) 2. Adult ADHD Options outcome to determine level of service delivery going forward. (30/06/2024) 3. Confirmation on levels of funding available to support demand. - (30/06/2024)	14/05/2024	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Moderate	6	Moderate

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Date Reviewed	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
7	WF47	Regional workforce reduction schemes and any subsequent local requirement to deliver the same, is likely to impact on Trust ability to recruit into future roles therefore impacting quality of care and compliance.	Objectives	Almost Certain	Severe	20	Significant	1.Maintaining continued presence in strategic workforce settings regionally to influence decision making from a Humber perspective 2.Internal communications outcome / network groups decisions to ensure dissemination of messages and internal alignment / understanding so there is consistent messaging in regional programmes of work such as the Breakthrough Programme. 3.Trust is represented across all ICB Workforce Groups. 4.Trust is maintaining defensible growth in opertational plan within the Trust	1.Regional HR Director Meeting 2.Workforce Board 3.Yorkshire and Humber HR Directors 4.Humber maintaining representation and understanding of regional position and progress - 5.Current recruitment and vacancy rates are positive.	1.Impact of Operational planning guidance and potential workforce reduction schemes within acute providers, which may lead to potential reputational impact for all NHS providers in region. 2.Impact to workforce morale / potential for unease in Trust workforce limiting engagegement due to regional decision making 3.Yorkshire and Humber HR Directors 4.Humber maintaining representation and understanding of regional position and progress	1.Limited progress since launch of Breakthrough programme. 2.Uncertainties around implications of Operational planning guidance across regional NHS workforce.	Likely	Severe	16	Significant	1.Continued delivery of local actions / internal programmes of work to address priority transformation areas using data such as staff survey (31/03/2025) 2.Continued attendance at breakthrough programme and presence / contribution to regional workforce groups (31/03/2025)	14/05/2024	Claire Jenkinson	Karen Phillips	Directorate Business Meeting	Workforce and OD Committee	Unlikely	Severe	8	High
8	FII238	As a result of difficulties within the ICS to meet challenging financial targets for 2024/25, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery .	Objectives	Possible	Catastrophic	15	Significant	1. Contractual discussions with commissioners and Trust taking all necessary action to ensure receipt of appropriate funding. 2. Budget Reduction Strategy in place up to 2026-27 and small amount of contingency/risk cover provided for in plan.	1. Monthly reporting to EMT 2. Quarterly Reporting to Finance Committee monitoring of performance against plans. 3. Monthly reports and Quarterly Accounts Returns to NHS I with quarterly feedback. 4. ODG and Divisional ODG reports monitoring financial position and performance against plans. 5. Accountability Review monitoring of financial position and discussed with budget holders (regular confirm and challenge).	1. The overaching ICS financial position and the ability for Commissioners to invest up to MHIS and the lack of full deployment of Mental Health Service Development Funding 2. Short term nature of Financial Planning from an ICS perspective	1. Final Trust Control Total 2024-25 not confirmed or agreed 2. Financial plan currently draft until control total is agreed .	Possible	Catastrophic	15	Significant	1. Ongoing maintenance of relationships with Commissioners (31/03/2025) 2. Continue to work with Commissioners to highlight the requirement for funding through MHIS and Service Development Funds (31/03/2025) 3. Continue to bid for national resource as and when it becomes available (31/03/2025)	20/05/2024	Iain Omand	Peter Beckwith	Directorate Business Meeting/ Executive Management Team	Board	Rare	Catastrophic	5	Moderate

Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting– 29 May 2024
Title of Report:	Board Assurance Framework Q4 2023/24
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:	The report provides the Trust Board with the Q4 2023/24 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:

- The Q4 version of the Board Assurance Framework presented in the revised 2023/24 template approved by EMT in June 2023.

Key Actions Commissioned/Work Underway:

- Work was completed to refresh the Trust Board Assurance Framework template for use in 2023/24 reporting in line with the refreshed trust strategy and feedback from the board development session.

Key Risks/Areas of Focus:

- No matter of concerns to highlight or key risks further to those included in the Board Assurance Framework to escalate.

Decisions Made:

Current assurance ratings for each section of the Board Assurance Framework:

Strategic Goal – Innovating for Quality and Patient Safety

- Overall rating 8 - High for Quarter 4 2023/24

Strategic Goal – Enhancing prevention, wellbeing, and recovery.

- Overall rating 12 - High for Quarter 4 2023/24

Strategic Goal – Fostering integration, partnerships, and alliances.

- Overall rating 8 - High for Quarter 4 2023/24

Strategic Goal – Promoting people, communities, and social values.

- Overall rating 6 - Moderate for Quarter 4 2023/24

	Strategic Goal – Developing an effective and empowered workforce. - Overall rating 8 - High for Quarter 4 2023/24 **Strategic Goal – Optimising an efficient and sustainable organisation.** - Overall rating 8 - High for Quarter 4 2023/24

Governance:

	Date		Date
Audit Committee	05/2024	Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	04/2024
Finance & Investment Committee	05/2024	Executive Management Team	05/2024
Mental Health Legislation Committee		Operational Delivery Group	04/2024
Charitable Funds Committee		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 2023/2024

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 April 2022)	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	SEEK	15
Optimising an efficient and sustainable organisation	Director of Finance	MATURE	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**	**SEEK**	**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**	**MATURE**	**IN**	⟷

Innovating for quality and patient safety

Lead Director: Dir. Nursing

Lead Committee: Quality Committee

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

Risk Score: 8

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 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
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)
- Trust is rated green for 24 of 29 aspects of statutory and mandatory training and amber for the remaining 5
- No incidents relating to medicine safety, safer staffing or relating to waiting lists that have caused harm moderate and above.
- PSIRF Policy and plan approved by ICB and Trust Board (September 2023)
- Peer review process in place aligned to CQC fundamental standards.
- 337 recorded Quality Improvement (QI) activities of which 212 were complete, 3 at idea stage/awaiting charters and 66 underway. There are 54 activities which have been closed as no longer viable.
- QI training increased with 1241 total places delivered.
- 175 (62%) QI activities underway or complete have indicated that they have included Patients and Carers in the planning and delivery of the work.
- 86 (30%) QI activities have indicated that they have collaborated with organisations outside the Trust.
- NHS National Staff Survey 2022, 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%).
- The Trust is currently delivering against its Clinical Audit Plan
- 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%)
- Significant assurance given by Audit Yorkshire for Trust Safer Staffing audit.
- Significant assurance given by Audit Yorkshire for Trust Patient Safety Governance audit.

Negative Assurance / Gaps in Assurance

- Trust CQC rating for 'Safe.' Remains requires improvement (2019 assessment)
- Annual Medicine Administration compliance rate 47.12% (September 2023) improved from 17.74% in May, but with target of 85% Trust compliance.
- Trust Waiting Time position

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
Mitigating actions to manage waiting lists in place with regular reports to Board (**Neuro diversity and Adult ADHD)**	June 2024	Lynn Parkinson	Adult ASD/ADHD Assessment waiting times are improving. Capacity and Demand work ongoing to identify areas for further support.
Neuro diversity services work at ICB level to determine how processes can be standardised / streamline to reduce system pressures	June 2024	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 2024	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.
Clinical-led work to determine gaps within services and determine pathway improvement works – Paul Johnson / Lynn Updates	June 2024	Lynn Parkinson	
Patient Safety Priorities identified following thematic review of incidents.	August 2024	Hilary Gledhill	QI projects in place for each priority. Monitoring in place with reports to QC commencing December 2023.

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 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
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 (March 2023). 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 (September 2023). 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 2024	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 2024	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 2024	Lynn Parkinson	Work is ongoing in the Mental Health Division to apply the principles to the Trauma Service.

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 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15	15	15	15

Positive Assurance

- At the end of Q3 23/24, the Trust held a total value of £66,396,809.00 in partnership-based contracts.
- Continued engagement with the East Riding Health and Care Committee, including supporting the ER Place team with restructuring of ER H&CC priorities three, recognisable and easily conveyed themes around inequality of access, outcomes and experience. Key deliverables include Rural and Coastal Communities, Integrated Neighbourhood Teams, Inclusion Groups and Complex Case Management
- The Trust is fully engaged in the programme of work developed by the Hull Health and Care Partnership to support their ambitions and priorities for the people of Hull. The overarching projects within the programme of work are: Integrated Neighbourhood Teams, Respiratory, Workforce
- Trust representatives attended East Riding Heath and Wellbeing Board Deep Dive events on Cost of Living and Climate Change & Health
- Updated our mapping of HTFT representation on ICB boards and groups in Feb 2024
- Ongoing engagement with ICB and Stakeholders to look at the better utilisation of Whitby Hospital, including looking at engagement with Secondary Care Providers to possibly bring more Services to Whitby Hospital. Additionally, discussions around a Health & Wellbeing Hub are ongoing with a paper being created to share with the ICB asking for support.
- The Trust is working jointly with the ICB, local authorities and the VCSE to review and redraft service specifications for several services. First draft specifications for CAMHS services and Children's Therapies have been developed by the CLD Division with support from the Partnerships and Strategy Team, for submission to the ICB by end March 2024.
- At the end of Q3 23/24, of the 375 QI ideas that have been identified, 112 (33%) of them indicated that they have collaborated with organisations outside the Trust (compared to 30% for Q2 23/24), and 67% indicated they would benefit Partner Organisations (compared to 66% for Q2 23/24).
- Interweave updates for Q4 23/24: -
  - Focus on data provision aided by consumer research:
    - Data maturity assessment has taken place across all providers and a data maturity action plan is being developed with each of the ICS partners.
    - The data quality team has been strengthened and two additional suppliers have been contracted to carry out the data maturity work.
- Work has been completed to improve onboarding process and the updated process is now available online.
- Costs have been provided to NHS England to carry out the NRL development. NHS England have asked Interweave to not start any development until 24/25 at very earliest.
- BaRS any2any discovery has been completed and the development of BaRS any2any is being progressed.

Negative Assurance / Gaps in Assurance

- An updated report of Trust representation at ICB meetings was taken to EMT in December 2023; Divisions are also being asked to contribute to this piece of work to ensure that operational representation is incorporated.
- QI data for Q3 23/24 is not yet available, therefore this cannot be reported on.
- Q3 23/24 data is not yet available, therefore DToC and OOA performance cannot be compared to Q2 23/24.

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.	November 2024	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	November 2024	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.

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 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
Current Risk Rating	6 MODERATE	6 MODERATE	6 MODERATE	6 MODERATE
Risk Appetite Threshold	15	15	15	15

Positive Assurance

- Trust Health Inequalities Programme: In February 2024, a suite of pages were launched on our staff Intranet to provide staff with accessible and easy to use resources on health inequalities. These pages cover our Trust approach to health inequalities, good practice examples, access to training and support, information on using data, advice on working with communities and a resource bank of information on health inequalities. A comms plan has been developed which aims to keep health inequalities high on the agenda within the Trust, comprising regular articles in The Global staff newsletter and regular staff training and information sessions. We recognise our staff are members of the communities we serve and are likely to be experiencing the same challenges and health inequalities. In Feb/March 2024, a series of staff roadshows ran to promote the Trust's staff benefits and health and wellbeing offer and gain insights from staff on what more the Trust could do to support wellbeing.
- Inclusion Groups Programme of the ER Health and Care Committee: Work has continued on ERYC inclusion health needs assessment and Smile VCSE mapping exercise. 2 VCSE inclusion health workshops were held in Bridlington in Feb 2024 to inform the development of training for VCSE and an Inclusion Champions scheme. The programme has taken on governance for the Travelling Communities Project Group and Bridlington Rough Sleepers Project.
- 20 VCSE organisation representatives are part of the Humber Co-production Network (March 2024).
- The demographic profile of staff at the end of Q4 23/24 is as follows:

	% BAME	% disabled	% LGBTQ+	% female	% part-time	% aged 50+
Q4 23/24	7.19%	9.14%	4.50%	79.34%	33.43%	34.54%
Q3 23/24	7.21%	9.12%	4.45%	79.30%	33.72%	34.90%

  - The demographic profile of SCoPEs has not changed by any significance since Q3 23/24.
  - The Trust's EDI Steering Group is responsible for overseeing and promoting equality, diversity, and inclusion within the organisation. This group is chaired by the Deputy Director of Workforce and OD and consists of representatives from staff network chairs and each division/directorate. In December, EMT agreed Staff Network Chairs should have protected time to attend their own network meetings as well as EDI Steering Group meetings. The Trust currently has 3 staff networks: Race Equality Network, Rainbow Alliance (LGBTQ+), and Humber Ability. In the past month the terms of reference for each network have been reviewed to reflect changes that include a provision for having an Executive Sponsor who supports the group and provides senior support in escalating areas of concern. A substantial budget has been allocated to each network to facilitate engagement and activities. In recent weeks, the LGBTQ+ Staff Network have used some of their allocated budget to successfully organise a well-attended event to commemorate International Day of Trans Visibility, featuring a range of external speakers. Currently, they are working on their plans to support PRIDE in Hull celebrations in July.
  - A Good Experience steering group continues to meet bi-monthly to provide strategic leadership and assurance for the project. A few of the steering group members had an initial meeting with York St John's University and the HNY ICB's Research team to discuss an opportunity to work in partnership on the initiative moving forwards. The university has research interests which focus on people's behaviours coupled with experience in large cultural shift change programmes and is willing to contribute to the project and support with project management/research skills. Workshops continue to be held across the patch to collect feedback on good and negative experiences inside and outside of the NHS and thematic analysis will help shape the MS form survey for further feedback to be collected at a later date. Due to the scale of this initiative and the community reach (1.7 million people), timescales have shifted to later in the year for creation of the Communications Engagement Charter. The Trust continues to host several forums for patients, service users, carers, staff and partner organisations to attend. Each forum listens to a variety of presentations updating the audience on work currently taking place across the NHS, public, private and third sector from a national, regional, local, Trust and service specific perspective.

Positive Assurance (continued)

- The WRES Service offer a series of workshops on Barriers to Employment. For the 6 month reporting period of October 2023 – March 2024, one resilience workshop was delivered with 5 attendees. However, WRES funding ceased on 31st December 2023.
- At the end of Q4 23/24, the Trust had 119 volunteers (compared to 103 at the end of Q3) and 26 in the recruitment process (compared to 47 at the end of Q3).
- The Trust continues to have a presence in schools/colleges, to drive interest in entry level roles; this is outside of the T-Level students we already place. In 2023/24, the Trust took on a total of 44 T-Level and 26 work experience students. As part of National Apprenticeship week, the Trust attended events at local schools and colleges to give an insight into our apprenticeship programme. As part of National Careers Week, the Trust attended local high schools to support Careers Fairs, attend assemblies and help raise awareness of careers in health. A video is being developed to share with managers about the benefits of supporting a work experience placement.
- At the end of Q4 23/24, the Trust had 15 staff (compared to 8 at the end of Q3) on the bank who carried out work as Experts by Experience. During Q3, these staff worked a total of 54 shifts (compared to 31 in Q3).
- At the end of Q4 23/24, there were 10 Peer Support Workers within the Trust (no change from Q3).
- For Q4 23/24, 2 volunteers had moved on to employment (compared to 0 during Q3).

Negative Assurance / Gaps in Assurance

- The Trust is committed to address how we assess the point of view of our communities, and how we collate information about the views of staff as members of their community to inform joint action plans with other organisations. Both these pieces of work will be picked up under the Health Inequalities agenda and PCREF in 2024.
- Discussions are ongoing with the ESR team about the possibility of including governors in the ESR. While the conversation about this has been escalated, there has not been any changes to the current situation.

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.	November 2024	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	November 2024	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.

Developing an effective and empowered workforce

Lead Director: Dir. of Workforce 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	Q1 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
Current Risk Rating	8 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15	15	15	15

Positive Assurance

- 6.69% vacancy rate (March 2024)
  - A rolling 12 monthly turnover rate figure of 10.68%, which is below the turnover rate this time last year (13.05%).
- Registered *Nursing* vacancy rate March 2024 – 6.30%.
- Headcount of 3164.44 (March 2024)
- In the 2023 NHS National Staff Survey;
  - The Trust positions better that the national average across all People Promise theme areas.
  - The Trust positions better the average for our benchmark group (51 MH and community Trusts) in all but one People Promise theme area, where we are equal to the average (we are a team)

  We are compassionate and inclusive – 7.6 out of 10
  We are recognised and rewarded – 6.59 out of 10
  We each have a voice that counts – 7.1 out of 10
  We are safe and healthy – nationally unreported
  We are always learning – 6.22 out of 10
  We work flexibly – 7.05 out of 10
  We are a team – 7.18 out of 10 (equal to the average)
  Engagement 7.18 out of 10
  Morale 6.37 out of 10
  - The Trust the most improved in the country for Trusts of its kind and second most improved in the NHS for the question 'would recommend the organisation as a place to work.
- Medical Workforce Plan approved.
- Updated Trust workforce plan
- Ongoing monitoring of hard to recruit roles in the recruitment and retention task and finish group.
- Overall statutory / mandatory training compliance 94.71% (March 2024).
- Trust People Strategy ratified which sets strategic direction for next four years.

Gaps in Assurance / Negative Assurance

- Consultant vacancy rate March 2024 – 30.99%.
- Pharmacist vacancy rate March 2024 of 18.31%
- The Workforce Scorecard (March 2024) reported a rolling sickness rate figure of 5.2%, and above national and regional benchmarks.
- Representation of BAME staff in Band 7 or above roles is low and is an area of focus for the Trust.
- Representation of disabled staff in Band 8c-VSM roles is low and is an area of focus for the Trust.
- Rising percentage of colleagues experiencing discrimination on grounds of sexual orientation, which places the Trust in the bottom 20% of the sector.
- Rising percentage of colleagues experiencing discrimination on grounds of age, which places the Trust in the bottom 20% of the sector.
- Rising percentage of ethnically diverse staff experiencing discrimination at work from manager / team leader or other colleagues which is 16.16% which is substantially higher than for white colleagues at 4.43% and 2% higher than the comparison figure at 13.90%.
- Rising percentage of ethnically diverse staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months which is 37.37%, and is substantially higher than for white colleagues at 20.74%, and higher than the comparison figure at 31.43%.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
Ongoing communications around leadership development programme uptake and encouragements of ethnically diverse colleagues and those with disabilities and long-term conditions at all levels.	March 2025	Karen Phillips	Trust has comprehensive improvement plan which is monitored via EMT and WFOD Committee on a regular basis. Trust is fully compliant with moving forward actions in regard to the national EDI improvement plan. Ring fenced places on internal leadership programmes for each staff network
Ongoing sponsorship of ethnically diverse colleagues and those with disabilities and long-term conditions at all levels for involvement with Trust Humber High Potential Development scheme and other leadership development programmes.	March 2025	Karen Phillips	Ring fenced places on the Humber High Potential Development scheme for sponsorship by the staff networks, and access to the Trust Leadership (Band 4-7) and Strategic Leadership (Band 8a+) programmes with a Trust KPI for all those in leadership positions to access this.
Focus on succession planning to address underrepresentation particularly in band 7 and above roles	March 2025	Karen Phillips	New succession planning processes embedded into workforce planning for 2024, with actions in place to enhance for 2025, with explicit focus on addressing underrepresentation across all protected characteristics.

			Recruitment deep dives and divisional EDI insight reports developed with recommended actions to address specific areas of underrepresentation in each division/corporate function.
Onboarding of recruited Specialty Doctors appointed through the ANCIPS event in India in January 2024 and development of a sustainable Medical Workforce Plan to show improvement trajectories and feasible piplines for recruitment/grow your own initiatives.	June 2024	Kwame Fofie	Onboarding to now be implemented for commencement in-post with the Trust for recruited medics following successful event. As at March 24 consultant vacancies reduced to 8.4WTE, with the Medical Workforce Plan showing an improving trajectory. This is monitored and overseen by the Executive Medical Director and progress and initiatives monitored in the Recruitment and Retention Task and Finish Group.
Refocus of the Recruitment Task and Finish Group to also focus on the retention of staff in light of Trust turnover being outside of target levels. In addition, the scope of the group broadened to focus on hard to recruit roles outside of nursing and consultant positions, now including Pharmacists.	March 2025	Karen Phillips	Changes to recruitment task and finish group underway to focus on recruitment and retention of Trust staff with terms of reference for the group approved by EMT. The Group will focus on hard to recruit roles beyond Nursing and Consultants. Now a focus on Pharmacist recruitment as 'hard to recruit' threshold has now been met. RRP agreed at EMT for Pharmacists for the next two years as well as enhanced targeted recruitment campaigns
Sickness absence is monitored at Divisional Accountability reviews and six-monthly deep dives to look at absence trends are completed with targeted actions addressed in relevant business areas.	March 2025	Karen Phillips	Next deep dive due in May 2024 with an overview of data for the period 1st April 23 – 31st March 24. Divisional accountability reviews monitoring and exploring absence on a monthly basis. Reports continue to feed into EMT and Workforce & OD Committee. Actions undertaken to reflect on absence reasons and realise appropriate actions as a result – exploration into mental health absence shared with WOD Committee, HWB group and EMT, as well as divisions to move forward actions. Substantive physio recruited into OH team to strengthen intervention/prevention of those reporting MSK issues as well as an OT recruited to support the wider wellness agenda. Focus remains on return-to-work interviews in accountability reviews as a preventative measure.
The Equality, Diversity and Inclusion agenda has been reviewed and expanded to include a number of actions to improve workplace experience of those in underrepresented groups with specific focus on age, sexual orientation and ethnically diverse staff, as highlighted as areas of focus within the National Staff Survey 2023.	March 2025	Karen Phillips	Respect campaign launched in November 2023 and now embedded into business-as-usual practises. Bullying and Harassment and Recruitment and Selection training in place to support managers addressing discrimination. No excuse for abuse task group assembled and moving forward actions to address patient to staff bullying, harassment and abuse. WRES,WDES, Pay Gap and EDI Annual reports reflect organisational priorities to address EDI areas of focus. People Promise Manager funded by NHSE in post and supporting EDI Lead to enhance compassionate policies to support those in underrepresented groups to feel supported and included, driving up a sense of belonging. Organisational interrogation of staff survey data at team level (where possible) to identify hotspot areas and provide bespoke actions.

Optimising an efficient and sustainable organisation

Lead Director:	Lead Committee:
Dir. Finance	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 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)
Current Risk Rating	12 HIGH	8 HIGH	8 HIGH	8 HIGH
Risk Appetite Threshold	15+	15+	15+	15+

Positive Assurance

- The Trust has met its financial planning target for 2023/24 and delivered a breakeven plan.
- The Trust has a draft financial plan the 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 £28m.
- Lead Provider: Month 8 position breakeven, according to plan and annual forecast
- H2 financial reset has the Trust remaining with a breakeven plan for 2023/24.
- Our current PLACE scores are as follows:
  - Cleanliness – 97.86% (National average – 98.01%)
  - Food and Hydration – 92.57% (National average – 90.23%)
  - Privacy, Dignity and Wellbeing – 90.20% (National average – 86.08%)
  - Condition, Appearance and Maintenance – 94.25% (National average – 95.79%)
  - Dementia – 88.42% (National average – 80.60%)
  - Disability – 83.47% (National average – 82.49%)
- Trust is 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*)

Negative Assurance / Gaps in Assurance

- Current draft plan for 2024/25 represents a financial deficit for the year
- 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 124 (based on 2021/22 data). 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.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Quarterly Update on Actions
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.	June 2024	Pete Beckwith	
Trust to continue to include on this measure in future reports to show trends over time. However, it is noted that the comparative data is flawed.	June 2024	Pete Beckwith	While we appear to be an outlier due to high costs, there are significant known discrepancies in the collated data which cause the cost of some Trusts to appear very low and skewing the overall National Cost Collection Index.

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.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 20

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Report on the Use of the Trust
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 2023 to 31st March 2024.

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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Annual report	29.5.24

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	Yes	If any action	N/A	Comment

Caring, Learning
& Growing Together

considered prior to presenting this paper to Trust Board?		required is this detailed in the report?		
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 2023 to 31st March 2024.

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 2023 – 31st March 2024, the Trust Seal has been used 4 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
3/23	15.5.23	Deed of Surrender relating to premises at Bransholme Health Centre, Goodhart Road, Hull HU7 4DW between Hull Citycare Limited lift Community Health Partnerships Limited and Humber Teaching NHS Foundations Trust
4/23	5.6.23	Licence for alterations relating to glazing works at Whitby Hospital, Springhill, Whitby, North Yorkshire YO21 1EE between NHS Property Services Ltd and Humber Teaching NHS Foundation Trust
5/23	7.8.23	Lease between Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust relating to premises on the ground floor at Hull Royal Infirmary, Anlaby Road, Hull HU3 2JZ
1/24	24.1.24	Lease of part of Alfred Bean Community Hospital between Humber Teaching NHS Foundation Trust and City Health Care Partnership CIC

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, 29 May 2024
Title of Report:	Standing Orders, Scheme of Delegation and Standing Financial Instructions - Annual Review
Author/s:	Name: Stella Jackson Pete Beckwith Title: Head of Corporate Affairs Director of Finance
Recommendation:	

To approve	/	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	On the recommendation of the Audit Committee, the Trust Board is asked to approve the proposed changes to the Standing Orders, Scheme of Delegation and Standing Financial Instructions as detailed in this report.

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.

Key Actions Commissioned/Work Underway:

- n/a

Key Risks/Areas of Focus:

- n/a

Decisions Made:

- n/a

Governance:

	Date		Date
Audit Committee	14/5/24	Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	14/5/24
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		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	

Standing Orders, Scheme of Delegation and Standing Financial Instructions

1. Introduction:

This document was last approved by Trust Board in May 2023 (following a full review) and November 2023 (in anticipation of changes required by the provider selection regime). The document has been reviewed again in 2024 and proposed changes are detailed below.

2. Proposed Changes:

a) General changes

Counter Fraud references, organisations and contacts have been updated throughout the document, typos have been corrected and a reference to a specific section of the Trust Constitution (section 7.2.3) has been removed on page 29 as section numbers may change following any reviews of the Constitution. The wording now refers the reader to the Constitution but not to a specific section of it.

These amendments are not material and have not, therefore, been highlighted below. They are, however, captured via track changes in the document which is attached at Appendix 1.

All references to Humber Coast and Vale have been amended to Humber and North Yorkshire to reflect the naming convention of the ICS.

b) Page 12 Section 2.1: Composition of the Membership of the Trust Board

The number of Associate Non-Executive Directors has been increased from one to two to reflect current working arrangements.

c) Page 35 - Scheme of Matters reserved to the Trust Board and delegation

Reference to the Trust Board approving the appointment and dismissal of the external auditor has been removed as this is the role of the Council of Governors.

d) Pages 60 - 62 – Scheme of Budgetary Delegation

The following changes are proposed to the financial thresholds on page 60 in order to align these with the financial thresholds on page 61:

- The Director of Finance to authorise goods and services including estates and maintenance of values between £100,000 and £249,999.

Additionally, it is proposed that the Expenditure on charitable and endowment funds approval is increased from `up to £1,000' to ` up to £4999' for the Health Stars Charity/Fundraising Manager (page 62).

e) Page 73 – Guidance on Public Procurement and Commissioning

Reference to IR35 added.

f) Pages 84 - Capital Procurement

Paragraph has been updated to reference different finance options, rather than solely focussing on Private Finance Initiatives.

g) Pages 88-102 – Competitive Process

Procurement references have been updated.

Humber Teaching
NHS Foundation Trust

Standing Orders,

Scheme of Delegation and Standing Financial Instructions

~~November 2023~~May 2024

Date Approved: 29 ~~November~~ May 2024~~2023~~

Review Date: May 2025~~4~~

Caring, Learning
& Growing Together

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;
- ~~An~~ Two Associate Non-Executive Director~~s~~ (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. ~~ChairChair.~~ 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 a minimum of 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 a minimum of three Non-Executive Directors.

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 ToR, 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 exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

4.8.4 Trust and Charitable Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Trust Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission and to provide assurance in relation to charitable funds to the Trust Board. In doing so, the Board will recognise that the establishment of a Trust and Charitable Funds Committee does not alter the responsibilities of the Board, which remains the trustee as a corporate body.

The provisions of this Standing Order must be read in conjunction with Standing Order 2.8 and Standing Financial Instructions 27.

The overall role of the Charitable Funds Committee is to oversee the operation of the charitable funds on behalf of Humber Teaching NHS Foundation Trust. The Committee will:-

- review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame.

- ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Board.
- review fund-raising and consider and recommend investment policies.

The Committee will be comprised of a minimum of three Non-Executive Directors.

4.8.5 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 three Non-Executive Directors.

4.8.6 Finance and Investment 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.

4.8.7 Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee is constituted as a sub-committee of the Trust Board.

The Workforce 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.

4.8.8 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 ~~Coast and Vale (HCV) Provider~~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.

4.8.9 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 ~~paragraph 34 of~~ 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 it is necessary that a document shall be sealed, the seal shall be affixed in the presence of a senior manager duly authorised by the Chief Executive and shall be attested by them.

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. 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. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 18. 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. Approve the formation of any joint venture, either contractual or corporate or a subsidiary company. 20. 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. 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.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		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 £500,000 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. Approve the appointment and dismissal of the internal auditors.~~ ~~2.~~1. Receive the annual management letter received from the external auditor and taking account of the advice, where appropriate, of the Audit Committee. ~~3.~~2. Receive an annual report from the Internal Auditor and agree necessary actions taking account of advice from the Audit Committee.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
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 mak~~ing~~ 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
	CHARITABLE FUNDS COMMITTEE	The Committee will; 1. Review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame. 2. Ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Trust Board. 3. Review fund-raising and consider and recommend investment policies.
	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 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

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		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.
	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 ~~Coast and Vale~~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.

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	~~4.~~ 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.

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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	Keep Seal in 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 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.
16.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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; f) Instructions to employees regarding the handling and payment of accounts within the Finance

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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 DIRECTOR OF FINANCE	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
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.
22.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from the Director of Finance).

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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.
23.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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 ~~and the Independent Regulator of all frauds~~.
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.
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

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		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
29	CHIEF EXECUTIVE	Ensure retention of document procedures in accordance with NHS Records Management: Code of Practice

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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

Quotation, Tendering and Control Procedures – only applicable to goods and non-health care services				
Goods and non-health care Services including Estates and Maintenance *(where this relates to contracts over more than one year, the annual value is delegated as per below)*				
Value (excluding VAT)	**Minimum No**	**Opened by**	**Adjudicated by**	**Authorised by**
Up to £9,999	At discretion of budget holder/Purchasing officer	Any Officer	Purchasing Officer or budget holder	Budget holder
£10,000 to £49,999	3 or more quotes	Any Senior Manager	Purchasing Officer or budget holder	Director
£50,000-£99,999	3 or more competitive tenders	Any Senior Manager	Head of Procurement/+1 Director	Director of Finance
£100,000 to £249,999	3 or more competitive tenders	2 Senior Managers/Directors not from originating department	Head of Procurement/+ 1 Director	Director of Finance
£250,000- £750,000	5 or more competitive tenders	2 Senior Managers/Directors not from originating department	Director of Finance + 1 other Director	Chief Executive
Over £750,000	6 or more competitive tenders	2 Senior Manager/Directors not from originating department	Director of Finance + 1 other Director	Trust Board
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.				

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
£~~100~~50,50,000-£249,999	Director of Finance
£250,000-£750,000	Chief Executive
~~All invoices o~~Over £750,000	Trust Board

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 £~~1000~~4,999	Fund Manager, Health Stars Charity/Fundraising Manager
~~£1000 - £4,999~~	~~Fund Manager, Director of Finance~~
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 Charitable Funds Committee
Over £25,000	Fund Manager, Director of Finance and Charitable Funds Committee (reported to Trust Board for information within Chairs Assurance Report)
Over £100,000	Trust Board as Corporate Trustees

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 Contract~~Directions issued by the Secretary of State for Health~~ on 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 ~~by the Department of Health Fraud and Corruption Manual and guidance.~~at NHS Requirement 9 of the Government Functional Standard (GOVS 013: Counter fraud).

11.5.3 The L~~ocal C~~ounter F~~raud S~~pecialist shall report to the Trust's Director of Finance and shall work with staff in NHS Counter Fraud Authority ~~and the Regional Counter Fraud Specialist~~ in accordance with the ~~Department of Health~~NHS Counter Fraud ~~and Corruption~~ Manual.

11.5.4 The L~~ocal C~~ounter F~~raud S~~pecialist 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 AND NON-HEALTH CARE SERVICES

This procedure is used for when the Trust is procuring goods 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 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 Public Contract Regulations (i.e. the contract opportunity is governed by the Public Contract Regulations and the value of
the contract opportunity as calculated pursuant to 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 16.6.9 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;

• for 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 Exceptions and Instances where Formal Tendering Need Not be Applied

Formal 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

(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 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

16.6.4 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.

16.6.5 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

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.

16.6.7 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.

16.6.8 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

16.6.9 Choice of Procedure

(a) Where a contract opportunity falls within the Public Contract Regulations and a process
compliant with the Public Contract Regulations is required then the Trust shall utilise an available tender procedure under 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 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 ~~Private~~ 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:

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(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 ~~relevant~~ LCFS and the NHS Counter Fraud Authority~~. Regional team~~

The Director of Finance must notify NHS Counter Fraud Authority, the External Auditor and the Independent Regulator of all frauds.

Commented [CN(ASTHNF2]: ?

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) SO 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 4.8.4 that defines the need for compliance with Charities Commission latest guidance and best practice.

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

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting, 29 May 2024</td></tr>
<tr><td>Title of Report:</td><td>Annual Declarations</td></tr>
<tr><td>Author/s:</td><td>Pete Beckwith
Director of Finance

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>x</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>This report provides evidence of how the Trust continues to meet the terms of its 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 and in particular the new conditions WS1, WS2 and WS3.
• Note that the report was shared with Governors at a Council of Governors meeting in January 2024 and no comments were made regarding the evidence provided.
• Approve this self-certification.</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Positive Assurances to Provide:

• High level of assurance provided in June 2022 by Audit Yorkshire regarding the annual declarations process.</td><td>Key Actions Commissioned/Work Underway:

• Evidence against the revised provider licence has been reviewed by the Executive Management Team, Trust Board and the Council of Governors.</td></tr>
<tr><td>Key Risks/Areas of Focus:

• None</td><td>Decisions Made:
• The board is asked to approve this self-certification</td></tr>
<tr><td>Governance:</td><td>
<table>
<tr><th></th><th>Date</th><th></th><th>Date</th></tr>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td></td><td>Workforce & Organisational Development Committee</td><td></td></tr>
<tr><td>Finance & Investment Committee</td><td></td><td>Executive Management Team</td><td>26/6/2023
14/5/2024</td></tr>
</table>
</td></tr>
</table>

Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	Trust Board 27/9/23 29/5/24 Council of Governors 18/1/24

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	

Council of Governors (January 2024)
Annual Declarations

1 Introduction

Up until the financial year 2023/24, NHS Providers were required to complete annual self-certifications (declarations) under the terms of 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 was shared with governors at a Council of Governors meeting held in January 2024 in order to appraise them of how the Trust is meeting its licence conditions. Governors were also invited to comment on the evidence provided and did not highlight any potential changes to this.

The Executive Management Team (EMT) and Trust Board have also considered the evidence at meetings held in June 2023 (EMT) and September 2023 (Trust Board). No further amendments have been made to the evidence since the Board reviewed this.

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.

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 Trust has submitted the core and context Digital Maturity Assessment in May 2023. The response has been created within the current digital governance oversight. • 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.
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. • Annual Governance Statement

Condition	Explanation	Comments
		• The 2022/23 Annual Head of Internal Audit Opinion provided '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 Clinical Commissioning Groups
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 2023).
Pricing Condition (P)		

Condition	Explanation	Comments
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, refreshed May 2023. • 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 is reviewed quarterly • 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 was considered in 2022 • 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 – May 2023 Board. Constitution has been reviewed and updated
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* *Annual Governance Statement* All Statutory requirements met Delivered Financial Targets in 2022/23 Previous use of Resource Score of 2 *(currently not recorded)* Trust plan agreed to meet its financial targets for 2023/24 Monthly Performance report to Trust Board Quality Report to Quality Committee Monthly returns to NHS Improvement

	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 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
		CQC Action Plan/Improvement 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 Workforce Committee

Humber Teaching NHS Foundation Trust

Agenda Item 23

Title & Date of Meeting:	Trust Board Public Meeting– 29th May 2024
Title of Report:	Going Concern – Annual statement 2023/24
Author/s:	Peter Beckwith/Director of Finance Iain Omand/Deputy Director of Finance

Recommendation:

To approve	☑	To receive & note	
For information		To ratify	
For Assurance			

Purpose of Paper:

The purpose of this report is to provide the Trust Board Team with the evidence to support the recommendation that the Trust's accounts are completed on a Going Concern basis.

The annual accounts are due to be presented to the Trust Board and Audit Committee in June, ahead of submission to NHSE.

Key Issues within the report:

Positive Assurances to Provide:

- Based on significant assessment of the Trust there are no material uncertainties that cast doubt over the Trust's ability to continue as a going concern

Key Actions Commissioned/Work Underway:

- Accounts are going through the normal year end process

. **Key Risks/Areas of Focus:**

- None

Decisions Made:

- The Trust Board are asked to approve the Trust Accounts are prepared on a Going Concern Basis.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	15.5.24
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		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	

Going Concern Assessment 2023/24

1. Introduction and Purpose

The purpose of this report is to provide the Trust Board with the evidence to support the recommendation that the Trust's accounts are completed on a Going Concern basis.

The annual accounts are due to be presented to the Trust Board and Audit Committee in June 2024, noting the audit of the accounts will not be complete due to the known issues in relation to the Local Government Pension Scheme.

2. Background

2.1 Concept

The accounting concept of going concern is a fundamental principal in the preparation of financial statements, particularly in relation to how assets and liabilities are recorded in its accounts.

If an organisation is a going concern, it is expected to operate indefinitely and not go out of business or liquidate its assets in the foreseeable future.

For going concern purposes the foreseeable future is generally taken to mean 12 months after the date the Trust's accounts were signed.

Under this assumption, the Trust's assets and liabilities are recorded on the basis that the assets will be realised and liabilities discharged in the normal course of business.

An organisation that was not a going concern would prepare its accounts on a different basis, reflecting their value on the winding up of the entity. Consequently, assets would be likely to be recorded at a much lower break-up value and medium and long-term liabilities would become short-term liabilities.

When preparing the annual accounts the Trust Board needs to consider whether:

- the trust is a going concern and it is appropriate for the accounts to be prepared on the going concern basis; or
- the trust is a going concern but there are uncertainties regarding future issues which should be disclosed; or
- The trust is not a going concern and the accounts may need to be prepared on an appropriate alternative basis.

2.2 International Accounting Standards

International Accounting Standard 1 (IAS1) '*Presentation of Financial Statements*' requires the Board of Directors to assess and satisfy themselves each year that it is appropriate to prepare its financial statements on a going concern basis.

IAS1 advises that the review should take into account as much information as possible but should look ahead at least 12 months from the date of accounts.

2.3 Treasury's Financial Reporting Manual

The Treasury's Financial Reporting Manual (FReM) interprets the requirements set out in IAS 1 (paras 25-26) as below:

- *The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern*

- *However, a trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up*

- *Where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements.*

- *Where a body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved*

The above is also referenced in the NHS Group Accounting Manual.

3. Considerations

The Trust Board should consider the specific events or considerations that individually or collectively might cast significant doubt on the going concern assumption.

As part of the assessment the following considerations have been taken into account and are discussed in the following paragraphs:

Financial conditions

- Historic financial performance
- Future financial plan
- Cost Improvement/Efficiency savings/ risk assessed delivery
- Liquidity and ability to meet liabilities.
- Existing borrowing and access to borrowing

Operating conditions

- Change in management structures
- Change in commissioned services
- Risk of non-compliance with Terms of Authorisation

3. Financial Considerations

3.1 Historic Financial Performance

The Trust has a strong financial standing over the previous 6 years and has met its control total in each year, with only technical accounting reasons (*which don't count towards the control total*) contributing to deficit positions posted in the Trusts accounts.

In 2023/24 the Trust has operated within the financial architecture put in place by the Integrated Care System (ICS). The Trust was funded through block contracts and was required to end the year with a breakeven position.

The Trust draft annual accounts for 2023/24 report:

- Before technical accounting judgements the Trust delivered a minor surplus of £0.006m which was in line with the Trust's target position set by the ICS
- The final accounts (*including technical accounting judgements*) records a deficit position of £10.089m which is inclusive of the following:
    - Impairment of £11.284m,
    - £0.120m Local Government Pension Scheme surplus,
    - £0.023m Donated Asset depreciation
    - Capital Grants of £1.092m.

3.2 Future Financial Plan

Block contracts/funding arrangements will remain in place across the system for 2024/25.

The Trust has set a draft budget for 2024/25 (Approved at the March 2024 Board) which is currently a deficit of circa £1m, however work is ongoing across the ICS to reduce the current level of deficit plans.

The Trust has an established Finance Committee with regular meetings reviewing financial position, cash and year end forecast.

A monthly finance report is tabled at EMT Monthly and Board Bi-Monthly.

3.3 Cost Improvement/Efficiency savings/ risk assessed delivery

The budget reduction strategy (BRS) has continued with a recurrent target of 1.5% across divisions and corporate directorates totalling £2.486m, this is inclusive of £0.299m being brought forward into 2023/24

The Trust's BRS arrangements are well embedded with plans fully in place by 1 April 2024 for the 2024/25 financial year, current plans have been approved that will achieve £2.019m with £0.294m to be confirmed in year.

An indicative target of 1.5% for 2025/26 and 2026/27 has been set and a number of schemes have been highlighted for those future years.

3.4 Liquidity and ability to meet liabilities

A key consideration of the going concern is that the Trust has the cash resources to meet its key obligations as they fall due in the foreseeable future.

The Trust ended the year with an overall cash balance of £28.012m.

A Better Payment Practice Code achievement of 92.7% on commercial debt which is a minor improvement on the previous year's return of 92.6%. Plans are in place to further improve this in 2024/25.

Detailed cash flow reports are scheduled on the workplan for the Finance Committee which meets on a quarterly basis.

3.5 Existing borrowing and access to borrowing

The Trust has no existing outstanding debt.

3.6 Other Financial Considerations

The Trust is a member of the NHS Resolution Clinical Negligence for Trusts and its Risk Pooling Scheme for Trusts. Those schemes provided an unlimited indemnity for the Trust.

There is no excess payable for CNST claims. For Employers Liability claims there is a £10,000 excess payable for each and every claim. There is a £3,000 excess payable for each and every public liability, products liability and professional indemnity claim.

The Trust has contingent liabilities in relation to NHS Litigation Claims that have been identified by NHS Litigation.

4. Operating Considerations

4.1 Change in management structures

There are no material planned changes to the management structure of the Trust.

The trust ensures that its income expectations are aligned with its Commissioners and this is a requirement of the wider ICS within which the Trust is represented and will work in partnership in developing the plans of the local health economy**.**

4.2 Lead Provider services

The Trust continues to be the Lead Provider across Humber and North Yorkshire for the following specialised services which were previously commissioned by NHSE.

- Adult Secure Services (Low/Medium)
- Children and Adolescent Mental Health Inpatient Services
- Adult Eating Disorder Inpatient Services

The value of this collaborative is circa £63m (Gross) in 2024/25.

4.3 Risk of non-compliance with Terms of Authorisation

The Trust has no serious non-compliance with regulatory or statutory requirements

There are no significant legal or regulatory proceedings pending against the Trust.

The Trust Board will be asked to sign off its Annual Declarations at the May Board.

5. Conclusion

Based on the significant assessment of the Trust that has taken place not only for this exercise, but over the past two years it can be concluded that there are no material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern.

6. Recommendation

Trust Board are asked to approve that the Trust's annual accounts are completed on a going concern basis and that the accounts have been prepared according to that principle.

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Agenda Item 24

Title & Date of Meeting:	Trust Board Public Meeting – 29th May 2024
Title of Report:	Freedom to Speak Up Guardian's Annual Report 2023/24
Author/s:	Michele Moran, Executive Lead for Freedom to Speak Up Alison Flack, Freedom to Speak Up Guardian
Recommendation:	

To approve	Yes	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	To present the Freedom to Speak Up Annual Report 2023/24 for approval by the Trust Board. The annual report has been amended following recommendations from the Workforce Committee to include actions being taken in response to Lucy Letby case.

Key Issues within the report:

Positive Assurances to Provide:

- The revised policy and procedure approved by the Trust Board, in line with the National Guardian's Office.
- The revised speak up strategy (2024-2027) to be approved by the May Trust Board.

Key Actions Commissioned/Work Underway:

- The development of an anonymous feedback questionnaire to gather staff's experience and to gather data on gender, ethnicity and age.

Key Risks/Areas of Focus:

- The continued recruitment of speaking up ambassador across the Trust divisions.
- The appointment of a medical staff ambassador.

Decisions Made:

- The Trust Board are asked to approved the Annual Report.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	08/05/24
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	

Caring, Learning
& Growing Together

			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	

Freedom to Speak up Guardian's Annual Report – 2023/24

The following report provides an update on the work undertaken as part of the Freedom to Speak Up processes and the role of the Guardian and our future plans.

Freedom to Speak Up Vision and Strategy (2024 - 2027)

Our Freedom to Speak Up Vision and Strategy has now been refreshed and is due for approval by the Trust Board in May 2024. Our FTSU strategy and vision supports our Trust strategy and is underpinned by our Trust values, caring, sharing and learning.

We have identified four key areas as our priorities:-

- Continuing to improve awareness of speaking up;
- Improving confidence for our staff in raising concerns;
- Providing training and support to all our leaders and managers;
- Improving our data collection and governance processes.

Board Leadership and Oversight

Michele Moran is the Executive Lead for speaking up and Dean Royles is the Non Executive Director Lead for speaking up. The Guardian meets with the Chair Person, Non Executive Director Lead and Executive Lead for speaking up on a quarterly basis. The Trust Board have also held development sessions on speaking up and have continued to review the self-assessment of speaking up processes.

The Executive Lead, Non Executive Director Lead, and Guardians have completed the required speaking up training provided by the National Guardian's Office. The Guardians have also attended the NGO National Conference.

The Trust Board is informed of all speak up concerns on a bi-monthly basis.

Training for Staff

All Trust staff are now required to complete Level 1 National Guardian's Office Speak Up training. All new staff receive information on speaking up at induction. We have received positive feedback from new staff on this training and how important it is for new staff to understand that the Trust encourages staff to speak up and understand the routes available for them to do this.

Level 2 and Level 3 NGO Speak Up training have now been published and available as part of the Trust's training programmes. We continue to encourage our managers to complete these.

Number of Speak Up Concerns Received from 1 April 2023 until 31 March 2024

During the period 1 April 2023 until 31 March 2024 we received 39 speak up concerns. This is an increase on the numbers during 2022/23 when 23 speak up concerns where received. It is important to note that in some instances, a number of staff have contacted the Guardian to raise similar concerns in the same area. The increased number of staff contacting the Guardian has also increased since the introduction of the mandatory speak up training. A recent comparison against similar size mental health trusts/community trusts regionally using quarter 3 information highlighted that our numbers are in the mid-range. We will be continuing to raise the profile of speaking up through the Trust's communication channels, our ambassadors and by attending team meetings.

Data on ethnicity, age and gender is starting to be collected and a process for collecting this implemented. To date, no staff member has responded to provide their ethnicity. This will continue to be a key focus in 2024.

Number of Speak Up Concerns Received

2019/20	58
2020/21	24
2021/22	27
2022/23	23
2023/24	39

Types of Concerns

During 2023/24 the speak up concerns raised fall into the following categories:-

- Staff seeking support for issues relating to their own terms and conditions, these staff are signposted to the HR team for support and advice. The introduction of the Trust's Respect campaign has also helped to reduce the number of staff contacting the Guardian.
- Allegations of bullying and harassment.
- Care and treatment of a patient.
- Staffing levels.
- Systems and processes relating to specific service areas.
- Team working.
- Relationships with line managers.
- Waiting list management.
- Employment processes.

The most notable division reporting concerns through the speak up route has been in mental health services.

Concerns received by Division

	2021/22	2022/23	2023/24
Children's & Learning Disability Services	8	2	12
Community & Primary Care Services	3	3	3
Corporate Services	4	3	2
Forensic Services	1	0	1
Mental Health Services	11	15	21
TOTAL	**27**	**23**	**39**

Staff Groups reporting concerns

	2021/22	2022/23	2023/24
Administrative Staff	3	3	2
Allied Health Professional	0	2	3
Hotel Services Staff	3	1	1
Medical Staff	3	0	3
Qualified Nurse	6	10	16
Social Worker	1	2	3
Unqualified Nurse	10	4	7
Not Known/Other	1	1	4
TOTAL	**27**	**23**	**39**

Learning from Speaking Up

One of the key roles of speaking up is to ensure that any learning from concerns raised is taken forward within the Trust. As a result of staff raising their concerns, there have been some key learning points.

These have included:

- A review of a patient's care in relation to addiction services.
- A review of patients on waiting lists and transfers to other services.
- A series of team and organisational development programmes and a review of clinical systems and process within a service area.
- A review of staff completing interview training in a specific team
- A review of the number of grievances submitted to the HR team and time taken to respond.

All staff reporting concerns are asked to provide feedback following their concerns being reviewed. Feedback has been mixed and, as a result of this, further work has been developed to ensure that expected outcomes from staff raising concerns is clear at the outset.

Staff members feedback to the Guardian

"I want to use this opportunity to thank you in a special way. Words can't thank you enough. You are my saviour. Your immediate intervention in my situation has really saved my life."

"I walked away feeling that my concerns were validated and listened to and for that I am much appreciative."

"Thank you for all your support. It is very much appreciated."

Some staff reported that they did not receive feedback on concerns in a timely manner, this is continuing to be reviewed. The Guardian now meets regularly with the Deputy Chief Operating Officer to receive updates on concerns which are fedback to staff.

Work will continue in 24/25 to improve reporting of outcomes back to staff raising concerns and also to receive further feedback. An anonymous questionnaire has been developed which allows staff to report their experience of speaking up and to also collect information regarding ethnicity, gender and age. This information will enable us to identify areas we need to target to raise awareness of speaking up.

Raising Awareness of the Freedom to Speak up Guardian Role and Function

We continue to promote the Guardian role virtually across the Trust by attending team meetings and publishing regular communications through the Trust communications programme. The Chief Executive also continues to raise awareness through the Chief Executive communication channels. The Guardians have attended the Trust's Senior Management Team forum, the Operational Leadership Group and also various team meetings to promote the role of speaking up, share information from the National Guardian's Office and to discuss barriers to speaking up. A number of virtual all staff events have been held to share information on speaking up.

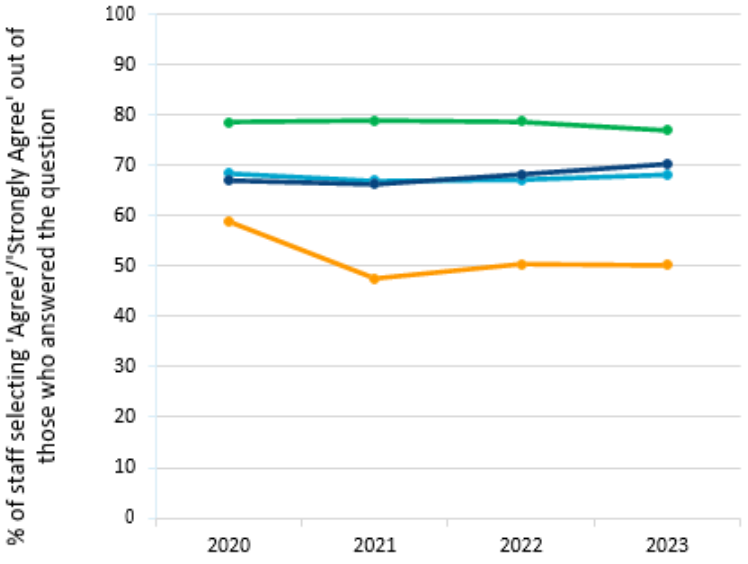
In response to the recent Lucy Letby case and the changes to the Good Medical Practice Guidance (2024), the Guardian has held briefing sessions with medical staff across the Trust.

During October, we participated in the annual Speak Up Month initiative that is supported by the National Guardian's Office. We held a number of virtual events to meet staff and talk about the role of speaking up in the Trust.

Staff Survey

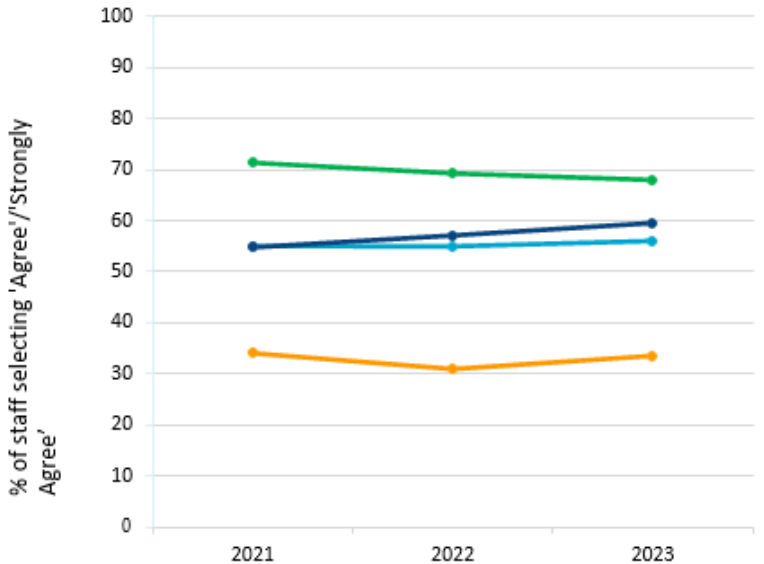
The recent staff survey results showed an improvement in the areas relating to raising concerns and speaking up. The details are shown in the table below. There is still further work and actions for us to develop to continue to improve these responses.

Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023
Your org	66.98%	66.21%	68.19%	70.26%
Best result	78.54%	78.86%	78.57%	76.89%
Average result	68.37%	66.89%	67.11%	68.14%
Worst result	58.87%	47.55%	50.40%	50.17%
Responses	1210	1295	1382	1835

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023
Your org	54.80%	57.10%	59.57%
Best result	71.41%	69.30%	68.01%
Average result	55.05%	55.00%	56.06%
Worst result	34.05%	30.98%	33.58%
Responses	1294	1385	1832

Progress Update on Our Plans for 24/25

- We will continue to recruit and develop our Ambassador programme across our divisions.

We have successfully recruited Ambassadors for all our divisions with the exception of children's and learning disabilities and a Medical Consultant Ambassador. This is currently being advertised across the Trust and expected to be completed in June 2024. The ambassadors are currently undertaking training and being supported in their roles. A meet the Board session for our ambassadors is currently being arranged.

- Implement the Well Led Review recommendations

These have been completed.

- A further board development session to review the self assessment processes.

The Trust Board continue to review progress in speaking up on a regular basis.

- We will review our current policy and procedure in line with the recently published information from the National Guardian's Office.

The revised policy and procedure for speaking up was approved by the Trust Board and has been published on the Trust intranet and communicated through Trust communication channels.

- We will review and publish our new Freedom to Speak Up Strategy.

The new Freedom to Speak Up Strategy and Vision (2024-2027) is expected to be approved by the Trust Board in May 2024.

Humber Teaching NHS Foundation Trust

Agenda Item 25

Title & Date of Meeting:	Trust Board Public Meeting– 29th May 2024
Title of Report:	Freedom to Speak Up Strategy 2024 – 2027
Author/s:	Michele Moran, Executive Lead for Freedom to Speak Up Alison Flack, Freedom to Speak Up Guardian
Recommendation:	

To approve	✓	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	The revised Freedom to Speak Up Strategy for 2024-2027 is presented to the Trust Board for approval. The strategy has been amended following feedback from the Executive Management Team to include further clarity on improved outcome measures on the staff survey.

Key Issues within the report:

Positive Assurances to Provide: • The revised policy and procedure for speaking up to align with the National Guardian's Office.	**Key Actions Commissioned/Work Underway:** • The priority areas identified in the strategy.
Key Risks/Areas of Focus: • To complete the recruitment of ambassadors to include a medical representative.	**Decisions Made:** • The Trust Board is asked to approve the new Freedom to Speak Up Strategy.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	08/05/24
Finance & Investment Committee		Executive Management Team	23/04/24
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		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	

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Freedom to Speak Up Vision and Strategy

2024 - 2027

Caring, Learning
& Growing Together

National Guardian
Freedom to Speak Up

Purpose

Following the Mid-Staffordshire Inquiry, Sir Robert Francis published a report in 2015 that highlighted the importance of cultures that embrace transparency and support raising concerns to improve patient safety. This report provided recommendations for NHS Trusts, supported by the National Guardian's Office and is now included in the NHS Contract which is monitored by the Care Quality Commission (CQC).

Sir Robert Francis's 'Freedom to Speak Up Review' published in February 2015 highlighted the need 'to ensure that NHS staff in England feel safe to raise concerns, confident that they will be listened to and the concerns will be acted upon'. The Review recommended a number of principles and actions, including the creation of a Freedom to Speak Up Guardian to support staff to raise concerns. Since this time, a significant amount of work has been undertaken nationally through the National Guardian's Office and within our Trust to ensure that speaking up becomes central to everything we do.

Consistent and strong leadership and a developing culture that places less emphasis on blame when things go wrong and more importance on transparency and learning from mistakes will help to support our strategy and most importantly focus on patient safety and ensuring patient safety is everyone's top priority.

This Strategy sets out the Trust's vision and strategy for Freedom to Speak Up, our objectives and actions and how we will measure its effectiveness. It should be read in conjunction with our **Freedom to Speak Up Policy and Procedure** published in October 2023.

Our Freedom to Speak Up Vision

"We will all work together to provide an open and transparent culture across the Trust to ensure that all members of staff feel safe and confident to speak out and raise their concerns."

Our Values

Our Freedom to Speak Up Strategy supports our Trust Strategy (2022-2027) and is underpinned by our core Trust values: "Caring, Learning and Growing".

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

Our Priorities

To deliver our vision, and so help bring about a change in culture, we need to see improvement across the following areas:

1. **Awareness** – so that everyone knows how to raise concerns and to whom concerns can be raised.
2. **Confidence in speaking up** – concerns are heard, promptly and thoroughly investigated, feedback is provided and outcomes are shared wherever possible.
3. **Training and support** – for all leaders and managers in understanding their own behaviours and dealing with concerns.
4. **Improving** our data collection and governance processes.

These areas of focus must involve all staff in the Trust, including agency staff, students/trainees, contracted workers and volunteers.

We will prioritise the following actions to deliver our vision.

Our Key Objectives and Actions

To deliver our vision the following key objectives and actions have been identified:

Objective 1

Improve awareness of the Speaking Up programme

1. All new starters are made aware of Speaking Up at corporate induction or at local training.
2. All staff will complete the National Guardian's Office Level 1 Speak Up Training as part of their mandatory training requirements.
3. A rolling communications programme to ensure all staff are made aware of the Speaking Up programme through marketing materials in all areas of the Trust (posters and leaflets), regular email updates and face to face communications.
4. There is clearly accessible information about Speaking Up and how to raise concerns on the Trust intranet.
5. Speaking Up Ambassadors will be available in all areas of the Trust and from a range of backgrounds and roles.
6. Members of the speaking up team will attend team meetings to raise the profile and importance of speaking up.

Objective 2

Improve confidence in Speaking Up

7. Individuals will all have the opportunity, and adequate time, to discuss their concerns with the Guardian or a member of the speak up team in line with the Trust's policy and procedure.
8. The number of cases raised and resolved, and key themes of concerns will be reported to staff on a regular basis through Trust communication channels.
9. Wherever possible, case studies will be developed and communicated to share outcomes from investigations.
10. Annual review of Freedom to Speak Up policy and strategy to ensure they are fit for purpose.
11. Concerns are dealt with promptly, independently and confidentiality.
12. All those who raise concerns receive feedback on the outcome of the investigation and have the opportunity to provide feedback themselves on the process.

Objective 3

Support all leaders and managers to understand their own behaviours and deal with concerns positively

13. Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively. Working with our managers and HR leaders to ensure speaking up training is embedded in all our development programmes.

Objective 4

Continue to improve our data collection and governance processes

14. Ensure monitoring and evaluation of the number and nature of concerns is timely and supported by appropriate governance.

15. Ensure that key learning related to concerns are articulated to all in an open and transparent manner, while respecting confidentiality.

16. Ensure feedback is obtained concerning staff's speak up experience to enable continuous improvement.

17. Ensure we fully meet and can evidence the expectations outlined in the National Guardians Office and NHS Improvement self review tool.

18. Regularly review the national case reviews to ensure that any recommendations and learning are implemented, where appropriate.

How will we monitor and measure our progress in our Trust?

We will use the following information to monitor our achievement against the strategy.

- A continued % increase in our staff survey scores in relation to the following questions:-
  1. I feel safe to speak up about anything that concerns me in my organisation.
  2. If I spoke up about something that concerned me, I am confident that the trust would address my concern.
- Grievances
- Exit interviews
- Retention figures
- Feedback on issues raised through the FTSU Guardian
- Bullying and harassment reports
- Patient safety incidents
- Issues raised to the Care Quality Commission
- Incident reporting
- National benchmarking data from the National Guardian's Office

How will progress against our strategy be reported?

A Freedom to Speak Up bi-annual report will be presented to the Trust Board by the Freedom to Speak up Guardian and the Executive Lead for raising concerns. It will include qualitative and quantitative information and other information that enable the Trust Board to fully engage with speak up to understand the issues that have been identified and receive assurance about the actions being taken.

The information will include the number and type of cases being dealt with through the Guardian, an analysis of the trends, including whether the number has increased or decreased. It will also include information of any instances where people who have spoken out may have suffered detriment and recommendations for improvements. We will also provide where available data on who is speaking up and raising concerns by ethnicity, gender and age.

How will we know we have made a difference?

The indicators that will demonstrate we have made a difference in achieving our vision is as follows:

What are the specific Freedom to Speak Up roles in our Trust?

It is everyone's responsibility to engender an open culture which invites and encourages both positive and negative feedback from all who use and work within our services. This feedback is used to inform future strategies to support our continual learning and improvement. Every member of our staff has a role to support a freedom to speak up culture.

The following roles have specific responsibilities in relation to speaking up.

- Chief Executive and Chairman
- Executive Director responsible for Freedom to Speak Up
- Non-Executive Director responsible for Freedom to Speak Up
- Medical Director and Director of Nursing
- Freedom to Speak Up Guardian and Deputy Guardian

Review

This strategy will be reviewed in March 2025.

Document Configuration	Document Ref
11th March, 2024	Version 01
Author Name / Job Title	Alison Flack, Freedom to Speak Up Guardian
Directorate Name	Freedom to Speak Up
Clinical / Executive Sponsor	Michele Moran, Chief Executive
Reporting Committee	Trust Board
Trust Board Ratification	March 2024
Review Date	March 2025
Distribution Channels	Trust Board
	All staff – midweek global
Regulator Link	**National Guardian's Office**
	NHSI
Key Internal Documents	
Key External Documents	NHSI Freedom to Speak Up Self-Assessment Tool

Humber Teaching NHS Foundation Trust

Agenda Item 26

Title & Date of Meeting:	Trust Public Board Meeting – 29th May 2024
Title of Report:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report
Author/s:	Name: Lynn Parkinson/Lisa James Title: Accountable Emergency Officer/EPRR 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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	14.05.24
Mental Health Legislation Committee		Operational Delivery Group	22.04.24
Charitable Funds Committee		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 2023 to 31st March 2024. The report provides an overview of EPRR activities during the last 12 months including its continued response to Industrial Action in 2023 and the outcome of the EPRR annual assurance assessment. This report also sets out EPRR priorities for 2024/25

Positive Assurances to Provide:

- That the Trust 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 2023-24
- To ensure audit recommendations are actioned.

Key Risks/Areas of Focus:	**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 develop 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 2023 – 31st March 2024

Caring, Learning
& Growing Together

FOREWORD

Throughout the year the Emergency Planning Team has assessed risk, worked collaboratively with key stakeholders, partners, managers and clinicians to ensure that the Trust has been able to provide an effective, resilient and coordinated response to the demands that continue to present. Industrial Action has been a large part of the Trusts response during 2023/24 with the Command and Control arrangements being stood up to manage potential disruptions to service due to actions being taken.

In 2023 changes to the Emergency Preparedness, Resilience and Response arrangements took place as Integrated Care Boards (ICB) came into being on 1st July 2023 and with them the responsibility of being a Category 1 responder under the Civil Contingencies Act (2004). This change is well on its way to becoming an embedded function and the Trust is working closely with its ICB colleagues and health partners in a much more positive way. The new local leadership offered by the ICBs has been readily accepted by the Trust and is a more supportive way of working on EPRR matters ensuring consistency across the Integrated Care System. This was particularly key during this years annual assurance submission on the EPRR Core Standards due to the new process that was implemented. A much more rigorous and evidence-based approach was taken based on the pilot implemented in the West Midlands last year which put organisations under significant pressure and re-calibrated the baseline for compliance. The ICB support during this process was invaluable and they will continue to monitor progress going forward.

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 and NHS Business Continuity Management 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 2023-24 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 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 Industrial action staged by RCN Nurses, Unite, Junior Doctors, Consultants and Teachers.

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 2023 to 31st March 2024. 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 in order 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 2022/23

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.

This year a new process was introduced for the Humber and North Yorkshire region as part of a phased rollout which started in the West Midlands last year as an initial pilot. The new process is deemed by NHSE to enhance the assurance arrangements for the EPRR core standards by introducing an evidence-based check and challenge process, whereby organisations are required to submit evidence to support their self-assessment. The rationale for the change is outlined in detail along with the expected impacts on organisations compliance ratings in the 'NHS England EPRR Core Standards Overview for Boards'.

The Trust received the annual assurance letter in May 2023 with the expected annual compliance requirements supported by an 80+ power point slide pack of additional compliance requirements as part of the new process, almost doubling the core standard compliance required. The EPRR team worked consistently with the ICB and its provider partners over the summer and into the autumn to understand the requirements in order to complete the self-assessment in a timely manner.

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 2023/24 EPRR annual deep dive focussed on EPRR responder training this year. Training is a fundamental element of embedding resilience with organisations as part of the cycle of emergency planning. 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 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. It must be noted that the deep dive standards are not considered as part of the Trust compliance rating.

The Trust completed its self-assessment against this year's applicable core standards and deep dive standards uploading evidence as required, the timeline for the 2023/24 process is outlined below:

- The Trust initially self-assessed as partially compliant and provided evidence to underpin each core standard for review by NHSE by the 29th of September 2023, signed off by the Trusts Accountable Emergency Officer.

- On receipt of this evidence NHSE carried out the primary evidence check.

- The Trust received a feedback letter on 13th October 2023 with the results of the primary evidence check, identifying a total of 40 of the 58 core standards being challenged with a compliance level of 10% of the core standards therefore rating the Trust as non-compliant. The Trust was given five working days to provide supplementary evidence.

- Supplementary evidence and pushback on 17 of the challenged core standards was re-submitted on 20th October 2023 by the Trust.

- Receipt of the supplementary evidence check, and challenge letter was received on 27th October 2023. NHSE had accepted some of the supplementary evidence and accepted push back on 8 core standards, these were returned to compliant, no additional non-compliant standards were added. The Trust moved up to 24%. Although overall compliance still remains at non-compliant, this outcome is comparable to other Trusts within ours and other ICB footprints and it has been identified that the Trust is not an outlier as a result.

- The Trust submitted its final position of non-compliant to the ICB (copy to the EPRR Regional Team) on 10th November 2023 as required by NHSE.

- The Local Health Resilience Partnership (LHRP) meeting took place on 21st November 2023 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 2023 to complete the assurance cycle.

The table below illustrates the compliance within each domain.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	3	3	0	0
Duty to risk assess	2	1	1	0	0
Duty to maintain plans	11	1	10	0	0
Command and control	2	1	1	0	0
Training and exercising	4	0	3	1	0
Response	5	2	3	0	2
Warning and informing	4	0	4	0	0
Cooperation	4	2	2	0	3
Business continuity	10	4	6	0	1
Hazmat/CBRN	10	0	8	2	9
Total	**58**	**14**	**41**	**3**	**15**

Although NHSE recognise the significance of taking this evidence-based approach and the additional demands and challenges it has placed across organisations, given the competing pressures and that Trust Boards may be concerned by the reduction in compliance ratings.

They state 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 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 2024, this action plan is due for completion in September 2024. It is anticipated that assessment for 2024/25 will take a similar timeline and the first submission will be around September 2024, it is hoped that on completion of the current actions the Trust will be in a much more positive position and compliance will be much higher in 2024.

5.2 Risk Assessment

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

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.

5.3 Partnership Working

The Trust is represented at both health and multi-agency emergency preparedness groups within the Yorkshire and Humber area and has been working collaboratively with these agencies throughout the year to support coordination and information sharing particularly around Industrial Action and the core standards work. 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 Sub Group
- Quarterly Local Health Resilience Partnership
- Vulnerable Persons working group
- Humber and North Yorkshire ICB Industrial Action system calls
- Yorkshire and Humber Mental Health and Community EPRR Group

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. In August 2023 the revised Operational Pressures Escalation Levels (OPEL) Framework for 2023/24 was released. Within the action cards for the ICS at OPEL 1 and OPEL 2 there were actions for Crisis services both Mental Health and CAMHS. Engagement with the ICS resulted in a more robust process being developed for when the health system is escalating and our teams are more responsive as a result.

The Trust daily situation report (Sitrep) has also been revised this year, previously only Mental Health was reported on however, it now includes all the Trust Divisions daily OPELs specifically incorporating operational headlines, bed states and any divisional internal pressures thus giving an overview of all Trust services. This is shared with all Operational Managers, Executives and the ICB daily.

5.4 Training, Exercising and Testing

Training

A key element of EPRR is the ability for the organisation and its staff to respond positively to incidents and emergencies. The new 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 deal with an incident should this arise. We have recently purchased a new system called CPDme which each individual can use to record their learning and collate their portfolios, this is also being used successfully by other NHS organisations.

These portfolios are in the process of being worked through with the Project Management Office before implementation takes place and training is being identified both internally and externally by the ICB. In October 2023, Directors, EPRR Specialists and some key individuals completed both Legal and Media Training which all contribute to the portfolios.

The EPRR team is also working with the Trust Instructional Designer to develop an annual mandatory e-learning training package for EPRR awareness with a view to this being launched later in the year.

As part of their own individual portfolios, two of the EPRR team have completed the Level 3 Education and Training qualification which will enable them to deliver training which is a requirement of the EPRR core standards. The Senior Emergency Planning

Officer has also successfully completed the Diploma in Health Emergency Planning which will contribute to their own portfolio.

Exercises

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

September 2023	-	EPRR Team attended a CBRN exercise delivered by Leeds and York Partnership NHS Foundation Trust.
November 2023	-	Local Resilience Forums Mitsubishi Chemical COMAH exercise held at County Hall, Beverley attended by the EPRR team.

Exercises held to test business continuity plans were held on:

6th November 2023	-	Forensic Inpatient Business Continuity (BC) Plan Tabletop exercise
3rd January 2024	-	Humber Centre Live Exercise
31st January 2024	-	Pine View Live Exercise
21st February 2024	-	Community Forensic BC Exercise

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.

Communications Tests were held on:

24th April 2023
31st October 2023

Our command-and-control arrangements continue to be tested whilst stepping up/down for the Industrial Action and the response required.

Any learning from the exercises and testing is addressed by updating relevant plans and documents and shared and addressed with the Operational Delivery Group (ODG) through the regular reporting processes.

5.5 Responding to external influences

NHS Alert Levels

As part of the changes to the new ways of working with EPRR, new arrangements to the Alert Levels are outlined in the table below, therefore we continue to be responsive to any changes and are able to step up to requests if required.

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 within an ICB footprint or requires mutual aid between providers within a single ICB.	Led by the ICB with support of 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 in order to lead the NHS response.	Led by NHSE national team

COVID19

Although still cognisant of the Covid19 virus the NHS is no longer in an official response, organisations have well established local arrangements to manage outbreaks within their services and continue to be vigilant.

Industrial Action

Planned Industrial Action over the last 12months 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 of the strike action. Planning meetings in advance of the Industrial Action took place with the Medical Workforce Team, Medical Director and Deputy Chief Operating Officer, Tactical meetings took place on the day before and morning of each day of action in order to identify any issues at the earliest opportunity. Following Industrial Action debrief forms were sent to all of those involved in the Tactical meetings in order to identify any learning, these also feed into the system debrief requests from the ICB.

Industrial Action took place on the following dates:

	2023	
RCN Nurses	-	30 April – 2 May.
Unite members (YAS)	-	1st May
NEU Teachers	-	2 May
Junior Drs	-	11-15 April
	-	14- 17 June
	-	13-14 July
	-	20-22 September
	-	2-5 October.
	-	20 December – 23 December
Consultants	-	19 - 20 September
	-	2 - 5 October.

2024

Junior Drs	-	3 – 9 January 24 – 28 February

Review of our planning and response demonstrates that this worked well and very little disruption to services was experienced.

5.6 Business Continuity Management

The EPRR team continue to support directorates and divisions with the annual updating of their business continuity plans and ensure these remain standardised across all services of the Trust. The need to test plans still remains an audit requirement and the team actively engage with teams in order to support and facilitate any desk top exercises as required.

In support of the Trusts business continuity plans, the Trust has a robust on-call manager and director rota system as well as a well-established evening duty manager rota which is also managed by the EPRR team.

The EPRR team continues to collate and publish a number of 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.

5.8 Emergency Preparedness Plans

The EPRR Team continues to develop, update and improve trust-wide resilience plans in alignment with updated national risk registers, local risk registers, national guidance, and learning from incidents, events, exercises and in response to new emerging specific threats or hazards. As a result of the core standards recommendations some of the plans currently being updated are:

- The Incident Response Plan (formerly Major/Critical Incident Plan) is in the process of being updated in line with the core standards requirements.
- The EPRR Arrangements Policy has been updated to include information about risk management, alignment to the Trust values, additional information on supplier contracts and systems for monitoring and embedding lessons identified.
- The Pandemic Plan has been reviewed and rewritten in collaboration with the Infection Prevention Control Team to include command and control arrangements,

lessons identified from Covid19, how staffing absence and wellbeing is overseen and expectations and actions through stages of a pandemic.

- The Manager on Call Standard Operating Procedure has been updated.
- The Trust Business Continuity Policy is being updated as a result of core standards recommendations.

6. Assurance and Governance Arrangements

6.1 Internal Audit

A Business Continuity and Resilience Audit concluded in April 2023 and the resulting outcome was 'Significant Assurance with only 1 moderate recommendation and 4 minors.

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

The LHRP for the NHS Humber and North Yorkshire Integrated Care Board has now been established and 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.

7. Summary

2023/24 has been another challenging year for Humber Teaching NHS Foundation Trust in terms of EPRR response. The EPRR team is dedicated to meeting the demands faced in terms of responding to Industrial Action whilst continuing to ensure the out of hours rotas have been managed, weekend and bank holiday plans have been distributed, 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 2024/25 has been planned.

8. 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 2024/25 are as detailed below:

- 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 currently achieving partial or non-compliance.

- Ensure the updating of the Trust's suite of plans, including the Incident Response Plan, policies and procedures in order 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.

- Roll out the Health Command Portfolios on the CPDme system and ensure all key individuals are fully briefed on expectations and responsibilities.

- Ensure that the new mandatory EPRR e-learning awareness training package is completed before the next core standards submission.

- Continue to improve on the system and monitoring mechanisms with our MH partners and stakeholders as a whole.

Humber Teaching NHS Foundation Trust

Agenda Item: 27

Title & Date of Meeting:	Trust Board Public Meeting, 29 May 2024
Title of Report:	Board and Committee Effectiveness Reviews 2023/24
Author/s:	Name: Stella Jackson Title: Head of Corporate Affairs
Recommendation:	

To approve	/	To discuss	
To note		To ratify	
For assurance			

Purpose of Paper:	To present completed effectiveness reviews for the Trust Board and each of the Board's sub committees for 2023/24. To present Committee Terms of Reference for Board approval.

Key Issues within the report:

Positive Assurances to Provide:

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

Key Actions Commissioned/Work Underway:

- The results of the Finance and Investment Committee effectiveness and terms of reference reviews will be considered by the Committee on 30 May and forwarded to the July Board meeting.
- The findings from the Board effectiveness review questionnaires will be discussed at the Part II Board meeting.

Key Risks/Areas of Focus:

- 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		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	

			Other (please detail)	29.5.24

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 2023-2024

1. Introduction

The Board has delegated functions to each of its committees as outlined in 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 on the table below.

	Non-Executive Director Committee Chair
Quality Committee	Phillip Earnshaw
Finance and Investment Committee	Francis Patton
Workforce & Organisational Development Committee	Dean Royles
Charitable Funds Committee	Stuart McKinnon-Evans
Collaborative Committee	Stuart McKinnon-Evans
Mental Health Legislation Committee	Mike Smith
Audit Committee	Stuart McKinnon-Evans
Remuneration and Nomination Committee	Trust Chair
Trust Board	Trust Chair

2. Completed Reviews

The effectiveness reviews and terms of reference for each committee are attached as appendices:

Appendix 1: Quality Committee
Appendix 2: Remuneration and Nomination Committee
Appendix 3: Workforce & Organisational Development Committee
Appendix 4: Charitable Funds Committee
Appendix 5: Collaborative Committee (at the request of the Committee Chair, also attached to this report is the paper which was considered at the February 2024 Audit Committee meeting regarding the benefits of the Collaborative).
Appendix 6: Mental Health Legislation Committee
Appendix 7: Audit Committee
Appendix 8: Trust Board

3. Summary

The Trust Board and all sub committees have undertaken a committee effectiveness review for 2023-2024 and have reviewed their Terms of Reference. The results of the Finance and Investment Committee effectiveness and terms of reference reviews will be shared at the July Board meeting. The Trust Board and all sub committees have a work plan for the 2024/25 year ahead and these are available on request.

4. Recommendations

The Board is asked to:

- To receive and discuss effectiveness reviews for the Trust Board and its sub committees.
- To approve the Terms of Reference for the Trust Board and sub committees.

Quality Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

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.*

1. Executive Summary

Chair to provide a brief written overview of the Committee's work during the year and whether they believe that the Committee has operated effectively and added value

The Quality Committee was convened on five occasions in 2023- 2024. All sessions have been quorate with good interaction from all colleagues. The September 2023 meeting focused on annual reports and several reports were brought to the committee.

As chair I was tasked with ensuring that we had a good, early roll-out of the new PSIRF reporting system that has been put in place to monitor patient safety and ensure that a culture of continuous improvement is embedded in the Trust when it comes to learning from incidents. As part of this implementation, all non-executive directors have attended a daily safety huddle and I have attended training led by NHS England for non-executive quality leads.

As part of increasing my knowledge on the journey of items to Quality Committee I have recently attended QPAS and was amazed to see the amount of work being done to ensure our Trust provides, high quality, safe care.

When areas of concern are highlighted to us, the Quality Committee takes ownership of the issue and monitors the improvement path and hopefully gets the issue to a point where assurance can be given to the Board.

I would like to thank all my fellow executive and non-executive committee members who have contributed throughout the year and have ensured 100% attendance. We are ably supported by many staff and their support is greatly appreciated. The committee has

operated effectively throughout the year and I believe it has added value enhancing the care we give to our patients.

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
To provide a strategic overview of Clinical Governance, Risk and Patient Experience to the Trust Board	• Annual reports for Safeguarding, Patient Safety, Healthcare Acquired infection, Patient and Carer Experience report (which includes Complaints, PALS and E&D), Clinical Audit, Zero Events and Research and Development reported to the Committee. • Quality Accounts 2022-23 oversight and approval prior to Board submission in June 2023 • Quality Risk Register and BAF.	Maintain oversight of quality priorities as outlined in the Quality Accounts.
To provide an assurance to the Trust Board that risks, and governance issues of all types are identified, monitored and controlled to an acceptable level.	Report of assurances and minutes of the meeting submitted to the Trust board. Quality Accounts reported in June 2023 Escalated key assurances for Board review/ratification e.g. annual reports for Safeguarding, Infection Control, R&D, Patient and Carer Experience. Medicines Management work from 2022 Community Mental Health Survey Review of Quality related risks and the BAF prior to submission to the Board. Closed Culture report	Maintain oversight of closed cultures work aligned to trust plans and findings from national reports
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	Review of the Board Assurance Framework quality related risks at each meeting. BAF presented quarterly to the Board. Quality related risks reported to each meeting via the Quality Committee Risk Register	
Drive improvements in the approach to quality improvement, innovation and quality assurance informed by the internal governance reporting structures and	The committee reviewed the divisional quality improvement plans. Annual review of Quality Improvement	Continued oversight of PSIRF roll out.

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
external horizon scanning and learning from others	Research and Development Annual Report and 6 monthly update Oversight of PSIRF roll out. Received presentations/discussion topics and information– including – Annual Patient Safety Report – Quality Priorities update – National Confidential Enquiry on Suicide presentation – Closed Cultures and Trust response/next steps – Allied Health Professionals Annual Report – Social Workers contribution to Quality Improvements – Clinical supervision – Annual Psychology Report – White Ribbon Accreditation – Learning Disability standards – Mental Health, Learning Disability and Autism transformation. – CQC compliance work and updates – Clinical Audit Annual Report and 6 monthly update – Annual NICE Guidance Report – Staff Survey Action Plan – Infection, Prevention and Control 5 year Plan – Annual Safeguarding Report and 5 year Plan – Sexual safety Reviewed Trust Response to recommendations from inspection of TEWV Redesigning Adult Inpatient Mental Health Services Presentation The Committee receives a Quality Insight Report at each meeting detailing national policy and Trust quality improvements and performance/actions taken.	
To receive regular assurance reports that ensure all areas/departments of the Trust produce a risk register	Discussion topic in relation to a specific quality related issue at each Committee, agreed with the chair prior to each meeting	

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
that relates local risks to achieving the Trust's strategic objectives.	Update on waiting list management and performance. Zero Events Annual Report noting these are now the Trusts patient safety priorities aligned to PSIRF roll out.	
To ensure that there is an effective mechanism for reporting significant risks and governance issues to the Trust Board in a timely manner.	Monthly reports to the Board via the executive briefings in the Chief Executive board briefing. The Committee Board Assurance report. The Board Assurance Framework	
To provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction	Six monthly Patient and Carer report and annual report Patient Survey results including GP survey and Mental Health inpatient Survey	
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.	Minutes received from Quality and Patient Safety Group. Chair of Quality Committee has observed the meeting.	
To monitor Trust compliance with the required standards for regulation and registration with the Care Quality Commission and other national guidelines	CQC updates included in the Quality Insight report CQC compliance work reported.	
To monitor and advise on the Trust approach to Research and Development	R&D Strategy and progress reports submitted. Supported annual conferences and events	

3. Attendance

3.1 The Quality Committee met on five occasions during 2023/24

Members:	No of meetings attended

Non-Executive Director (Chair)	*5/5*
Two Non-Executive Directors	*5/5*
Director of Nursing, Allied Health and Social Care Professionals (Management support to the Committee)	*5/5*
Medical Director	*5/5*
Chief Operating Officer	*5/5*

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 effective, participation is good and the Committee is mature. There is input from senior staff and sufficient time for discussion.

3.3 Include any recommendation for change to membership & reasons why.

ToR to include an open invite to the Chairman.

4. Quoracy

The Committee was quorate on all occasions.

5. Reporting / Groups or Committees

Which groups report to the Quality Committee?
Quality and Patient Safety Group

Has the Committee approved the Terms of Reference for each of these groups?
Yes [**X**] No [ ] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [**X**] No [ ]

Has the Quality Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [X] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

Has the Quality Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2021/22?
Yes [X] No [ ]

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***

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?* ***Yes***

- *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

No changes to the ToR required following review in the meeting in March 2024.

8. Workplan for 2023/24

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

Yes [**X**] No [ ]. *If no, when will it be presented to your committee?* _____

9. Any Actions Arising from this Effectiveness Review? YES [ ] NO [X]
If any, please summarise in bullet point format below

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.

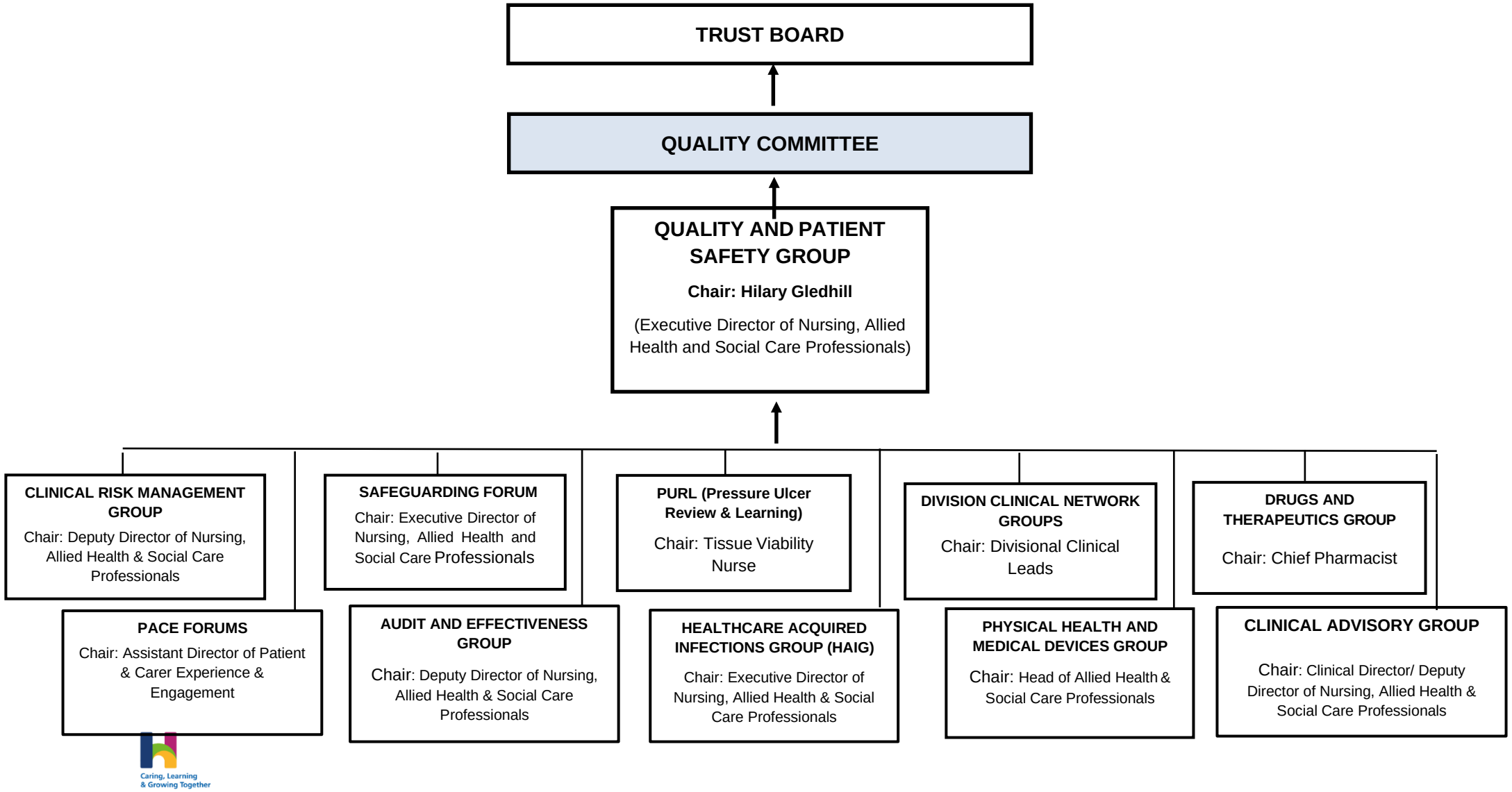
	• To advise the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action. • To ensure that there is an effective mechanism for reporting significant quality related risks and governance issues to the Trust Board in a timely manner. • 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 Allied Health Professionals • Deputy Director of Nursing, Allied Health and Social Care Professionals • Assistant Director of Nursing, Patient Safety and Compliance. 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 Chairman and 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 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. Formal minutes will be taken of the meeting and presented to the Board with the assurance report. 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*
Date approved by *Trust Board*	
Review Date	*March 2025*

Humber Teaching NHS Foundation Trust

CLINICAL & QUALITY GOVERNANCE REPORTING STRUCTURE



Caring, Learning & Growing Together

Humber Teaching
NHS Foundation Trust

Remuneration and Nomination Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

The purpose of the Remuneration and Nomination Committee is to provide a forum for agreement of remuneration and terms of service for Trust Executives in accordance with national requirements and Executive Director appointments.

1. Executive Summary

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

The Committee's duties fall under three key headings in the table below at section 2. The Committee has operated effectively and there is evidence of each of these functions being delivered in year within the agendas, minutes and decisions recorded.

2. Delivery of functions delegated by Board.

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
National Requirements	Within meeting agendas and minutes - decisions adhered to national requirements when appointment/remunerating.	none
Appointments Role	Within meeting agendas and minutes - executive director appointments made	none
Remuneration Role	Within meeting agendas and minutes - executive remuneration agreed	none

3. Attendance

3.1 The Committee met on 10 occasions during 2023/24

Members:	No of meetings attended.
Caroline Flint, Chair Francis Patton, Non-Executive Director Mike Smith, Non-Executive Director Dean Royles, Non-Executive Director Hanif Malik, Non-Executive Director	10/10 9/10 8/10 8/10 4/5

Stuart Mckinnon-Evans, Non-Executive Director Phillip Earnshaw	9/10 9/10

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 made up of all Non-Executive Directors. All Non-Executive Directors attended meetings and contributed in year. The minutes of the meeting reflect engagement and challenge of members.

The Chief Executive attends each meeting, except when matters are discussed relating to the Chief Executive.

The Director of Workforce and Organisational Development (or their deputy) attends as required and provides advice and support to the committee.

3.3 Include any recommendation for change to membership & reasons why.

No recommendations for any change.

4. Quoracy

The Committee was quorate on all occasions.

5. Reporting / Groups or Committees

Has the Remuneration and Nomination Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group/committee provided the required level of assurance?

The nature of the Committee means it does not have any reporting groups and there are no proposals for change. Executive advice on matters for committee discussion is provided through attendance by the Chief Executive or Director of Workforce and Organisational Development as appropriate.

Summary notes of key discussions and decisions have been presented or discussed at the Part II Trust Board meetings.

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?*

  The committee's work is largely reactive, and an outline work plan is in place to reflect essential annual discussions i.e., review of the terms of reference, effectiveness review etc but remains a reactive document. On occasions where emerging issues have presented, the Committee has convened on an exceptional basis to take necessary action.

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*

  Yes

- *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

A small number of changes are recommended by the Committee (shown in track changes in the attached terms of reference):

- The membership section has been updated to reflect the Chair's membership of the Committee.
- The minutes and reporting section has been updated to reflect current practice regarding the reporting of Committee business to the Board.
- A small number of other amendments have been made to reflect current practice of correct typo errors.

The terms of reference are attached for approval.

8. Any Actions Arising from this Effectiveness Review?

An effectiveness review questionnaire was sent to Board members for completion and return. This confirmed Board members considered the Committee to be effective and no key actions were identified.

NHS
Humber Teaching
NHS Foundation Trust

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 the succession of 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~~and 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.

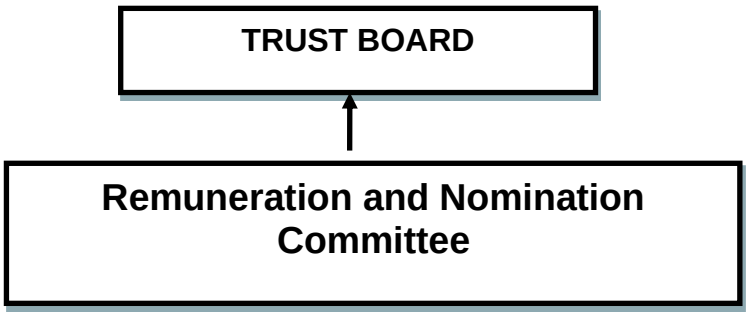
In adhering to all relevant laws, ~~regulations~~regulations, and Trust policies:

- 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 ~~Workforce~~ 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 Trust Secretary 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 ~~and abridged minutes~~ 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	~~June 2023~~27 March 2024
Board Approved	~~26 July 2023~~ May 2024
Review Date	March~~May~~ 2025~~4~~

REMUNERATION AND NOMINATION COMMITTEE REPORTING STRUCTURE



Humber Teaching NHS Foundation Trust

Workforce and OD Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

The purpose of the Workforce and OD Committee is 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. Its purpose is also to provide assurance to the Trust Board in relation to the health and wellbeing of staff and to provide assurance on the delivery of the relevant strategic objective assigned to the Workforce and Organisational Development Committee - Goal 4 – Developing an effective and empowered workforce.

1. Executive Summary

The Committee undertakes its delegated functions on behalf of the Trust Board. The Committee is one of the newer committees and continues to develop. The Committee achieved its objectives for 2023/24 and delivered on delegated functions. In addition, it has considered;

- Workforce Insight Reports
- Risk Registers
- Freedom to Speak Up Annual Report
- Presentations on 2022 Staff Survey Results
- Recruitment Task and Finish Group updates
- NHS People Plan
- Annual Equality Diversity and Inclusion Report
- Workforce Race Equality Standards and Workforce Disability Equality Standards reports
- Safer Staffing reports
- Gender Pay Gap report
- Leavers and Absence Deep Dive reports
- Trust Workforce Plan
- Statutory mandatory training recovery plan
- Guardian of safe working updates

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
Provide oversight and assurance to the Board in relation robust processes for the effective management of	Monthly Insight report Workforce Scorecard Risk Register, reports from FTSUG and Guardian of Safe Working	

Workforce and Organisational Development;		
Scrutinise structures in place to support workforce and organisational development to be assured that the structures operate effectively and action is taken to address areas of concern.	Insight report Sub group updates	
Receive assurance on the delivery of the Workforce and OD Strategy	Insight report Revised strategy to go to WOD following discussion at strategic time out. Sub group reports and deep dives. Staff survey analysis	
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.	Risk register provided (recently included in Insight report)	
Be assured of the Trust's response to all relevant Directives, Regulations, 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.	Insight report	
Receive assurance that the Trust has effective and transparent mechanisms in place to monitor workforce and organisational development performance.	Insight Report Workforce Scorecard Deep dives	
To be assured that the views of staff are captured, understood and responded to.	Staff survey reports EDI and HWWB reports	
Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for equality and diversity.	Annual EDI Report Staff survey reports	

Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for staff health and wellbeing.	Updates from the H&W Group (Lynn Parkinson chair)	
Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for safe working for junior doctors	Junior doctors report	
Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for freedom to speak up.	FTSU included in the Insight report	

3. Attendance

3.1 The Workforce and OD Committee met on 4 occasions during 2023/24. The meetings took place quarterly between 01 April 2023 – 31 March 2024 on 17 May 2023, 06 September, 22 November and 21 February 2024.

Members:	**No of meetings attended**
Dean Royles - Non-Executive Director (Chair)	*04/04*
Francis Patton - Non-Executive Director (New Deputy Chair)	*04/04*
Hanif Malik - Non-Executive Director (left the organisation in September 2023)	*01/04*
Phillip Earnshaw – Non-Executive Director	*03/04*
Steve McGowan - Director of Workforce and Organisational Development (not been at work since end of June 2023 to current day)	*01/04*
Lynn Parkinson - Chief Operating Officer	*04/04*
Kwame Fofie – Medical Director	*04/04*
Hilary Gledhill – Executive Director of Nursing, Allied Health and Social Care Professionals	*02/04*
In attendance:	
Karen Phillips – Deputy Director of Workforce and OD	*04/04*
Alison Meads – Head of Strategic People Services	*02/04*
Vickie Murray – Head of Operational People Services	*03/04*
Caroline Flint – Chair – Open invite to the meeting, optional attendance	*01/04*
Michele Moran – Chief Executive – Open invite to the meeting, optional attendance	*01/04*

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.

The membership composition is effective, and all members have contributed to effective debate and discussion. Occasional attendance from others supplements the standing committee members.

4. Quoracy

The Committee was quorate on all occasions.

5. Reporting / Groups or Committees

Which groups report to Workforce and OD Committee? *(these should be clearly identified on the schematic on your ToR)*. Please list:

- Staff Health Wellbeing and Engagement Group
- Equality, Diversity, and Inclusion Group
- Medical Education Committee

Has the Committee approved the Terms of Reference for each of these groups?
Yes [X] No [ ] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [X] No [ ]

Has the Workforce and OD Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [X] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

Has Workforce and OD Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2023/24.
Yes [X] No [ ]

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. Work plan has been approved and we have considered additional deep dives and assurance as appropriate.

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?* Yes. Feedback from members is that papers are well prepared and useful.

- *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 the committees terms of reference in light of the annual evaluation.

Revised terms of reference are attached. Minor changes to job titles have been made.

8. Workplan for 2024/25

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

Yes [X] No [ ]. *If no, when will it be presented to your committee?* _____

9. Any Actions Arising from this Effectiveness Review? YES [x] NO [ ]
If any, please summarise in bullet point format below

Following feedback received from the questionnaires, the assurance reports *will be added to the agenda for noting.*

Humber Teaching NHS Foundation Trust

Agenda item 18b

Workforce and Organisational Development Committee

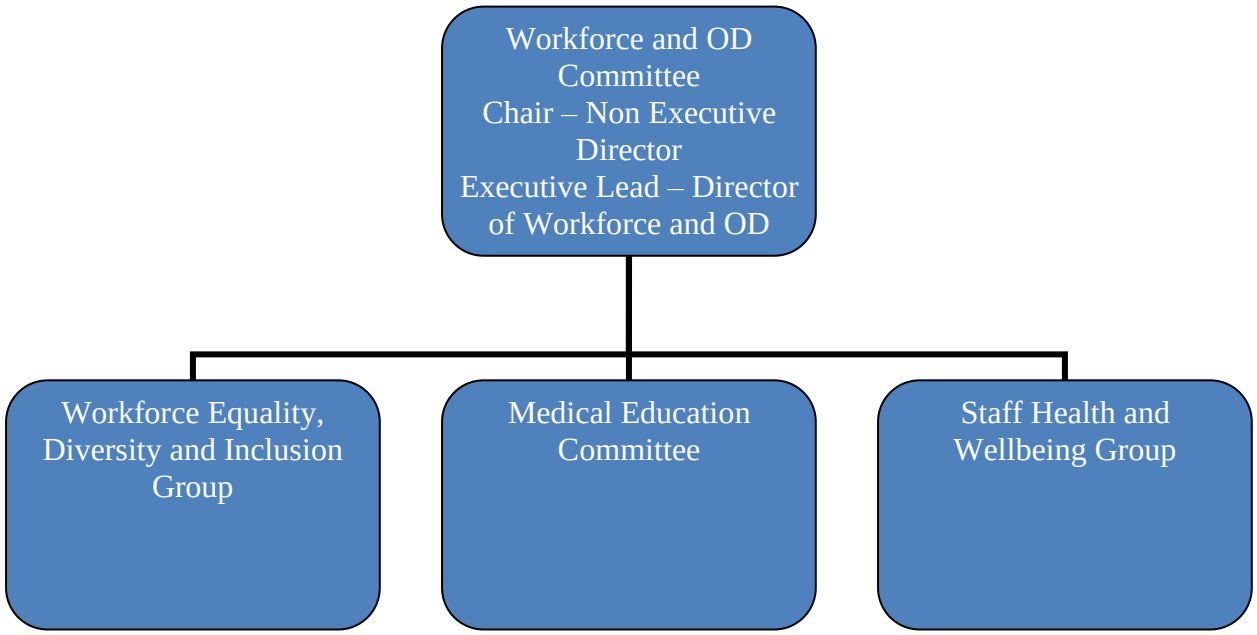
Terms of Reference

Authority	The Workforce 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 Workforce and OD 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 Workforce 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 • 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 • ~~Director of Workforce and Organisational Development~~Associate Director of People & OD • Chief Operating Officer • Medical Director • Executive Director of Nursing, Allied Health and Social Care Professionals The following roles will be routine attendees at the committee: • ~~Deputy Director of Workforce and OD~~Deputy Associate Director of People & OD • Head of ~~Strategic People Services~~People Experience • Head of Operational People Services

	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 has 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 Director of Workforce 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. Formal minutes will be taken of the meeting and presented to the Board with the assurance report. 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.
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
Approved by Trust Board	31 May 2023
Review	May 2024

Workforce and Organisational Development Committee Schematic



Humber Teaching NHS Foundation Trust

Charitable Funds Committee

Annual Review of Committee Effectiveness and Terms of Reference 1 April 2023 to 31 March 2024

The overall role of the Charitable Funds Committee is to oversee the operation of the charitable funds on behalf of Humber Teaching NHS Foundation Trust's Board of Directors – the Corporate Trustee.

1. Executive Summary

During the year, the Committee remained concerned about poor fundraising performance, and the slow conversion of funds raised into charitable activity. Although the Committee's monitoring mechanisms were in place to identify the risks and issues, performance did not improve.

The decision was taken to part company with the Charity's operating partner Smile. The transition to an entirely in-house operation is underway. A stocktake of the success of the transition, the efficacy on new internal processes, and of evidence and prospects for an uptick in performance overall will be taken midway though 2024/25.

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
To monitor and review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame.	A Finance Report and Insight Report (*With details on wishes*) are received at every committee meeting.	Following the transfer of the charity in-house a initial review of governance has taken place, and will be reviewed mid year

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
To ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Trust Board as Corporate Trustee.	Annual Accounts were approved at Trust Board in January 2024 *(noted at the Feb 24 Committee)*	Account to be brought to the committee meeting in August or November 2024.
To develop the strategy and objectives for the charity for consideration by the Board		An updated/refreshed strategy and objectives document needs to be brought to the committee in 2024.
To assist the Board in meeting its responsibilities as the corporate trustee of the fund by overseeing the operation and development of charitable funds, expenditure and any investment plans	A Chairs Report is presented to Trust Board (the Corporate Trustee) after every committee meeting,	None
To monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements.	The Committee undertook a fundamental review of charitable activity arrangements, and performance management arrangements revised and made a recommendation to board to bring management in house.	A Transition Plan is in place to enable the transfer of management into the Trust wef from 1st April 2024 – there is oversight of this plan at EMT.
To make decisions on behalf of the Board within the defined delegation and financial limits set out in the trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions.	Finance Report Committee considers all requests over £5k at each committee meeting	None

3. Attendance

3.1 The Charitable Funds Committee met on 4 occasions during 2023/24.

Members:	No of meetings attended
Stuart McKinnon-Evans - Non-Executive Director - Chair	*4/4*
Francis Patton – Non Executive Director	*3/4*
Hanif Malik – Associate Non Executive Director	*2/4 (left in Sep 2023)*
Director of Finance	*4/4*
Director of Workforce & OD (Deputy Director of Workforce & OD has been attending on behalf of the Director)	*1/4 & (3/4)*
Attendees:	
Chief Executive of Humber Teaching NHS Foundation Trust	4/4
Chief Executive Officer, HEY Smile Foundation	4/4
Head of Smile Health, HEY Smile Foundation	4/4
Marketing and Communications Manager, Humber Teaching NHS Foundation Trust	4/4
Deputy Chief Operating Officer, Humber Teaching NHS Foundation Trust	4/4

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

Membership has been effective with joint membership and links with other committees. It is important the non-members who attend Committees for agenda items are fully briefed on the contribution expected of them.

3.3 Include any recommendation for change to membership & reasons why

Membership of the committee has been reviewed and included in the updated Terms of Reference, this will be kept under review during 2024/25.

Executive Leadership for the charity has moved to the Director of Finance

4. Quoracy

The Committee was quorate on all occasions.

5. Reporting / Groups or Committees

There are no committees/ groups reporting to Charitable Funds Committee.

Has the Committee approved the Terms of Reference for each of these groups? Yes [ ] No [ ] Not applicable – no groups formally report to CFC

Are ToR annual reviews for each reporting group on your Committee work plan to approve?
Yes [ ] No [ ] Not applicable – no groups formally report to CFC

Has the Charitable Funds Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance?
Yes [ ] No [ ] Not applicable – no groups formally report to CFC

Has Charitable Funds Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2023/24?
Yes [ ] No [ ] Not applicable – no groups formally report to CFC

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, but the workplan should be reviewed more explicitly at meetings.
- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?* Yes
- *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, though some actions have not been completed to initially defined timescale.

7. Review of Terms of Reference

Proposed Changes to Terms of Reference are attached. The membership section has been updated and the scheme of delegation removed.

8. Workplan for 2024/25

Has a workplan for the year ahead, 2024/25 been prepared? Yes [✓] No [ ]

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

The decision to bring management of the charity in house offers the opportunity for papers to be rescoped and also for internal groups to be established to provide the appropriate assurance internally to the Executive Management Team, ahead of the Committee.

NHS
Humber Teaching
NHS Foundation Trust

Charitable Funds Committee
Terms of Reference

Constitution and Authority	Humber Teaching NHS Foundation Trust is the Corporate Trustee of the charity known as Health Stars. The Charitable Funds Committee is established as a Committee of the Trust Board to oversee the charity's operation on behalf of the Corporate Trustee. The Trust Board may delegate to the Committee or to the Director of Finance matters relating to the operation of the funds, but decisions regarding the investment of funds must be made within an overall strategy determined by the Trust Board taking account of the recommendations made by the Committee.
Role / Purpose	The overall role of the Charitable Funds Committee is to oversee the operation of the charitable funds on behalf of Humber Teaching NHS Foundation Trust's Board of Directors – the Corporate Trustee. Registered charity number …
Scope and Duties	The committees key roles are: • To monitor and review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame. • To ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Trust Board as Corporate Trustee. • To develop the strategy and objectives for the charity for consideration by the Board • To assist the Board in meeting its responsibilities as the corporate trustee of the fund by overseeing the operation and development of charitable funds, expenditure and any investment plans • To monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements • To make decisions on behalf of the Board within the defined delegation and financial limits set out in the trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions. ~~The Committee has delegated authority to approve expenditure of charitable funds in accordance with the financial delegation limits are set out below:~~ • ~~**Scheme of Budgetary Delegation**~~**:**

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Caring, Learning
& Growing Together

	~~**Expenditure on Charitable and Endowment Funds**~~
	~~Up to £1000~~ ~~Fund Manager, Health Stars Charity/Fundraising Manager~~
	~~£1000 - £4,999~~ ~~Fund Manager, Director of Finance~~
	~~Over £5,000*~~ ~~*Any expenditure over £5,000 is subject to procurement rules and budgetary delegation~~ ~~Fund Manager, Director of Finance and Charitable Funds Committee~~
	~~Over £25,000~~ ~~Fund Manager, Director of Finance and Charitable Funds Committee (reported to Trust Board for information within Chairs Assurance Report)~~
	~~Over £100,000~~ ~~Trust Board as Corporate Trustees~~
	Operational issues that relate to the work of the charity should be discussed in Executive Management Team meetings and operational decisions fed into discussions and decision making at the Committee.
Membership	The Charitable Funds Committee shall be appointed by the Trust Board and consist of up to: • 3 Non-Executive Directors • Director of Finance. (Executive Lead for Charitable Funds) • Director of Workforce and Organisational Development The Chief Executive has a standing invitation to attend any committee meeting. The following will be invited to attend the committee: • Deputy Director of Communications and Charitable Funds • The Charity Manager • ~~Smile Representatives~~ • ~~The Communications Manager~~Finance Team Representative • Deputy Chief Operating Officer The Committee will appoint a Chairman and Vice-Chairman to be reviewed annually.
Quorum	The quorum necessary for the transaction of business shall be if two members are present including at least one Non-Executive Director from Humber Teaching NHS Foundation Trust. Deputies may cover in the absence of the nominated member.
Chair	The Committee shall be chaired by a Non-Executive Director.
Frequency of Meetings	The Committee shall meet as and when required, but at least four times a year.
Agenda and Papers	The agenda is to be agreed with the Committee Chairman taking account of the annual cycle of Committee business. All papers are to be forwarded to members and those attending no later than 5

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	working days before the date of the meeting unless otherwise agreed by the Chairman. Minutes are taken of the proceedings and resolutions of the Committee including recording the names of those present and in attendance. Minutes shall be promptly circulated to all members. A record is kept of matters arising and issues to be carried forward.
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 presented to the Board with the assurance report. 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 Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure or require executive action. The Committee's annual report and annual accounts will be considered by the Committee prior to submission to the 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	May 2024~~April 2022~~
Board Approved	~~18 May 2022 - tbc~~May 2024
Review Date	~~March/April 2023~~May 2025

CHARITABLE FUNDS COMMITTEE REPORTING STRUCTURE

TRUST BOARD

▲

Charitable Funds Committee

▲

Project groups set up to contribute to the aims of the Charity will report to Charitable Funds Committee throughout the lifespan of the group/s ~~(as at April 2022 these include):~~

~~Whitby Project Oversight Group~~

Caring, Learning & Growing Together

Agenda Item 13

Title & Date of Meeting:	Audit Committee – 13th February 2024
Title of Report:	Benefits of Provider Collaboration
Author/s:	Name: Peter Beckwith/Mel Bradbury Title: Director of Finance/Collaborative Planning Director
Recommendation:	To approve ☐ / To receive & note ✓ For information ☐ / To ratify ☐ For Assurance ☐
Purpose of Paper:	The purpose of this paper is to provide evidence on some of the reported benefits of the Specialist Lead Provider Collaborative.

Key Issues within the report:

Positive Assurances to Provide:	**Key Actions Commissioned/Work Underway:**
• Details of achievements and positive impacts of the lead provider collaborative are detailed in the body of the report.	• Work has commenced on the Annual Report, due for publication in 2024.
Key Risks/Areas of Focus: • None of significance to note or requiring escalation.	**Decisions Made:** • The Audit Committee are asked to note the report.

Governance:

	Date		Date
Audit Committee	13.2.24	Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		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	N/A	Comment

		this detailed in the report?		
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?	√			

Benefits of the Humber North Yorkshire Provider Collaborative

Dated: 5.12.2023

Introduction

As detailed in the NHS Mental Health Implementation Plan, an NHS-led Provider Collaborative is a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. They will do this by taking responsibility for the budget and pathway for their given population. The Collaborative will be led by a Lead Provider, - in Humber Coast and Vale this is Humber Teaching NHS Foundation Trust. The Lead Provider remains accountable to NHSE/I for the commissioning of high-quality specialised services.

Humber and North Yorkshire Specialised Mental Health, Learning Disability and Autism Provider Collaborative (HNY PC) was established on 1st October 2021. The vision for HNY Provider Collaborative has been agreed by all partners as:

"Working as an open and transparent partnership to improve access, experience and meaningful outcomes for all those who use our services and communities through true co-production, person centred care, supporting and empowering a collaborative workforce, and optimising the use of resources".

HNY PC Annual Report May 2023

The HNY PC Annual Report was published in May 2023 and noted the following achievements over the previous 12 months:

- Phase 2 rollout of the Specialist Community Forensic Team model, which is helping ensure equity of access and provision of these services across HNY – an additional investment of £556k per annum
- Alignment of mental health, learning disability and autism forensic community services across Humber with plans to align services in North Yorkshire and York in 2023
- Reduced length of stay in Adult Secure by 209 days
- First Episode Rapid Early Intervention for Eating Disorders (FREED Champion) investment and new service available across the Humberside area
- Schoen Clinic York, sustained AED capacity through proving robust assurance following challenging CQC inspection
- Introduction of a new in-patient eating disorder service at Inspire
- Investment into alternatives to hospital for young people with eating disorders at Mill Lodge
- Completion of national Safe and Wellbeing reviews during 2022

Key Principles

There are key principles which underpin the Provider Collaborative model:

- Collaboration between Providers and across local systems
- Experts by Experience and clinicians leading improvements in care pathways
- Managing resources across the collaborative to invest in community alternatives and reduce inappropriate admissions/care away from home

- Working with local stakeholders
- Improvements in quality, patient experience and outcomes driving change
- Advancing equality for the local population

The Humber North Yorkshire Provider Collaborative is addressing and achieving the outcomes of these six principles in the following ways:

1. Collaboration between Providers and across local systems

HNY PC have developed three robust workstreams for Adult Secure, CAMHS and AED inpatients.

Each workstream meets bi-monthly and includes all health and social care partners who work together to agree shared priorities.

The benefits of these workstreams mean that there are specific objectives informing the annual priorities and work plan. There is shared ownership and commitment to achieving the priorities and instead of provider organisations working separately there is collaboration between providers which supports a system wide approach to shared challenges and thinking together to avoid duplication and achieve solutions.

2. Experts by experience and clinicians leading improvements in care pathways.

Clinical Leads have been established at the centre of the HNY PC which will ensure that service improvement is underpinned by experienced clinical guidance.

In addition, the HNY PC has appointed a *Head of Lived Experience and Involvement*. This role will ensure the HNY PC has a clear strategic direction demonstrating a commitment to embedding the voice of service users and their families and carers in all future service developments.

The HNY PC is also currently funding the Yorkshire and Humber *Involvement Network* to develop and deliver an engagement plan across all three workstream areas. This additional resource means that all service transformation work will now have the benefit of being shaped by people who have used HNY PC services.

3. Managing resources across the collaborative to invest in community alternatives and reduce inappropriate admissions/care away from home

Working with all providers allows the collaborative to work at scale and make the most of collective resources. A project group has been established to increase options for alternatives to inpatient admissions for children and young people with eating disorders across Humber and North Yorkshire. This project group is currently overseeing over a million pounds worth of funding to increase the options for alternatives to inpatient admission at Inspire and Mill-Lodge Inpatient units.

Adults with Eating Disorders are now able to access day service provision at both Schoen Clinic and Rharian Fields. In addition, Rharian Fields can now admit 16 and 17 year olds.

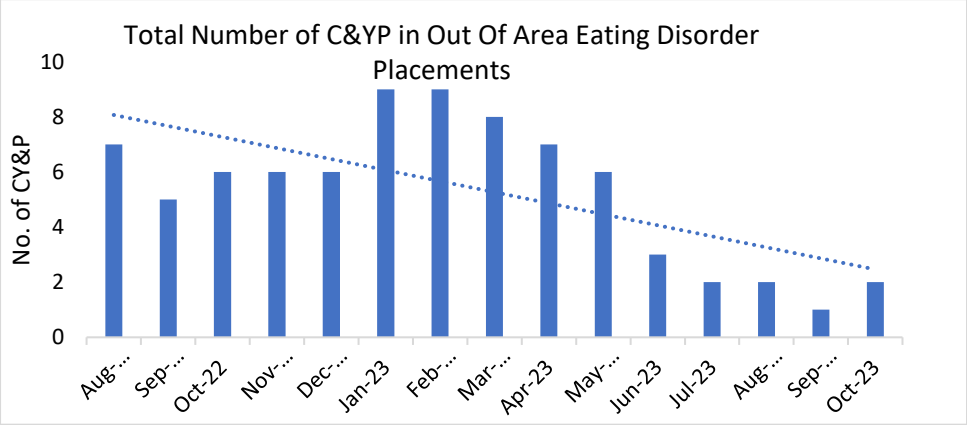
4. Working with local stakeholders

The HNY PC has worked with partners to establish a single referral route through establishing weekly referral meetings on a Friday morning. These referral meetings have been established for CAMHS and AED inpatient units and bring together all partners concerned with admissions for each workstream. These referral meetings not only demonstrate a commitment to working together but also reduce duplication for colleagues and for service users.

5. Improvements in quality, patient experience and outcomes driving change

5.1 CAMHS

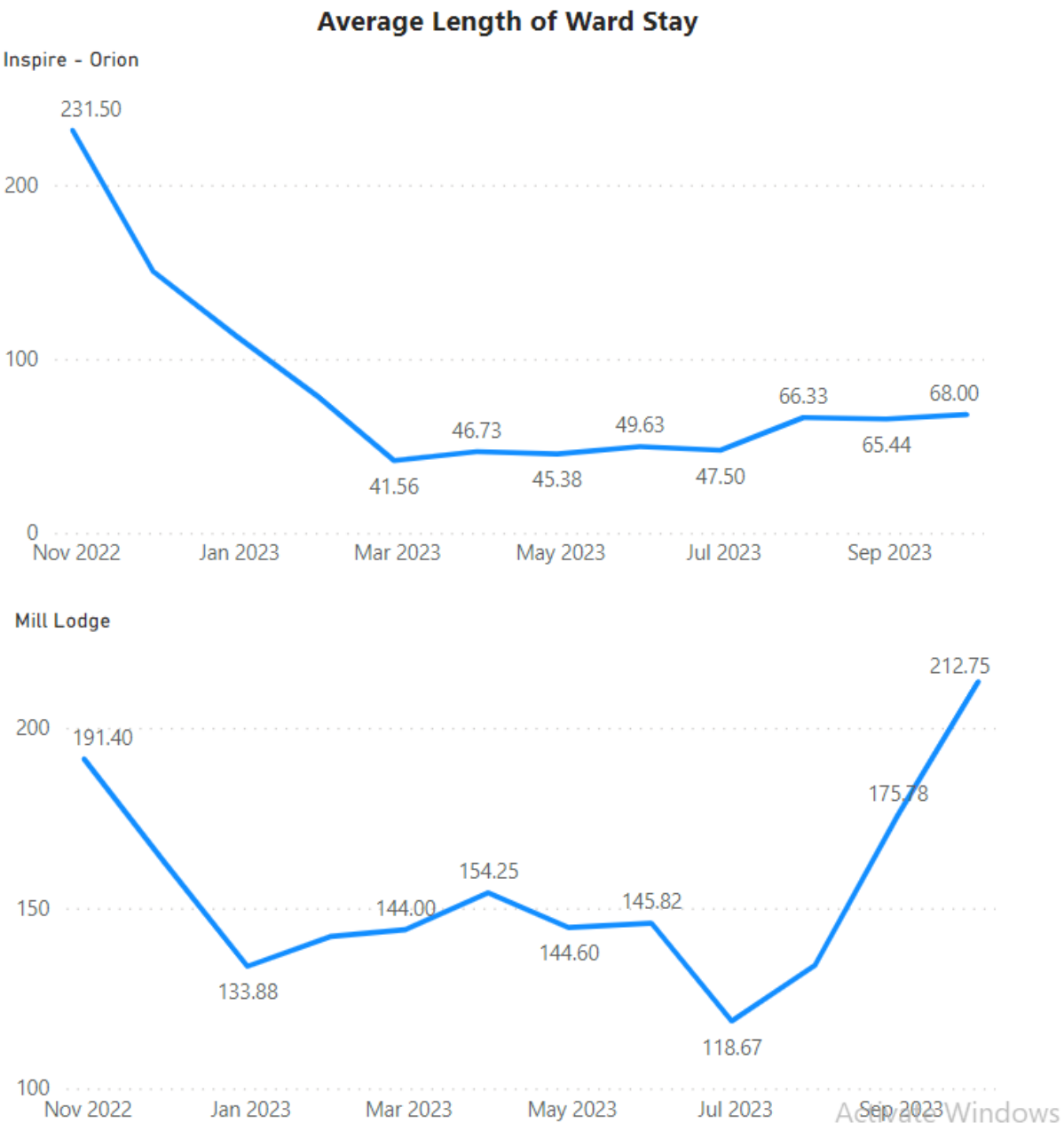
Inspire CAMHS in-patient unit are now able to admit children & young people with an eating disorder, which has contributed to an overall reduction in out of area CAMHS placements.



The *Alternative to Hospital Admissions for Children & Young People with an Eating Disorder* project is progressing well and will further support the reduction in bed usage for eating disorders.

The number of Clinically Ready for Discharge (CRFD) inpatients fell from a high of 15 in September 2022 to just 1 by March/April 2023 and although the numbers have risen slightly they remain comparatively low – 3 since September 2023.

Average length of stay at Inspire has reduced since November 2022 – however has increased at Mill Lodge – this is due to the high number of young people with complex eating disorders at the unit.

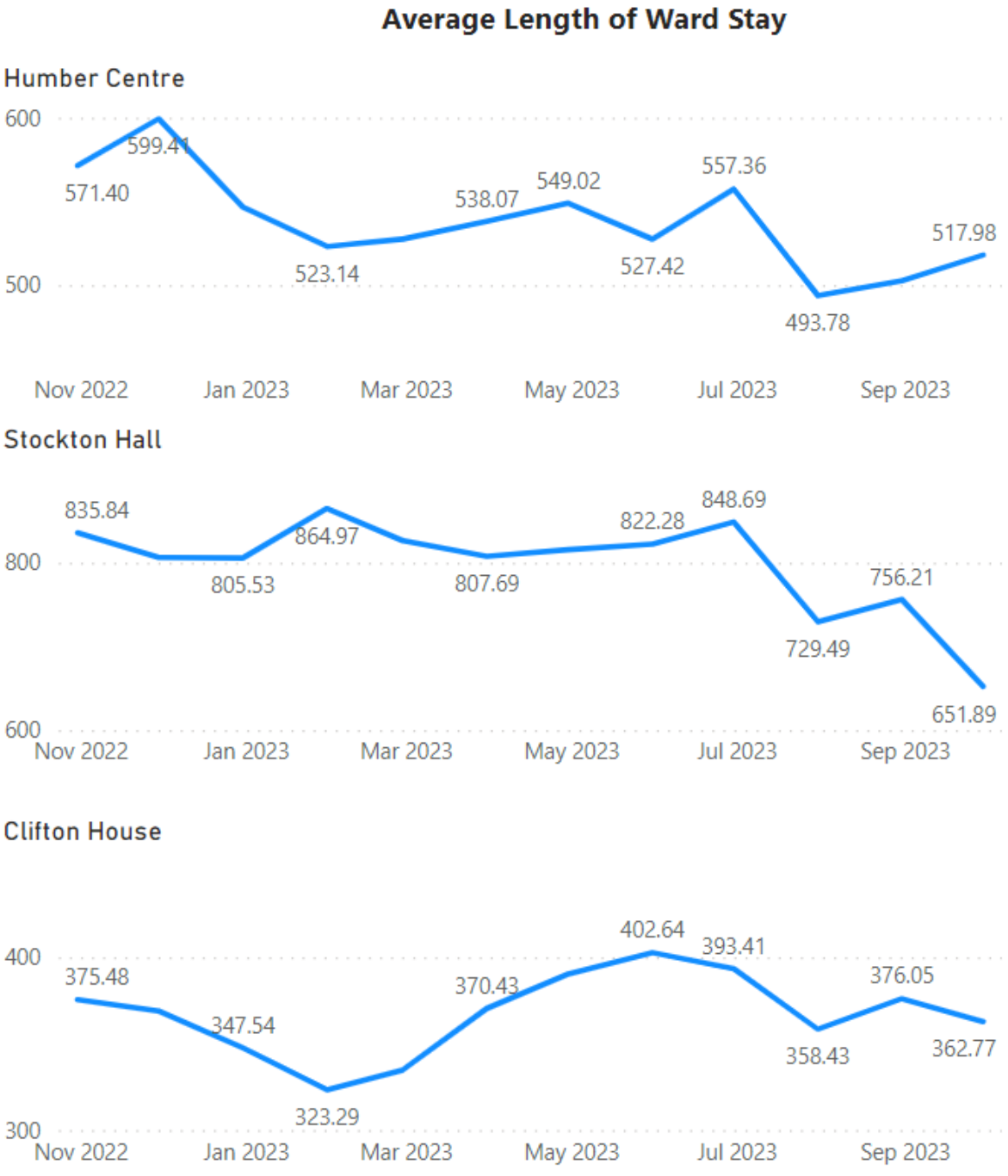


The *Alternative to Hospital Admissions for Children & Young People with an Eating Disorder* project is progressing well and will further support the reduction in bed usage for ED patients.

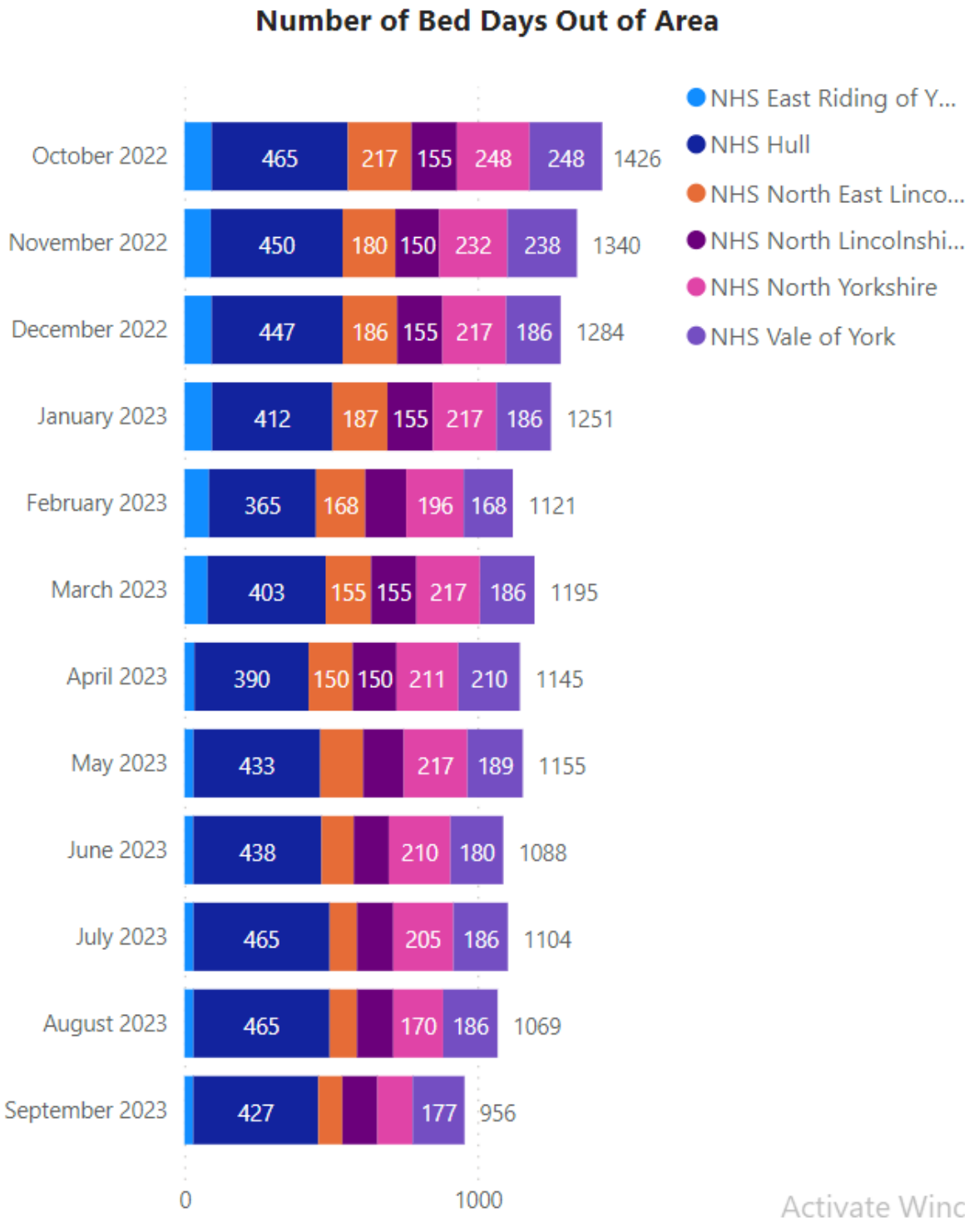
The waiting list for admission has reduced from 9 in July 2022 to 1 in October 2023.

5.2 Adult Secure

- HNY Providers have reduced the average length of stay within services by 305 days
- Continue to see a reduction in medium and low secure patient population from 186 in October 2021 (Go Live) to 132 patients; as of November 2023
- The HNY Single Point of Access has developed to now cover both inpatient and community Forensic Services
- Reduced the need for Out of Area beds by 61% since Go Live
- Reduced average length of stay at all 3 HNY providers

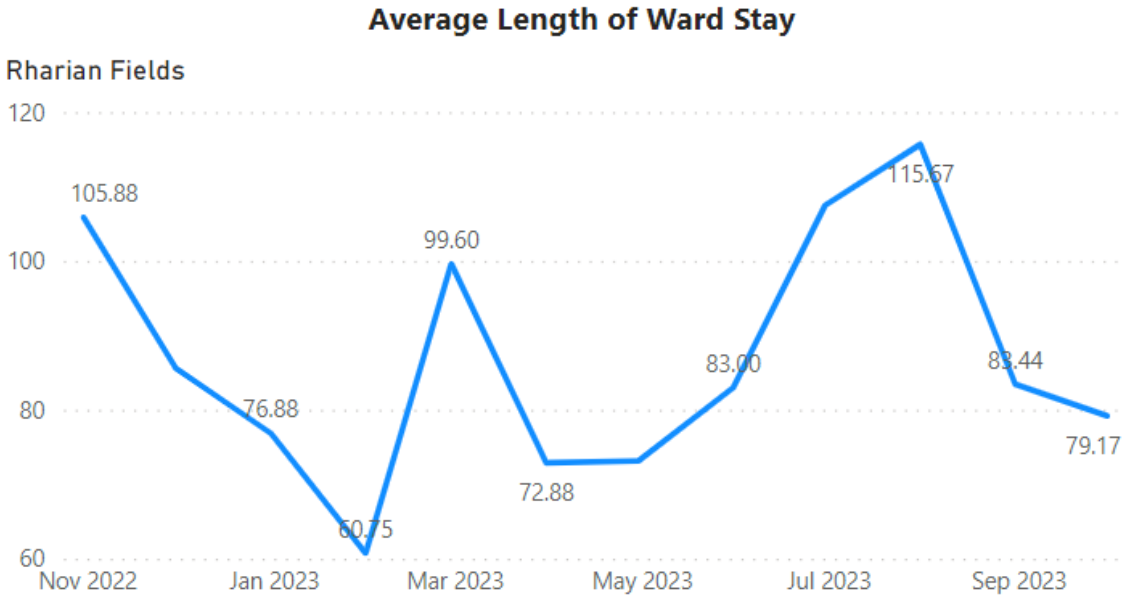


Adult Secure - number of bed days out of area has reduced since Go Live



5.3 Adult Eating Disorders

- Integrated processes have been established to manage all referrals, removing the need for funding a single point of access (SPA).
- Both Rharian Fields and Schoen Clinic now provide a Day Service and this is supporting step-down care.
- There has been an increase in Out Of Area (OOA) bed usage due to acuity and complexity of need – 4 patients out of area in November 2023.
- Average length of stay has started to increase at Schoen Clinic, York – this is being closely monitored by the Collaborative



6 Additional Supporting Information

6.1 CAMHS

Historically, accessing inpatient services for children and young people was reported to have lacked consistency. Referral mechanisms and joint working hubs have therefore been established to ensure access to inpatient services, which is coordinated considering the system pressures. Moreover, the case management function of CAMHS has been increased which has resulted in a reduction in waiting times to access inpatient services thus reducing reported inequalities in access for children and young people in the geographical area.

6.2 AED

It was identified that there was variation across the HNY region in gaining access to early intervention for adults in the community whose needs related to eating disorders. This has been addressed through the roll out of FREED champions across the Humber area with plans to roll out across North Yorkshire and York during 2023.

To ensure access that is proportionate and least restrictive for all service users, day care models as alternatives to hospital admission are now being delivered across the HNY region.

6.3 Secure Care

Service users who were being cared for far away from home had reduced access to oversight and in reach from specialist community forensic teams compared to those closer to home. We have addressed this by considerable investment into the teams to ensure more robust access for all service users. This has had positive results in terms of repatriations and has helped to reduce the length of stay.

There has been alignment of LD FOLS (Learning Disability Forensic Outreach Liaison Service) and SCFT (Specialist Community Forensics Team) across the Humber area with the aim to reduce unnecessary variation in access and experience for people with a learning disability or autism diagnosis.

The University of Hull completed a research project into inequality experienced by people stepping down from secure care. The findings showed the importance of relationships with professionals, support workers, family/friends and others were central to service users' ability to feel confident of living successfully in the community. Practitioners require skills to successfully joint work with third sector services to influence future service design. Early planning for discharge, with opportunities for service users to scale-up independence skills and develop relationships with community providers prior to discharge will support transition. Staff and service users needed specific skills and training on digital literacy and staying safe in an online world. These findings have been shared with our Community Forensic workstream and integrated into our operational delivery.

It has been identified that people in secure care experience longer delays in transfer of care to the community. This has led to inequality in accessing least restrictive environments and being cared for close to home. Improvements in data reporting and monitoring have allowed us to understand this more fully, address this with place where possible and escalate within the ICB where this has not been the case.

6.4 Health Inequalities

Health inequalities will be explicitly woven through each workstream's work plan. Consideration should be given to the four groups reported to be at most risk of experiencing health inequalities based on:

- Social economic status and deprivation
- Vulnerable or inclusion health groups
- Protected characteristics under the Equality Act 2010
- Geography

A project plan has been produced in relation to the agreed initiatives above with clear leads and milestones in outcomes so that update reports can be provided to the Provider Collaborative Oversight Group (PCOG). The Health Inequalities project group is now meeting regularly and progress is being monitored. Many of the suggested areas of work moving forward need to be addressed as an entire system and cannot be accurately understood or tacked by commissioners or providers of inpatient services alone.

Humber Teaching
NHS Foundation Trust

Collaborative Committee – Humber and North Yorkshire Specialised Provider Collaborative

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

Humber Teaching NHS Foundation Trust (HTFT) is the Lead Provider within the Humber and North Yorkshire (HNY) Provider Collaborative (PC) and will hold the Lead Contract with NHS England. HTFT 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 Lead Provider as an internal committee to provide assurance to the HTFT Board as Lead Provider within the Collaborative in relation to Contracting, Planning and Quality Assurance functions of the Provider Collaborative. These functions have been traditionally grouped under the label of commissioning. The Collaborative Committee is constituted as a standing committee of the Humber Teaching NHS Foundation Trust's Board of Directors.

The Collaborative Committee provides assurance to the HTFT Board on matters of finance, quality assurance and performance, to ensure delivery of the overall HNY Specialised Provider Collaborative aims to transform care for people in low and medium secure mental health services, CAMHS in-patient and Adult in-patient eating disorders services.

Day to Day provision of patient care is the responsibility of Providers within the Provider Collaborative Partnership. Services are commissioned utilising NHS Standard Contracts with clear Key Performance Indicators (KPIs) and Outcomes.

The Provider Collaborative 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 aims to generate financial savings. These savings are reinvested in other parts of the Secure, CAMHS and Eating Disorders mental health and learning disability pathways through formal contracting and commissioning arrangements.

This approach ensures delineation between the Provider Partnership and Commissioning functions of the Provider Collaborative and enables our overall partnership to be conducted in an open and transparent way.

1. Executive Summary

The Collaborative Committee had its inaugural meeting on 8 December 2020 and was initially titled the Commissioning Committee. The Committee was established to provide internal assurance and oversight to Humber Teaching NHS Foundation Trust as the Lead Provider and accountable to NHS England on the performance of the Provider Collaborative.

The Collaborative Committee has met on 4 occasions over the last 12 months and has worked efficiently in the delivery of its objectives and duties:

- As Lead Provider provide assurance to the HTFT Board that it is fulfilling its duties and obligations within the HNY Specialised Mental Health Learning Disability and Autism Provider Collaborative
- Be assured that there are appropriate arrangements in place in respect of Serious Incidents, Safeguarding and a system is in place to ensure quality of care and to continuously learn and improve.
- Ensure that the Collaborative Planning and Quality Team (CPaQT) are working with partners; HNY place and ICS as well as neighbouring Provider Collaboratives to plan and quality assure care for people who originate from HNY area with the continued aim to improve services for people with a diagnosis of mental illness, learning disability and autism.
- Overall Contract management, including quality assurance across NHS and independent sector.

Reflecting HTFT's role, both as a provider of health and social care within the Collaborative and as a commissioner of the overall Collaborative, there are clear governance framework in place which ensure clear delineation of the two functions. All members of the committee who are employed by HTFT as a provider declare their interest at each meeting and any sensitive information shared and discussed at the meeting is dealt with appropriately.

2. Delivery of functions delegated by Board

Functions within ToR	**Evidence to support delivery**	**Outstanding issues / action plan**
Financial planning Provide assurance to the HTFT Board that the planning programme is effectively established and managed and that risks to delivery of the plan and any significant service impacts, or risks are effectively managed or mitigated. Along with PCOG and with Financial Risk and Gain Share partners review in year performance against commissioned services and financial plans and examine the effectiveness of any remedial action plans. Provide assurance to the HTFT Board (as lead provider) on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money.	Financial reports for each work stream area and projected financial position are shared at each committee for information and discussion. During 2023/24 new investment into CAMHS alternatives to hospital in North Yorkshire (Mill Lodge new day care service) and York. HNY PC received new 1 year funding from NHS England for CAMHS alternative to hospital in Humberside. Development of new	*During 2023/24 HNY Provider Collaborative and members of CPaQT continued to engage with HNY ICS to identify and implement more cost-effective capacity/arrangements.* *HNY PC 2024/25 priorities will be shared with HNY ICS to seek further options for improving care pathways.*

	eating disorder service at Inspire which has reduced the use of out of area beds. Increased funding to the Yorkshire and Humber Involvement Network (service user involvement). Due to temporary closure of Nova at Inspire – reducing in contract value to reflect current bed availability.	
Transactional Following review and approval at PCOG; will ratify business cases (for both new service proposal and reduction of service delivery) and investments and/or disinvestments - provide financial assessment and scrutiny which will then be translated into contractual agreements which are held by the Lead Provider	Following development of business cases by workstreams and support at PCOG new investment ratified for: • FREED (adult eating disorder) Champion investment across Humberside • Yorkshire and Humber Involvement Network • New investment into CAMHS alternatives to hospital in North Yorkshire (Mill Lodge new day care service) All improve patient care and outcomes and have been built into 2023/24 contracts with Providers	*Adult Secure bed modelling work completed in 2023/24* *Each workstream is reviewing 2024/25 priorities – working alongside all inpatient, community and place health and social care partners. With our continued aim to reduce health inequalities and improve patient care.* *All workstreams will also have a priority on 'best use of resources' for 2024/25*
Contracting To be assured that contracts are in place to address risk in relation to the quality and performance of commissioned services and thereby	Lead Provider Contract signed by HTFT. Sub-contracts and lead provider to lead provider contracts have	*Continue to work closely with NHS England on timely sharing of Contract Variations.*

undertake the duties as expected of the Lead Provider. Following discussion and approval at PCOG will ratify and enact Contract Variations and necessary formal Commissioning Intentions dialogue with Provider Collaborative	been shared with partners and other provider collaborative. Sub-contract performance and quality meeting have commenced with partners in the collaborative Contracts register is held on HTFT system Intend (moving to Atamis early 2024) New Contracts Lead appointed following previous candidate leaving post.	*Contract negotiations with all providers commencing February 2024 – following financial planning round.*
Risk Management: Each work stream is responsible for its own specific Risk Register. Risks rated at 12 or higher will be shared at the 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 to, the HTFT Risk Register	All work stream risk registers are held on DATIX. Each work stream has its own risk register which the work stream have responsibility for reviewing and updating at each work stream meeting by all partners. Each work stream will review its own risk register at every work stream meting and in addition the CPaQT members meet every 2 months to review all the risk registers to ensure consistency of approach and to undertake peer review of each work stream risks.	*None Identified*
Quality Assurance To be assured that quality, clinical governance, patient, and public engagement issues are appropriately addressed in all service developments/reconfiguration of	Information and reports are shared at each meeting to ensure oversight. There is a Quality Assurance and Oversight work stream	*Continuously review and improve the consistency of reporting from the three workstreams –*

services and are in line with statutory requirements, national policy, and guidance.	as part of the Provider Collaborative governance framework. Following increased Case Manager capacity in 2022 6-8 inpatient review has been at 95-100% during 2023. Bi Annual and Annual quality assurance visits are complete. New system of Routine and Routine plus quality monitoring of HNY providers has been introduced. New Business Intelligence reports including weekly snapshot have helped with quality assurance and monitoring.	*seek ways to learn and improve reporting.*

3. Attendance

3.1 The Collaborative Committee met on 5 occasions during 2023/2024

Members:	No of meetings attended
• Non-Executive Director (Chair)	*5/5*
• Associate Non-Executive Director (left August / September 2023)	*3/3*
• Non-Executive Director	*4/5*
• Chief Executive (Vice Chair)	*3/5*
• Executive Director of Finance/Senior Information Risk Owner	*4/5*
• Director of Nursing, Allied Health and Social Care Professionals	*2/5*
• Collaborative Planning Director – CPaQT	*5/5*
• Clinical and Quality Director – CPaQT	*3/3*
• Assistant Clinical & Quality Director – CPaQT (in absence of Clinical & Quality Director being in post)	*3/5*

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.

All members have contributed positively, and all have asked relevant questions and provided suggestions to ensure positive progress and outcome.

At our effectiveness review in March 2024, comments from members included:

Effective committee with a Chair who encourages discussion which enables all members to participate freely.

I agree meeting is chaired well, papers are of high quality, presentations/ updates from specialists are good and helpful.

The Collab Committee has been a working progress and it feels at this time that it is where it needs to be in terms of the level of reporting to the Committee, the information discussed, outcomes, regularity of meetings and time keeping within the meetings.

3.3 Include any recommendation for change to membership & reasons why

None Identified

4. Quoracy

The Committee was quorate on all occasions the committee met. (

From the ToR:
The quorum necessary for the transaction of business and decision making is three (3) members including.

1 Non-Executive Director and 1 Executive Director – one of whom must be the Chair or Vice Chair

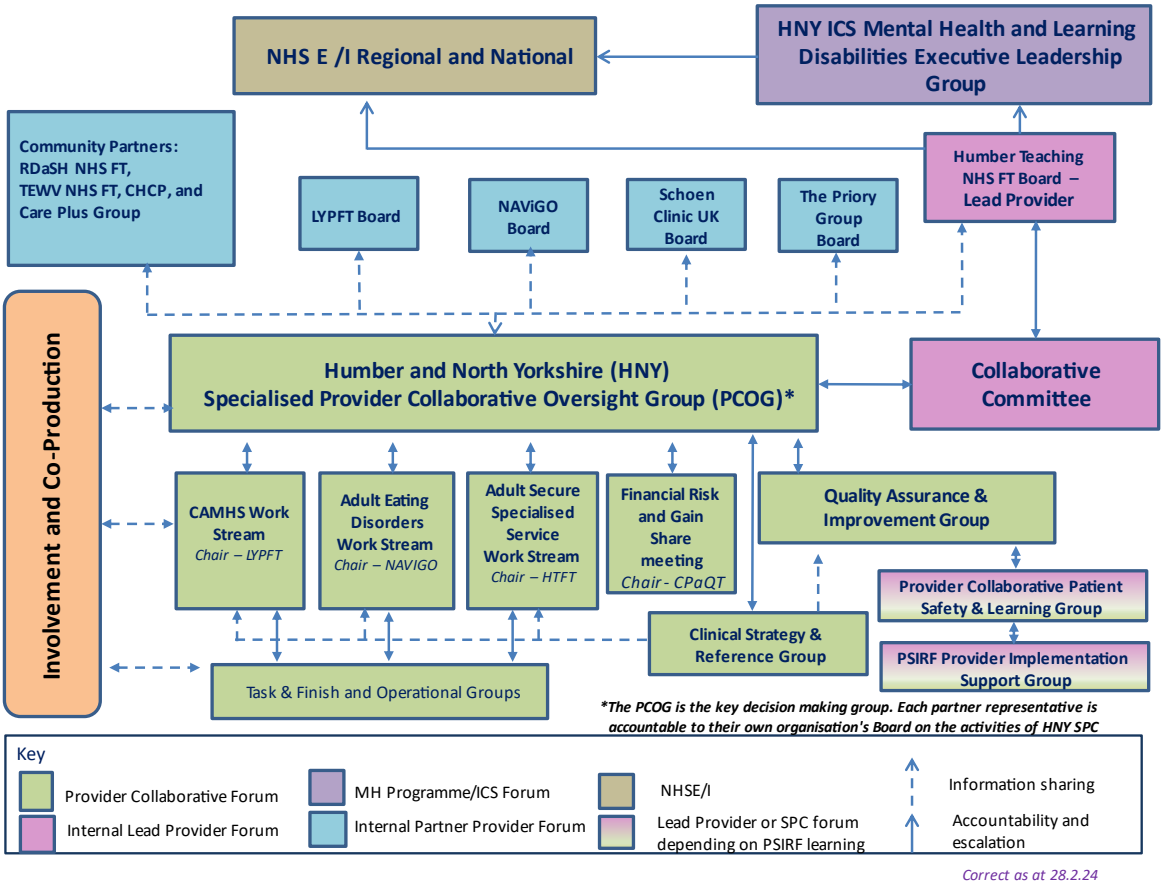
Decisions will be reached by consensus. If a decision cannot be reached by consensus, then it will be escalated to the Humber Teaching NHS FT Board for resolution.

5. Reporting / Groups or Committees

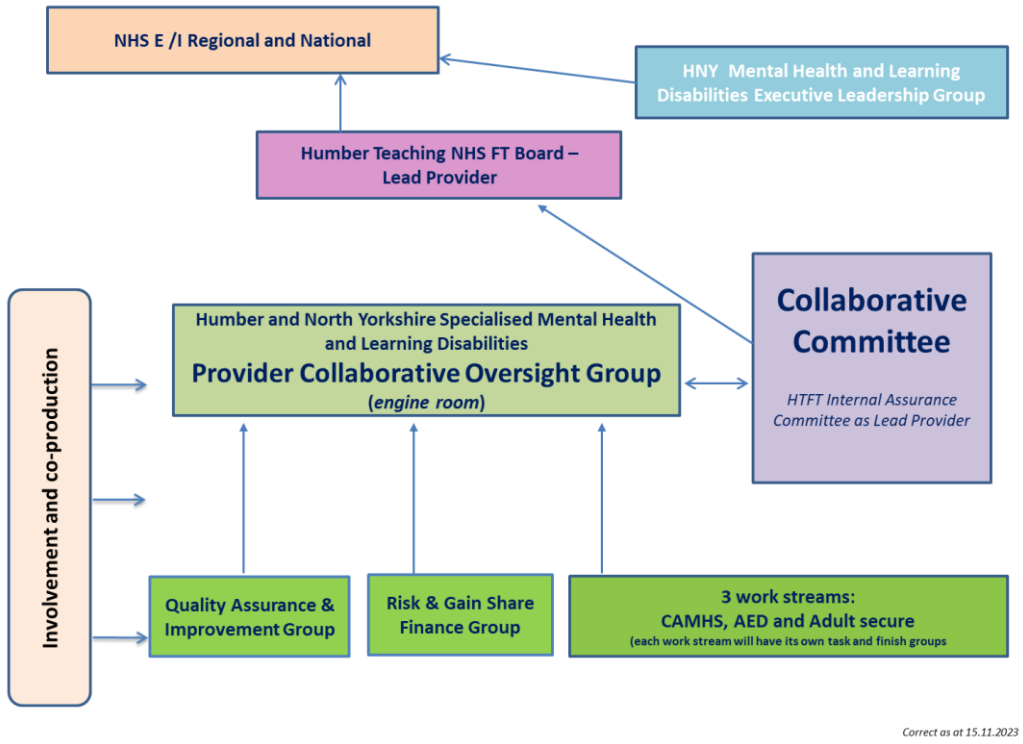
Which groups report to Collaborative Committee *(these should be clearly identified on the schematic on your ToR)*. Please list:

Whilst the Provider Collaborative Oversight Group does not report to the Collaborative Committee there is a link between the 2 meetings and within the Provider Collaborative Partnership Agreement it is acknowledged that the Collaborative Committee ratifies and enacts decisions and recommendations from the Provider Collaborative Oversight Group.

The schematic below shows all the groups and work streams within the Collaborative and reporting – this is part of our Partnership Agreement and governance.



The schematic below demonstrates the Governance Process for the Humber Teaching NHS Foundation Trust.



Has the Committee approved the Terms of Reference for each of these groups?

As per the schematic the sub-groups do not formally report to the CC. However, for transparency the Committee received and reviewed all the 3-work stream Terms of Reference, Quality Assurance and Improvement Group Terms of Reference and the PCOG Terms of Reference.

Are Terms of Reference annual reviews for each reporting group on your Committee workplan to approve?

As per the schematic the sub-groups do not formally report to the CC. However, for transparency the Committee received and reviewed all the 3-work stream Terms of Reference, Quality Assurance and Improvement Group Terms of Reference and the PCOG Terms of Reference.

Has the Collaborative Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance?
Yes work stream reports and Chairs Logs are shared at each Collaborative Committee meeting.

Has Collaborative Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2023/2024?

Yes [ ] No [X]

The work stream groups do not report directly to the Collaborative Committee. These are groups which are part of the Specialised Provider Collaborative, they are not committees of HTFT and do not produce an annual assurance report.

However, the Provider Collaborative overall does produce an annual report which is shared with NHS England as part of our contractual agreement. The 2022 Annual report was produced and shared with all partners, including HTFT Board members in May 2023.

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
  CC work plan reviewed during 2023/24 and updated to reflect meetings moving to quarterly

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*

  Yes
  However, on occasion papers have been scheduled on the day or shared 2 days before hand. This has been by exception and only where appropriate.

- *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

The terms of reference were reviewed by the Collaborative Committee in March 2024 and a copy has been shared with the HTFT Head of Corporate Affairs.

CC ToR FINAL MARCH 2024.docx

8. Workplan for 2022/23

Has a workplan for the year ahead, 2024/2025 been prepared?

Yes [X]

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

If any, please summarise in bullet point format below

The Collaborative Committee reviewed the effectiveness at the meeting on 1 March 2024. In addition, committee member have received and completed the SELF-ASSESSMENT CHECKLIST (2023/24). It is noted that membership of the committee will change due to change in Non-Executive Directors.

In addition, the committee agreed to add the following objectives:

- Work at system level and include outcomes which we want to achieve and can monitor:
- Reduce out of area bed usage.
- In area improved alternatives to hospital pathways
- Reduce use of in-patient admissions overall

So that the committee can review in February 2025 the effectiveness of the committee work during 2024.

Summary of views from Collaborative Committee members -

WORKED WELL

It is clear that members of the committee have read the papers prior to the meeting and have appropriate questions, comments and challenge during the meeting.

Effective committee with a Chair who encourages discussion which enables all members to participate freely.

Good meeting, positive progress being made on agenda and discussions.

I agree meeting is chaired well, papers are of high quality, presentations/ updates from specialists are good and helpful.

The Collab Committee has been a working progress and it feels at this time that it is where it needs to be in terms of the level of reporting to the Committee, the information discussed, outcomes, regularity of meetings and time keeping within the meetings.

NEXT STEPS TO IMPROVE FURTHER:

My only suggestion for improvement is to ask if there's any possibility of provider representatives meeting us (probably virtually) at some time?

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

NHS
Humber Teaching
NHS Foundation Trust

Humber Teaching NHS Foundation Trust
Provider Collaborative Committee

Terms of Reference Updated for 2024 – Draft Version 0.1

Constitution & Authority	Humber Teaching NHS Foundation Trust (HTFT) is the Lead Provider within the Humber and North Yorkshire (HNY) Provider Collaborative (PC) and will hold the Lead Contract with NHS E/I. HTFT 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. As detailed in the *NHS Mental Health Implementation Framework*, from April 2020 NHS England and NHS Improvement aim to mainstream the New Care Models approach for specialised mental health, learning disability and autism services, enabling local service providers to join together under NHS-led Provider Collaboratives. The Collaborative Committee has been established by the Lead Provider as an internal committee to provide assurance to the HTFT Board as Lead Provider within the Collaborative in relation to Contracting, Planning and Quality Assurance functions of the Provider Collaborative. These functions have been traditionally grouped under the label of 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 Provider Collaborative Oversight Group (PCOG) is the forum in which we come together as a Partnership with collective expertise in provision, planning and quality assurance. The PCOG holds collective accountability and responsibility to steer the strategy and support the operational delivery of the Provider Collaborative programme across the partnership in line with the principles and requirements of the partnership agreement on clinical quality and business requirements.

	The Collaborative Planning and Quality Team (CPaQT); reporting to PCOG ~~the provider Collaborative Oversight Group~~ and the Collaborative Committee, is an enabler supporting all partners within the Collaborative to ensure appropriate health care services are commissioned to serve the needs of the HNY population and in so doing, improve the efficiency, effectiveness, economy, and quality of services, reduce inequalities, and promote the involvement of patients, our partners, and the public alike in the development of our services. The Collaborative Committee will provide overview to enable HTFT to meet its legal and statutory requirements as the HNY PC Lead Provider and will operate within the delegated powers to complete any activity within the parameters of these Terms of Reference. The Committee will have 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 finance, quality assurance and performance ensuring delivery of the overall HNY Specialised Provider Collaborative aims to transform care for people in low and medium secure mental health services, CAMHS in-patient and Adult in-patient eating disorders services. Day to Day provision of patient care is the responsibility of Providers within the Provider Collaborative Partnership. Services will be commissioned utilising NHS Standard Contracts with clear Key Performance Indicators (KPIs) and Outcomes. Via the PCOG the Collaborative Committee will take a partnership approach to working with Providers within the Provider Collaborative to deliver our overall strategic aims which are to improve care pathways and patient care outcomes. The Provider Collaborative 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 through formal contracting and commissioning arrangements. This approach will ensure delineation between the Provider Partnership and Commissioning functions of the Provider Collaborative and enable our overall partnership to be conducted in an open and transparent way and follow due process.
Scope & Duties	The objectives and duties of the Committee are to: • As Lead Provider provide assurance to the HTFT Board – that it is fulfilling its duties and obligations within the HNY Specialised Mental Health Learning Disability and Autism Provider Collaborative

	• Be assured that there are appropriate arrangements in place in respect of Serious Incidents, Safeguarding and a system is in place to ensure quality of care and to continuously learn and improve • Working closely with PCOG linking in with the wider commissioning, planning and quality assurance system including other Provider Collaborative and local and national commissioners to improve services along whole pathways of care and manage pressures within the wider system • Overall Contract management, including quality assurance across NHS and independent sector. This will be the first line of arbitration/mediation between partners Specific responsibilities *Financial planning* ❖ Provide assurance to the HTFT Board that the planning programme is effectively established and managed and that risks to delivery of the plan and any significant service impacts or risks are effectively managed or mitigated ❖ Along with PCOG and with Financial Risk and Gain Share partners review in year performance against commissioned services and financial plans and examine the effectiveness of any remedial action plans. ❖ Provide assurance to the HTFT Board (as lead 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 support by the Provider Collaborative Oversight Group~~ review and approval at PCOG; will ratify business cases (for both new service proposal and reduction of service delivery) and investments and/or disinvestments - provide financial assessment and scrutiny which will then be translated into contractual agreements which are held by the Lead Provider *Contracting* ❖ To be assured 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 Lead Provider. ❖ Following ~~agreement~~ discussion and approval at PCOG will ratify and enact Contract Variations and necessary formal Commissioning Intentions dialogue with Provider Collaborative *Risk Management:* ❖ Each work stream is responsible for its own specific Risk Register. Risks rated at 12 or higher will be shared at the PCOG and Collaborative Committee. ❖ The Collaborative Committee will review Risk Registers and will suggest modifications to the risk registers, including

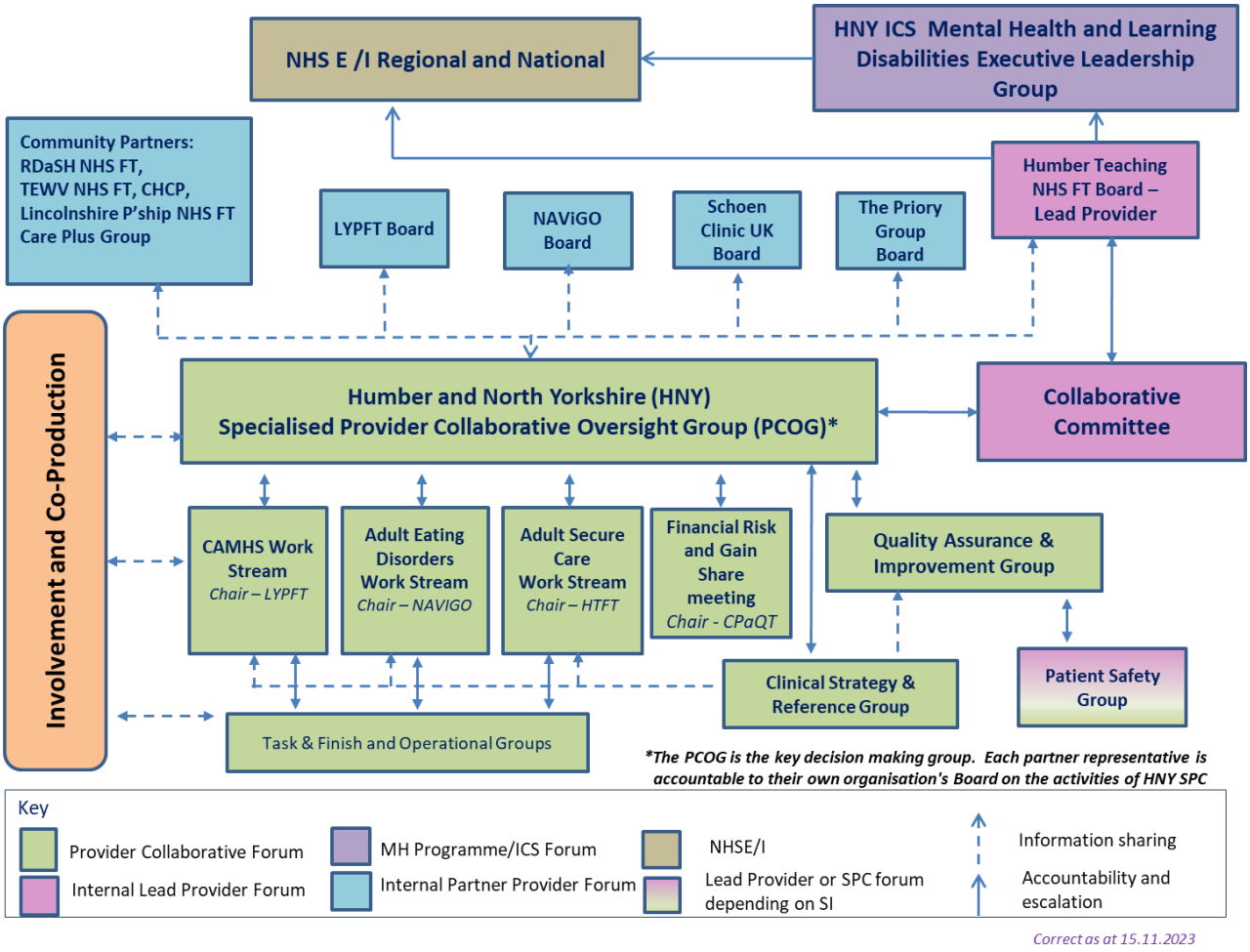
	ownership and delivery of action plans against defined timescales ❖ Discuss and review of any issue likely to require inclusion ~~on, or modification~~ to, ~~any risk register~~ the HTFT Risk Register *Quality Assurance* ❖ To be assured that quality, clinical governance, patient and public engagement 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 minutes and/or reports from sub-groups of the PCOG and the PCOG itself – for review and overall assurance. The Collaborative Committee will have relationships 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 the 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 ▪ ~~HNY Integrated Care System~~ ▪ ~~NHSE/I~~ ▪ 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 • Associate Non-Executive Director • Chief Executive (Vice Chair) • Executive Director of Finance/Senior Information Risk Owner • Director of Nursing, Allied Health and Social Care Professionals • ~~Programme Lead – Collaborative – Planning and Quality Team~~ • Collaborative Planning Director • ~~Clinical Director~~ • Clinical and Quality Assurance Director
Attendance	**HNY Provider Collaborative Planning and Quality team** • ~~Quality Assurance and Improvement Lead~~ Assistant Director of Clinical and Quality Assurance • Head of Secure ~~Commissioning~~ Planning

	• Head of CAMHS and Adult Eating Disorder ~~Commissioning~~ Planning • Finance Manager • Head of Lived Experience and Involvement ~~Expert by Experience~~ **Clinical Work Stream Leads (as per specific agenda items)** • Clinical Lead, Adult Secure • Clinical Lead, Adult Eating Disorders and CAMHS • ~~Clinical Lead, CAMHS inpatient Care~~
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 will be chaired by HTFT Non-Executive Director. Vice-Chair will be Chief Executive, HTFT, to deputise for the Chair when necessary.
Frequency of meetings	Meeting will be held monthly, however frequency may increase during the annual planning cycle to ensure that the work undertaken by the Collaborative Planning and Quality Team are timely, reflecting the fast pace nature of contract negotiations. Meetings may be held in person or utilising technology (Microsoft Teams)
Accountability and Reporting Arrangements	The Collaborative Committee is responsible for providing an assurance report and the minutes after each Collaborative Committee meeting this will be to Part 1 of the Trust Board on its areas of responsibility of commercial confidentiality identified areas for Part 2 of The Board Members will be invited to declare any conflicts of interest.
Agenda & Papers	The ~~Business Manager or Programme Lead~~ 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 ~~Collaborative Planning and Quality Team Secretary~~ 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)	Initial ToR Approval December 2022
HFT Board Approved (Date)	Revised 2023 ToR approved25 January 2023 new date to be added for 224 approved
Review Date	December 2024

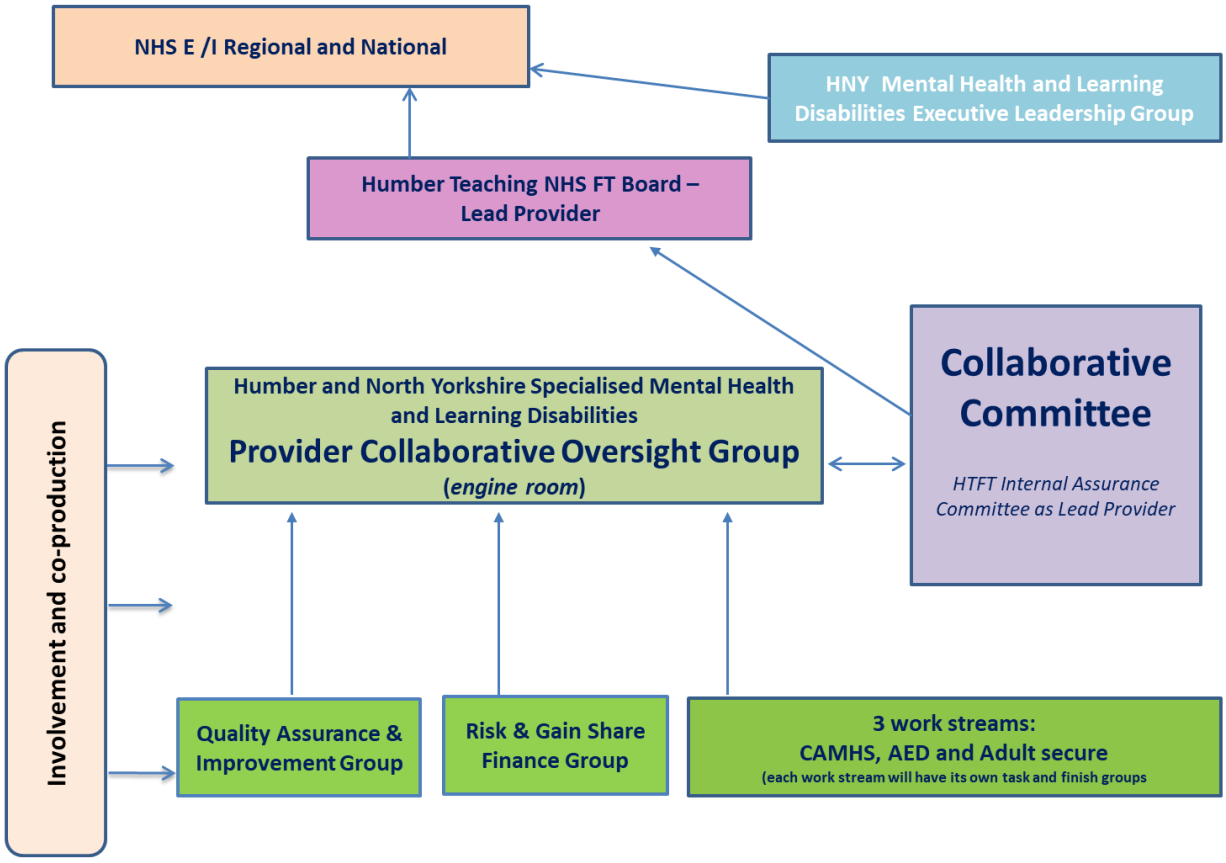
Reporting Schematic:

Overall Provider Collaborative Governance Framework



Correct as at 15.11.2023

Lead Provider Delineation Governance Framework



Correct as at 15.11.2023

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.

In addition, we have specific Vision, Mission and Goals for our Planning and Quality Assurance work –

Our Vision (where we are going)
We will be effective and innovative planners of positive health outcomes by delivering the principle of care is provided within the least restrictive environment.
We will commission robust care pathways for our population working in partnership with (NHS, Independent Care providers, voluntary sector, and social care). We will enable people to feel empowered to care for themselves and remain independent for as long as possible.

Our Mission (why we are here)
We commission safe, accessible, high quality services to improve the health outcomes and meet the clinical needs of the people of Humber and North Yorkshire.

Our Goals (how we will get there)
- Safe, Accessible, High Quality Health Outcomes
- Seamless Alliances and Integration
- Empowering Staff to deliver the high-quality care
- Responsible Use of all Resources available

Values (how we will behave)
- We *Do the Right Thing* by making decisions that are clinically safe
- We *Acknowledge Difficulties* and seek creative solutions
- We *Empower Staff* by encouraging them to be innovative, receptive to change and courageous in the way they work
- We are *Caring and Compassionate* by always putting the person at the heart of all decision making.
- We are *Approachable, supporting our Commitment* to our people who access services
- We *Acknowledge and Promote* the work of our colleagues and partners
- Planning and Care Provision are a partnership, and We *Listen to and Support* each other
- We work *Openly and Transparently*

Humber Teaching NHS Foundation Trust

MENTAL HEALTH LEGISLATION COMMITTEE

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

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.

1. Executive Summary

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

- The Committee undertakes its delegated function on behalf of the Trust Board in relation to the discharge of duties and responsibilities under the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and all other mental health related legislation. The Committee achieved its objectives for 2023-24 and delivered the functions delegated by the Board as outlined in section 2 below.
- The Committee had oversight of various policies/procedures. It also noted various other Standard Operating Procedures (SOPs) and policies reviewed or amended and approved via the MHL Steering Group. The Committee received assurance that all Mental Health Legislation policies were up-to-date.
- Received MAPPA presentation – development of SPOC (single point of contact) in the divisions, MAPPA section on intranet gives easy access to updates and archived material, MAPPA level 4 (terrorists) guidance now complete. MAPPA Update received - Overall continue in good position in relation to MAPPA requirements, receiving really positive feedback. Trust asked to provide increased training for Humberside Police; this indicates an increasingly positive working relationship that will benefit patients.
- Mental Health Legislation Committee Terms of Reference reviewed.
- Reducing Restrictive Interventions (RRI) terms of reference reviewed, Mental Health Legislation Steering Group terms of reference reviewed, and Associate Hospital

Managers' Forum terms of reference presented as part of Committee Effectiveness Review paper.

- Mental Health Legislation Committee Effectiveness Review paper and workplan approved.
- Received regular Mental Health Legislation Quarterly Performance reports and noted no obvious outliers with regards to key metrics. The Committee noted how there has positively been only one use of section 4s for a number of months and that the commentary on the use of section 4 had been wholly appropriate. Useful discussion with regards to whether section 2 is less restrictive than section 3. Applied CTOs has remained fairly static; noted a number of patients on recurrent CTOs sometimes two or three within a month. Absent without leave (AWOLs) – noted difficult situation when patients refuse to return after leaving the unit for a smoke break. Benchmarking data, although not to be relied upon for comparisons, proved helpful but going forward will be useful to correlate detentions against bed numbers. Work on out of area bed use across mental health providers in our Integrated Care System (ICS) is taking place through the mental health, learning disability and autism collaborative and we are fully engaged in this programme.
- Section 136 - link made with right care right person in conjunction with Humberside police. This work is in national spotlight, though section 136 detentions remain high, noted police now release within one hour.
- Committee noted section 136 working group looking at how to reduce the use of section 136 and there's an aspiration to find alternatives that are more in line with patient needs, along with report on Right Care Right Person (RCRP):
    - MOU (Memorandum of Understanding) in place to make sure everyone works to the same principles.
    - Robust mechanisms in place to escalate concerns on identifying instances where staff stray from those principles and raise with Crisis Care Concordat to make sure the partners get it right for patients.
- Received reports on Community Treatment Orders (CTO) - cross reference our Trust processes with CQC recommendations from their focused visits report – good assurance and improvement in completing the Z48 on admission with 81.25% compliance rate.
- Received detailed insight reports highlighting relevant documents of interest and updates regarding mental health legislation. For example:
    - Liberty Protection Safeguards (LPS) implementation date delayed until after the next general election
    - Care Quality Commission - Monitoring the Mental Health Act in 2020/21, in particular lack of understanding regarding the implementation of Deprivation of Liberty Safeguards (DoLS) and use of blanket restrictions.,
    - Case (Ordinary residence and section 117) – Worcestershire Judgement
    - Rapid Review into data on mental health inpatient settings 28.06.23 - Department of Health & Social Care - discussions took place about the recommendation for half of Non-Executive Directors (NEDs) to be trained as Associate Hospital Managers (AHM).

  - Putting into practice the principles of the Mental Health Act reforms: a national quality improvement (QI) programme
  - Putting into practice the principles of the Mental Health Act reforms: a national QI programme - Medical Director receives coaching once a month and Psychiatric Intensive Care Unit (PICU) staff receive weekly coaching sessions looking at different ways of supporting patients from diverse backgrounds. Also looking at ways to embed learning across the Trust.
  - Restraint Reduction Network (RRN) Blanket Restrictions Resource Toolkit
  - Baroness Hollins final report '*My Heart Breaks'* published 08.11.23 - Independent Care (Education) and Treatment Review 2019 to 2023. The report summarised findings about the national use of long-term segregation for autistic people and those with a learning disability. In terms of the recommendations, Humber already has very robust monitoring mechanisms in place for anyone restricted in this way.
- Received regular RRI quarterly reports. Good assurance with the case studies which present a helpful context for reducing restrictive practices approach. Reports informed committee that data is within normal variations overall. Benchmarking e.g. prone restraint compares well with the restraint reduction network. High percentage training compliance, high acuity. Co-production service users at heart of this work and RRI group will continue this focus. Use of Force dashboard data included in report, which shows real time data at ward level. National Reducing Restrictions Network publication toolkit to reduce blanket restrictions; pilot at Inspire and Newbridges to adapt to suit adult mental health, RRI group monitoring. Key actions for quarter 4:
  - Training
  - Use of force policy review
  - Piloting use of safety pods on Avondale and Section 136 suite
  - RRI quality improvement plan review
  - Prone restraint – whilst majority are administration of medication, we continue to monitor and are looking at other appropriate plans in place as alternative to have medication in prone position.
- Committee received presentation on Safewards: Ongoing Safewards initiatives - supports reducing restrictive practices and interventions. Family and carers involved – Safewards lead is working on PBS plans part of co-production group, this work has received the co-production stamp.
- Associate Hospital Managers Annual Progress Report noted - positive diversity intervention resulting from the task and finish group and the face to face hearings reinstated if patient chooses / requested.
- Committee received reports on completion of Z48 (capacity to consent to treatment form) - position improving, required timescale for completion reduced from 7 to 3 days, with improved monitoring and further analysis by registrar who carried out a re-audit. Robust reminder system in place to ensure Z48s completed within the 3 working day timescale. Z48 form guidance has been updated and recirculated to all Consultants and they have been offered individual support by the Mental Health

Legislation Team to aid completion. Further audit to include context/process, data by percentage and timescales (how far overdue).

- Mental Health Legisltation Committee Annual Review paper received and approved.
- Committee received positive assurance from the Mental Health Legislation steering group minutes and it was also reported that only outstanding actions from CQC MHA visits were in relation to seclusion room environments – work currently underway on all adult mental health inpatient settings.
- Summary of Ligature Anchor Point Annual Report noted.

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
To have oversight of Trust-wide policies and procedures relating to Mental Health Legislation.	Minutes detail policies and procedures approved, and also detail regular updates on status of required policies in line with the Mental Health Act Code of Practice.	Policy plan approved and adhered to.
To receive reviews of assessment reports and recommendations from external bodies relating to Mental Health Legislation in the Trust.	CQC reports and visits included within MHL subgroup report. Action tracker for requirements and evidence available for in-depth scrutiny.	To continue to monitor compliance and evidence logs for CQC MHA action plans.
To monitor key indicators capable of showing Trust compliance with Mental Health Legislation.	New style report for performance monitoring of key indicators. Discussed and analysed quarterly at committee following scrutiny at steering group.	Ongoing review of current statistical presentation of data in performance report - continued use of statistical process control (SPC) charts. Now includes comparisons with similar sized Trusts.
To receive regular data on key indicators underpinning delivery of the Trust's duties and responsibilities under Mental Health Legislation.	Ward level MHA audits are completed on My Assurance monthly. Deep dive MHA audit completed annually on every ward by Mental	Audit results reported via the Mental Health Legislation Steering Group and action taken where necessary.

	Health Legislation team.	
To receive minutes and/or reports from the Mental Health Legislation (MHL) Steering Group and the Associate Hospital Managers' (AHM) Forum.	MHL Steering Group minutes submitted to Committee and summary of AHM Forum minutes provided in subgroup report.	MHL Steering Group minutes presented for information and AHM summary of key issues arising included in Committee update.
To regularly review the Board Assurance Framework (BAF).	Minutes detail discussion of BAF in each Committee.	To continue to review and monitor.
Where appropriate to commission specific pieces of work and audits relating to Mental Health Legislation	RRI work - quarterly improvement reports against restrictive practices received by MHLC quarterly	To continue to review and monitor.

3. Attendance

3.1 The Mental Health Legislation Committee met on four occasions during 2023/24- May, August & November 2023 and February 2024 - three chaired by Mike Smith and one by Dean Royles on 3 August 2023. The meetings have benefitted from Dr Kwame Fofie, (Medical Director) leading on reporting and providing clinical leadership to the Committee and also the new Clinical Director, Mr Paul Johnson, who has provided the clinical leadership at Committee meetings in relation to reducing restrictive interventions.

Members:	No of meetings attended
Non-Executive Director, Mike Smith	*4/4*
Non-Executive Director, Dean Royles	*3/4*
Non-Executive Director, Phillip Earnshaw	*4/4*
Interim Executive Medical Director, Dr Dasari Michael (November 23)	*1/1*
Executive Medical Director, Dr Kwame Fofie	*3/4*
Executive Director of Nursing, Allied Health and Social Care Professionals / Caldicott Guardian, Hilary Gledhill	*4/4*
Deputy Chief Executive and Chief Operating Officer, Lynn Parkinson	*4/4*
Mental Health Act Clinical Manager, Michelle Nolan	*4/4*
Mental Health Legislation Manager, Sara Johns	*3/4*
RRI Lead (Clinical Director), Paul Johnson	*2/4*

Local Authority Representative (East Riding Local Authority), John Heffernan	*2/4*
Local Authority Representative (Hull Local Authority), Caron Hodgson	*1/4*
Named Nurse for Safeguarding Adult/MCA Lead, Rosie O'Connell	*3/4*
Kirsten Bingham (AMHP Service Lead)	*3/4*
Consultant Psychiatrist, Joanne Watkins	*3/4*
In addition to the members list Ms Kate Yorke (Associate Director of Psychology) attended the MHLC in May 2023 for item 6 and November 2022 for item 4; Caroline Flint, Trust Chair, attended on 02 November 2023; Mrs Stella Jackson (Head of Corporate Affairs) observed the meeting in November 2023; Ms Tracy Flanagan, (Assistant Director of Nursing and Quality) and Ms Dani Wilkinson, (Professional Nurse Educator and Safewards Mental Health Divisional Lead) attended on 1 February 2024 for item 5; Ms Janani Jaganathan, (Higher Trainee/ Specialty Registrar ST4/SpR4), Ms Priyanka Perera, (Associate Non-Executive Director), and Mrs Stella Jackson (Head of Corporate Affairs) observed the meeting on 1 February 2024.	

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.

The membership composition is effective and all members have contributed well. The importance of regular representation from Hull Local Authority is being progressed again as it is valuable to have their input and advice in order for all providers to maintain and develop effective services and good practice. As they have the legal responsibility for ensuring appropriate coverage for AMHPs in Hull, their input is important.

3.3 Include any recommendation for change to membership & reasons why

Following Dr Kwame Fofie taking up his post as Executive Medical Director, Dr Joanne Watkins has attended subsequent Committees as Medical representative. Paul Johnson, current RRI lead, will continue attending the meetings as the new Clinical Director however a new RRI lead will be appointed to attend.

4. Quoracy

The Committee was quorate on all four occasions.

5. Reporting / Groups or Committees

Which groups report to Mental Health Legislation Committee? *(these should be clearly identified on the schematic on your ToR)*. Please list:

- Mental Health Legislation Steering Group.
- Associate Hospital Managers' Forum

- Reducing Restrictive Interventions Group

Has the Committee approved the Terms of Reference for each of these groups?
Yes [✓] No [ ] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [✓] No [ ]

Has the Mental Health Legislation Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [✓] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

The Mental Health Legislation Committee has received sufficient assurance that its reporting groups are operating effectively. The Mental Health Legislation Steering Group is working effectively, and all meetings in this annual period were quorate. In respect of mental health legislation, the Steering Group has an important role giving operational input to the Committee. The Clinical Director has the task of chairing and overseeing attendance at the Steering Group. A summary of the minutes from this meeting is provided; however, provision of the minutes from the Mental Health Legislation Steering Group, along with other areas of mental health legislation provides the Committee with the required level of assurance.

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. A task and finish group was established early 2023 looking at increasing the diversity of hospital managers and this work has come to fruition with the appointment of two individuals from a younger age bracket who should bring in new perspectives, particularly for our Child and Adolescent Mental Health (CAHMs) patients, and also 2 other people of diverse ethnic backgrounds. The Committee recommends the appointment / re-appointment of AHMs for periods not exceeding 3 years.

Has Mental Health Legislation Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2022/23?
Yes [✓] No [ ]

Committee receives an annual Associate Hospital Managers Report but the Steering Group reports quarterly. The Committee no longer receives an annual RRI Report as this is again produced quarterly.

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?*
    - A work plan, as outlined in the Cycle of Business, was agreed at the start of the year and meetings and agendas have been appropriately scheduled to meet that.

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*
    - The reports and papers presented have been of a high quality and prepared in time for issue 5 working days ahead of the meeting.

- *Is the quality and timeliness of the minutes satisfactory?*
    - The quality and timeliness of the minutes are of a very good standard.

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

    - An action log has been maintained and actions are clearly recorded, assigned to individuals with timelines and followed through.
    - Relationships have been established with the Quality Committee and issues have been cross referenced between committees e.g. ligature anchor point annual audits. This avoids duplication and aids escalation.
    - Insight report provided, combining themes and issues report with publications and policy highlight report. This has established a contextual backdrop at each meeting.
    - Strong relationships with clinicians and Mental Health Teams.
    - Mental Health Legislation Committee taken as the authoritative voice on issues, taking a sophisticated view looking at both the external world and internal processes and seeking to understand and act upon issues.

7. Review of Terms of Reference

Chair to summarise any recommended changes to the committee's terms of reference in light of the annual evaluation.

The Terms of Reference were reviewed by the Mental Health Legislation Committee in May 2024 as part of Committee Effectiveness Review. These are attached for approval and track changes have been used to outline the proposed changes.

8. Workplan for 2024/25

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

Yes [✓] No [ ]. *If no, when will it be presented to your committee?* _____

Humber Teaching
NHS Foundation Trust

Terms of Reference

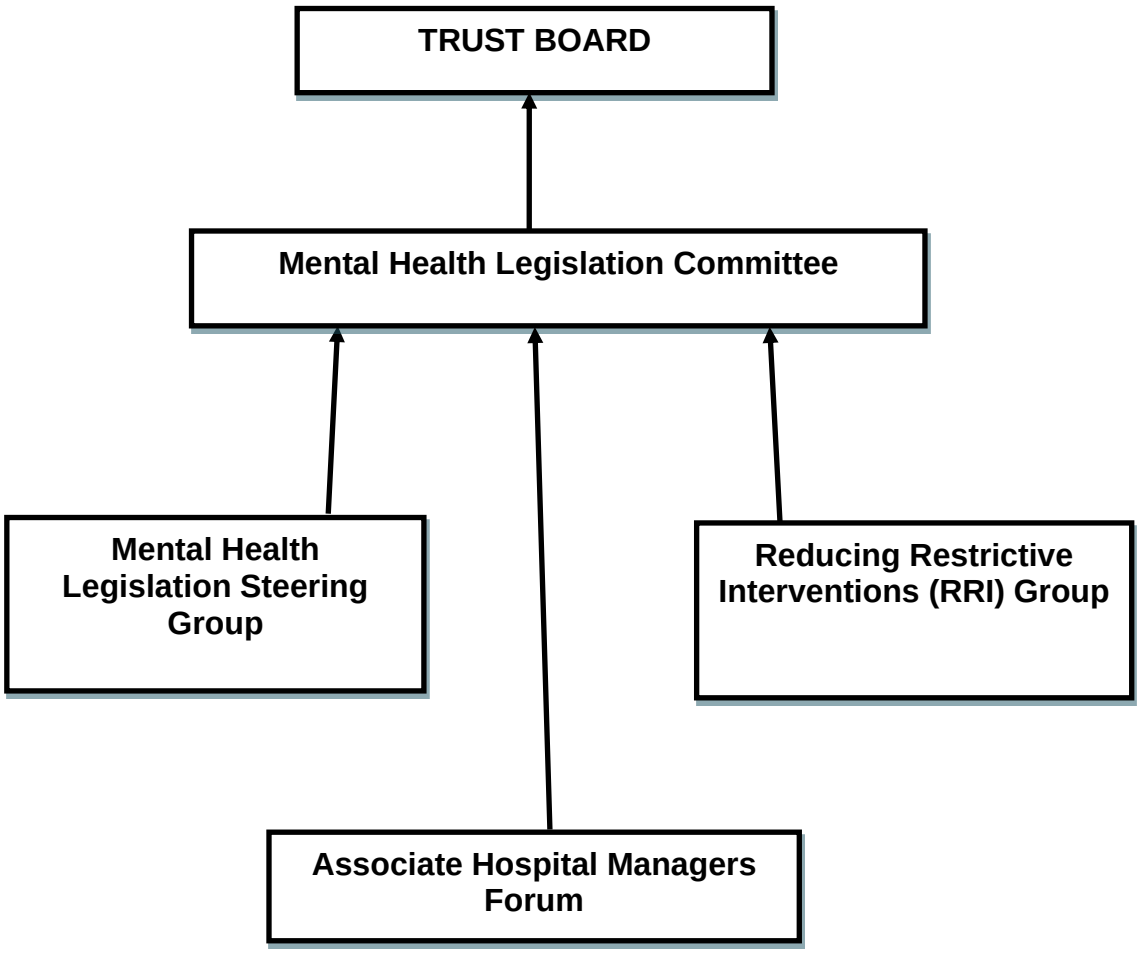
Mental Health Legislation Committee

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 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 ~~• Clinical Lead for RRI~~ ~~• Mental Health Act Clinical Manager~~ ~~• Mental Health Legislation Manager~~ ~~• Named Professional for Safeguarding (Adults), MCA and Prevent Lead~~ ~~• Hull AMHP Lead~~ ~~• Local Authority representation covering the Humber area~~ The ~~Committee will have~~following will be required / invited to attend the meetings ~~in attendance~~: • Clinical Lead for RRI • Mental Health Act Clinical Manager • Mental Health Legislation Manager • Named Professional for Safeguarding (Adults), MCA and Prevent Lead • Hull AMHP Lead • 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. 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 (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 ~~presented to the Confidential Board, whilst~~ a Committee Chair~~the~~ assurance report will ~~go~~ be forwarded to the Public Board. ~~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.~~
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	~~04 May 2023~~02 May 2024
Board Approved	~~31 May 2023~~
Review Date	~~May 2024~~May2025

MENTAL HEALTH LEGISLATION COMMITTEE REPORTING STRUCTURE



AUDIT COMMITTEE

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

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, in particular Strategic Goal 3, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

1. Executive Summary

Chair of Committee to complete.

In terms of the reference to the objective for 2023/24 it was, "to keep this standard of work up, making incremental improvements as opportunities are identified." This year's effectiveness review shows that the Committee achieved that goal. The Committee remains well supported by able and professional teams from inside and outside the Trust, who present high-quality work with on the whole positive conclusions and insights. Despite the strong set of positive assurances the Committee receives about the Trust's control environment, risk management, behaviours and culture, and associated governance mechanisms, we are not complacent: the non-executive and executive personnel alike seek robust assurance, diligently enquire throughout the business cycle, and make connections about the Trust's performance and controls through their work outside the Committee's formal domain.

Stuart Mckinnon- Evans
Chair of the Audit Committee

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
Keep an overview of the key elements of the Trust's governance and finance.	This forms the main work of the committee with updates from internal and external audit at each meeting, highlighting areas of concern and any actions required. All actions are followed up for assurance by the Committee. The chair of the Committee reviewed the annual report, annual accounts and the annual governance statement which addressed this issue	None

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 in June 2023 reviewed the Trust's Annual Accounts and External Audit Opinion, prior to these documents being submitted to the Trust Board	None
Review the Trust's Internal Controls	Internal Controls reviewed through the Internal Audit Reporting mechanism.	None
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;	External Audit produce an update to each committee and attend to present. External Audit attended Council of Governors in January 2024 present their work on the Annual Accounts	None
Monitor risks that are identified by the systems of internal control;	Updates are received at each Audit Committee on completed audits and audit follow up work. Updates are provided at the meeting on recommendations made and actions taken.	Actions from audits that are overdue for implementation are updated at each meeting. An internal system is in place to monitor outstanding recommendations and to remind managers of the agreed timescales and actions
Make recommendations to the Council of Governors through regarding the appointment, re-appointment and removal of the external auditor, including tender procedures	The Council of Governors approved an extension to the existing External Audit arrangements in October 2023.	None
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	The Policy for Use of Audit for Non Audit Services was reviewed and approved by the Director of Finance in October 2023 (EMT Approval November 2023). Use of External Auditors for non-audit work is reported in the Trust's Annual Report.	None
Approve the appointment and/or removal of the internal auditors;	The Trust Appointed new Internal Auditors (Audit Yorkshire) on 1 October 2020 through a competitive tender process. The Trust is a member organisation and will continue receiving the services of Audit Yorkshire	None
Report to the Bord identifying any matters in respect of which it considers that action or	Regular updates are provided to the Board	None

improvement is needed, making recommendations as to the steps to be taken	following each audit committee.	
Produce an annual report for the Trust Board	On June Agenda.	None
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	Whistleblowing/Raising Concerns is included within Counter Fraud and is also considered by Workforce Committee and included in the reportable incidents log to the trust board.	The Trust Board continue to receive regular Freedom to Speak Up reports and any concerns would be reported to the Board (in private) as part of the incidents log.

2.1 The Committee has specific ownership of Strategic Goal 3 (Fostering Integration, partnership and alliances). This was reviewed throughout the year by the Audit Committee as part of the Board Assurance Framework which is a standing item on the agenda.

3. Attendance

3.1 The Audit Committee has met on 5 occasions to date during 2023/24. The table below assumes attendance at the February 2024 meeting.

Members:	No of meetings attended
Stuart McKinnon-Evans Non Executive Director (Chair)	*5/5*
Francis Patton – Non-Executive Director	*4/5*
Mike Smith – Non-Executive Director	*2/5*
In Attendance:	
Michele Moran – Chief Executive *	*3/5*
Peter Beckwith – Director of Finance	*5/5*
*denotes optional attendance at committee	

3.2 Mike Smith was unable to attend 3 meetings due to health related reasons.

3.3 Chair (and Executive lead) are of the view that the Membership composition is effective and there is an appropriate level of contribution from all members of the Committee.

3.4 Two questionnaires were completed by members of the Committee and those in Attendance and the findings have been shared with Audit Committee members.

4. Quoracy

The quorum necessary for the transaction of business is two.

The Committee was not quorate at its May 2023 meeting and all items for approval were ratified at the June meeting.

The Committee was quorate on all other occasions.

5. Reporting / Groups or Committees

Following the review of digital governance arrangements, it was agreed the Information Governance Group would no longer report into the Audit Committee.

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***
- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?* ***Yes***
- *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 (TOR)

The latest version of the Terms of Reference is included at Appendix 1. The Committee reviewed any required changes to the TOR and they are highlighted by tracked changes at Appendix 1. In summary:

- Reference to the Governor Finance and Audit Group has been removed
- References to the Trust Secretary have been replaced with references to administrative support as per current practice
- The Information Governance Group has been removed from the reporting groups schedule as this Group no longer reports to the Audit Committee.

8. Workplan for 2024/25

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

Yes [✓] No [ ]. On the Agenda

9. Any Actions Arising from this Effectiveness Review? YES [ ] NO [✓]
If any, please summarise in bullet point format below

Appendix 7

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 further 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 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 , ~~through the Governor Finance and Audit Group, regarding the appointment, re-appointment 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; • 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
	• ~~Trust Secretariat~~Administrative Support
	
	The Chair
	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 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 agreement, 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 ensure 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).* **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 Audit Committee will receive assurance reports from the Information Governance Group, which is a delegated sub group of the audit committee.~~ They may also request reports from individual functions within the Trust (e.g. clinical audit) as they 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.

~~Trust Secretariat~~Administrative Support

The Audit Committee shall be supported administratively by the ~~Trust Secret~~Finance Directorate Administrator ~~ary~~ 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 as required . The Director of Finance is the Executive lead for this Committee. The Director of Finance, Trust Secretary 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 ~~Trust Secretary~~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. Formal minutes will be taken of the meeting and presented to the Board with the assurance report. 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 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. The minutes of Audit Committee meetings shall be formally recorded by the ~~Trust Secretary~~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. This will cover the following duties:- • Accountability including reporting arrangements to the Trust Board • Membership, including nominated deputy where appropriate • Frequency of meetings • Requirements for a quorum • Required frequency of attendance by members • Process for monitoring compliance with all of the above • The work and achievements of the Audit Committee

	• Outcome of the Audit Committee's annual self-assessment • An action plan, if appropriate, to rectify any deficiencies (to be monitored by the Board). 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	~~11 May 2022~~14th May 2024
Board Approved	29th ~~18~~ May 20224
Review Date	May 2025~~3~~

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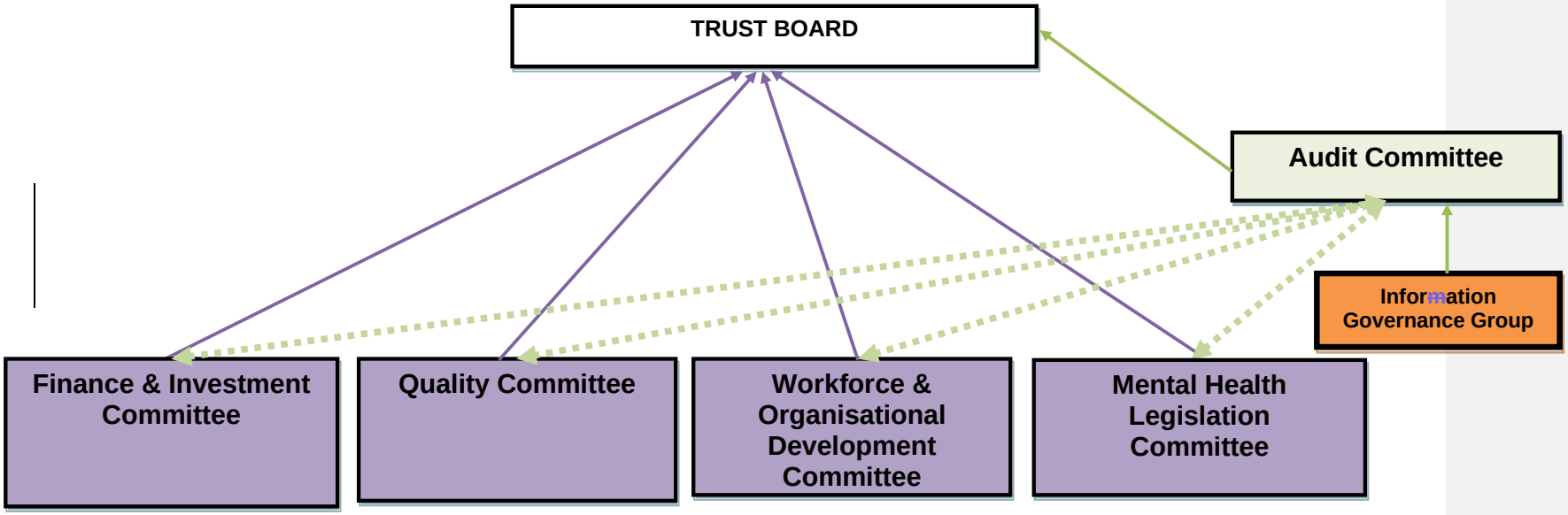
AUDIT COMMITTEE REPORTING STRUCTURE



Caring, Learning
& Growing Together

Trust Board
Annual Review of Trust Board Effectiveness and Terms of Reference
1st April 2023 to 31st March 2024

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

Since January 2023, the Board has been holding formal meetings on a bi-monthly basis, with Strategic Board Development meetings occurring during the months when the Board did 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 at a later date 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 monthly Board 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 December 2023, the Board reviewed the items discussed at these meetings, the outcomes and action taken to progress each key area of work. The Board 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
- the quality of papers presented to Board continues to be good resulting in the Board focussing on and being clear about the key issues it needed to discuss

2. Delivery of functions delegated by Board

A number of functions are delegated *to* sub committees and assurance is provided at each Board.

3. Attendance

3.1 The Board met on six occasions during 2023/24 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	*6/6*
Mike Smith, Non-Executive Director	*6/6*
Dean Royles, Non-Executive Director	*6/6*
Stuart McKinnon-Evans, Non-Executive Director	*5/6*
Phillip Earnshaw, Non-Executive Director	*6/6*
Hanif Malik, Associate Non-Executive Director *(Non-voting)*	*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	*5/6*
Director of Workforce & OD, Steve McGowan *(Non-voting) – currently on secondment**	*1/5*
Deputy Director of Workforce & OD (Non-voting) – attended on behalf of the Director	*5/5*

* The Director of Workforce and OD had a period of long-term sickness which impacted on attendance. The Deputy Director attended on their behalf.

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

The composition of the Board was reviewed during the year and it was agreed that the number of Associate Non-Executive Directors should increase from one to two and two new appointments were made in 2023. There are no recommendations for any further change for the year ahead.

4. Quoracy

The Board meetings were quorate on all occasions.

5. Reporting Committees to Board

The following committees report to the Board:-

- Quality Committee
- Audit Committee
- Workforce & Organisation Development Committee
- Mental Health Legislation Committee
- Finance and Investment Committee
- Charitable Funds Committee
- Remuneration & 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 2023/24 will be presented to the Board in May 2023 for approval.

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 2023/24?

Yes - these are scheduled for presentation at the May 2024 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, in order 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.

A number of amendments are proposed as detailed below and highlighted in the terms of reference attached at Appendix 1:

- Reference to the Fit and Proper Person Test requirements to be updated to reflect Framework requirements published by NHS England;
- Attendance at meetings to be monitored by the Head of Corporate Affairs rather than the Trust Secretary
- The number of Associate Non-Executive Directors to increase from 1 to 2

The ToR are attached at Appendix 1 for approval.

8. Workplan for 2023/24

Has a workplan for the year ahead, 2023/24 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. However, some comments were made regarding Board development, meetings and ways of working which sought to further improve the effectiveness of the Board. These will be shared with Board members at the Board meeting in Private.

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 grown 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 into account the requirements of the Care Quality Commission in relation to directors being fit and proper for their roles. ~~the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to the Fit and Proper Persons Test.~~
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) • 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 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 ▪ 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 & 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 ~~Trust Secretary~~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

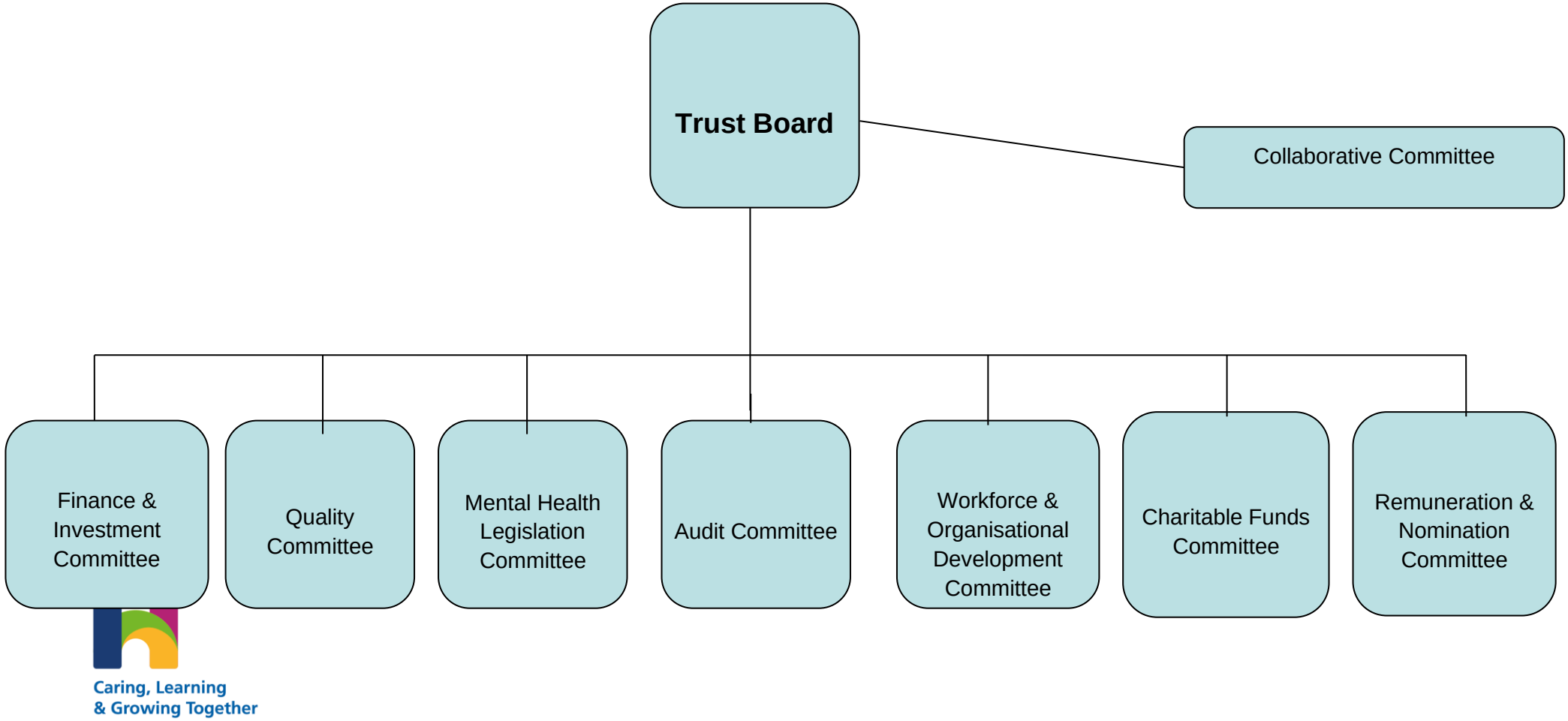
	circumstances will be at the discretion of the Chair. Where there are formal acting up arrangements in place the person acting up may attend and will assume the voting rights of the Director they are acting up for. If no formal acting up arrangements are in place the person attending may not assume the 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 • 21 Associate Non-Executive Directors (non-voting)* *Associate Non-Executive Director appointments will be non-voting and not count towards the 6 other Non-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) • Director of Workforce & 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'*

	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 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
Review Date	May 2025

Sub Committee Structure



Humber Teaching NHS Foundation Trust

Agenda Item 28

Title & Date of Meeting:	Trust Public Board Meeting – 29th May 2024
Title of Report:	Mental Health Legislation Committee Assurance Report following meeting of 01st February 2024
Author/s:	Name: Michael Smith Title: Non-Executive Director and Chair of Mental Health Legislation Committee
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	x		

Purpose of Paper:	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 02nd May 2024.

Key Issues within the report:

Positive Assurance to Provide:

- Committee assured regarding Reducing Restrictive Interventions (RRI) report:
  - Instances of violence and aggression reduced following spike in Q3.
  - Use of seclusion continues to reduce.
  - DMI compliance at 86.98% against 85% target.
  - Number of missed seclusion reviews for both nursing and medical continues to reduce.
  - Co-production service users by experience continues at strength within RRI group and have contributed to reviewing Use of Force Policy which has been awarded co-production stamp.
  - Restraint reduced in Q4; prone restraint reduced to five instances.
  - Continue to Pilot the use of safety pods within Avondale Unit and the 136 suites.

Key Actions Commissioned/Work Underway:

- S136 T&F group ongoing exploring options of reducing numbers of detentions as Trust still has high number of S136 detentions for size of patch and diversity than want to see. Work also focussing on patient experience in terms of S136. Committee to be kept updated on progress.
- Received update on completion of Z48 - Two junior Doctors have volunteered to take on the re-audit of consent to treatment. Meeting held to discuss terms of reference.

- MHL performance report within normal variations:
    - Only 1 Section 4 in the quarter with the last one being February 2023 – appropriate usage.
    - Accurate recording of S136 data.
    - No under 18s admitted to adult ward.
    - Benchmarking data proved helpful - provided populations and bed numbers of other Trusts so able to correlate detentions against bed numbers.
- Committee noted Insight report, in particular Care Quality Commission - Monitoring the Mental Health Act in 2022/23 - work ongoing across Trust around identified issues.
- Committee received MAPPA 6-monthly Report.
- Committee received Annual Associate Hospital Managers Progress Report.
- All mental health legislation related policies / procedures / guidance up to date.
- MHLSG (Mental Health Legislation Steering group) minutes noted. Committee was assured good discussion and debate, and good attendance both internal and external – meeting quorate for the last year.
- MHLSG subgroups and CQC MHA visits updates report noted.
-

Key Risks/Areas of Focus:

- Delayed discharges for service users in secure beds – one delayed discharge reported in Q4. Ongoing discussions at fortnightly DToC meetings with local authorities to ensure everything is being done to identify appropriate placements.

Decisions Made:

- Committee approved Mental Health Legislation Committee Workplan.
- Committee approved Mental Health Legislation Committee Effectiveness Report 2023-24
- Committee approved Mental Health Legislation Committee Terms of Reference.
- Committee approved Reducing Restrictive Interventions Terms of Reference.
- Committee approved Mental Health Legislation Steering Group Terms of Reference.
- Committee approved Associate Hospital Managers Forum Terms of Reference.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	

Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee	1.2.24	Operational Delivery Group	
Charitable Funds Committee		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
	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

- Insight report: - The paper covers key Publications; Policy highlights and summaries of relevant reports and papers as follows:
  - Putting into practice the principles of the Mental Health Act reforms: a national QI programme - Medical Director receives coaching once a month and PICU staff receive weekly coaching sessions looking at different ways of supporting patients from diverse backgrounds. Programme due to end March 2024 extended to May 2024 – learning will then be rolled out across Trust starting with Mental Health Division
  - Baroness Hollins final report '*My Heart Breaks'* published 08.11.23 - Independent Care (Education) and Treatment Review 2019 to 2023. Action from last committee meeting for RRI group to consider the recommendation that all instances of enforced social isolation, including seclusion and long term segregation of patients with learning disabilities and autism be renamed solitary confinement. Committee discussed negative connotation of wording - RRI group action to gain views of patients at co-production group in May and discuss at Forensic patient involvement

day in June.
    - Care Quality Commission - Monitoring the Mental Health Act in 2022/23 published and work ongoing across Trust around identified issues including workforce retention, inequalities in mental health care, long waits for children and young people, reducing restrictive practices, closed cultures.
    - Delayed discharges for service users in secure beds – one delayed discharge reported in Q4. Ongoing discussions at fortnightly DToC meetings with local authorities to ensure everything is being done to identify appropriate placements.

- Committee received MAPPA 6-monthly Report key points were:
    - New Probation lead in post; Sally Adegbembo.
    - Trust involved in review of MAPPA guidance.
    - The Associate Director of Psychology has now retired from the Trust and clinical and operational leadership is now being provided by Mr Johnson, Clinical Director and Helen Courtney, Clinical Lead following a detailed hand over.
    - The Trust has developed a system of Single Points of Contact (SPOC) in all the Divisions, now supported by the Clinical Lead so that MAPPA issues can be well co-ordinated and communicated.

- Committee approved Mental Health Legislation Committee Terms of Reference.

- Committee approved Reducing Restrictive Interventions Terms of Reference.

- Committee approved Mental Health Legislation Steering Group Terms of Reference.

- Committee approved Associate Hospital Managers Forum Terms of Reference.

- Committee received Annual Associate Hospital Managers Progress Report highlighting key points:
    - 14 AHMs in total
    - Recruitment drive to increase diversity has proved successful – 4 new AHMs of diverse backgrounds.
    - Regular Training / case law updates provided at the beginning of each of the Forums.
    - Reviews and appraisals completed and arranged in line with Board dates.
    - Re-appointments approved by the Board.
    - Feedback mechanisms in place for any problem areas.
    - Slight increase in numbers of requests for AHM Reviews; continued consideration of innovative ways to increase numbers of requests for AHM Reviews.
    - Training of Non-Executive Directors following recommendation of Rapid Review into data on MH inpatient settings 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. Two Non-executive Directors have volunteered to be trained in the AHM role and to attend up to 2 hearings a year.
    - The identified NEDs will receive some bite sized training options incorporating the most important aspects of the role including information around the different sections and the criteria required for continued detention.
    - Future AHM recruitment would include an expectation to attend face to face reviews as well as virtual, and the requirement to chair once competent.
    - Recruitment decided on volunteer route as this allowed for speedier process, but this has seen an issue with providing honorary contracts which is being looked at by HR.

- Committee approved Mental Health Legislation Committee Workplan.

- Committee received and noted comments of Mental Health Legislation Committee Effectiveness Questionnaire completed by 8 members of the Committee.

- Committee approved Mental Health Legislation Committee Effectiveness Report 2023-24

- Committee noted and assured MHL performance report within normal variations:
    - Only 1 Section 4 in the quarter with the last one being February 2023 – appropriate usage.
    - Numbers of S136 episodes are now consistent with the number input into the system - working group with police and partners looking at use of S136 to ensure patients not brought to 136 suite unnecessarily.
    - Numbers of people detained on admission continues to reduce.
    - No under 18s admitted to adult ward.
    - Benchmarking data, although not to be relied upon for comparisons, proved helpful and current report provided populations and bed numbers of other Trusts so able to correlate detentions against bed numbers. Work on out of area bed use across MH providers in our ICS is taking place through the mental health, LD and autism collaborative and we are fully engaged in this programme.

- Received quarter 4 report on Reducing Restrictive Interventions key highlights:
    - Instances of violence and aggression reduced following spike in Q3. Continued to reduce and return to normal variation.
    - Use of seclusion continues to reduce, which is positive.
    - DMI compliance at 86.98% against 85% target.
    - Number of missed seclusion reviews for both nursing and medical continues to reduce and evidenced within missed review report.
    - Co-production service users by experience continues at strength within RRI group and have contributed to reviewing Use of Force Policy which has been awarded co-production stamp.
    - Restraint reduced in Q4 despite increasing planned restraint on Orion in relation to NG tube feeding, reflecting increased number of young people requiring NG feeding.
    - Prone restraint reduced to five instances. All instances have been for administration of medication and least amount of time under prone restraint used. DATIX entries shows evidence of trying to avoid prone restraint.
    - Work ongoing around CTR and disengagement training, which is just under 85% compliance target; focus of Divisions to address.
    - Looking to further reduce missed reviews and refining of report.
    - Explore the use of restrictive interventions within ethnic minority groups.
    - Continue to Pilot the use of safety pods within Avondale Unit and the 136 suites.

- All mental health legislation related policies/procedures/guidance up to date, some currently under review.

- MHLSG (Mental Health Legislation Steering group) minutes noted – good discussion and debate, and good attendance both internal and external – meeting quorate for the last year.

MHLSG subgroups and CQC MHA visits

Humber Teaching NHS Foundation Trust

Agenda Item 29

Title & Date of Meeting:	Trust Board Public Meeting 29 May 2024
Title of Report:	Assurance Report from May 14 2024 Audit Committee
Author/s:	Stuart McKinnon-Evans
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	x		

Purpose of Paper:	To inform the Trust Board of the outcome of the Audit Committee of May 14 2024

Key Issues within the report:

Positive Assurance to Provide:

- Single tender waiver regime is operating well.
- The Committee's effectiveness review was positive.
- Losses and special payments controls are in place. Payments totalled £285 in last 12 months.
- Standing orders and financial instructions have been updated.
- Policy and procedures for declarations of interest (including gifts, hospitality and sponsorship) are operating as intended.
- The Board Assurance Framework for "Fostering integration, partnership, and alliances" shows an acceptable level of progress and residual risk, at a score of 8.
- Assurance gained about how risk management is undertaken in Community Primary Care Division, and how teams are involved in the identification, reporting, review and mitigation of risks. Good use of MI and statistics to support risk management.
- Internal audit programme 2023/24: significant assurance received for final reports on: payroll; use of agency staff;

Key Actions Commissioned/Work Underway:

- To consider the future membership of the Committee, in view of the upcoming departure of two experienced NEDs.
- Review the survey/questionnaire process for committee effectiveness reviews, due to low reported response rates.
- 2023/24 accounts audit process is underway.
- Minor further changes to SFIs

capacity and demand modelling; and divisional risk management). All KPIs being achieved and on track to complete. Internal Audit that the Trust's response the any findings is constructive and swift. • Counter Fraud programme for 2023/24 completed as intended.	
Key Risks/Areas of Focus: • At Trust level, the salient risks are insufficient AMHP resource; consultant vacancies; excess demand for ADHD services; inability to cope with demand for speech and language dysphagia. • The Primary Care Division's highest risks relate to reduced capacity in Scarborough Community Therapy service, and in Scarborough and Ryedale Stroke service, backlog of work in triage and clinical letters in Bridlington.	**Decisions Made:** • Endorsed year end accounting judgements endorsed. • Approved Counter Fraud plan for 2024/25 • Approved External Audit Strategy for 2023/24 accounts, taking on board the likely late completion of the process because of reliance on the local government pension scheme audit being completed.

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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Report produced for the Trust Board	29.5.24

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 Committee, which was quorate, considered the following matters:

Single Tender Waivers/Procurement Update: 32 contracts with a total value of £11.4m are currently in place which were awarded on a single tender basis and previously endorsed. 2 new contracts were considered with a total value of £183K (reflecting the new regulations). Since the last report, 9 single tender contracts have expired, with only one of these being followed by a new contract with the same supplier. The single tender waiver controls continue to operate, having been evolved to suit the new regulatory regime. Contrary to initial expectations, it appears that the new regulations will likely lead to more clinical services being competed: the procurement lead's view is that only in a handful of circumstances will there be a single potential provider for a new service.

Review of Committee Effectiveness and Terms of Reference: The Committee agreed the outcome of the annual effectiveness review, noting minor changes to the Terms of Reference. Some concerns were raised about the low level of reported responses to survey/questionnaires, which process will be reviewed. The key immediate task is to find replacements to the two soon-to-depart very experienced NEDs.

Losses and Special Payments: 3 special payments totalling £285 were made in the last 12 months. No concerns were raised.

Declaration of Gifts, Hospitality and Sponsorship: The annual report covered conflicts of interest more generally. The Committee considered the declaration process, the progress to ensure all decision-makers have declared, and the log of interests declared.

Year end accounting judgements: We took a report on the approach to finalising year end, noting and endorsing the early view on accounting judgements being made. Changes to the Trust's accounting policies were considered and agreed.

Board Assurance Framework: The BAF page on "fostering partnerships and alliances" was considered. We noted many examples of how the Trusts is engaging with place-based partners, though remarking once again that many of the positive assurance tend to relate to enabling activity, rather than results/impact/outcomes of the work. Some gaps in assurance did not have accompanying actions. We discussed why the ongoing negotiation with ICS about the evolution of mental health services does not feature on the face of the BAF, especially in view of the upcoming Board-to-Board session. After consideration, the Committee agreed the current rating of 8 for progress and residual risk, which is inside the tolerable range defined for this goal.

Trust-wide risk register: The corporate risk register was considered. It contains 4 residuals risks rated 12+ relating to: insufficient AMHP resource; consultant vacancies; excess demand for ADHD services; inability to cope with demand for speech and language dysphagia. New risks are still being discussed relating to estates, financial sustainability, and digitalisation at Trust level.

A deep-dive into the Primary Care and Community Services Divisional risk register: We heard in detail about the three highest residual risks with a residual score 12, relating to: reduced capacity in Scarborough Community Therapy service, and in Scarborough and Ryedale Stroke service; backlog of work in triage and clinical letters (Bridlington). All these risks may impair patient safety and confidence in the Trust. Responses include recruitment and active management of

highest risk cases. There was good evidence of MI and statistics to support the management of risks, as well as inroads being made into queues through innovation in process management.

Standing Order Schemes of Delegation and SFIs: The Committee considered and agreed the proposed changes to the Standing Orders, Scheme of Delegation and Standing Financial Instructions. The changes were all to ensure the documents reflected current reality and or to eradicate wording inconsistencies. Some minor changes related to the use of Private Finance Initiative were recommended.

Internal Audit Progress report: Four final reports for 2023/24 received significant assurance (payroll; use of agency staff; capacity and demand modelling; and divisional risk management). It was noted that the Committee Chair had gained independent assurance about the process and quality of risk management in the Children's and LD Division through discussion with a staff governor and the divisional risk leadership team.

We noted a major recommendation relating to employees who are recruited to the Bank (new checks need to be run). Two further reports (NHS Green Agenda, and Standard Operating Procedures) are drafted, and fieldwork commenced to ensure the 2023/24 programme will be completed to report to June Audit Committee. 31 recommendations have been completed since the last meeting of the Audit Committee. 9 recommendations are overdue, and about to be resolved, and 15 recommendations had not met their due date at the time of the report. Several of these relate to handling of service user's property, and follow action is diarised. Internal Audit take comfort from the Trust's constructive and swift response to findings.

Counter Fraud Progress Report: The Committee received the report on Counter Fraud activity in Q4 of 2023/24. Once again, the Committee noted the activity undertaken across the themes of: inform and involve (including monthly newsletters; letters to all new starters; masterclasses; Q&A sessions; and alerts.); prevent and deter (including use of data matching through the National Fraud Initiative to identify potential employment and supplier-related anomalies); investigations (no new referrals in the period, and two investigations are now closed, with conclusions of no criminal fraud); and strategic governance. Good engagement between the internal and external teams continues. We discussed the effectiveness of communications, and whether year-end appraisals could incorporate prompts about fraud awareness. All of the planned days for 2023/24 have been delivered, which completes the annual plan.

Counter Fraud Plan for 2024/25: The proposed Counter Fraud plan for 2024/25 follows the tried and tested approach taken hitherto, comprising 60 days input. It is designed to ensure the Trust meets national guidelines, as well as reflecting the specific risk profile of the Trust on employee-related fraud indicators. Cybercrime continues to be on the rise and now is the highest source of threat. The plan was discussed and approved.

External Audit progress: Mazars presented the Audit Strategy Memorandum for the 2023/24 account audit. The highest risk recognised, also reflected in the paper on accounting judgements, relates to the valuation of specialised land and buildings. The fee is held at last year's level of £75K, which is welcome. Work is well underway to complete the audit, though once again the final sign off cannot complete before the audit of the local government pension scheme is completed towards the end of the calendar year. The handover from retiring to new audit manager is complete. The Committee endorsed the Memorandum.

Changes to Contracts: No changes to contracts were notified.
Finally, the Committee undertook a brief self-assessment against **"Being Humber"**, concluding that indeed we had been.

Humber Teaching NHS Foundation Trust

Agenda Item 30

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 29 May 2024</td></tr>
<tr><td>Title of Report:</td><td>Workforce & OD Committee Assurance Report</td></tr>
<tr><td>Author/s:</td><td>Dean Royles – Non-Executive Director</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 Workforce 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 08 May 2024 and a summary of key points for the board to note.</td></tr>
<tr><td colspan="2">Key Issues within the report:</td></tr>
<tr><td>Positive Assurances to Provide:
Reporting groups to the committee (Staff Health and Wellbeing and EDI) continue to be engaged and well attended.
Noted positive assurance form the People Insight Report, particularly regarding the reduction in consultant vacancy rates and the E-Rostering project, which is on track for completion date in September 2024.
Noted a full review of the Risk Register and BAF had taken place and will continue to be done following the completion of the People Insight Report.
The committee welcomed the Guardian of Safe Working report with a verbal update agreed.
Medical workforce update was received and noted, with references made to good progress made in reducing vacancies.
Gender Pay Gap and Ethnicity Pay Gap presented and corporately approved by the committee.</td><td>Key Actions Commissioned/Work Underway:
DBS and Statutory and Mandatory Deep Dives to continue to be presented to committee bi-annually
The Respect campaign to continue to be promoted across the Trust to support the Trust to seek solutions.</td></tr>
</table>

• The DBS and Statutory and Mandatory deep dives were presented for the committee to discuss. • Freedom To Speak Up Strategy and Annual plan were received and approved in principle.	
Key Risks/Areas of Focus: • It is an improving position but Turnover for consultant vacancies remains high. • Whilst the Trust is presenting a stable position with the suite of workforce metrics, focus required on bringing those that are outside of target in line with it.	**Decisions Made:** • Freedom to Speak Up Strategy corporately approved.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	08/05/2024
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		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

Assurance Report 08 May 2024

Reporting Groups to the Committee:

Staff Health & Wellbeing: The Staff Health & Wellbeing group continues to be a well chaired and engaged group wanting to make a difference. The last meeting held in March 2024 looked at the staff survey and sickness absence reports to see what/if any impact on the work plan, the group will continue to look at and explore things in more detail and will dig deeper into areas to see if there are any concerns.

There was also an update on the wage stream system where Bank Staff are able to draw down on their salary in relation to bank shifts, which has had a positive impact on bank staff.

Equality, Diversity and Inclusion Group: The EDI Group continues to be an important group within the organisation and receives updates from the staff networks. Continuing to support those and encourage attendance as a vibrant part of the organisation, which are also bringing us some practical examples of how we can change things to improve the lives of people.

The Respect campaign has been important in highlighting bullying and harassment, which allows us to get better reporting so we can seek to find solutions there and looking at things like the staff survey to see how that informs the work plan.

Information was also noted on the horizon work around multi-generational rational workforces and noted the NHS England Task and Finish group.

Medical Education Committee: Within the medical education update it was noted that they are concentrating on their under and postgraduate students. There is an importance on keeping a real focus on this in terms of improving the pipeline

of people from the experience that they get here and wanting them to remain with us as they develop their careers.

It was also noted that the training that's taking place in terms of increasing understanding of neuro diversity in a range of different areas. Also noted the areas, the benefits and the risks of the medical school expansion, and the challenge regarding continuing to be innovative in the way that we look to expand those placement opportunities. We know that if people get good placement in education with us they're more likely to want to return to us and develop their careers in the future.

People Insight Report:
The People Insight report continues to provide good assurance information and statistics around the organisation. Overall, showing a stable position and pleasing to see the vacancy rate reducing but still recognising above where the Trust wants it to be. There is also positive assurance about the number of consultant vacancies reducing which feels really good and positive to note.

Assurance was also noted around the E-Rostering project being at around 67% and was looking to be on track to be complaint by the end of the project in September 2024.

It was noted that given the reduction within the vacancy rate the Executive Team may wish to have a discussion as to whether they wished to refine the 10% vacancy rate or to leave it as it is. It was also noted that the Executive Team may also wish to have a discussion in relation to the good progress in relation to stat mand training and increase the L&D target from 85%.

Risk Register and BAF:
A detailed discussion around the risk register and the BAF took place and was noted that there's been a full review undertaken with the risk manager for 2024/25. It was also noted the importance of doing this after the Insight report to give a sense of the work that's happening to address areas of risk.

Guardian of Safe Working Hours Quarterly Report:
It was noted that we're seeing the exceptions coming back to normal after a difficult reporting period and hoping that they will stabilise, but with the caveat that industrial action can change things. Also reporting positive assurance that there were no exemptions due to patient safety issues or doctors not being able to attend learning and educational opportunities.

Noted the new terms of reference would be signed off at the next meeting with them, and continue to build those relationships and also noted the importance of auditing to make sure that people are paid and that is something that we can pick up through one of the internal audit reports at some point in the future.

Medical Workforce Plan Update:
Received the six-monthly medical workforce update, and noted the good progress being made in terms of reducing vacancies and looking at what we're hoping to do in terms of agency reduction. The principles outlined in the document are valid and

appropriate and the committee look forward to getting the next update in 6 months' time. Thanks to everyone who's worked hard on this agenda and building that reputation for us as a place to come and work.

Gender Pay Gap:
The Committee corporately approved the gender pay gap for publication and noted the work that's been done on the ethnicity pay gap. It was agreed to have a look at the presentation and whether it's in line with what other organisations are doing and if not, how we separate or otherwise articulate the ethnicity pay gap in a way that is sensitive and recognises the questions that people may ask whether staff or external bodies.

DBS Deep Dive:
The report was noted, and assurance was given in relation to the ongoing continued work regarding the outstanding expired DBS's. For clarification this doesn't mean that a member of staff hasn't had a DBS, it's just that they haven't renewed their DBS in time in relation to the Trust's 3-year DBS rolling programme.

Deep Dive into outstanding Stat/man competencies:
It was noted that the compliance figure for statutory and mandatory training was 94.96% which is outstanding and something that the Trust is proud of, and assurance was given that further work is continuing in relation to the non-compliance figures.

PROUD Leadership Update:
The proud leadership update was noted and received in relation to all the work that's going on in respect of developing the programme. It was also noted that the high potential scheme, has seen 33% of people achieving career progression within the organisation.

Freedom To Speak Up Strategy:
The committee noted the strategy, which is focusing on four areas, improving awareness of the programme, improving confidence in speaking up, support for leaders and managers and continue to improve data collection. The document has been to another subcommittee and appropriate places for engagement. The committee were happy to approve the strategy.

Freedom to Speak Up Annual Report:
The Committee noted the Annual Report and were assured with the progress made in relation to divisional and medical staff ambassadors. Assurance was also given in relation to escalating things with either Dean Royles as the board champion or beyond the organisation if it was felt things weren't being taken seriously. The committee were happy to approve the document in principal.

Workforce & OD Committee Effectiveness Review & Terms of Reference:
The Draft Workforce & OD Committee Effectiveness Review 2023/24 and Terms of Reference were presented to the Workforce & OD Committee for assurance, apart from some minor spelling amendments both documents were approved by the committee.

Effectiveness Reviews/Terms of Reference for reporting groups:

Staff Health & Wellbeing:
The draft Staff Health & Wellbeing Effectiveness Review 2023/24 and Terms of Reference were presented to the Workforce & OD Committee for assurance, and it was noted that the documents where on the agenda for approval at the next Staff Health & Wellbeing meeting on 23 May 2024 for the group to approve both documents. The Committee approved the documents in principle.

Equality, Diversity and Inclusion Group:
The draft Equality, Diversity and Inclusion Group Effectiveness Review 2023/24 and Terms of Reference were presented to the Workforce & OD Committee for assurance, and it was noted that the documents were on the agenda for approval at the next EDI Group meeting on 06 June 2024 for the group to approve both documents. The committee approved the documents in principle.

Medical Education Committee:
The Medical Education Committee Effectiveness Review 2023/24 and Terms of Reference were presented to the Workforce & OD Committee for assurance. The Workforce & OD Committee approved the documents in principle.

Humber Teaching NHS Foundation Trust

Agenda Item 31

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Assurance Report from Charitable Funds Committee of 8 May 2024
Author/s:	Stuart McKinnon-Evans
Recommendation:	

To approve		To discuss	
To note		To ratify	
For assurance	x		

Purpose of Paper:	Through this report, the Charitable Funds Committee provides information and assurance to the Board as Corporate Trustee, from its 8 May 2024 meeting.

Key Issues within the report:

Positive Assurance to Provide:

- The Cardio Walls project is near completion
- Progress of transition from Smile is well advanced: in-house team established; Charitable Funds Operational Group reporting into EMT established; distinction between "Wishes" (up to £5K) and "Dreams" (over £5K) established, with supporting governance
- Fund balances are reconciled to cash and investments held
- The in-house team is confident, motivated and engaged with staff and units
- All 37 wishes carried over from Smile's administration have been fulfilled
- Investigation into previously reported concerns at Mill View found the funds raised had been duly spent; there had been confusion in communications between the unit and Smile, which led to normal process not being followed. (NB this issue has previously been reported in error to relate to Avondale.)

Key Actions Commissioned/Work Underway:

- 3 "dream schemes" are being pursued: (New waiting area at Inspire; Sensory room at East Riding Community Hospital; Dementia friendly day room at Malton Hospital)
- New wishes process is under development (go live end of May)
- Charity website and branding is being redesigned
- Communications and relaunch plan are underway, with stronger key messages aimed at audiences, supported by stories and case studies
- New format for reporting is designed
- Fundzones will be rationalised

Key Risks/Areas of Focus:

- There is not yet a fundraising strategy supported by actions, beyond the current "dream schemes"
- The in-house team expect to need support to open doors to and build relationships with

Decisions Made:

- To endorse the work in progress in transition
- To develop a more comprehensive fundraising plan

potential wealthy donors • Some documentation to verify whether historic funds are restricted or unrestricted may be missing	• To further review the role and effectiveness of the Committee mid-year

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	
Charitable Funds Committee	x	Collaborative Committee	
		Other (please detail) Report produced for the Trust Board	29.5.24

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 meeting focussed on the implementation of the transition plan.

Work Plan: the work plan was accepted. The committee agreed the work plan with minor amendments.

Transition Plan: The transfer of all functions in-house is complete, with the new charity team in place, supported by the Charitable Funds Operational Group.

Funding Approval: No project approvals were required, but we agreed to consider one upcoming

by correspondence.

Insight Report: The list of 37 Wishes carried over from Smile's administration have been rationalised, closed or fulfilled. This is very welcome, and accompanied by a redesign of the wishes processes which will go live in May. Work has progressed to: establish the inhouse charity management/administration team; distinguish between "wishes" up to £5K and "dreams" over £5k with supporting documentation (dreams will need business cases), governance and scheme of delegation; review financial and governance arrangements against the Charity Commission checklist. Work to reconstruct the website funded by the NHS Charities Together grant continues. The Cardio Walls project is nearly complete. The committee discussed the current 3 dreams: "Worth the wait" (waiting room) at Inspire; the sensory room at East Riding Community Hospital (which is well advanced); and the dementia friendly facility in Malton.

We discussed the skill set of the team and were assured that the in-house team is capable and motivated. They may need additional support to identify and open doors to wealthy donors. Their current key concerns are to ensure slick wishes process, launch the comms plan (see below), and build staff confidence about Health Stars.

Following concerns that fund-raising for a mural at Millview appeared to bypass the normal charitable funds channels, an investigation has concluded no issues about probity of funds raised and funds expended. There was confusion in communications between the unit and Smile, which had led to normal procedure not being followed. (NB previous minutes/assurance reports stated in error that the issue was at Avondale.)

Finance report: The report confirmed the opening balances per Fund Zone, reconciled to balance sheet cash and investments (with an immaterial discrepancy under investigation). The report did not show actual income and expenditure year to date, to be included in next report, once the accounting team have mastered the Zero Accounting System operated by 360.A draft format for future reporting was discussed and approved with the addition of a regular brief headline status report for each Fund Zone. Work is underway to rationalise these Funds, including to confirm the status of restriction/non-restriction and where possible to pool funds to allow more flexibility in funding wishes/dreams. There is a concern that some documentation may have been destroyed when the old Trust HQ building was cleared, so we may need to have recourse to Charity Commission to establish non-restriction.

Communications and Fundraising Update: The report and discussion centred on communications planning, particularly key messages for audience segments. Stories and case studies are being developed to illustrate the key messages. The structure of the communication would follow the maxim: "this is who we support, this is how we do it, and this is how you [the donor] can help". The Health Stars website is being redesigned for relaunch on May 20. Focus in the last 2-3 months has been on making the wish process slicker, and to build confidence amongst staff and units that it is easy to engage with the charity.

The Committee asked about how a fundraising plan will be developed – target prospects, grant applications, approaches to trusts and foundations, as well as the management of campaigns aimed at staff and friends and family. We will receive the first iteration of such a plan at the next Committee.

Effectiveness Review: This year's effectiveness review has identified actions relating to safe transition from Smile to the in-house arrangement. They key challenge is to improve the overall effectiveness of fundraising, and the conversion of funds raised into charitable benefits. The key question for the Committee is how it supports the new team. A further review of the Committee's role will be undertaken at mid-year.

Risk Register: The risk register was reviewed. Following discussion and additions to the analysis

presented, the key residual risks related to: poor external understanding of what Health Stars does; compliance with fundraising regulations; achieving fundraising targets; lack of capacity in the team; and ensuring an efficient wish/dreams process.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 32

Title & Date of Meeting:	Trust Board Public Meeting – 29 May 2024
Title of Report:	Board Strategic Development Meeting Agenda –26 June 2024
Author/s:	Caroline Flint Chair
Recommendation:	

To approve		To discuss	
To note	✓	To ratify	
For assurance			

Purpose of Paper:	To provide, for information the agenda for the June meeting

Key Issues within the report:

Positive Assurances to Provide: • Areas of discussion	**Key Actions Commissioned/Work Underway:** • As per the agenda
Key Risks/Areas of Focus: • Nothing to escalate	**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	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Board update	✓ 29.5.24

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

Caring, Learning
& Growing Together

✓	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
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NHS Foundation Trust

Board Strategic Development Meeting

Agenda

26 June 2024, 10.00am – 3.45 pm
Multi-use Room, Trust Headquarters

		Lead	Action	Report format	Timings
1.	Apologies for Absence	CF	Note	verbal	10.00
2.	Notes from 24 April 2024 Meeting and Action Log	CF	Note	✓	10.05
3.	Business Item: • Quality Accounts • Annual Report and Accounts	 HG SJ/PB	Approve	✓	10.15
4.	Work of the Staff Networks	KP	Discuss	✓	10.35
5.	Pre-Board to Board (Humber/ICB) Strategic Discussion	CF	Discuss	✓	11.00
	Lunch with Staff Network colleagues				12.00
6.	Review of Trust Risk Appetite	HG	Discuss	✓	13.00
7.	Health Inequalities Strategy	KF	Discuss	✓	13.45
8.	**Date, Time and Venue of Next Meeting** • Strategic Board to Board (Humber/ICB), 1 July 2024 at 1.00 pm, Lecture Theatre • EPR, 23 July at 2.30 pm via Microsoft Teams • Strategic Board Development Meeting, 30 October 2024, 10.00am, Multi-Use Room, Trust Headquarters				