

Trust Board Meeting 27 May 2026

Agenda - Public Meeting

For a meeting to be held at 10:00am Wednesday 27 May 2026, via Microsoft Teams

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

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

- Setting and overseeing the strategic direction of the Trust, having taken account of the views of the Trust's members and public at large
- Ensuring accountability by holding the Trust to account for the delivery of the strategy; and through seeking assurance that systems of control are robust and reliable
- Ensuring compliance with statutory requirements of the Trust (including the Provider License conditions and the Care Quality Commission registration)
- Shaping a positive culture for the organisation
- Monitoring the work of the Executive Directors
- Taking those decisions that it has reserved to itself
- Consider whether any items on this agenda will pose a risk to achievement of the strategic objectives as identified in the Board Assurance Framework

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

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence	CF	Note	verbal
2.	Declarations of Interest	CF	Note	✓
3.	Minutes of the Meeting held on 25 March 2026	CF	Approve	✓
4.	Action Log, Matters Arising and Work Plan	CF	Discuss / Approve	✓
5.	Patient Story	KF/LP	Discuss	
6.	Chair's Report	CF	Note	✓
7.	Chief Executives Report • Including policies to ratify	MM	Discuss/Ratify	✓

8.	Publications and Highlights Report	MM	Note	√
9.	Board Assurance Framework Update (Oliver Sims, Corporate Risk & Incident Manager attending)	MM	Note	√
Patient Safety and Quality				
10.	Risk Management Enabling Strategy Annual Report	SS	Note	√
11.	Insightful Board Update	SS/SJ	Discuss	√
12.	Antimicrobial Stewardship (AMS) Progress Update	KF	Approve	√
Building a Shared Purpose and Vision				
13.	Annual EPRR Assurance Report	LP	Assurance	√
Investing in People and Culture				
14.	Staff Survey Presentation to Board (IQVIA attending)	KP	Discuss / Presentation	√
15.	Resident Doctors Ten Point Plan Update, Board Assurance Framework and Next Steps	KF	Assurance	√
Developing Leadership Behaviours				
16.	Fit and Proper Person Compliance	CF	Assurance	√
17.	Annual Committee Effectiveness and Terms of Reference Review	CF/SJ	Approve	√
18.	Trust Board Effectiveness and Terms of Reference Review	CF/SJ	Approve	√
Embedding Improvement into Management Systems and Processes				
19.	Finance Report	PB	Note	√
20.	Performance Report	PB	Note	√
21.	Risk Register Update Oliver Sims, Corporate Risk & Incident Manager attending	SS	Discuss	√
22.	Review of Standing Orders, Scheme of Delegation and Standing Financial Instructions	SJ/PB	Approve	√

23.	Report on the Use of the Trust Seal	MM	Note	√
24.	Compliance with the New Provider License	SJ	Assurance	√
25.	Review of Constitution	SJ	Note	√
	Assurance Committee Reports			
26.	Finance Committee Assurance Report	KN	Assurance	√
27.	People & Organisational Development Committee Assurance Report	PE	Assurance	√
28.	Quality Committee Assurance Report	PE	Assurance	√
29.	Audit Committee Assurance Report	KS	Assurance	√
30.	Mental Health Legislation Committee	SP	Assurance	√
31.	July Board Strategic Development Meeting Agenda	CF	Note	√
32.	Items to Escalate including to the High Level Risk Register & for Communication. Has anything on the agenda contributed to or improved the Board Assurance Framework position?	CF	Note	verbal
33.	Any Other Urgent Business	CF	Note	verbal
34.	Review of Meeting – Being Humber • Has the Board focused on the right areas? • Did the quality of the papers enable Board members to perform their role effectively – did they enable the right level of discussion to occur? • Was debate allowed to flow and were all Board members encouraged to contribute? • Has the meeting been conducted in accordance with the Trust's cultural and behavioural standards framework (Being Humber)	CF	Discuss	verbal

35.	Exclusion of Members of the Public from the Part II Meeting	
36.	Date, Time and Venue of Next Meeting Wednesday 29 July 2026, 9.30am via Microsoft Teams	

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Declarations of Interest															
Author/s:	Rt Hon Caroline Flint Trust Chair															
Recommendation:	<table border="1"> <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>				To approve		To discuss		To note	✓	To ratify		For assurance			
To approve		To discuss														
To note	✓	To ratify														
For assurance																
Purpose of Paper:	The report provides the Board with a list of current Executive Directors and Non-Executive Directors interests. Changes have been made to the following declarations: • Addition to Karen Philips • Addition to Peter Beckwith • Removal from Lynn Parkinson • Addition of Caroline Wollerton • Addition of Andrew Brown • Addition of 'Member of the Charitable Funds Corporate body', to all Board members															
Key Issues within the report:																
Positive Assurances to Provide: • Updated declarations		Key Actions Commissioned/Work Underway: • N/A														
Key Risks/Areas of Focus: • No issues to note		Decisions Made: • N/A														
Governance:		Date		Date												
	Audit Committee		Remuneration & Nominations Committee													
	Quality Committee		People & Organisational Development Committee													
	Finance Committee		Executive Management Team													
	Mental Health Legislation Committee		Operational Delivery Group													

	Collaborative Committee		Other (please detail) Monthly Board report	✓ 25.03.26

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

✓ Tick those that apply

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

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

To be advised of any future implications as and when required by the author

Directors' Declaration of Interests

Name	Declaration of Interest
Executive / Directors	
Ms Michele Moran Chief Executive (Voting Member)	• IMAS partner • Humber and North Yorkshire ICB Board Member (voting) • Co-opted Parish Councillor – Bamford with Thornhill • Member of the Charitable Funds Corporate body
Mr Peter Beckwith, Director of Finance (Voting Member)	• Trustee of Heathstars, and Executive Lead for Humber Teaching NHS Foundation Trust • Son is a Resident Doctor at University Hospitals Sussex NHS Foundation Trust • Daughter is employee of the Trust • Member of the Charitable Funds Corporate body
Dr Kwame Opoku-Fofie, Medical Director (Voting member)	• Director of Bluewaters Healthcare Limited • Spouse is Director of Bluewaters Healthcare Limited • Spouse is the Deputy Chief Pharmacist of Humber Teaching NHS Foundation Trust • Executive Lead for The Trust Research Department – which receives grant and funding to the department • Spouse is Clinical Director Harthill Primary Care Network (PCN) • Member of the Charitable Funds Corporate body
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	• Son works for Labour MP as Communications Lead • Son works for Department of Health and Social Care • Member of the Charitable Funds Corporate body
Mrs Karen Phillips, Executive Director of People and Organisational Development	• Member of the NHS Professionals Strategic Advisory Board • Member of the Charitable Funds Corporate body
Mrs Sarah Smyth, Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	• Member of the Charitable Funds Corporate body
Non Executive Directors	
Rt Hon Caroline Flint – Chair (Voting Member)	• Chair of the Committee on Fuel Poverty which is an advisory non-departmental public body sponsored by the Department for Energy Security and Net Zero (DESNZ) • Member of the Charitable Funds Corporate body
Mr Andrew Brown, Non-Executive Director (Voting Member)	• Chairman of Welcome to Whiby CIC • Director of Nanotime LTD

	• Daughter is partner in Brown and Asquith Therapies which provides Mental Health Support Services • Friend is a Director and Shareholder in the Ethos Partnership which provides consultancy services to some NHS trusts. • Member of the Charitable Funds Corporate body
Dr Phillip Earnshaw, Non-Executive Director (Voting Member)	• Director of Conexus GP Federation • Owner of Phillip Earnshaw Ltd • Trustee of Prince of Wales Hospice • Five Towns PCN Clinical Director • Board Member of Wakefield District Health & Care Partnership • Chair and Trustee Smawthorne Community Project is a local charity in Castleford • Member of the Charitable Funds Corporate body
Mr Keith Nurcombe, Non-Executive Director (Voting Member)	• Director of Dietary Assessments LTD • Director of WMSG (Part of West Midlands Combined Authority • Crown representative – Cabinet Office – UK Government • Chair of the Avalon Group • Chair of Derbyshire Health United (CIC) • Member of the Charitable Funds Corporate body
Ms Stephanie Poole, Non-Executive Director (Voting Member)	• Husband is a Trustee of Yorkshire Coast Sight Support (YCSS), a registered charity • Member of the Charitable Funds Corporate body
Ms Kathryn Smart, Non-Executive Director (Voting Member)	• Doncaster & Bassetlaw NHS FT – Non-Executive Director / Deputy Chair and Audit Chair • Incommunities Ltd, Bradford – Non-Executive Director / Audit Chair • St Leger Homes, Doncaster – Co-opted Board member • Associate Hospital Manager – Rotherham Doncaster and South Humber NHS Foundation Trust • Member of the Charitable Funds Corporate body
Ms Caroline Wollerton, Non-Executive Director (Voting Member)	• Non-Executive Director at Locala CIC • Daughter is a Clinical Nurse Specialist at Tees, Esk and Wear Valleys NHS Foundation Trust • Daughter is the owner of the Yorkshire ADHD Assessment Clinic • Member of the Charitable Funds Corporate body

Trust Board Meeting

Minutes of the Public Trust Board Meeting

held on Wednesday 25 March 2026
09:30am – 12:39pm via Microsoft Teams

Present:	Rt Hon Caroline Flint, Chair (CF) Mrs Michele Moran, Chief Executive (MM) Mrs Karen Phillips, Executive Director of People and Organisational Development (KP) Mrs Kathryn Smart, Non-Executive Director (KS) Mr Keith Nurcombe, Non-Executive Director (KN) Dr Kwame Fofie, Executive Medical Director (KF) Mrs Lynn Parkinson, Deputy Chief Executive / Chief Operating Officer (LP) Mr Peter Beckwith, Executive Director of Finance (PB) Dr Phillip Earnshaw, Non-Executive Director (PE) Mrs Sarah Smyth, Executive Director of Nursing, Allied Health and Social Care Professionals (SS) Ms Stephanie Poole, Non-Executive Director (SP)
In Attendance:	Alison Meads, Head of People Experience (AM) Alison Flack, Director of Strategy (AF) Nicola Furley Administration Manager - Minutes (NF) Oliver Sims, Corporate Risk and Incident Manager (OS) Rosie O'Connell, Head of Safeguarding (RO) – (agenda item 29)

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

25/26	Apologies Stella Jackson, Head of Corporate Affairs (SJ)	
26/26	Declarations of Interest The declarations were noted. Board members have been made aware that any changes to declarations should be notified to the Head of Corporate Affairs. If any items on the agenda present a potential conflict of interest, the person should declare the interest and remove themselves from the meeting for that item. The Chief Executive; Executive Director of Finance; and Stephanie Poole, Non-Executive Director have a standing declaration of interest regarding items relating to the Collaborative Committee.	

27/26	Minutes of the Meeting held on 28 January 2026 Kathryn Smart, Non-Executive was not recorded as present in the minutes but did attend. <u>Resolved:</u> The minutes of the meeting held on 28.01.2026 were approved as a true and accurate record of the meeting – with above change noted.	
28/26	Action Log, Matters Arising and Workplan 2025/26 The action log and workplan for 2025/26 were noted. There were no matters arising.	
29/26	Service Story – Alison Meads, Head of People Experience and Rosie O’Connell, Head of Safeguarding Karen Phillips opened the session by outlining the joint work being undertaken between the People and Organisational Development (OD) and Safeguarding teams. A presentation was then delivered covering the programme’s rationale, the collaborative approach adopted, key deliverables achieved to date, early impact and outcomes following implementation, and future priorities, including measuring cultural change and using data to inform action. Alison Meads provided context on the purpose of the work, highlighting intended improvements in patient safety and staff culture, and referencing the relevant legislative framework, including the Worker Protection Act (October 2024) and the NHS Sexual Safety and Healthcare Charter (September 2023), both of which establish expectations of zero tolerance for sexual harassment and harmful behaviours. Rosie O’Connell outlined the development of an integrated approach between Safeguarding and People OD teams, including shared leadership, coordinated governance, and strengthened assurance through triangulation of information and earlier identification of emerging themes. A comprehensive programme had been implemented, comprising sexual safety leads, a sexual misconduct policy aligned to national frameworks, simplified reporting mechanisms, access to specialist support services, trauma-informed training focused on patient engagement, and a dedicated intranet resource. Early outcomes indicated increased staff awareness, engagement and confidence in reporting, alongside a reduction in reported unwanted sexual behaviour in staff survey data (from 2.7% to 1.9%). Discussion highlighted the use of qualitative staff survey data to inform continuous improvement, supported by established processes including a Sexual Safety Review Group, clear reporting pathways, and alignment with Freedom to Speak Up arrangements to enable anonymous reporting. It was confirmed that appropriate training is in place, with access to external agencies where required. Emphasis was placed on the importance of timely reporting and organisational response, and on embedding a culture in which staff feel confident to raise concerns and trust that these will be acted upon by line managers. Safeguarding arrangements for patients were also outlined, including trauma-informed approaches, links with the police, and appropriate referral pathways. The availability of psychological and pastoral support for staff was noted,	

	alongside escalation routes to external agencies and professional bodies where appropriate. The Board emphasised the importance of line managers as key points of contact, accessible reporting routes, and alignment with wider cultural initiatives, including the Respect campaign and Being Humber standards. It was noted the approach is being positively received across the organisation. The Trust Board thanked Alison and Rosie for presenting this service story.	
30/26	Chair's Report The Trust Chair thanked staff for their contributions across the organisation. It was noted, via verbal update, that the Secretary of State had presented annual spending plans to Parliament, including a reduction in mental health funding for the current year. <i>Stephenie Poole declared an interest in the Senior Independent Director appointment and left the meeting at 10:08 due SP rejoined at 10:09.</i> The Board confirmed the appointment of Phillip Earnshaw as Resident Doctor Non-Executive Director, aligned to the 10 Point Plan, and noted that Kathryn Smart had qualified as an Associate Hospital Manager, bringing the number of Non-Executive Directors meeting this requirement to three, in line with national expectations. Updates were provided on Board membership, committee allocations, operational performance, workforce, and national policy developments. The Chair outlined committee allocations for new Non-Executive Directors and changes to Board membership, providing assurance on compliance with Associate Hospital Manager requirements and the added value of this role in strengthening Board insight. The discussion also covered Non-Executive Director visits. It was confirmed that feedback is formally captured through Board reporting processes, including both positive and negative observations, with quarterly updates presented to the Board. Feedback is shared via the Chief Executive and Chair to support organisational learning, and the Business Support Unit will shortly produce a timetable of unplanned site visits. Phillip Earnshaw confirmed a forthcoming visit to Townend Court. <u>Resolved: The Chair's report was noted and the appointment of Stephanie Poole as Senior Independent Director was approved.</u>	
31/26	Chief Executive's Report The Chief Executive summarised the report, noting the Trust's achievement of Segment 1 status and a ranking of 7th out of 61 trusts. Appreciation was expressed to staff for this accomplishment. The Board noted continued strong performance, including no community waits exceeding 52 weeks, effective length of stay, low readmission rates indicating robust care pathways, and achievement of a 97.5% two-hour response rate, all contributing to Segment 1 status.	

Karen Phillips updated on the national requirement to review Band 5 nursing roles. Preparatory work was underway, including engagement with trade unions and procurement of a national job evaluation system, with a commitment to transparency and staff involvement. Karen also outlined key national challenges for mental health services, including rising demand, workforce pressures and health inequalities. Progress in consultant recruitment was highlighted, including reduced vacancy rates, use of skill mix and alternative workforce models, and an ambition to eliminate agency consultant usage. The Board requested continued updates, including clarity on remaining workforce gaps.

Lynn Parkinson provided an operational update, including the transition from the Care Programme Approach to a personalised care framework. This emphasises co-production, accessible and meaningful care plans, and qualitative outcome measures, reflecting a shift towards clinically led care. Implementation is progressing at service level, supported by qualitative measures in the absence of national KPIs. In response to a query from the Chair, Lynn confirmed that ensuring care plans are accessible and relevant to patients, families and carers remains a priority, with ongoing work to embed this within the Electronic Patient Record system and to undertake audits for assurance. In response to a question from Kathryn Smart; Lynn confirmed that multi-agency discharge events are in place and that wards review discharge outcomes weekly. The importance of accessible care planning and effective discharge arrangements was emphasised.

Peter Beckwith provided a financial update, noting a forecast surplus and improved performance within the mental health division. While the Trust was meeting most criteria for additional funding, system-level performance restricted access to this. Concerns were raised by The Chief Executive Moran and Keith Nurcombe regarding the rationale and impact of this approach, particularly for mental health trusts where system partners were in deficit. It was noted that funds achieved are not available for revenue use but contribute to the bottom line. Peter referenced similar concerns raised externally. The Chief Executive reaffirmed that the Trust would continue to prioritise service development and patient-centred improvements irrespective of the assessment framework.

The Board also recognised recent staff engagement initiatives, including seasonal appreciation visits, Mental Health Nurses Day and Social Work Week.

It was noted that information on the Systm1 task policy would be shared with Phillip Earnshaw. The Board also discussed health visitor-led home vaccinations and queried their impact on uptake; this work remains ongoing.

The following policies were ratified by the Board:

- SystmOne use of task changes
- Uniform dress code and ID badge
- NICE implementation
- Leave Policy

Resolved: Trust Board noted the update.

32/26	Publications and Highlights Report The Chief Executive Moran presented the report, which was taken as read. It was noted that the Maternal Care Bundle and Improving Postnatal Care Toolkit had been developed and shared with the 0–19 service. National guidance had been issued for children and young people’s eating disorder services, alongside updated guidance on digital communication with patients and service users. The HFMA had also published briefings on productivity in mental health, learning disability and neurodiversity services, and on improving value from medicines expenditure. The Board noted the Community Mental Health Survey 2024 results, which highlighted areas for improvement alongside recognised challenges and limitations. It was further noted that the CQC’s annual report on the use of the Mental Health Act identified sector-wide challenges, with the Trust responding positively through clear priorities and targeted programmes. The CQC had also published research on medicines in community mental health services, and the Trust had taken a proactive approach in addressing the themes identified. <u>Resolved: The Publications and Highlights Report was noted.</u>	
33/26	2025 Patient Led Assessment of Care Environment (PLACE) results Pete Beckwith presented the 2025 PLACE assessment results, noting that overall performance remained strong and stable, and thanked staff, governors and volunteers for their contributions. The number of exceptions had reduced significantly from 382 to 162, with actions in place and monitored through the Health and Safety Group. Improvements were noted in dementia and disability standards, with further work ongoing. Progress in creating dementia-friendly environments was highlighted, particularly at the Malton site, although some elements remained subject to external factors. At Mill View functional ward, environmental improvements, including dimmable lighting, were being implemented; however, achieving appropriate lighting levels presented operational challenges and work was ongoing to balance these requirements. Sarah Smyth welcomed the report and progress made. Phillip Earnshaw queried the responsiveness of Estates to work logged. In response, Peter advised that internal data shows approximately 98% of maintenance jobs are completed within required timescales when appropriately logged, emphasising the importance of using correct reporting processes. Kathryn Smart raised concerns regarding lower food scores at Mill View; Pete confirmed that catering was currently provided by Castle Hill Hospital, with planned improvements including recruitment to a Catering Manager post, as discussed at the Executive Management Team. The Chair sought assurance that identified issues were recognised and being addressed, including dementia-friendly provision within memory care environments. Pete confirmed that estate-related constraints, including lease arrangements, were being progressed to support further improvements and increased organisational control. The Chief Executive Moran encouraged continued governor involvement in PLACE visits, recognising the value of independent input, and	

	highlighted the importance of staff logging Estates requests to support timely resolution. <u>Resolved: Trust Board noted the report, progress made, and ongoing actions.</u>	
34/26	Executive Briefing Townend Court Sarah Smyth presented a summary of the recent CQC inspection at Townend Court. The Board noted an overall rating of “Good”, with “Requires Improvement” in the responsive domain. Areas for improvement were outlined, including responsiveness, care planning, environmental factors and length of stay. Action plans were in place, with progress monitored by the CQC. The Board noted that responsiveness was affected by factors beyond the Trust’s direct control, including bespoke onward care transfers requiring system-level escalation. Sarah highlighted a high volume of estates-related issues at the site, often linked to the patient cohort. While maintenance responses were generally timely, delays could occur where specialist parts or works were required. Supporting evidence, including detailed estates logs, had been shared with the CQC to provide context. Sarah acknowledged the volume of issues identified, noting that the intensity and small size of the service may concentrate incidents and not fully reflect overall care quality. Phillip Earnshaw and the Chair raised concerns regarding communication with families and the accessibility of care plans. Sarah acknowledged the need for improvement, noting that while feedback may be drawn from a limited cohort, enhancing accessible and meaningful care planning remains a Trust-wide priority. Sarah confirmed that delivery of the action plan would be monitored through operational groups and the Quality Committee to ensure ongoing oversight and assurance. <u>Resolved: Trust Board noted the update.</u>	
35/26	EPR Optimisation Update Lynn Parkinson provided an update on optimisation of the Electronic Patient Record (EPR) system, led through a dedicated Optimisation Group with support from the Digital Team. The Board noted strong clinical and operational engagement, completion of divisional prioritisation reports to improve use of System1, development of a forward workplan, delivery of bespoke staff training, effective collaboration between clinical and digital teams and alignment with wider productivity and efficiency programmes. An update on electronic prescribing and medication administration confirmed system launch in 2025, completion of prescriber training, a deadline of 1 April 2026 for full adoption, and a target utilisation rate of 95%. The Board emphasised the need for consistent use and supported the elimination of paper prescribing. The status of the pathology ordering system was discussed and noted. In response to a query from Kathryn Smart, Lynn Parkinson confirmed that	

	optimisation was being delivered through a structured workplan, with ongoing requests incorporated and reviews scheduled at six and twelve months to support continuous improvement. Stephanie Poole raised concerns regarding Business Intelligence (BI) capacity to support delivery, including dashboards and case management systems. Lynn acknowledged this, confirming organisational commitment to EPR optimisation, the need to prioritise BI resources, and that development would continue iteratively. It was confirmed that a benefits realisation paper would be presented to the Board. Further discussion noted that all patient contacts are now recorded within the EPR, with no alternative systems in use; optimisation was transitioning from implementation to continuous improvement; new templates, including safeguarding and medication, were being developed; and digital tools such as voice recognition and mobile applications were supporting productivity and reducing administrative burden while maintaining quality. The Board emphasised the importance of ongoing staff engagement, monitoring system usage, balancing demand for BI support with capacity, and aligning benefits realisation with the original business case, recognising phased delivery and the need to adjust timelines. <u>Resolved: Trust Board noted the current position and that the benefits realisation paper will be presented to the Board.</u>	
36/26	National Staff Survey Results 2025 Karen Phillips presented the 2025 National Staff Survey results, outlining overall performance, areas for improvement and next steps. The Trust achieved its highest-ever response rate, providing a robust and representative view of staff experience. Improvements were sustained across all seven People Promise themes, with particularly strong performance in advocacy, compassionate culture, inclusion and confidence in reporting concerns. The Trust was ranked 7th out of 49 comparable providers. Areas requiring further focus were identified, including appraisal quality, health and wellbeing (notably musculoskeletal issues), burnout and staff experience of feeling valued. While overall results were positive, some staff reported lower satisfaction in day-to-day experience, requiring further analysis and targeted action. Survey findings were being cascaded to divisions, supported by HR Business Partners, with clear accountability for action planning and delivery. Targeted focus was being applied to Mental Health Unplanned Care and Forensic services, where greater local ownership and improvement were required. The Chief Executive outlined ongoing listening exercises to gather qualitative feedback, particularly regarding staff experience of feeling valued, to inform more tailored and meaningful interventions and strengthen engagement and inclusion. In response to a question by Kathryn Smart, Karen confirmed that detailed, service-level data is reviewed by local senior leadership teams, enabling co-production of improvement actions with staff. <u>Resolved: Trust Board noted the update.</u>	

37/26	Board Member Appraisal process 2026 Karen Phillips presented the revised Board appraisal process, designed to improve accessibility and streamline delivery. The updated approach utilised MS Forms for both self-assessment and multi-source feedback, reducing administrative burden and enhancing usability. It was confirmed that the process included opportunities for feedback from external stakeholders and governors. The Chair requested sight of the appraisal documentation and clarification on stakeholder selection, emphasising the need to ensure meaningful feedback and accessibility for governors. Karen agreed to circulate the relevant documentation and stakeholder details for review. <u>Resolved: Trust Board noted the update and approved the process.</u>	
38/26	Humber and NY Integrated Care System – Alison Flack Alison Flack introduced a paper which outlined the Quarter 3 position across Humber and North Yorkshire. Progress was being made to reduce out of area placements, particularly for older adults and within rehabilitation pathways. Independent Placement Support (IPS) funding had been released, with increased activity anticipated. In response to Steph Poole, it was confirmed that the collaborative is hosted by Humber, with partners including Navigo, CHCP, Care Plus Group (North East Lincolnshire), TEWV and RDaSH, alongside engagement with the voluntary sector and local authorities. Phillip Earnshaw requested information on mental health support for schools; Alison Flack confirmed plans to achieve full national coverage of Mental Health Support Teams by 2030, with rollout underway in the East Riding. Responding to a query on out of area placements, Lynn confirmed that collaborative working had been effective, with no working age adults currently placed out of area. Plans were in development for PICU provision and for Navigo on the south bank, aiming to eliminate out of area placements across both north and south bank areas. Further work was planned to address out of area placements for older adults, including development of additional step-up/step-down beds. <u>Resolved: Trust Board noted the update.</u>	
39/26	Finance Report Peter Beckwith presented the report, noting that system partners were reporting a £93m deficit, consistent with the Quarter 4 position. The Trust was forecasting a £3m surplus, primarily due to non-recurrent income received during the year. Cash balances were slightly higher than usual, reflecting the timing of salary payments and the shorter month of February. The Mental Health division reported an improved financial position, attributed to divisional performance and targeted interventions. On behalf of the Board, the Chair expressed thanks to the Finance teams in recognition of sustained pressures over the previous six months.	

	Kathryn Smart sought assurance that the Mental Health underspend was linked to staffing improvements and enhanced rostering, and queried whether this would be sustained within 2026/27 planning. PB confirmed this was the case. In response to a query on agency usage and consultant recruitment, the Chair advised that the consultant vacancy rate was approximately 20%, and Kwame Fofie confirmed this was reducing towards single figures, equating to around 10 vacancies. <u>Resolved: Trust Board noted the Finance report.</u>	
40/26	Performance Report Peter Beckwith reported continued positive performance across key workforce metrics, including vacancies, statutory and mandatory training, and clinical supervision. Staff sickness absence remains an area of focus but was improving. There had been reductions in 52-week waits (excluding Neuro) and sustained performance against CPA and EIP measures. The report format and content was currently under review, with proposed amendments to be presented to the Strategic Board in May. Phillip Earnshaw noted the positive position, acknowledging recent improvements in psychiatrist response times. He noted an increase in delays in transfer of care for older people; Lynn confirmed these had since reduced. Sarah Smyth added that, within Forensic services, delays may reflect the complexity of patient needs and contribute to fluctuations in incidents. It was also noted that changes to the patient cohort, supported by the introduction of community forensic services, had enabled earlier discharge of longer-stay patients, resulting in a more acute inpatient population. Concerns regarding UCR referrals were discussed; it was noted these originated from system partners, and Lynn confirmed this was being addressed through information sharing with relevant agencies. A similar position was noted for Perinatal services, where increased demand had followed awareness-raising activity. It was acknowledged that access targets are subject to national scrutiny, with plans in place to improve performance. <u>Resolved: Trust Board noted the performance report.</u>	
41/26	Risk Register Update Oliver Simms presented an overview of the report, highlighting risks rated 15 and above, with four currently assessed as significant. A detailed update on these risks, including mitigating actions, was included within the report. MM to meet with OS to conduct a review of the ICB risk register and assess system risks and plans The Executive Management Team had undertaken a detailed review, with the Operational Delivery Group also scrutinising risks to ensure the register remained current and reflective of the live position. It was then reported that Humber Health Partnership had been placed into Segment 5; and the implications of this for the Trust were not yet clear.	

	<u>Resolved: Trust Board noted the risk register update.</u>	
42/26	BAF update Oliver Simms presented the Quarter 3 Board Assurance Framework, noting it had been reviewed by committees and informed by feedback. The annual audit had provided significant assurance, alongside recommendations to improve clarity and succinctness, which would be incorporated into the Quarter 4 version. Recent amendments included improved mapping of inputs and outputs to strengthen assurance, and clearer identification of gaps linked to actions to enhance usability and navigation. Sarah Smyth confirmed that Executive Directors had scheduled a dedicated review of the framework, in line with audit recommendations, to ensure a comprehensive and aligned approach. Phillip Earnshaw noted that the next Quality Committee would undertake a deep dive into the strategic objective relating to prevention, wellbeing and recovery, focusing on alignment between actions and priorities, and identifying any gaps. <u>Resolved: Trust Board noted the BAF update.</u>	
43/26	People and OD Com Assurance report People enabling strategy Karen Phillips provided an update on key workforce issues, highlighting sickness absence and the impact of wellbeing support for staff and the organisation. It was also noted that ESR would be replaced by a new national system. Phillip Earnshaw provided an update regarding matters discussed at the People and Organisational Development Committee. <u>Resolved: Trust Board noted the assurance report.</u>	
44/26	Mental Health Legislation Committee Assurance report. Stephanie Poole reported no significant concerns regarding activity levels or improvements in restrictive practices. Ongoing monitoring of changes to the Mental Health Act was noted, with the Insight report identified as a key mechanism for oversight. It was further noted that the MAPPA audit, following transition to the new SystmOne system, would remain on the agenda to support continued monitoring and assurance. <u>Resolved: Trust Board noted the assurance report.</u>	
45/26	Audit Committee Assurance Report Kathryn Smart reported positive outcomes from audits of the budget reduction strategy and service users' property and money, both providing good assurance. Two audits provided less than significant assurance, relating to discretionary spend and prescribing at discharge. Actions were in place to address these, with work on discretionary spend nearing completion and the prescribing audit escalated to the Executive Management Team.	

	Kathryn confirmed that the internal audit plan for 2026/27 had been approved, with key focus areas including risk management, the Board Assurance Framework, preparedness for well-led inspections, discharge readiness, sickness absence and EPR implementation. <u>Resolved: Trust Board noted the assurance report.</u>	
46/26	Collaborative Committee Assurance Report Stephanie Poole provided an overview of the Provider Collaborative, confirming that four partner organisations were working with Humber as the lead provider across CAMHS, adult mental health, secure services, and eating disorder pathways. Positive feedback from NHS England was noted, including recognition at the Quarter 3 contract monitoring meeting. Alison Flack provided a detailed update on progress across the collaborative, including the continued rollout of Oliver McGowan training with increasing involvement of Experts by Experience. It was also noted that procurement for the Crisis Text 111 service had recommenced. The Board was updated on ongoing capital bids to support the development of neighbourhood hubs and emergency department mental health teams, alongside digital innovation work, including exploration of the Limbic AI tool to improve access to Talking Therapies in collaboration with system partners and the Humber digital team. Performance updates highlighted continued efforts to reduce out-of-area placements, with a focus on improving patient flow and identifying risks for individuals clinically ready for discharge, particularly within CAMHS and Adult Secure services. Plans were in place to achieve full coverage of Mental Health Support Teams by 2030, including development of new teams in East Riding. Further work was also underway to eliminate out-of-area placements for PICU and older adult services through expansion of community provision and step-down capacity. The Chief Executive Moran noted a proposed terminology change from “collaborative” to “partnership” to reduce confusion. The Board noted the collaborative’s positive financial position, which was projected to year-end, reflecting effective management, oversight, and continued programme delivery. <u>Resolved: Trust Board noted the assurance report and it was agreed that future reports include regular updates with comparative data to demonstrate progress over time.</u>	
47/26	April Board Strategic Development Meeting Agenda The Chair outlined arrangements for the April Strategic Board Development Meeting. She requested feedback on the proposed agenda wording to ensure it accurately reflected the suggested discussion topics. <u>Resolved: Trust Board noted.</u>	
48/26	Items to escalate including the High Level Risk Register and for Communication, any issues relevant to the Board Assurance Framework None.	

49/26	AOB None.	
50/26	Review of the meeting – Being Humber The Board agreed there had been focused and relevant/interesting topics for discussion.	
51/26	Exclusion of Members of the Public from the Part II Meeting It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. The meeting concluded at 12:39pm.	
52/26	Date, Time and Venue of Next Meeting 27 th May 2026, 9.30am via Microsoft Teams	

Signed Date

Chair

Agenda Item 04

Action Log:

Actions Arising from Public Trust Board Meetings

Summary of actions from March 2026 Board meeting and update report on earlier actions due for delivery in May 2026 <i>Rows greyed out indicate action closed and update provided here</i>						
Date of Board	Minute No	Agenda Item	Action	Lead	Timescale	Update Report
25.03.2026	41/26	Risk Register Update	1. Meet with Oliver Sims to conduct a review of the ICB risk register and assess system risks and plans.	MM	June 2026	ICB risks are being reviewed.
25.03.2026	35/26	EPR Optimisation Update	1. Provide a benefits realisation paper on EPR optimisation to the Board. 2. Continue oversight of EPR optimisation workplan and ensure regular reporting of 6 and 12month review cycles.	LP LP	September 2026 September 2026	
25.03.2026	33/26	PLACE Results	1. Continue monitoring and reporting on Estates responsiveness and maintenance performance.	PB	June 2026	1. Continue monitoring and reporting on Estates responsiveness and maintenance performance. Estates responsiveness and maintenance performance is reported via the H&S Group as a standing agenda item. A performance dashboard is presented at each of these meetings.

			2. Progress improvements to catering provision at Mill View, including recruitment of a Catering Manager. 3. Progress lease arrangements to support estate improvements (e.g. dementia/memory care areas).			2. Progress improvements to catering provision at Mill View, including recruitment of a Catering Manager. Designer has been commissioned to develop a proposal to increase the size of the current dispensing kitchen and facilitate a commercial kitchen facility. This will enable Humber Teaching NHS Foundation Trust to bring the catering provision in house, as the catering provision is currently provided by the acute Trust. The Catering Manager position is being reviewed due to not successfully appointing to the role in the previous recruitment exercise. Progress lease arrangements to support estate improvements (e.g. dementia/memory care areas). 3. Progress lease arrangements to support estate improvements (e.g. dementia/memory care areas) This action relates to Malton Hospital and Fitzwilliam Ward specifically. Negotiations continue with York LLP to progress with the development of a lease for the accommodation. York LLP have

						however approved works to be progressed to improve the environment and associated dementia friendly spaces. Wraps to bedroom doors and a corridor wayfinding seating area were installed in March 2026. Works to provide a dementia friendly room have been commissioned, with works to progress this planned to commence at the end of May 2026.
25.03.2026	31/26 30/26	Chief Executives Report Chairs Report	1. Review Systm1 task policy information when received. Undertake planned visit to Townend Court.	PE	June 2026	
25.03.2026	31/26	Chief Executives Report	Ensure concerns regarding the current funding allocation approach towards MH Trusts are formally recorded/escalated.	KN	May 2026	This was undertaken through Finance Committee escalation report at the last meeting in term of concerns about mental health funding being used to support wider system issues.
25.03.2026	34/26	Executive Briefing – Townend Court	Provide ongoing updates on Townend Court action plan through operational groups and Quality Committee.	SS		Completed. The Townend updates will be through the Insight report which goes to Quality Committee.
25.03.2026	37/26	Board Member Appraisal Process 2026	Circulate Board appraisal documentation, including MS Forms and stakeholder lists, to CF and Board members.	KP		Completed.

25.03.2026	38/26	Humber & NY Integrated Care System	Provide future Provider Collaborative reports with comparative data and progress tracking for key initiatives.	AF		Future reports will include this information.
25.03.2026	31/26	Chief Executives Report	1. Review additional documentation on the Board appraisal process (to be circulated by Karen).	MM		Action completed.
	30/26	Chairs Report	2. Formally raise/system log concerns regarding funding arrangements impacting mental health trusts.			Action completed.
			3. Ensure feedback from NED visits is shared with CF and incorporated into Board reporting.			Action completed

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
26.11.25	159/25	Risk Register Update	Quality Committee to discuss effectiveness of signposting patients who are on Trust waiting lists.	Quality Chair	March 2026	This was discussed at the December 2025 Quality Committee and updated through the Chairs Report that went to the Board in January 2026.
A copy of the full action log recording actions reported back to Board and confirmed as completed/closed is available from the Head of Corporate Affairs						

Board Public Workplan April 2026/March 2027 (v5)

Chair of Board: Caroline Flint
Executive Lead: Michele Moran

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

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

Board Dates:-	Strategic Headings	LEAD	27 May 2026	29 Jul 2026	30 Sep 2026	25 Nov 2026	27 Jan 2027	31 Mar 2027
Reports:								
Reaffirmation of Slavery and Human Trafficking Policy Statement in Chief Executive report	Corporate	MM					x	
Fit and Proper Person Compliance	Corporate	CF	x					
Winter Plan	Corporate	LP			X			
Compliance with the New Provider License	Corporate	SJ	x					
Staff Survey Presentation to Board (IQVIA attending)	Corporate	KP	x					
Staff Survey Progress Report	Corporate	KP			X			
Review of the Constitution	Corporate	SJ		x				
EDS22 Report (for approval)	Corporate	KP			X			
Auditors Letter	Corporate	PB				x		
Annual Members Meeting Minutes	Corporate	CF				x		
Risk Management Enabling Strategy Annual Report	Corporate	SS	x					x
Health Inequalities Six Monthly Update (March and September)	Corporate	KF			x			x
Strategic Board Development Agenda	Corporate	CF	x	x	X	x	x	x
Annual Operating Plan	Corporate	PB					x	
Multi-Professional Enabling Strategy	Quality	SS	x					
Digital Enabling Strategy	Corporate	PB		x			6-monthly update	
Adhoc/future Items								
Freedom to Speak Up Strategy 2024-2027 (next due May 2027)	Corporate	MM						
Review of Committee Membership and NED Champions (part of Chair report)	Corporate	CF			X			
Insightful Board Update	Corporate	SS/SJ	x					
Mental Health Inpatient Redesign and Granville Court Development Progress Update (requested at the April Strategic Board Development meeting)	Corporate	PB				x		
Antimicrobial Resistance (performance against national AMC targets, benchmarking for Antimicrobial utilisation and resistance and key concerns/immediate actions)	Quality	KF	x					
Resident Doctors Ten Point Plan Update, Board Assurance Framework and Next Steps	Corporate	KF	x					
Deleted /Removed Items								

Agenda Item 06

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Trust Chair's report															
Author/s:	Rt Hon Caroline Flint															
Recommendation:	<table border="1"> <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>				To approve		To discuss	√	To note	√	To ratify		For assurance	√		
To approve		To discuss	√													
To note	√	To ratify														
For assurance	√															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	To provide updates on the Chair, Non-Executive Directors (NEDs) and Governor activities since the last Public Board meeting.															
Key Issues within the report:																
Positive Assurances - Two new Non-Executive Directors start at Humber, Carrie Wollerton and Andy Brown. - Well attended Council of Governors meeting and development events. - Visits to service and Humber events - External engagement with key players at Integrated Care Board (ICB) and regional level as well as local MPs.		Key Actions Commissioned/Work Underway: - Board Preparations for a Care Quality Commission (CQC) inspection and Well Led Review. - Developing plan to recruit an Associate Non-Executive Director (ANED). 10 Year Business Strategy.														
Key Risks/Areas of Focus: Potential of national political destabilisation.		Decisions Made: NA														
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date												
	Audit Committee		Remuneration & Nominations Committee													
	Quality Committee		People & Organisational Development Committee													

	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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 27 May 2026

News

Board will be aware that Right Honourable Wes Streeting resigned from his role as Secretary of State for Health and Social Care on the 14 May 2026. The new Secretary of State is Rt Hon James Murray who previously was Chief Secretary to the Treasury. In this role he oversaw the spending plans of Whitehall departments and with the Chancellor agreeing their budgets. Therefore, he will have an in-depth knowledge of the NHS's financial challenges and the strategy through the 10-year plan and three shifts to improve services.

Welcome to Caroline Wollerton (known as Carrie) and Andrew Brown (known as Andy). Carrie joined Humber on 1 April 2026, and Andy on 22 April 2026. Carrie will chair the People and Organisation Development Committee and attend Mental Health Legislation and Quality Committees. Andy will be attending Mental Health Legislation, Finance, and People and Organisation Development Committees. My thanks to governors who took part in the stakeholder panels and interviews.

On the 31 March 2026, Michele Moran and I met with Scarborough and Whitby MP Alison Hume to discuss increasing the use of Whitby Hospital. Like Alison we want to see the potential of the site and facilities be realised which is why we submitted an expression of interest for the transfer of Whitby Hospital into our ownership from NHS Property Services (NHSPS).

Trust Board Strategic Development Meeting 29 April 2026

We spent the day discussing the changing operating context for Humber to build a shared Board understanding of our opportunities and challenges to enable the Board to agree strategically what we want Humber to be in the future.

Through a series of plenary, slido and small group exercises we agreed an outline direction of travel to inform the development of a 10-year business strategy.

As usual we invite some staff to join us over a sandwich lunch and this time we met a few colleagues from each of our Perinatal, Health Visitor/School Nurse, Human Resources, Estates and Hotel Services and Finance Teams.

1. Chair's Activities Round Up

Catch Up with Humber MPs, 17 April 2026 – over two sessions to brief MPs and their staff I was supported by Pete Beckwith and Kwame Fofie as Michele Moran was on leave. We covered a range of issues, and the feedback was welcome.

Pine View – Forensic Services 28 April 2026 – thanks to staff Gloria and Debbie for showing me around and answering all my questions. It was good to catch up on developments since my last visit and get to chat with some patients too. I got some good insights into how the regular Multi-Disciplinary Team meetings work, how patients can use them too. The Patients' Council across our Forensic Services seem to be working well. The spaces throughout were very clean and I was glad to meet a couple of our cleaning staff and comment on this. It was good to hear that patients like to help out too.

Northeast and Yorkshire Roadshow Newcastle 22 April 2026 – great to meet with colleagues across our NHS region. Pete Beckwith Director of Finance and I attended for Humber. The presentations demonstrating outcomes, nationally, regionally and by ICB showing us where more

progress was needed along with case studies from our region of innovation and evidence-based outcomes.

HEY MIND Golden Gala 24 April 2026 – it was a pleasure to get dressed up and celebrate with friends and partners fifty years of HEY MIND. Governor Tim Durkin is a founding member, and it was lovely to hear Tim speak about establishing the organisation. We also heard from HEY MIND CEO Emma Dallimore, also one of our governors.

Internal meetings included:

Complaints Catch Up with David Napier 6 May 2026
Governor Briefings 26 Mar, 30 Apr 2026
Governor Development Session 2 Apr 2026
Council of Governors 16 April 2026
Remuneration Committee 29 April 2026
Virtual Long Service Awards 19 May 2026
Appointments, Terms and Conditions Committee 21 May 2026

External meetings included:

Alison Hume MP Scarborough and Whitby, 31 Mar 2026
NHS Alliance Mental Health Chairs Network, 8 April, 13 May 2026
NHS Alliance Mental Health Conference, 14/15 April 2026
MPs Briefing x 2, 17 April 2026
Northeast and Yorkshire NHS Region Roadshow, 22 April 2026
HEY MINDS Golden Gala, 24 April 2026
Informal Catch up with ICB Chair Jason Stamp, 14 May 2026
ICS Chairs and ICB Chair Jason Stamp, 19 May 2026
Catch up with Marie Burnham Chair Tees, Esk and Wear Valleys NHS FT, 19 May 2026

NED/ED Visits

Caroline Flint	28.04.26	Pine View – Forensic Services - Announced
Kwame Fofie & Carrie Wollerton	29.04.26	Humber Centre - Unannounced

2. Governor Activities Round Up

Changes to Council of Governor Meetings timings - the Board and Council of Governors are supportive of the Council of Governors moving to a morning session both for online and in person meetings. Currently the timings straddle the middle of the day. The new timings will free up the afternoon for both governors, Board and operational staff who attend. I discussed with Lead Governor Tony Douglas who was in support. He also suggested that Governors' pre meetings should happen online earlier after papers are received to encourage participation and be less rushed. His suggestion is the Monday before the meeting. Katie will assist governors in setting this up. The new arrangements for Council of Governor (CoG) meetings will start from July 2026.

16 Jul 0930-1130	Online
15 Oct 0930-1215	In person (coffee/tea from 0900/sandwich lunch after)

Council of Governors met on 16 April 2026 and received an excellent presentation from Katy and Laura from our Perinatal and Maternal Health Team. Alongside the standard performance and

assurance items we undertook the Review of the Constitution for which it was agreed no changes this year were required.

Appointments, Terms and Conditions Committee (ATC) at time of writing will be meeting on 21 May 2026, to discuss the ATC Effectiveness Review feedback and ATC content for the Annual Report. At the July 2026 meeting I will be providing a roadmap to recruit an Associate Non-Executive Director for which the Council of Governors have already approved in principle.

Governor Development and Information:

Governor Briefings

26 Mar 2026	Health MOTs for staff.
30 Apr 2026	Being Humber and CoG Effectiveness Review Feedback.

The next Governor Briefing is on 28 May 2026

Governor Development Session - On the 2 April 2026 we met online and covered:

- Digital Board
- Do-It-Profiler and other digital/AI Innovations
- The role of Governors in an External Well Led Review and CQC inspection

We had good presentations and discussion with 9 Governors and 2 NEDs. The recordings, slides, chat links are sent to all Governors and NEDs. It was agreed that further sessions on preparing for External Well Led Review and CQC inspection will be held for all governors to ensure everyone is aware of their role and confident. Also, that the Engaging Members' Group would scope networks and engagement with the public to understand how governors are fulfilling this role.

The next Governor Development Session will be on the 2 July 2026.

Agenda Item 07

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026			
Title of Report:	Chief Executive's Report			
Author/s:	Michele Moran Chief Executive			
Recommendation:	To approve		To discuss	✓
	To note		To ratify	✓
	For assurance			
Purpose of Paper:	To provide the Board with an update on local, regional and national issues. Areas of note include: Ratification of policies for: • Social Media and Website • Bullying and Harassment Resolution • Disciplinary • Sexual Misconduct • Recruitment and Selection • Document Control Policy • Patient Safety Incident Response Framework (PSIRF) • Entry and Exit for Non-Secure Mental Health and Learning Disability Inpatient Units • Inpatient Leave • Sickness Absence Management			
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		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail) Monthly report to Board	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Chief Executive's Report

1 Policies for Approval

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
Social Media and Website	24/3/2026	Chief Executive	- The policy has been updated to incorporate clear governance principles for the use of the Intranet and Sharepoint, ensuring the Intranet remains the Trust's single source of truth for authoritative information. - The policy also includes additional guidance to support staff who experience threatening behaviour on social media.
Bullying and Harassment Resolution	7/4/2026	Executive Director of People and Organisational Development	Wording has been added to this policy to reflect our current and pre-existing practices, and to reflect our compliance with the requirements of the NHS National Sexual Safety Assurance Framework
Disciplinary	7/4/2026	Executive Director of People and Organisational Development	Wording has been added to this policy to reflect our current and pre-existing practices, and to reflect our compliance with the requirements of the NHS National Sexual Safety Assurance Framework
Sexual Misconduct	7/4/2026	Executive Director of People and	Wording has been added to this policy to reflect our

		Organisational Development	current and pre-existing practices, and to reflect our compliance with the requirements of the NHS National Sexual Safety Assurance Framework
Recruitment and Selection	7/4/2026	Executive Director of People and Organisational Development	Wording has been added to this policy to reflect our current and pre-existing practices, and to reflect our compliance with the requirements of the NHS National Sexual Safety Assurance Framework
Document Control Policy	28/4/2026	Chief Executive	The Document Control Policy has been amended to highlight that EMT is able to request to see or be requested to review minor changes to policies, without Board having to ratify.
Patient Safety Incident Response Framework (PSIRF)	12/5/2026	Executive Director of Nursing, Quality and Professions	This policy has had a full review in response to: • Updated Patient Safety Incident Response Plan 2026-2029 • Actions from the PSIRF internal audit • Feedback from staff consultation events in quarter 3.
Entry and Exit for Non-Secure Mental Health and Learning Disability Inpatient Units	12/5/26	Executive Medical Director	This policy has had a full review. • Definitions of entry and exit have been added • The need for induction to cover entry and exit processes for new Ward staff has been emphasised • Reference to case law regarding the responsibilities of informal patients has been added.
Inpatient Leave	12/5/26	Executive Medical Director	The policy has been updated as follows: • Escorted and accompanied leave

			definitions have been added. Recording of emergency leave is clarified
Sickness Absence Management	12/5/26	Executive Director of People and OD	This is a new policy which has been compiled and considered in consultation with range of stakeholders as part of the Towards a Healthier Workforce programme of work.

2. Leadership Visibility

This month I have spent time in Malton, with our Homeless team and several mental health hubs.

As usual I meet with all our PROUD cohorts and the start and end of their journey, the course receives excellent feedback.

As always really useful conversations with staff who continue to develop services and look towards innovative approaches.

2.1 Around the Trust

East Riding Infant Feeding

The infant feeding team (Health Visitors) have maintained their Gold accreditation status from UNICEF, this is the seventh year in succession, which is an amazing achievement and one that makes so much difference to our communities.

3. Around the System

Humber and North Yorkshire ICB Appointments:

Place/Partnership Directors

Hull/ER	Simon Cox
NY/Y	Lisa Pope
NL/NEL	Helen Phillips

Director of Performance and Contract Delivery (Neighbourhoods and Primary Care) - Alex Seale

Director of Performance and Contract Delivery (MH and Acute) - Shaun Jones

There is still no confirmation on two outstanding exec director roles.

Non- Executive Appointments:

Dean Royles – Remuneration
Beverley Reilly – Quality
Sue Holden – Finance

Katrina Magee – Audit and Governance:
Jo Pick – Insight and Experience:
Rob Walsh – Communities

Humber Health Partnerships

Following a competitive recruitment process, Lyn Simpson has been appointed as substantive Group Chief Executive. Lyn's appointment has been agreed with NHS England and is supported by Jim Mackey, Chief Executive of NHS England.

New Ambulance Station for Hull

Yorkshire Ambulance Service NHS Trust (YAS) has announced its new ambulance station for Hull. The Trust is investing £6m over a number of years to provide a new ambulance station off Clough Road in Hull, due to open in Summer 2026. YAS are investing in the new station to improve the efficiency of services, support staff and to ultimately enhance the quality of care delivered to patients across the city and wider region.

Local Elections 2026:

The following have been elected:

Rhiannon Margaret Beeson	Liberal Democrat, Avenue
Lucy Alice Lennon	Liberal Democrat, Beverley and Newland
Maria Coward	Liberal Democrat, Boothferry
Sharon Hofman	Labour, Bricknell
Motokin Ali	Liberal Democrat, Central
Martin Baker	Reform UK, Derringham
Linda Chambers	Liberal Democrat, Drypool
Jackie Dad	Liberal Democrat, Holderness
Aaron Paul Pickering	Reform UK, Longhill & Bilton Grange
Duncan Graham	Reform UK, Marfeet
Lisa Alexandra Graham	Reform UK, Newington & Gipsyville
Deborah Louise Carnall	Reform UK, North Carr
Neil Fletcher	Reform UK, Orchard Park
Tracey Irene Henry	Liberal Democrat, Pickering
Richard Christopher Kelly	Reform UK, Southcoates
Salman Anwar	Reform UK, St Andrew's & Docklands
Simon Taylor	Reform UK, Sutton
Laura Juskey	Liberal Democrat, University
Ben Padwick	Reform UK, West Carr

4. National Update

New Secretary of State for Health

James Murray has been a minister in the Treasury since the 2024 general election, and chief secretary to the Treasury since September last year.

Before being elected Ealing North MP in 2019, he served as a deputy to the Mayor of London Sadiq Khan, advising him on housing, from 2016-19; and before that as a councillor and council cabinet member in Islington.

NHS Professionals (NHSP) - New Chair Appointed

Professor Sir Stephen Powis has been appointed as Chair of NHSP. Sir Stephen was previously National Medical Director for NHS England from 2018 to 2025.

NHSP is the largest provider of flexible workforce services to the NHS, working in partnership with 66% of NHS Trusts to support safe staffing across a wide range of clinical and non-clinical roles.

Regional Chair Appointments:

East – Nick Carver

London – Ian Peters

Midlands – Russell Hardy

North West – Kathy Cowell

North East and Yorkshire – Bill McCarthy

South East – Jonathan Montgomery

South West – Dame Gill Morgan

Modern Service Framework (MSF) for Severe Mental Illness (SMI) – A Short Briefing

NHS England is developing a 10-year Modern Service Framework for Severe Mental Illness, aligning with the national 10-Year Health Plan.

The MSF will set long-term outcomes (“moonshot”), system-wide standards, and implementation expectations for mental health services.

The proposed ambition is that by 2035, people with SMI will live longer, healthier, and more fulfilling lives through integrated and equitable care.

The framework represents a shift from guidance (e.g. NICE) to system delivery expectations at scale, including measurable outcomes and assurance.

Key implications:

This is likely to become the defining national framework for mental health service design, performance expectations, and transformation over the next decade, with direct consequences for HTFT strategy, operating model, and partnerships.

Strategic Context

Policy Alignment

The MSF is explicitly aligned to three national shifts:

- Prevention over treatment
- Community over hospital
- Digital over analogue

It will:

- Define evidence-based interventions

- Set delivery and quality standards
- Drive equity and value in service provision [Background...on SMI MSF | PDF]

Scope

The MSF applies to adults and older adults with severe and complex mental health needs, including:

- Psychosis, bipolar disorder
- Complex trauma and personality disorder diagnoses
- Severe eating disorders
- Co-morbid substance use, neurodevelopmental conditions and frailty

Implication

The scope closely mirrors HTFT core service lines, meaning near-total organisational impact.

Emerging Framework Structure

Outcome “Moonshot”

Reduce mortality and morbidity gap

Improve quality of life and recovery

Ensure equitable outcomes across populations [Background...on SMI MSF | PDF]

Three Core Pillars

- Health & Wellbeing
- Reduce premature mortality
- Improve physical and mental health outcomes and Stabilise symptoms and prevent crisis

High-Quality Care

- Timely access and continuity
- Reduced harm, compulsion and restrictive practice
- Integrated, person-centred care

Opportunities & Inclusion

- Employment, housing, and social participation
- Autonomy and independence [Background...on SMI MSF | PDF]

Delivery Model and Development Timeline

A national call for interventions (May 2026) to identify scalable, high-impact approaches – we are submitting

Workstreams across:

- Neighbourhood/community
- Crisis pathways
- Inpatient care
- Digital and innovation
- The MSF is moving rapidly from concept to operational standards within 12–18 months.

Key Strategic Implications for HTFT

- Service Model Transformation - Increased expectation of community-based, neighbourhood models of care
- Pressure to reduce reliance on inpatient and crisis services
- Greater need for end-to-end pathway integration

Opportunities for HTFT;

- Shape the MSF through submission of interventions (deadline 28 May 2026)
- Position as a lead provider in community SMI care models
- Drive innovation and research partnerships
- Strengthen ICS leadership role
- Improve long-term patient outcomes and population health
- Map HTFT strategy against MSF pillars and “moonshot”
- Identify gaps and priority areas
- Reduction in restrictive practice
- Physical health for SMI patients
- Inequalities reduction

Mental Health Strategy

New Mental Health strategy will transform care in England and drive shift from crisis intervention to preventative care:

1. Call for Evidence launched during Mental Health Awareness Week to seek evidence of best practice in communities
2. Part of 10 Year Health Plan commitment to give mental health the attention it deserves

Frontline workers, clinicians and mental health experts being invited to share their views on how to transform mental health care for children and adults in England, as the government launches a Call for Evidence to shape its once-in-a-generation cross-government Mental Health Strategy.

The strategy will drive a fundamental shift towards prevention – treating people earlier and faster and supporting those with mental health conditions to live a full life and stay active in education, work, family life and their communities.

NHS Modernisation Bill

This was referred to in the recent Kings Speech – Headlines include:

- Reshape system control, accountability and data use
- Focus on leaner national centre, stronger local delivery, empowered patients
- Sets legal foundations for delivery of the 10 Year Health Plan

Major Structural Changes

NHS England to be abolished → powers move to DHSC and systems
Push for a more centralised, ministerially accountable NHS

Integrated Care Systems (ICS) Reset

ICBs gain expanded commissioning powers (incl. primary care, dentistry, pharmacy)

Integrated Care Partnerships abolished

New requirement for mayoral representation on ICB boards

Foundation Trust (FT) Overhaul

Governors and membership structures removed

Secretary of State gains stronger powers (appointments, spending limits, deauthorisation)

Single Patient Record (SPR)

Initial rollout: maternity and frailty pathways by 2028

Patient Voice & Safety Changes

Healthwatch (national & local) abolished

Patient safety body folded into CQC

Increased Ministerial Powers

Expanded powers of direction over trusts, FTs and ICBs

Includes ability to cap both capital and revenue spending

Primary Care Gap

No major legislative reform for primary care integration

5. Director Updates

5.1 Chief Operating Officer Update

5.1.2 Leadership Visibility

The Chief Operating Officer continues to undertake a series of visits to in patient units and community teams, unannounced and out of hours. Current operational challenges are discussed, areas of transformational change work are considered and any barriers to making progress are picked up and addressed. Overall staff are motivated and committed to service improvement. Visits have included Whitby Hospital, Scarborough Services and Pine View. The Chief Operating Officer continues to deputise for the Chief Executive when required and has attended the North Yorkshire Health Collaborative Joint Committee and the Hull Risk Summit.

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

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

Our operational pressures continue to be monitored through our daily OPEL (operational pressures escalation levels) and 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. Triggers and action cards associated with each level in the OPEL framework continue to be reviewed to ensure that the actions taken to prevent escalation are robust. Triggers continue to be in place that stand up daily executive director level response when necessary. We continue to report daily via the national UEC-RAIDR system.

Operational service pressures have been moderate in most areas of the Trust in February and early March. The highest pressures were seen in our Adult Mental Health Division with short periods of high demand for mental health beds.

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

System pressures reduced in the Humber and North Yorkshire areas during April and through to early May. Acute hospital partners in all parts of our area have reported pressures during this period predominantly at OPEL 3 with further reduced escalation to OPEL 4.

System work has continued to focus on reducing the number of patients in the acute hospitals who do not meet the criteria to reside in order to improve patient flow, reduce ambulance handover times and to recover elective activity which has been adversely impacted by pressures. Local UEC Boards continue to focus on prioritised plans to address and expedite Urgent and Emergency Care (UEC) performance in our integrated care system. Performance indicators demonstrate that the 4 hour and 12-hour emergency department wait time targets remain challenged in Hull and ERY, however ambulance CAT2 calls (category 2) response times continue to show some improvement.

The Trusts **winter plan** for 2025/26 was stood down at the end March. Humber and North Yorkshire ICB led winter debrief sessions across the system to identify themes, lessons and actions in order to inform the 2026/27 HNY Winter Plan. Detailed evaluations are available for each of the three UEC Boards and broad findings were:

Key Successes:

- Effective system collaboration and communication – implementation of the new OPEL Framework
- New services innovation, discharge to assess models, virtual wards, pathway redirection, non-conveyance support.
- Improved discharge and capacity management
- Urgent Care Enhancements, additional urgent care GP funding, streaming/speciality in-reach respiratory hubs
- Workforce – enhancements in terms of IPC, consultant availability, improved weekend staffing
- Enhanced VCSE Support – good practice cited from Hull and ERY with other systems confirming different models of VSCE support.
- Additional primary care capacity support for winter was well utilised

Key Recommendations:

- Earlier planning and identification of funding
- Enhanced discharge and capacity – better forecasting of demand, increased out of hospital capacity, discharge offer 7 days, review of out of hospital

pathways to ensure shared understanding and adequacy of offer. Care home weekend availability.

- Workforce/Resource – robust planning including rota planning in advance, incorporation of winter sickness and gaps. Improve vaccination uptake.
- Escalation – pre-agreed escalation points and better data sharing to enhance co-ordination. Service integration and pathway development.
- Technology and Data – continue to maximise use of IT systems – Optica/SystmOne

This learning and recommendations will be taken forward in our winter planning and preparedness for winter 2026/27.

A further period of **industrial action** by the BMA resident doctors took place from 07.00 on Tuesday 7th April until 06:59 hours on Monday 13th April. Our emergency planning arrangements were utilised to plan for and manage the period of action. Our plans were effective and we experienced minimal disruption to our services.

Waiting times for both children's and adult neurodiversity services continues to be the most significant area of pressure and challenge for operational services. In all these areas demand exceeds commissioned capacity. The Trust has continued dialogue with the ICB to agree a way forward on these waiting times for 2026/27 and beyond. Occupancy and patient flow in our CAMHS inpatient beds continues to be good. Focus continues on our children's early intervention services, particularly embedding the mental health support teams in schools. Our children's services have been working closely with the local authorities to develop proposals which form part of the Local Authority's SEND Transformation Programme, supported through new SEND (special educational needs and disability) Reform funding announced in a white paper Every Child Achieving and Thriving, February 2026. The proposals are focussed on providing early, needs-led, non-statutory support, strengthening SEND support and reducing reliance on EHCPs (education, health and Care Plans) and diagnostic thresholds as the primary route to help.

Nationally requirements are in place to eradicate the use of inappropriate out of area mental health beds and our services are implementing plans to achieve this, our data demonstrates that we have seen a reduction in out of area bed days. In April and early May working age adults placed out of area has been zero.

Work is still being undertaken to reduce the use of older peoples out of area beds with plans now implemented to expand the use of the Older Peoples Acute Community Service (intensive community support) and the older peoples crisis intervention team, with a plan to introduce community older people's step/down beds still being progressed. Out of area placements for our Psychiatric Intensive Care Unit (PICU) continues to be a focus for improvement. Plans are continuing to change for our current PICU based at Miranda House to an all-male unit and to make alternative provision for female patients by developing a High Dependency Unit (HDU) within our current estate. The current timescale for achieving this is Quarter end of Quarter 2 2026/27. Further intensive work on improving mental health patient flow is taking place to address the demand for adult mental health out of area placements.

Patients who are Clinically Ready for Discharge (CRFD) from our mental health beds remains a key priority. Patients are waiting predominantly for specialised hospital

placements with other NHS providers or local authority provided residential placements. Escalation mechanisms remain in place with partner agencies to take action to resolve the delayed transfers and discharges that our patients are experiencing. The nationally recommended rapid improvement methodology for multiagency discharge event (MaDE) is being utilised across all of our inpatient beds to reduce the number of bed days lost due to delayed transfers or discharges for those patients who are clinically ready for discharge. Our data demonstrates that we have seen a rise in the number of adult and older people and the associated bed days in delayed transfers during April and early May, escalation continues to take place to the ICB and Local Authority partners to support in reducing these.

The overall staff absence position has deteriorated slightly in April and recovered in early May, and sickness is currently at 6.26% (inclusive of 1.22% mat leave).

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

Operational focus remains on recovering access/waiting times where these continue to be a challenge. Divisions continue to pursue a range of service change and transformation programmes which are set out in their service plans, these are reported via the Operational Delivery Group to the Executive Management Team. They demonstrate that they are underpinned by capacity and demand modelling work, respond to external benchmarking data and are supported by a Quality Improvement (QI) approach where this is applicable to improve outcomes for our patients.

Targeted work is taking place to improve and sustain performance against the operational measures included in the [NHS Oversight Framework](#) and the expectations set out in the [NHS Medium Term Planning Framework](#), this continues to be overseen through our Performance and Productivity group, reported via Organisational Delivery Group (ODG) and escalated to the Executive Management team. Focus on improved efficiency and productivity continues. Work is taking place to continue to reduce the Trust's National Cost Collection Index, each service has a targeted plan for those areas above the Trusts target and service transformation plans are required to set out the expected productivity and efficiency gains.

The EPR Programme Board remains in place with a focus on stabilisation and optimising the use of the new system in order to realise the programme benefits as set out in the business case.

5.1.4 Community CAMHS (Child and Adolescent Mental Health Service) Pathway Improvement and Day Service Development

Reflecting during Mental Health Awareness Week, the CLEAR (Clinically Led workforcE and Activity Redesign) of community CAMHS demonstrates the significant value when clinicians, families and young people come together to shape service change collaboratively.

NHS planning guidance continues to prioritise earlier intervention, improved access and more joined-up support for children and young people's mental health services. Creating mental health services that feel connected, responsive and centred around children, young people and families requires more than pathway redesign alone - it requires collaboration, shared ownership and listening to the experiences of those who use and deliver care every day.

Through the CLEAR Programme (NHS improvement methodology and tools), the community CAMHS redesign project has supported a more connected, family-focused approach to care - helping improve access, strengthen coordination across services and create a more consistent experience for children, young people and families. Alongside this, staff have reported clearer pathways, stronger collaboration and a greater shared sense of purpose across teams.

“Early results are very encouraging. Waiting lists for further interventions such as CBT and creative therapies are reducing, largely because the six sessions of Family Partnership offered at the outset are enabling many young people to move forward without needing additional input.” **Service Manager, Humber Teaching NHS Foundation Trust**

These kinds of outcomes demonstrate the value of transformation that is shaped collectively - where staff, patients, families and systems work together with a shared purpose to create more connected and responsive mental health support for children and young people.



You can read more about the CLEAR Core CAMHS redesign here:
[CLEAR- HUMBER COMMUNITY CAMHS pathway redesign](#)

Inspire Day Service

NHS England have recently published the CYP's Intensive Mental Health Service Specification (in development form) which replaces the original Tier 4 CYP inpatient specification. The new specification has a greater focus on admission prevention and includes the requirement to deliver an intensive day service function that aligns closely with inpatient services to prevent admission.

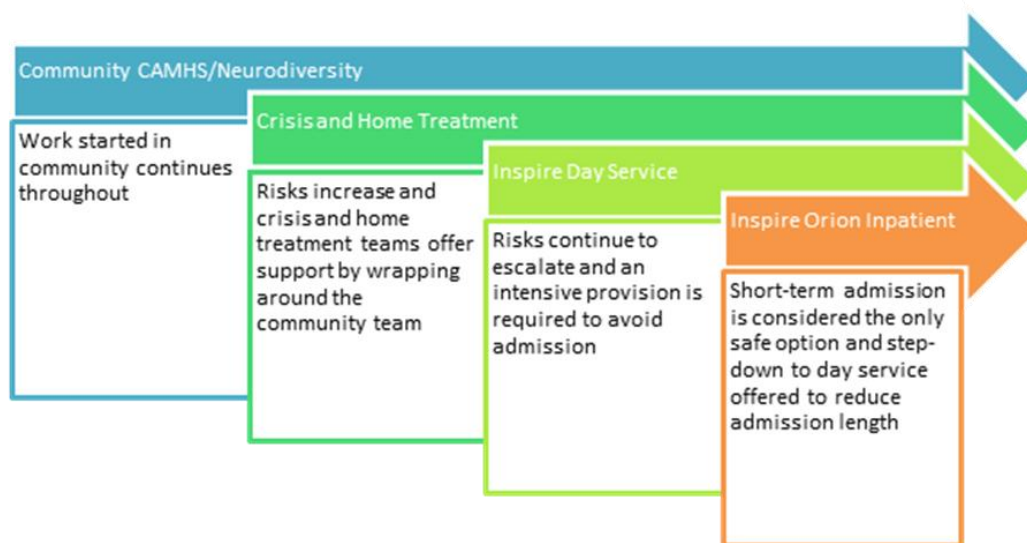
Despite considerable progress in developing services towards admissions avoidance, more young people are presenting to services with co-occurring trauma, significant attachment and relationship difficulties, neurodiversity, and a higher number of CYP who are in local authority care. We, therefore, need to move to more of a “wrap around” model within intensive support services working in a more integrated way with traditional CAMHS pathways so that young people do not fall between gaps in service and intensive support can be safely dialled up in the community when required to further prevent admission.

The day service will provide an intensive non-residential, family-focused alternative to inpatient admission for young people to prevent a crisis admission. It will support families, and the system around a young person. Based at Inspire, the service will include education, where appropriate, and structured support during the day to prevent admission or to support transition from inpatient care. The Day Service will collaborate closely with the inpatient service at Inspire with the aim of achieving a whole single pathway approach, and a single integrated multi-disciplinary team.

Consistent support, flexibility and systemic involvement, are often the reasons reported by families and professionals as the gaps that potentially lead to a young person being admitted to hospital are key principles of the service.

Whole CAMHS pathway approach

The model below demonstrates how the day service will fit with existing services when risk increases.



The Inspire day service will operate 5 days per week initially supported by inclusion criteria to ensure the CYP and family can work within the model.

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

5.2.1 Leadership Visibility

On 11 March 2026, the Executive Director of Nursing, Quality and Professions visited the Driffield Community Mental Health Team (CMHT), which provides mental health services for adults in the Driffield area. The service operates as part of the wider Adult Community Mental Health Service for Bridlington and Driffield and works in partnership with East Riding of Yorkshire Council.

The team delivers a recovery-focused community mental health service for adults with enduring mental health needs across Driffield and Bridlington, working closely with service users and carers, families, primary care, and local statutory and non-statutory agencies. The CMHT is a multidisciplinary service, comprising a wide range of health and social care professionals supported by administrative staff.

Services provided include comprehensive mental health assessments, individualised care planning, evidence-based interventions, support delivered in line with the Care Programme Approach, and recovery-focused care tailored to individual strengths and needs. The service places strong emphasis on diversity, inclusion, and respect, ensuring care is responsive to individuals from all backgrounds.

During the visit, the Executive Director was particularly impressed by the team's strong collaboration with Primary Care Networks and the proactive approach to workforce development, including diversification of roles and skill mix to support high-quality, integrated care delivery.

5.2.2 International Nurses Day 12th May

On International Nurses Day, 12 May 2026, the Executive Director of Nursing, Quality and Professions and the Chief Executive shared a personal message of thanks to nurses across the Trust.

They expressed their sincere appreciation to every nurse working in inpatient wards, community services and specialist teams, recognising that their dedication, compassion and professionalism make a difference every single day.

Reflecting on this year's theme, "*Our Nurses. Our Future. Empowered Nurses Save Lives,*" they highlighted the significant impact nurses have in delivering safe, high-quality care in complex and challenging environments. They acknowledged the skill, integrity and humanity shown in supporting patients, families and colleagues.

They recognised the leadership demonstrated by nurses at every level, noting how staff innovate, advocate and consistently go the extra mile for those in their care. They also acknowledged the pressures many nurses face and reaffirmed the Trust's commitment to supporting staff wellbeing, listening to their voices, and creating environments where nurses feel valued, empowered and able to thrive in their careers.

The Executive Director of Nursing and Chief Executive also recognised how nurses embody the Trust's values of caring, learning and growing:

- **Caring:** Demonstrated through compassion, dignity and respect shown to patients, families and colleagues every day, delivering safe, person-centred care in both moments of crisis and recovery
- **Learning:** Evident in reflective practice, the sharing of knowledge, embracing innovation and striving to continuously improve outcomes for patients
- **Growing:** Seen in the way nurses develop as professionals, leaders and teams, supporting one another, overcoming challenges and shaping the future of nursing within the Trust

They thanked nurses for the pride they bring to the profession, for the way they support one another, and for the essential role they play in saving lives and shaping the future of healthcare.

They concluded by emphasising that nurses are valued and celebrated not only on International Nurses Day, but every day.

5.2.3 Nursing and Midwifery Council (NMC) consultation

On the 8th May 2026, the NMC [launched a 12-week public consultation](#) until 23 July on the nursing and midwifery education standards, with a focus on practice learning.

This review, alongside the modernisation of the Code and revalidation process, and the advanced practice review, is part of a series of strategic measures the NMC are taking to support nursing and midwifery practice and protect the public through modernised standards.

Proposed reduction in nursing hours

For nursing programmes, the proposal is to reduce the minimum number of programme hours from 4,600 to 3,600, to place a greater emphasis on the quality of practice learning experiences rather than the achievement of a set number of practice learning hours.

Globally, there is significant variation in the number of learning hours required to become a registered nurse. The current requirement of 4,600 hours stems back to EU legislation which no longer applies to the UK.

Outside of the EU, there is significant variation in the number of nursing programme hours and within this, the number of practice hours. They are generally lower than the hours mandated by the EU directive – 4,600 in total, of which 2,300 are practice learning.

For example, in the USA, students are required to complete around 700 hours of practice learning, 800 hours in Australia and 1,100 hours in New Zealand.

Reducing the minimum requirement for practice learning hours would give approved education institutions (AEIs) the opportunity to design more innovative and creative programmes, with a lower minimum to meet, the emphasis could shift more clearly towards the quality of learning rather than the quantity of hours.

Other areas for consultation

Other areas for consultation include:

- Strengthening anti-racism, bias awareness and cultural curiosity, safety and respect in nursing and midwifery education and training
- If pre-registration nursing programme hours are reduced, how would this impact on the pre-registration nursing associate programme.
- Ensuring that all nursing students have at least one community practice learning experience in health or social care.

This review and consultation sits alongside the wider EDI work, including the [upcoming anti-racism principles](#) which set out the expectations across education

and practice for nursing and midwifery professionals, with the aim of helping to tackle the Black maternal health crisis and wider health inequalities experienced by service users across the UK.

5.2.4 Allied Health Professional (AHP) Update

The Allied Health Professional (AHP) workforce continues to provide assurance of its sustained commitment to delivering high quality, safe and patient centred care across all services. AHP practice and service delivery are being driven by the 2026–2027 AHP key objectives, ensuring clear alignment with the Trust’s strategic priorities. This work is underpinned by evidence and research informed approaches, with a strong focus on aligning the workforce to current and future service demand through effective workforce planning, service evaluation and transformation.

Workforce recruitment, retention and staff development remain central to the delivery of high-quality care. Progress continues against the AHP Grow Your Own workforce strategy, with six AHP Support Workers successfully onboarded onto Level 6 Apprenticeships in March 2026. In addition, NHSE funding for Level 3 and Level 5 apprenticeships has enabled a further five support workers to access development opportunities, while generating approximately £15,000 of external funding for the Trust. This approach supports workforce sustainability, career progression and long-term service resilience.

5.2.5 Chief Social Worker visit - April

Social Workers and Approved Mental Health Professional’s joined colleagues at Hull Council to welcome the Chief Social Worker, Sarah McClinton to Hull. Colleagues from across the mental health division came together for a valuable session focused on national developments in adult social work and local innovation. The chief Social Worker, shared insights into the current national picture, including the continued emphasis on strengths-based practice, prevention, and supporting people to live well in their communities. Her update highlighted how these approaches are being reinforced across the country, alongside a growing focus on workforce wellbeing, professional development, and integrated working between health and social care.

The visit also included a lively marketplace event, creating space for open conversation and shared learning. Colleagues had the opportunity to talk directly with her about their work, reflect on challenges, and showcase examples of innovation happening across our services.



5.2.6 Care Quality Commission (CQC) - update

The CQC want to improve how they assess and rate health and social care providers by moving to a sector-based approach to regulation.

Feedback from the consultation at the end of last year showed overwhelming support for the proposal to move away from a single assessment framework to separate frameworks that are more specific and relevant to the health and care sectors that they can regulate.

CQC have therefore developed an initial 4 draft assessment frameworks for:

- Adult social care
- Mental health care
- Primary care and community services
- Hospitals (secondary and specialist care)

These draft frameworks give clearer, more transparent and consistent judgements about quality across sectors. The CQC are now inviting feedback from colleagues, providers, people who use services, and other partners through the online survey by 12 June. These will be discussed the Trust Quality Standards Group and the Executive Management Team.

[Give your views on draft sector-specific assessment frameworks - Care Quality Commission](#)

5.2.7 Anti-Racist Network update

A one-hour pilot anti-racist practice training session was delivered by the network at Avondale and received positive feedback. Training materials will be shared with interested staff, with content continuing to evolve. The importance of co-production with the staff network and Trust-level support for wider rollout was emphasised.

Recruitment to the occupational health psychologist role has progressed, with interviews completed and an offer made, although the appointment is not yet confirmed. The role was identified as key to strengthening support for network members.

Work is underway to increase network visibility and membership through printed and digital approaches, including QR codes, a Teams channel, and refreshed intranet content.

A face-to-face network meeting is planned for 7 October 2026, alongside encouragement for members to share anonymised lived experiences to support training and engagement activities.

5.2.8 World Hand Hygiene Day Tuesday 5th May

On 5 May, the Trust marked World Hand Hygiene Day, recognising the vital role that staff play every day in protecting patients, families, carers and colleagues through excellent hand hygiene.

The Executive Director of Nursing, Quality and Professions/ Director of Infection Prevention and Control extended her sincere thanks to all staff for their continued commitment to this essential aspect of care. Clean hands remain one of the most

effective actions we can take to prevent harm and save lives. Hand hygiene is not only a technical practice but also a visible expression of care, compassion and professionalism.

Across mental health and community services, care is built on relationships and trust. Maintaining high standards of hand hygiene is fundamental to sustaining that trust and ensuring that people feel safe, respected and protected while in our care.

The Executive Director of Nursing, Quality and Professions/ Director of Infection Prevention and Control would like to personally acknowledge staff for:

- Maintaining high standards, even in busy and complex environments
- Supporting and reminding one another in a positive and respectful way
- Speaking up when systems, supplies or environments make it more difficult to do the right thing

On this World Hand Hygiene Day, all staff are encouraged to pause, reflect and recommit:

- Are hands being cleaned at the right moments?
- Do environments support safe practice?
- Are staff role modelling the behaviours expected of others?

Infection prevention is everyone's responsibility. Through small, consistent actions, we collectively create safe, therapeutic and compassionate care environments.

The Executive Director of Nursing, Quality and Professions/ Director of Infection Prevention and Control thanks all staff for the commitment shown every day, these actions truly make a difference.

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

5.3.1 Leadership Visibility

I have maintained a visible presence across the organisation, spending significant time working within office environments across a range of locations, including The Maples.

This approach has continued to support informal engagement with colleagues, helping to build relationships, understand local issues and maintain connection with teams.

A full programme of visits has now been diarised for the year ahead to ensure a consistent and structured approach to leadership visibility across all services.

5.3.2 NHS Staff Standards

We have undertaken initial due diligence on the emerging NHS Staff Standards to assess alignment with our existing *Being Humber* approach to staff experience. This review indicates strong alignment in intent, particularly in prioritising consistent, measurable improvements in staff experience across key areas such as wellbeing, inclusion, safety and line management.

Through the national consultation, we have provided feedback to help shape the final framework, emphasising our preference for a seamless integration with Being Humber, rather than the introduction of parallel approaches. Our focus is to ensure that national requirements strengthen and complement our established programme, maintaining clarity for staff and supporting continued improvement in experience and retention.

5.3.2 Band 5 Job evaluation update

Following the recent national announcement requiring NHS organisations to review all Band 5 nursing roles, the Trust has undertaken initial preparatory work to ensure readiness. This includes collating existing job descriptions, refreshing generic Band 5 nurse templates aligned to Agenda for Change, and establishing draft governance arrangements with nursing, HR and staff-side involvement.

Initial scoping indicates that the requirement is significant in scale, with a large number of Band 5 roles across multiple divisions, and potential implications for management capacity, workforce engagement and financial exposure if not managed in a structured way. National guidance on detailed delivery expectations is still emerging.

A paper is being prepared which will set out:

- the Trust's current position and level of preparedness;
- a proposed staged, manager-led approach supported by clinical and HR governance;
- key workforce, capacity and financial considerations; and
- options for resourcing and delivery to ensure consistency, assurance and timely completion.

EMT will be asked to consider and endorse the proposed approach and agree next steps for delivery.

5.3.3 Employee Relations Investigations – National Development Programme

NHS England has commissioned a national development programme to strengthen the quality, consistency and inclusivity of employee relations investigations across the NHS, responding to national evidence of variation in practice, avoidable harm to staff, and unequal impacts on some workforce groups. The programme focuses on trauma-informed, fair and restorative investigation approaches, with specialist modules covering race discrimination, sexual misconduct and restorative just culture.

The Trust will be represented by Stacey Oglesby, Head of People Operations, and John Duncan, Equality, Diversity and Inclusion Partner, who will attend the programme and undertake the *train-the-trainer* components. This will enable them to deliver elements of the training locally, building sustainable internal capability, strengthening investigative practice, and supporting our wider workforce culture, wellbeing and inclusion objectives.

5.3.4 Future Workforce Solution

The Future Workforce Solution transformation project continues to proceed at a national level. The system provider, Infosys, are currently working alongside early adopters with the aim to roll out in 2027.

Humber's own implementation timeline should be received in the second half of 2026, and we continue to participate in activities and design workshops which will inform the development direction of the new solution.

At a local level several projects are ongoing to continue maximising our use of the current ESR solution to develop and embed a fully self-service culture. In turn this will allow the Trust to gain the most benefit from the new workforce solution once available. Projects include expanding the ESR functionality used during the current appraisal window and deployment of full Manager Self Service across our divisions.

Organisationally we continue to await receiving the foundational readiness guidance, which will support local planning and preparing for a smooth adoption of the new solution.

5.3.5 Immigration

The implementation of the Agenda for Change pay award from 1 April 2026 will mitigate the current risk associated with salary thresholds, as Band 3 pay rates will exceed the minimum salary requirement. We anticipate the Government may review and uplift the threshold again in future; this will be monitored and assessed as changes arise.

The uplift is also expected to increase application numbers for Band 3 HCA roles. With longlisting processes now implemented, the additional volume should be manageable. We continue to review individual cases to ensure all previous NHS service is recognised for salary placement in line with Agenda for Change Terms and Conditions.

Band 2 staff are ineligible for sponsorship because the roles do not meet the minimum skills threshold of RQF level 3 (A-Level or equivalent) or above, regardless of salary.

5.3.6 Flexible workforce: Agency & Bank reduction

The Trust continues to make good progress in reducing reliance on temporary staffing, supported by strong divisional leadership, improved operational grip and coordinated oversight from the Flexible Workforce Team.

This has been achieved through strengthened governance, tighter controls, proactive conversion of agency workers and a sustained "Bank First" approach, while maintaining safe staffing levels and strong fill rates.

Since the start of 2026, 38% of the agency workforce has been converted, including 10 agency nurses moving to the Trust bank and one physiotherapist to a substantive post, improving bank cover and reducing ongoing agency reliance.

High fill rates continue to be maintained predominantly through the internal bank, providing assurance that reductions are not impacting patient safety or service delivery. All agency consultants have now transitioned to direct engagement arrangements, reducing risk and improving control, with current focus on renegotiating rates.

A refreshed Bank and Agency Optimisation Plan is in development for EMT, setting out a structured, multi-year approach aligned to national requirements. The Trust's staff bank remains a key strength, with strong engagement and retention evidenced in the 2025 NHS National Bank Staff Survey, and targeted actions are in place to further enhance morale, wellbeing, development and local feedback.

5.3.7 Working Towards a Healthier Workforce – An intelligence Led approach to reducing sickness absence

This strategy supports the NHS 10-year plan shift from sickness to prevention through two interventions: the Rapid Response Sickness Intervention Model (RRSIM) and the Towards a Healthier Workforce Working Group.

RRSIM is now embedded, with 37 teams receiving targeted support based on risk and need.

The Working Group is progressing key enablers, including a new Sickness Absence Management Policy aligned to the *Being Humber* framework, promoting a compassionate, consistent and legally compliant approach. Manager training and alignment with Trust-wide psychological support are also in development.

5.3.8 Sickness Absence Performance

There has been four consecutive months of incremental improvement in overall sickness absence, with monthly performance returning below the 5% target in March.

The February to March position reinforces this positive trajectory with monthly sickness reduced from 5.62% to 4.91% and the rolling rate improved from 5.58% to 5.55%. Overall, this indicates that reductions in short-term absence and strengthened operational grip are driving improvement in headline performance.

5.3.9 People Experience and our People Promises

The Trust continues to strengthen colleague voice and engagement, recognising its direct impact on staff experience, patient safety and quality of care.

Key actions include:

- **NSS 2025:** Introduction of department-level results and toolkits to support local ownership, conversation and targeted action.
- **Listening Exercise:** Trust-wide engagement in April, with 88 submissions identifying practical improvements, priorities and opportunities to simplify processes.
- **Shared Voices, Shared Action:** Ongoing sharing of how feedback drives change, reinforcing confidence in engagement.
- **NQPS:** Significant increase in participation (18%, up from 9%), with enhanced focus on local action and feedback visibility.
- **Your Experience & Stay Conversations:** Six-monthly conversations launched to strengthen engagement, wellbeing and experience, with appraisal alignment from 2027.

- **Exit Insights:** Improved exit interview processes, with further work to increase completion and learning.
- **Multi-generational workforce:** Focus groups completed, with analysis underway to inform future action.
- **New Starter Experience:** Targeted survey launched to capture early insights and improve onboarding experience.
- **Just Learning Culture:** Proposed policy to support a restorative, learning-focused approach to managing issues, aligned to reducing avoidable harm.

Statutory and Mandatory Training Update

April shows a strong start for mandatory training, with high overall compliance (93.8%) and sustained performance across most areas.

Resuscitation training remains below target and continues to require focused improvement. Violence reduction, safeguarding and other core programmes remain strong, with most above 85% and corporate induction above 98%.

A slight dip from March reflects the rollout of Oliver McGowan training and ESR changes, requiring significant staff refresh. Compliance is expected to recover above 85% by November 2026.

5.3.10 Learning and Development Communications and Engagement

Developed with Internal Communications, the *Learning & Development Round Up* is a new regular newsletter promoting training, CPD and development opportunities across the Trust.

It highlights upcoming events, showcases internal programmes, supports digital skills and signposts external learning, while increasing visibility of in-house expertise.

Early engagement is positive, with strong click-through rates and increased course bookings. Content and frequency will be refined based on ongoing feedback. The newsletter also promotes leadership and career development, reinforcing a proactive, Trust-wide approach to continuous learning.

- [Learning and Development Round-Up - 9th April 2026](#)
- [Learning and Development Round-Up - 7th May](#)

Everyday Skills Hub: Making Learning Easier to Access Across Humber

The Learning and Development team has continued to promote the Everyday Skills Hub, a new resource designed to make it easier for colleagues across Humber to access practical learning and guidance that supports everyday work.

The hub brings together a range of existing resources in one place, covering topics such as communication, organisation, digital productivity, systems use and sustainable working practices.

It also introduces colleagues to emerging digital tools available across the Trust, including AI enabled resources and the Microsoft suite. The Everyday Skills Hub forms part of a wider programme of Learning Hubs being developed to help staff

browse and discover learning more easily, complementing our ESR learning management system and supporting a culture of continuous development across Humber.

Explore the [Everyday Skills Hub](#)

Leadership and Talent Development Update

- **Humber Talent Programme 2026 Update**

The 2026 Humber Talent Programme opened for applications in January, with submissions accepted until 13 March 2026. During this period, 32 applications were received from colleagues across the Trust.

Following a comprehensive shortlisting process, 10 candidates from across the Trust were successfully selected and have accepted their places on the programme. The successful candidates are listed below;

1. Melanie Lowe, Perinatal Peer Support Worker
2. Rowan Bye, Registered Nurse
3. Gemma Hare, Communications & Events Officer
4. Nontokozo Dube, Registered Nurse- Adult
5. Saffron Precious, Registered Nurse (Mental Health)/Care-coordinator
6. Rochelle Featherstone, Digital Transformation Delivery Lead
7. Emily Major, Specialist Mental Health Nurse
8. Sarah Burnham, CPN Band 5
9. Rachel Clannachan, Project Manager
10. Romie Thompson, Clinical lead Beverley PCMHN

A welcome workshop was delivered on 29 April 2026, introducing participants to the programme and outlining expectations for the year ahead. Candidates will now begin a 12-month structured learning journey, with a strong focus on self-development through both professional and personal development lenses.

Career Development & Widening Participation

The Career Development Team continues to strengthen local workforce pipelines through partnerships with schools, colleges and communities.

Focus areas include:

- Expanding placements and apprenticeships across teams
- Targeted outreach and careers engagement events
- Improving access in deprived communities and promoting T Level pathways
- Embedding Career Conversations to support personalised development plans for all staff by 2027

Early progress includes pilot conversations, strengthened manager support, and integration of career development within appraisal processes.

Apprenticeships

Apprenticeships remain central to workforce development and patient care. There are currently 140 apprentices on programme, with 48 staff completing an apprenticeship in the last year.

We use apprenticeship to support leadership capability across the Trust. Level 3 and Level 5 leadership apprenticeships are due to lose levy funding this year. We are focussing a final push to maximise onboarding of apprentices from our existing and potential manager population. The final cohorts must be defined by September 26.

Work Placements & Outreach

In the last 12 months we have hosted 87 T Level and work experience placements, supporting progression into further education, employment and apprenticeships. Managers have previously expressed interest in on-site engagement sessions, allowing teams to access informal career and apprenticeship advice directly within their work areas.

Our team have started these at Mill View Court and the Humber Centre allowing staff to connect their career goals with the pathways that we have established at Humber.

Key highlights included delivery of the Trust's first Psychology Day on 4 March 26, welcoming 45 students. The event featured interactive workshops and sessions led by clinical psychologists, therapists and wellbeing practitioners, providing valuable insight into careers within psychological professions and inspiring future pathways into the NHS.

Sexual Violence and Misconduct Update

The Trust has responded to the Worker Protection Act 2023 and NHS England Sexual Safety Charter with a comprehensive programme to prevent harassment and strengthen culture.

Governance is embedded, with clear executive and operational leadership and a Sexual Safety Group reporting to QPaS.

Key measures include Trust-wide risk assessments, a national-aligned Sexual Misconduct Policy with a 'Report It' process, trained HR teams, and targeted communications and engagement.

Delivery against the 83 national requirements is strong (75 Green, 8 Amber, 0 Red). Focus is now shifting from implementation to impact — embedding sustainable cultural change, strengthening capability, and preparing for enhanced duties under the Employment Rights Act 2026.

5.3.11 Equality, Diversity and Inclusion

- **New Annual Reports Drafted** - The Trust's 2025 Annual Workforce Equality Reports for the Gender Pay Gap (GPG), Workforce Race Equality Standard (WRES), and Workforce Disability Equality Standard (WDES) are currently in draft. Each report includes detailed data analysis to identify trends, disparities, and areas requiring further improvement. Accompanying action plans will be developed collaboratively with stakeholders, including staff networks and

executive sponsors, to ensure that identified inequalities are addressed through targeted, evidence-based interventions.

- **Patient and Carer Race Equality Framework (PCREF)** - The Trust has made measurable progress against the PCREF, completing its first benchmarking exercise during the reporting period. This has enabled the identification of key inequalities in access, experience, and outcomes for racialised patients and carers. The next phase of work will focus on the development of a locally tailored PCREF action plan, co-produced with stakeholders, to drive improvement and embed race equity across mental health services.
- **International Holocaust Remembrance Alliance (IHRA)** - The Trust has formally adopted the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism, in line with NHS England and Department of Health and Social Care expectations. This adoption strengthens the Trust's commitment to tackling antisemitism, promoting understanding, and ensuring that antisemitic behaviour is clearly identified, challenged, and addressed through existing EDI and disciplinary frameworks.

5.4 Executive Medical Director Updates

5.4.1 Leadership Viability

The Executive Medical Director continues to prioritise regular visits across the Trust to engage directly with frontline teams, gaining valuable insight into effective practice, operational challenges, and service transformation, and ensuring that staff voices inform leadership decisions.

During an unannounced visit to the Humber Centre on Wednesday 29 April 2026, accompanied by Non-Executive Director Caroline Wollerton, the team was observed to be highly motivated, experienced, and proud of the service they provide. Staff spoke confidently about their processes, achievements, and challenges, demonstrating a strong sense of commitment, and feeling well supported in their roles. We also received positive feedback from patients on the units visited, highlighting the quality of care and staff engagement.

5.4.2 Response to NHS England Letter: Unexpected Disclosure of Significant Results via the NHS App:

The Trust has reviewed the NHS England guidance regarding the unexpected disclosure of significant results via the NHS App and confirms that current risk is low, as the Trust does not operate patient engagement portals or automated result-sharing systems. Existing practice ensures that sensitive or distressing information is communicated directly by clinicians with appropriate support, which is particularly important in mental health and community settings where information often requires careful interpretation.

Looking ahead, the planned implementation of Wayfinder and integration with the NHS App will introduce new digital risks, and the Trust will ensure robust safeguards are in place prior to go-live, including clear clinical workflows, system controls, staff training, and patient support arrangements.

The Board can therefore take assurance that current arrangements are safe and that future developments will be subject to strong clinical governance and oversight.

5.4.3 Research

The National Institute for Health and Care Research (NIHR) have invested £157 million over 5 years in 10 NIHR Applied Research Collaborations (ARCs) starting April 2026. Bradford Teaching Hospitals NHS Foundation Trust is hosting the Yorkshire & Humber ARC (Y&H ARC). These new ARCs support the transformation set out in the NHS 10 Year Plan by tackling some of the UK's most pressing health and social care challenges through high-quality applied research and driving effective interventions and models of care into practice. We're delighted to announce that our Trust is a funded partner in the new Y&H ARC and that Dr Hannah Armitt, Senior Clinical Research Psychologist in our Research Team, is a key researcher for the 'Prevention and early intervention for children and families' theme.

5.4.4 Patient and Carer Experience (PACE)

- The first Forum meetings of 2026 for Hull and East Riding, Whitby and District, and Scarborough and Ryedale were replaced with a series of "Your Voice Matters: Patient and Carer Experience Forum Marketplace and Events". The events were well attended by members of our local communities. The sessions generated some excellent discussions about the future of our forums, and we received valuable feedback that will help shape how patients and carers are involved at Humber Teaching NHS Foundation Trust going forward.
- The Trust's Panel Volunteer Framework has recently been revised to ensure that staff are provided with the right tools to fully support patients, service users and carers when they volunteer to be involved in Trust recruitment activities. The review of the Framework has been fully coproduced with current Panel Volunteers and staff who have utilised the initiative. The Panel Volunteer Framework was approved at QPaS, in March 2026 and launched through Global Communications in April 2026. Alongside the review of the Panel Volunteer Framework, as of 1 April 2026 the management of the Panel Volunteer initiative has transferred to the Voluntary Services Team. To further promote the launch of the new Framework and the transition of the initiative to the Voluntary Services Team, some lunch and learn sessions are being developed to take place during National Volunteer Week (1 – 5 June 2026).
- The Recovery & Wellbeing College has recorded a new Podcast to add to the multiple podcasts available. The new Podcast was recorded with the Cyber Prevent & Protect Officer from Humberside Police regarding 'How to be more cyber secure', it covers all things cyber-crime, including how to spot potential scams and how to safeguard yourself against them. More podcasts are in the planning in collaboration with other local organisations.
- Over the past year (April 2025 to March 2026), more than 5,600 volunteer hours were recorded, demonstrating a significant contribution from volunteers across our services. A Volunteer Awards Afternoon is being planned for the first week of June to coincide with Volunteers' Week, providing an opportunity to recognise

and celebrate the contribution of our Volunteers. In addition, the new Volunteer to Career project has commenced, with the first five recruits starting in Volunteer Healthcare Assistant roles at Maister Lodge and Maister Court, where they will begin learning the HCA role and progressing towards their Care Certificate.

5.4.5 Psychological Professions

Anne, Clinical Psychologist in the Humber Traumatic Stress Service has delivered some **Trauma Informed Care training for GPs in the Modality Partnership**, and we have subsequently had a request for further support for their non-clinical but patient-facing staff, to support them with becoming more trauma aware: Sarah, AD of Psychological Professions will be delivering this session. Once again, this cements us as a regional centre of expertise in trauma-informed practice.

Clare Hilton, Lead Psychologist for Older People's Mental Health will be leaving the Trust after 23 years of service. The following excerpts from her resignation letter outline her positive experiences as a member of our Trust:

'I would like to take this opportunity to sincerely thank you and the wider Trust for the support, encouragement and professional development I have received during my 23 years with Humber. It has been a privilege to work in OPMHS. And I do truly mean that.

This has been a very difficult decision for me to make, as I have genuinely loved working in my various roles in the Trust. I have greatly valued my current position and hold the colleagues I work with in the highest regard. The people I have worked alongside have made my time here feel both rewarding and meaningful – and the majority of them are also absolutely hilarious – so it's also been a lot of fun – even when the work has been hard.'

Virtual Bouquets: a number of great pieces of work by our psychological professionals have been recognised in recent weeks:

Higher Assistant Psychologists Lydia and Leona, and Principal Clinical and Forensic Psychologist Kay received bouquets for their "effort, perseverance and hard work in getting a trauma psychoeducation group up and running within a prison environment."

Tracy, Principal Forensic Psychologist, was sent a bouquet by her colleagues in the community forensic team, who said: "Thank you Tracy for consistently looking out for your colleagues, the team really value your thoughtful contributions, both clinically and from a well-being perspective!"

In **Adult Mental Health**, we continue to see various brilliant examples of different professions coming together to deliver innovative care:

- Clinical Psychologist Lolly, Clinical Associate Psychologist (CAP) Caz and Occupational Therapist Pat have delivered another round of training for the Coping with Emotions/SCMi workbook to 11 members of staff from community and inpatient services. Caz continues to offer the monthly drop-in session to support staff with embedding the workbook into their practice and Lolly runs a supervision group for staff facilitating the groups for clients in Hull and Goole.
- Caz (CAP) and Kate Reynolds (Mental Health and Well-Being Practitioner) have been working hard to continue to deliver the Coping with Emotions

group for clients in Hull CMHT and PCMHN- they've done amazing to keep the group going during times of stretched staffing, providing high quality care.

- Pat (OT), Kelly and Rachel (Specialist Mental Health Nurses) have been running the Coping with Emotions group for clients in Goole CMHT and PCMHN following training and support from the psychologists that were previously in post - they have done really well with this, as their service has not had a Psychologist in post for a long time now but they've kept this going.

5.5 Executive Director of Finance Updates

5.5.1 Leadership Visibility

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

5.5.2 Cyber Security Updates

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

Alerts fall into two types of notification:

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

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

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

Activity updated since the last board report:

- Cyber Alerts issued during 2026: 42 (Including 12 in April)
- High Priority Cyber Alerts Issued during 2026: 9 (Including 2 in April)
- April Cyber Alerts with patch(s) NOT approved for deployment: 0
- April Cyber Alerts with patch(s) fully deployed to all devices (or not applicable): 2
- April Cyber Alerts not 100% deployed (due to devices still to check in): 0

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

Servers:

There are 52 servers, 44 on-premise and 8 in Azure cloud running Windows Server 2022 (the latest version). All servers are fully patched to April 2026.

5.5.3 Digital updates**Digital & BI – CEO Highlights**

Requesting and Results (R&) now in Early Life Support. The **requesting and results workflow** supporting pathology integration into SystmOne is live and in ELS, reducing reliance on Lorenzo and GP workarounds while improving access to results. This provides faster availability of diagnostic results, improved clinical decision-making, and reduced administrative burden for staff.

Do IT Profiler now in Early Life Support - The **Do IT Profiler** solution is live and progressing through ELS, supporting structured clinical profiling and improved data capture. Do It Profiler will provide improved patient stratification and insight, enabling more personalised care planning and stronger population-level analytics.

Planned bed closure functionality (SystmOne) - New capability enables services to record and manage bed availability accurately in real time, improving operational visibility and strengthening dataset integrity for BI reporting. This aims to improve bed utilisation and capacity management, with more reliable data underpinning operational decisions.

Standardised activity recording and data capture enhancements – The introduction of consistent SystmOne templates and coding standards is delivering improved data completeness and consistency across services. This provides higher quality data enabling more accurate reporting, benchmarking, and performance management.

Enhanced clinical data capture (presenting complaints) - Improved data capture processes are now supporting compliance monitoring and richer BI dashboards providing stronger clinical insight and improved service planning through more granular and reliable data.

Trust-wide data quality improvement showing measurable impact with continued progress in the data quality programme is delivering improvements in priority datasets and enabling stronger assurance for operational and regulatory reporting.

Enhanced cost and productivity reporting (Power BI) - Updated Power BI reporting provides improved visibility of cost, activity, and productivity, supporting more informed financial and operational decision-making. This is strongly linked to the Trust's productivity work

Increasing maturity of digital and BI capability – the continued improvement in data governance, reporting standardisation, and dashboard utilisation is enabling more consistent, data-driven decision-making across clinical and operational teams.

5.5.4 Facilities Management Updates

- The National Healthcare Estates and Facilities Day will take place on 17 June 2026. Plans are being developed within the department.

Hard FM - Operational Estates

- Matrons walk rounds recommenced with engagement form site, Infection Planning and Control, hard and soft Facilities Management.
- Asbestos awareness training has been arranged this year face to face to allow individuals to ask questions and interact with their learning.

Hard FM - Development and Sustainability

- Works have commenced at Townend Court (Phase 1 - Beech Ward Refurb) as part of the scheme to provide a female HDU.
- Procurement exercise has commenced for PSCP with site visits undertaken from P23 contractors. PCBC presented to the ICB, setting out the programme for the consultation process.
- Supporting Comms Team on Social Values Report by linking in with design partners to provide interviews.
- Task Force on Climate-related Financial Disclosure (TCFD) update provided to Comms for inclusion in annual report, along with a information and highlights from estates projects (Maples and Sustainability and Infrastructure Updates).
- Support bids / business cases for Neighbourhood Mental Health Centres (Hull & ER) and Mental Health ED Front Door schemes.

Safety

- New risk assessment pro formas have been developed in line with new fire related guidance (HTM 05-01). As a result, the pro formas for H&S and Security have also been revised.
- H&S report for June 2026 has a section describing the Responsible Person concept for Fire, H&S and the new Martyn's Law (Terrorism Act).

Soft FM - Hotel Services

- Environmental Health Food Safety Inspections are underway, and we anticipate a number of visits across the Estate.
- External audit of compliance against national cleaning standards requirements completed in Q1, positive outcome, considering introduction of a policy as opposed to the SOP that we currently have.

5.5.5 PARTNERSHIPS AND STRATEGY

Capital

The Trust will receive over £1.2 million additional capital investment in Mental Health, Community and Addiction Services over the next three years (with over £780K of that in 26/27). The funding has been earmarked for additional equipment and software to improve the services that we deliver to our patients. Included within the funding is £590K for a software platform and digital Mental Health crisis care pathway that supports the secure completion and communication of Mental Health

Act statutory forms as well as £230K for two FibroScan Transient Elastography Scanners.

The Trust has also submitted bids for a capital estates money to deliver two Mental Health Neighbourhood Centres and a Mental health ED. The current position is:

- Neighbourhood Mental Health Centre ER - £1.4m to be delivered 28/29
- Neighbourhood Mental Health Centre Hull - £1.35m to be delivered 26/27
- Mental Health ED - £5m – funding over 5 years

The capital estates money has been approved in principle pending some further information for the Hull Neighbourhood Mental Health Centre and the Mental Health ED. All schemes will require a full business case before funding is released.

0-19s

Papers have now been submitted to both Hull and East Riding Local Authorities outlining the Trust's health response to the SEND White Paper through the Experts at Hand model. Hull has formally approved the proposal, and East Riding has indicated agreement in principle.

This will position the Trust as a key delivery partner within the local SEND transformation, embedding a preventative, multidisciplinary expert health offer within mainstream education.

The Trust proposals set out a phased investment, delivering system-wide impact through earlier intervention, reduced reliance on EHCP pathways, and strengthened inclusion for children and young people with SEND.

The Trust's offer incorporates Speech and Language Therapy, Occupational Therapy, Sensory, Neurodiversity and School Nursing Services.

Primary Care

The King Street Medical Centre in Cottingham successfully transferred to the Greengates Medical Group on 31st March. The project has been formally closed.

The Humber Primary Care Practice in Bridlington transferred to Drs Reddy & Nunn on 22nd April. The legal documentation to underpin the transfer is yet to be formally signed, as such the project remains open. Hill Dickinson, providing legal representation for the Trust, are working with their counterparts from Drs Reddy & Nunn to bring this to a conclusion.

The Trust is working with a partner organisation on the safe transfer of the Market Weighton Practice. Heads of Terms (including an exclusivity clause) and a Confidentiality Agreement to underpin the partnership have been signed, due diligence information has been shared, and the Trust is continuing to make good progress.

Health Inequalities

Citizens Advice Hull and East Riding have agreed to pilot supporting the MADE group for one year using their Health Inequalities funding, to help reduce delayed discharges.

The QI pilot on Avondale with Citizens Advice Hull and East Riding to improve patient access to finance and debt advice is progressing well, with steady referrals and work underway to develop a data-sharing agreement.

6. Communications Update

See Appendix 1 & 2.

7. Health Stars Update

See Appendix 3.

Media Coverage – YTD



142 positive stories published in local/national media



5 Negative stories published

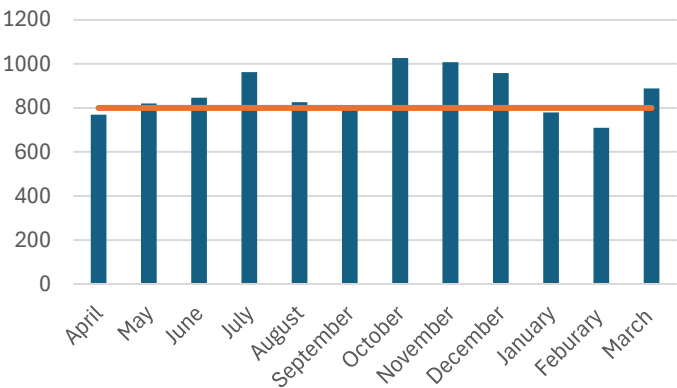
Monthly target of 5 positive stories:
1 negative story

Q4

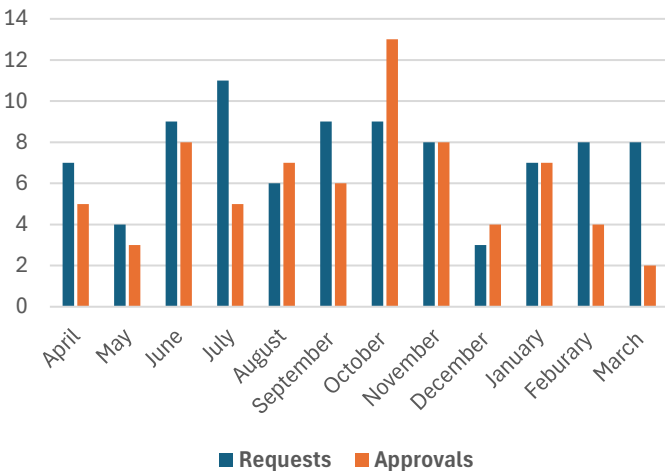
Funnel Stages	Number of Items
Published with key messages	19
Published with high reach	12
Published	39
Picked up by journalists	19
Press releases issued	12

Brand Management

Brand Portal Visits



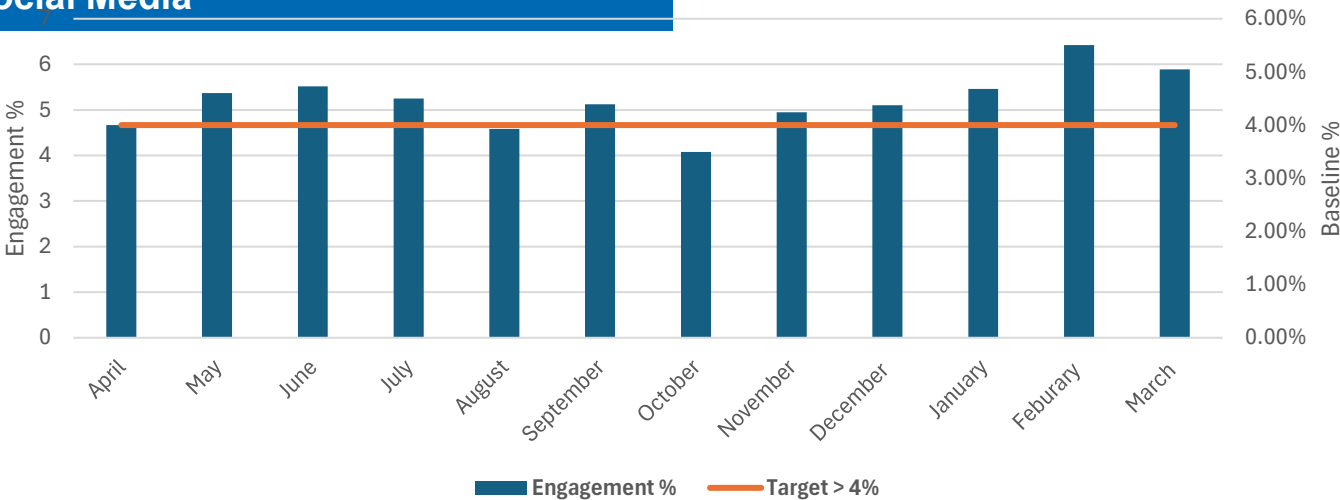
Brand Requests vs Approvals



The requests v approvals graph shows steady demand for brand support across the year, with predictable seasonal dips and a clear peak in July. Approvals generally keep pace with requests, indicating the process is working well. The pattern suggests teams are engaging with brand governance, but there is further opportunity for them to use the self-serve tools and templates available, coming to the Communications Team primarily for final approvals rather than full support.

Social Media

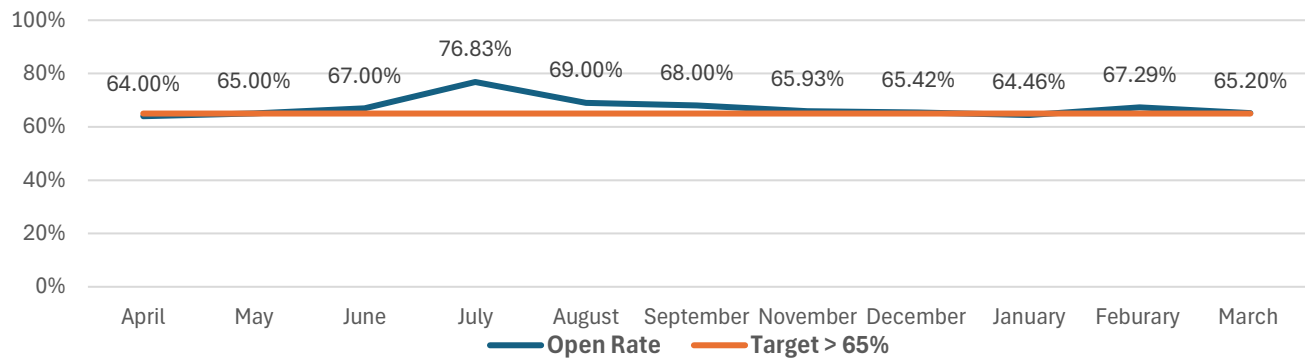
Social Media Engagement Rate



Social media engagement rate shows how actively people are interacting with our posts. It helps us understand whether our content is connecting with our audience.

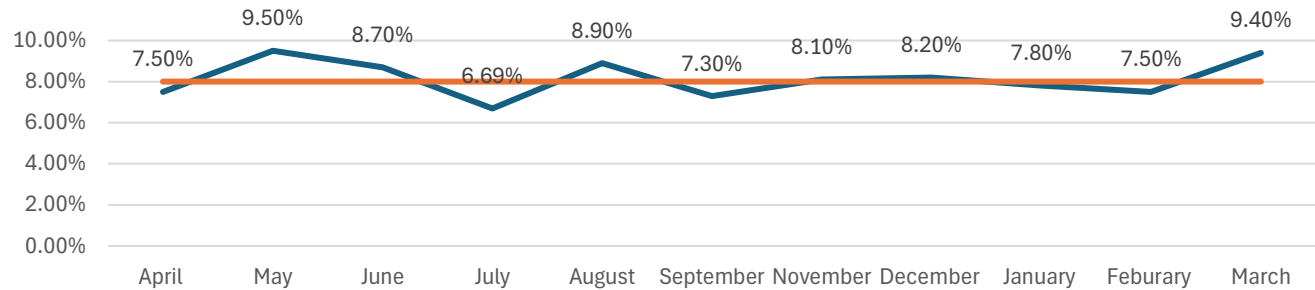
Internal Communications

Global Open Rate

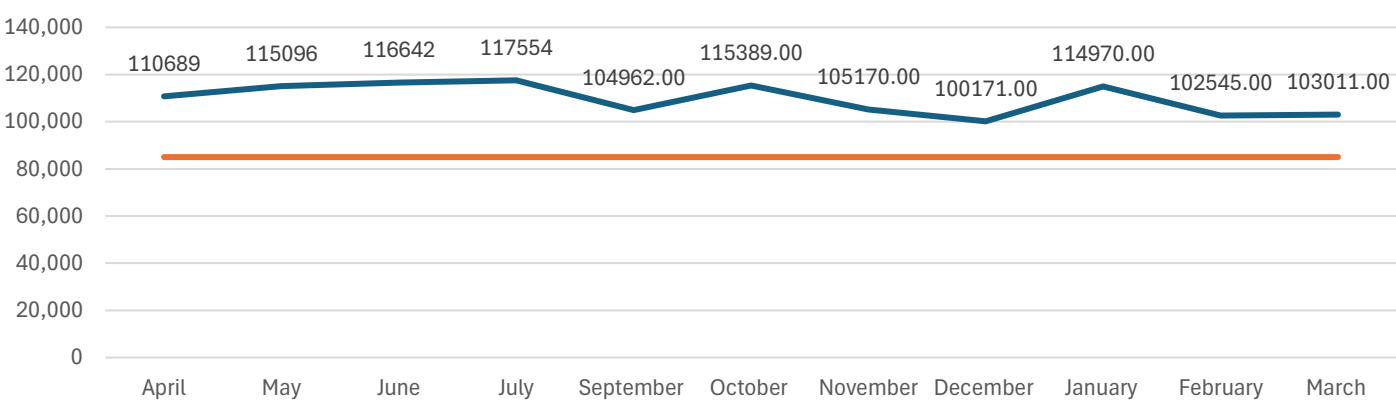


Global staff newsletter performance shows how many colleagues are opening and engaging with our regular updates. The click-through rate (CTR) shows how many go on to interact further by clicking on links, stories, or calls to action. Slight drop expected in February due to half term.

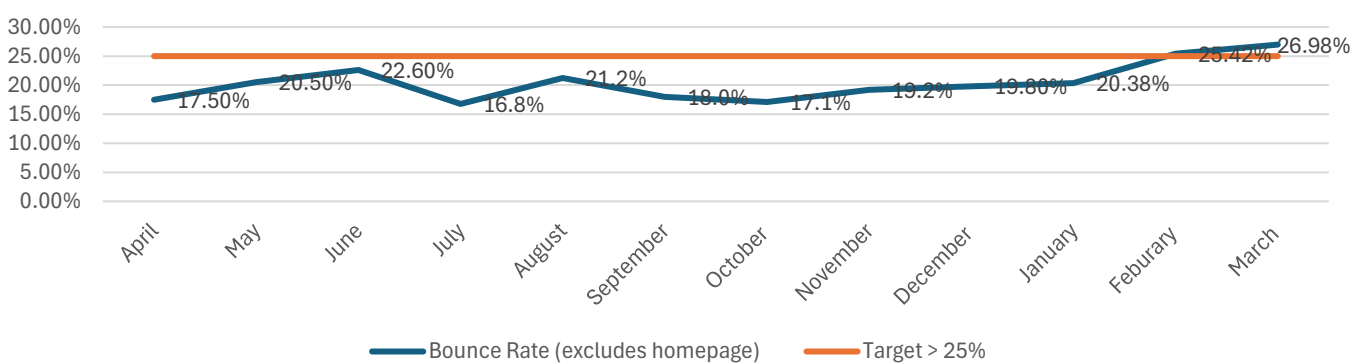
Global Click Through



Intranet Sessions

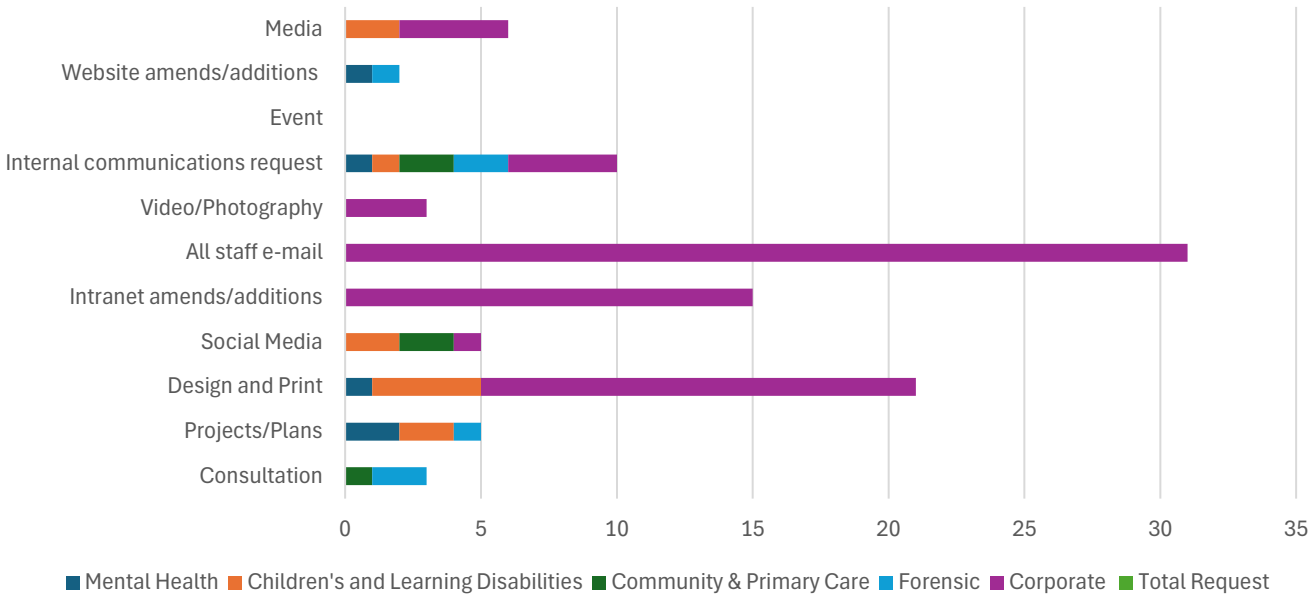


Intranet Bounce Rate (Excluding homepage)



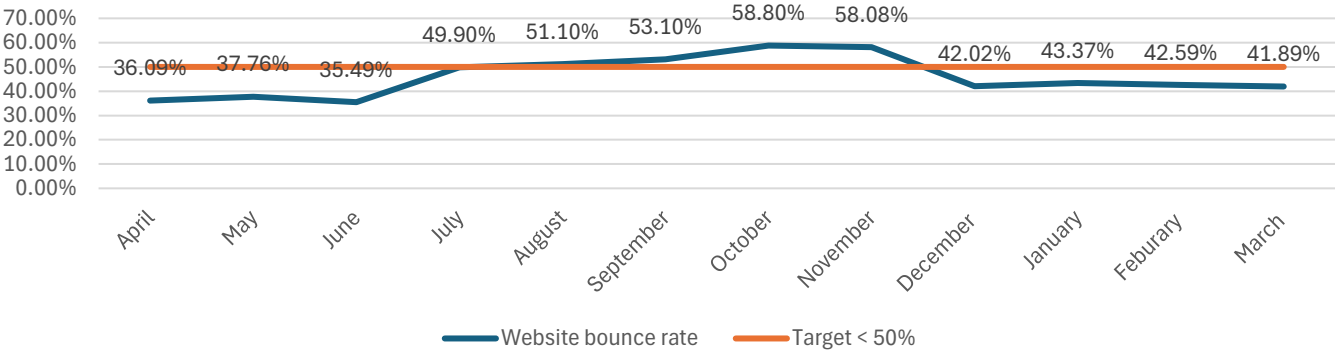
Communications Service

Support By Area



Website

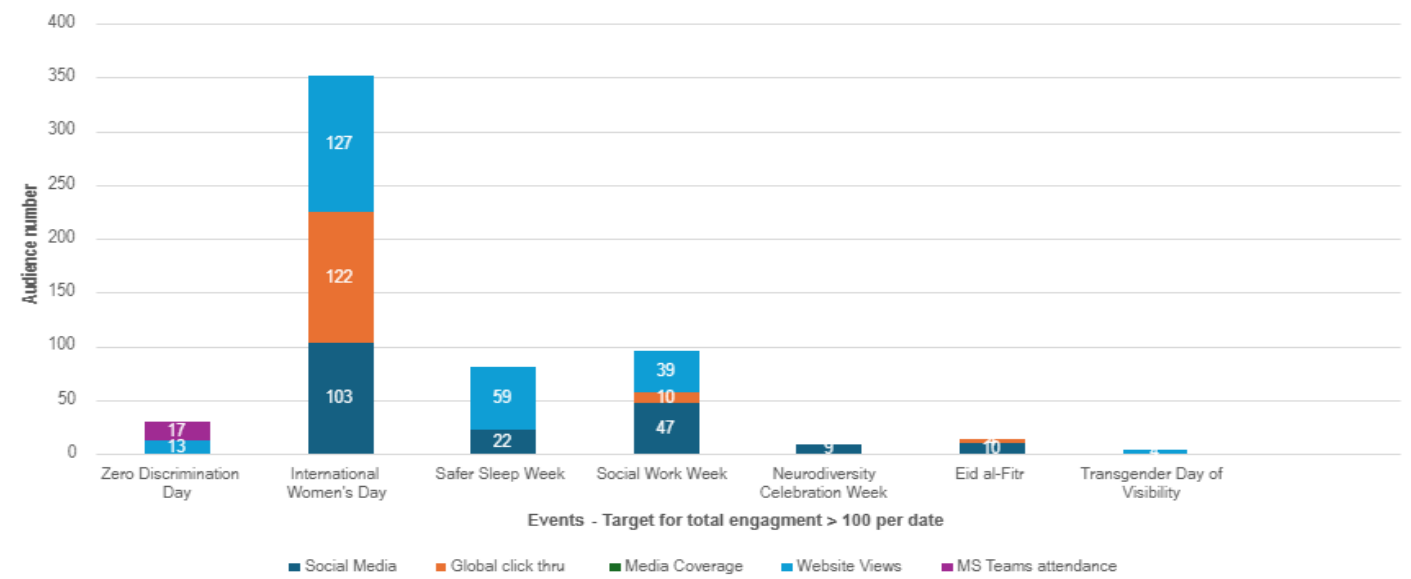
Homepage Bounce Rate



Bounce rate has reduced following the introduction of the new search function, enabling users to find precise information more quickly. As users increasingly reach the content they need via the shortest possible route, some fluctuation in overall page views is expected.

Events

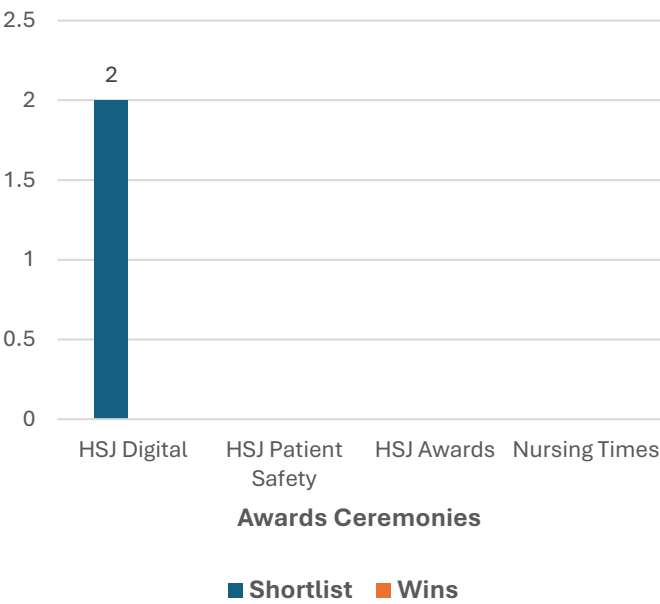
Awareness Days Engagement



February and March saw a marked uplift in awareness-day performance, with multiple red-rated dates significantly exceeding engagement targets — including 689 engagements for Mental Health Nurses Day, 233 for Time to Talk Day, 206 for Children’s Mental Health Week, and 352 for International Women’s Day in March. Non-red dates also performed strongly, with Social Work Week and Safer Sleep Week both surpassing their 50-engagement target. This sustained improvement reflects the impact of weekly content-planning meetings and the refreshed, proactive approach to contacting awareness-day leads, resulting in better-planned, multi-channel content that aligns with staff interests and Trust priorities.

Awards nominations and wins

The awards season has now begun. The new NHS Excellence Awards closed for nominations in March – we supported 19 nominations. We are supporting teams who are entering the HSJ Patient Safety Awards, HSJ Awards and The Nursing Times Awards.



Communications Board Report – January – March 2026

This is the final report to the Board on the delivery of the first year of the 2025–2027 Communications Plan.

Progress against the strategy is reported in two ways. Operational performance of core communications channels is monitored quarterly and shared with the Executive Management Team through a dashboard (appendix 1). This report will come to the board quarterly and focuses on the second strand: progress made against the strategic priorities identified to support delivery of the seven objectives.

Strategy theme: Promoting people, communities, and social values

Project title	Strategic intent	Key activity during the reporting period	Progress and impact	Target outcomes by 2027
Shared Content Strategy	To improve the consistency, accessibility, and impact of content by coordinating how stories and messages are planned, created, and shared across channels.	Content planning meetings embedded as standard practice. Yearly review has taken place with a focus on content that is best engaged with, strategy to adapt accordingly.	Average social media engagement rate of 5.18% percent, with a peak of 30 percent. Reduction in single use content, limited to one off announcements. 20 people focused stories suitable for press or social media published since April 2025. 222 social media posts published across the period, averaging three posts per day. This brings the yearly total to 1,122.	Sustained average social media engagement rate of 8%. No single use content outside exceptional announcements. Fully embedded content planning and logging process. A minimum of ten people focused press or social media stories published each year. Consistent weekday posting of three to twelve posts, excluding event days.
Health Inequalities	To reduce barriers to accessing information by improving the availability,	Patient information library initial build is complete.	Patient information library is currently being tested ahead of launch. This will provide a single source of accessible information to patients.	Measurable increase in access to patient information, with usage KPIs set six months after launch.

Project title	Strategic intent	Key activity during the reporting period	Progress and impact	Target outcomes by 2027
	accessibility, and inclusivity of patient communications.	The Trust website is ready for re-auditing to achieve WCAG 2.2 rating New guidance on online documents has been produced and new templates added to the brand centre.	All accessibility issues within the Humber website that would be unseen to those who do not use screen readers have now been fixed. This will ensure that we are compliant with WCAG 2.2, which is the 'gold standard' for website accessibility. Accessibility checklist is continuing to be well used by members of staff, the number of documents that need multiple amends has decreased significantly. All documents on Trust external-facing websites are now in formats that can be accessible.	Accessibility checklist applied to all documents submitted through the Brand inbox. Month on month increase in the number of documents available in multiple accessible formats.

Strategy Theme: Developing and Effective and Empowered Workforce

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Cultural communications	To support a positive and inclusive culture through clear, compassionate internal communication, strengthen leadership visibility, improve message cascades, and increase two way communication.	Updated intranet AI search function being well used, with further improvements currently being carried out to further enhance the functionality so that the search looks for words within policy documents, instead of just the title of the document.	Improved access to information through a more usable intranet. There has been an increase in visits to the news section of the intranet which has	New staff newsletter design, name, and editorial focus agreed by Executive Management Team. Sustained improvement in staff engagement with internal communications.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		This will be completed by end May. The new Weekly Global has been running for two months. With a cleaner, design it is easier to navigate. The open rate remains consistent whilst engagement has increased meaning more staff clicking links and for information within the articles. New fortnightly managers operational update developed to be sent from Deputy COO has received positive feedback. Support given to our IT team set up a new M365 network. Encouraging communication between staff, who will share tips and advice on how to perform tasks within Microsoft 365 tools. 44 staff members have signed up, with continued efforts to	been visited by 1,376 different users, making it an increasingly important news channel. More direct and timely operational direction for managers, supporting improved cascade of actions alongside existing staff and executive communications. The M365 network will support collaborative working to find solutions to everyday Microsoft issues, leading to a more digitally confident workforce.	Continued year on year improvement in Staff Survey participation and feedback on communication and leadership visibility.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		further increase this number being made.		
Communications training hub	To build confidence and capability across the organisation by sharing communications skills and expertise through accessible online and in person training.	Communications training booklet created and designed for online use. Media training has now been accessed by 73 staff across the Trust Working with EPRR Team to create bespoke Director on Call media training Media Training is now accessible on ESR and shows against staff's training records, legitimising the sessions and adding greater impact.	Increased access to consistent communications and media training materials. Improved visibility and sustainability of training through ESR, reducing reliance on ad hoc sessions. Strengthened protection for potential times of crisis.	Fully launched communications training hub combining digital and in person offer. Measurable increase in uptake of communications and media training. Improved staff confidence in local communication activity, reflected in feedback and reduced reactive demand on the communications team.
Humblebelievable recruitment campaign	To support recruitment and retention through a strong, consistent employer brand and an award winning, data led recruitment marketing campaign.	New Year, New Job and Spring recruitment campaigns are now complete.	Recruitment campaign performance maintained in line with previous year with 150,000 visits to the Join Humber website. Engagement rate on website has grown to 50% from 30%.	Sustained or improved recruitment campaign performance year on year. Nursing vacancy rate reduced to around 6% or below. Continued growth in jobs bulletin subscribers and engagement,

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
			Join Humber jobs bulletin subscriber base consistently sits at 2700, with an open rate consistently above 40%	supporting a strong recruitment pipeline.

Strategy Theme: Enhancing prevention, wellbeing and recovery.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Trauma-informed communications	To support the Trust's aspiration to embed a trauma-informed culture by recognising the impact of trauma, fostering safe and trusting communication, and adapting practices to support recovery and prevent re-traumatisation.	Two podcasts recorded sharing the work of the Care Culture and equity group under the 'See the Story' campaign umbrella. Intranet hub and podcast to launch in May during Mental Health Awareness Month. Co-produced Trauma Informed Language Guide complete - to be launched following Care Culture and Equity Group approval in June.	KPI of 'See the Story' campaign is the increase in Trauma Informed self-assessments and the number of Trauma informed training sessions booked via ESR. Early foundations in place to support consistent application of trauma-informed standards across services.	80% of materials submitted to the Brand inbox meet agreed trauma-informed communication standards by Q3 2027. Improved staff self-assessment of trauma-informed practice and community awareness by Q3 2027. Increased use of accessibility tools including ReachDeck and AccessAble to more than 60% by 2027.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Digital accessibility	To maintain a fully inclusive and accessible digital environment by implementing website accessibility audits and acting on recommendations, removing barriers to accessing digital communications.	Audit actions that required web development approved by Digital Delivery group. This will be completed by the end of March 2026. Internal audit actions complete. Accreditation process to begin in May 2026. Microsoft Sway newsletter templates rolled out on Brand Centre. Plain text templates and accessibility guidance added to Brand Centre.	Improved consistency and quality of accessible digital content. Clear delivery plan in place to address audit findings and reduce non-compliance risk. Increased staff awareness of digital accessibility standards and responsibilities.	AbilityNet accreditation achieved and maintained. Trust website named in the Top 30 NHS websites for accessibility. All Recommendations from accessibility audits implemented to meet web accessibility standards. Measurable increase in the percentage of digital content and platforms meeting accessibility requirements. Expanded accessibility resources available through the Brand Centre.

Communications Partner Projects

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Community and primary care	To support integrated community and primary care pathways by providing clear, targeted communications that improve understanding, referral quality, and partnership working.	Completed – member of staff on maternity leave.	Positive feedback from the Virtual Wards Service Manager and Matron on support to communicate service priorities.	Sustained improvement in referral quality and bed occupancy for virtual ward services. Positive partner feedback on the effectiveness of

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
			Improved shared understanding of pathway focus areas across partner organisations. Early indications of improved appropriateness of referrals and sustained bed occupancy.	communication across integrated pathways. Consistent access to communications support for community services during periods of staff absence.
Mental health, Recovery and Wellbeing College	To increase awareness and engagement with the Humber Recovery and Wellbeing College by reaching wider audiences through targeted, interest-based communications.	Ongoing promotional activity focused primarily on staff audiences, with secondary emphasis on social media has continued beyond initial campaign period. Minimum of two social media posts per week. Recovery-focused content published weekly on Trust social media channels.	30% increase in social media followers since the campaign began. Sustained session attendance growth of 25% supported by positive feedback from new attendees.	Doubling of social media following for the Recovery and Wellbeing College. Sustained increase in session attendance of at least twenty five percent. Clear evidence of improved reach and engagement following analysis after the winter campaigning period.
Forensic	Raising the profile of the Forensic Division by sharing its news, achievements, and stories more widely across both internal Trust channels and external platforms.	South West Lodge video was produced for use at stakeholder event Forensic stories are now shared regularly in the Global for increased awareness Trust-wide	Forensic division now has the lowest vacancy rate across the Trust.	Increase in stories shared in both Global and Trust website news, raising the profile of the division.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		External stories have been shared on Trust channels – EDI award, Conference presentation		
Children's and learning disabilities	To strengthen communications across children's and learning disabilities services through a Communications Champions Forum, supporting consistent messaging and shared responses to local health priorities.	Campaigns around potty training and immunisations have been developed ready for launch.	4 external facing stories have been produced and growing reactive and proactive communications channels continue.	Identify external facing stories and share through channels – aim for 3 external facing per year

Strategy Theme: Fostering Integration Partnerships and Alliances

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Cultivating collaboration and managing internal efficiencies	To strengthen collaboration, improve internal culture, and embed more sustainable ways of working within the communications function, supporting a resilient and future-ready service aligned to organisational priorities.	Actions taken to address internal culture themes identified through staff survey feedback – focus on education and knowledge sharing in Q4. Q4 surveys shared – results being analysed this month to set benchmark for this time next year. Including feedback on Communications Partner role.	Increased focus on priority areas through clearer planning. Strategic approach to service-level communications and relation building. Positive feedback on communications involvement in Trust-wide projects.	At least 80% overall team satisfaction. More than seventy percent of team members report satisfaction working in the communications team. More than 60% of senior managers report feeling

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		Key priority areas for 2026-27 selected in Q1.	Higher levels of efficiency and collaboration due to introduction of shared digital tools across the team.	well supported by the communications team. 80% or more of team members report confidence in new processes and tools by year end.

Strategy theme: Optimising an efficient and sustainable organisation

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
Digital empowerment, innovation and quality	To empower staff and communities to understand and confidently use digital tools, promote innovation and quality, and support the shift from analogue to digital in line with the national 10 Year Plan.	Interweave communications support ongoing, including for the Summit 3.5 event in Birmingham in March. Communications support provided to Trust-wide BeDigital programmes, including the new BeDigital Glossary and Resulting Go Live. BeDigital Week 2026 complete.	Improved visibility and understanding of Trust-wide digital programmes and their benefits. Stronger narrative around the value of digital investment and innovation. Increased confidence among senior leaders through clearer reporting of digital communications impact	See BeDigital Strategic Communications Plan 2026-28, which is in line with the Trust's Enabling Digital Strategy. See Interweave Communications Strategy 2025-27.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		Positive case studies from digital investment captured and shared. Digital Literacy Framework begins in Q1. Regular EMT and Board updates provided using meaningful digital communications data and outputs.	aligned to organisational goals and the 10 Year Plan. Early strengthening of media relationships to support future digital innovation coverage.	

Strategy Theme: innovating for Quality & Patient Safety

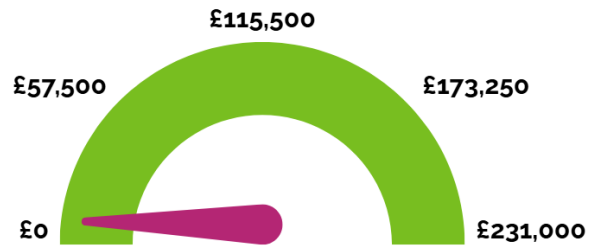
Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
CQC communications support	To support quality improvement and regulatory readiness by providing clear, timely communications aligned to CQC requirements and internal quality priorities.	Q4 self-assessments completed. Attendance at Quality Standards Group to report on progress and	Improved clarity and shared understanding of CQC position and progress. Stronger alignment between quality activity and communications support. Increased confidence in the Trust's approach to CQC	Sustained improvement across CQC self-assessment domains. Clear and consistent communications support embedded within quality governance structures. Improved organisational readiness and assurance ahead of inspection activity.

Project title	Strategic intent	Progress during the reporting period	Impact	Target outcomes by 2027
		support priority areas. Supported recent inspections and part of new inspection response plan.	readiness, reflected in positive senior feedback and improved self-assessment outcomes. Improved process to manage inspection outcomes	
Freedom to Speak Up	To increase awareness, confidence, and appropriate use of the Freedom to Speak Up process, supporting a culture of openness, learning, and patient safety.	Plan for 2026/2027 by using staff survey results to help with planning for the next year. Book in to attending 2026 FTSU Meetings New posters on staff sites	Data from the staff survey will help inform relevant plans and decisions. Ensure consistent support and relationship building with the communications team. More visibility of FTSU and reporting procedure in staff facing areas.	Increase in the percentage of staff who report awareness of Freedom to Speak Up and understanding of the process through Staff Survey results. Increase in low-level Freedom to Speak Up reporting, indicating greater confidence to raise concerns early.

Health Stars: Performance Dashboard

April 2026

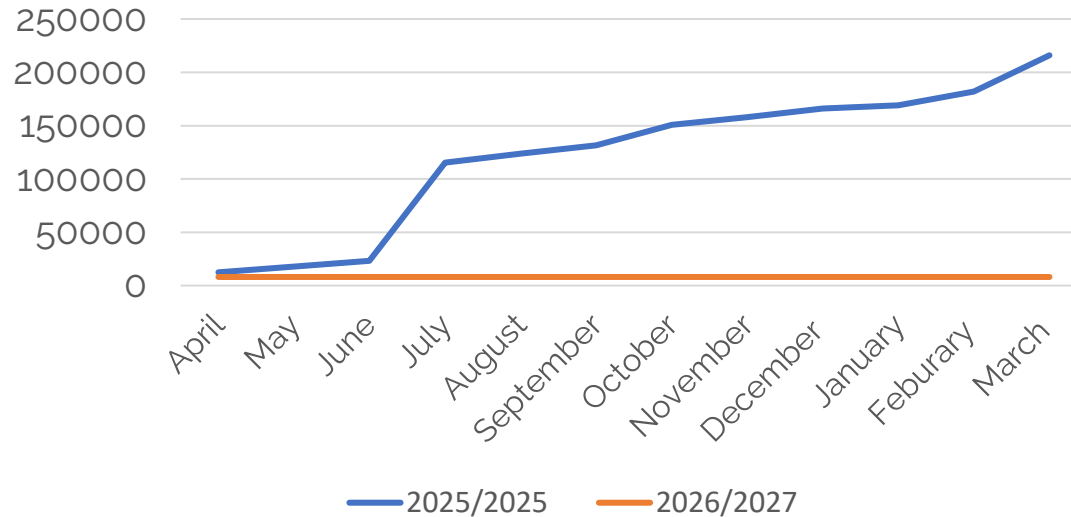
Funds raised to date



£8,086

Target: £231,000

Income by month



Fundraiser of the month

Get Caked raised £1205!

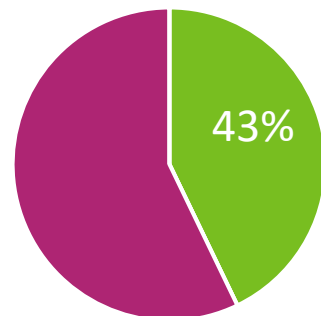


Total wishes received to date:

7

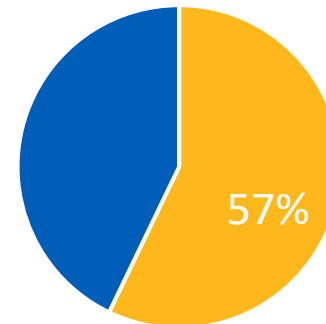
(2025/26 = 10)

Wishes approvals



■ Approved ■ Declined ■ In Progress ■ Closed

Wish Benefit



■ Patient ■ Staff ■ Other

HIGHLIGHTS

- ★ 111 participants signed up to 2026 events
- ★ 16 teams signed up to Golf Day
- ★ Workforce Wellbeing Exchange event launched as part of Humber Biz Week
- ★ HYAG raised £150 in bucket collection

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Publications and Policy Highlights														
Author/s:	Michele Moran Chief Executive														
Recommendation:	<table border="1"> <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>			To approve		To discuss		To note	√	To ratify		For assurance			
To approve		To discuss													
To note	√	To ratify													
For assurance															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	To inform and update the Trust Board on recent publications and policy since the March 2026 Board meeting (as detailed below): • Neighbourhood Health Framework • Towards Population Health Delivery Models • Direct Commissioning • Martha's Rule: Core Standards • National Staff Survey Results • NHS Workforce – International Recruitment • Considerations for creating effective strategic partnerships to deliver the Ten Year Plan • Integrated Health Organisations • Digital Transformation Strategies • NHS England statement on information on health inequalities • The Future of Freedom to Speak Up • Supporting young people to transition into adolescent and adult services • Good practice in caring for people with dementia														
Key Issues within the report:															
Positive Assurances to Provide: • n/a		Key Actions Commissioned/Work Underway: • n/a													
Key Risks/Areas of Focus: • n/a		Decisions Made: • n/a													

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

Monitoring and assurance framework summary:

Links to Strategic Goals (please indicate which strategic goal/s this paper relates to)				
√ Tick those that apply				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
√	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Publications and Policy Highlights

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

1. Neighbourhood Health Framework

The Department of Health and Social Care has published a framework which defines neighbourhood health and sets out the challenges neighbourhood health and care services should address. It aims to establish clear metrics for success and maps out the process systems that should go through to establish local metrics. It also defines the roles of integrated care board, local authorities, health and wellbeing board, and other partners in neighbourhood health's development and implementation.

Link: <https://www.gov.uk/government/publications/neighbourhood-health-framework>

Lead: Executive Director of Finance/Chief Executive:

Work on neighbourhood health is being led by the Integrated Care Board, and the Trust (Via Executive Management Team) will monitor progress and evolving model to ensure the migration to Neighbourhood Health is successful and the Trust are able to play an appropriate role.

2. Towards Population Health Delivery Models

To realise the ambitions set out in the 10 Year Health Plan, services must be delivered in new ways that better meet patients' needs and provide care as close to home as possible. As set out in the Neighbourhood Health Framework, this means improving routine health care services, moving to a more proactive care model for people with multiple long-term conditions and delivering better alternatives to hospital care.

NHS England has published a document which sets out new population health delivery models to facilitate these changes, supporting integrated care boards (ICBs) to commission providers around the needs of defined populations. ICBs, working with partners (including local authorities and health and wellbeing boards) will agree neighbourhood footprints that form clearly defined populations. Single neighbourhood, multi-neighbourhood and integrated health organisation contracts will be commissioned around these populations.

Link: <https://www.england.nhs.uk/publication/improving-postnatal-care-a-toolkit-for-integrated-care-boards-partners-and-providers/>

The NHS Alliance has produced a briefing outlining the headline points and analysis of NHSE's blueprint for how the new population-level delivery models will operate.

Link: <https://thenhsalliance.org/resources/towards-population-health-delivery-models-what-you-need-to-know>

Lead: Executive Director of Finance/Chief Executive:

Population Health is linked to the Neighbourhood Health agenda – similar to item 1 the Trust will continue to be involved as this work progresses, and regular updates will be provided to the Trust Board.

3. Direct Commissioning

NHS England has published a letter which confirms plans to transfer their direct commissioning functions to ICBs from next April (2027), including the services in scope. It sets out the role of new regional “Offices for Pan-ICB Commissioning” (OPICs), OPIC arrangements, and next steps for transition.

Link: [NHS England » Direct commissioning update](#)

Lead: Executive Director of Finance:

Delegation will mostly impact on the Specialist Provider Collaborative which the Trust Lead/Host and the Trust remain in ongoing dialogue with NHSE. Regular updates will be provided to the Collaborative Committee.

4. Martha’s Rule: Core Standards

NHS England data has highlighted there were over 10,000 calls to Martha’s Rule in the first 16 months of the NHS scheme to trigger an urgent review of care. The data shows that one in three calls to Martha’s Rule by patients, families and staff identified rapid worsening of a patient’s condition, helping the NHS to identify concerns more quickly and make crucial interventions to care.

Martha’s Rule has now been included in the NHS Standard Contract. This guidance helps providers to meet this requirement by describing what they should have in place for the safe, effective and reliable implementation of Martha’s Rule.

Link: [NHS England » Over 10,000 calls to Martha’s Rule in first 16 months to trigger urgent review of care](#)

Lead: Executive Medical Director:

The Trust welcomes the introduction of Martha’s Rule as an important step in strengthening patient safety and ensuring that the voices of patients, carers, and staff are heard.

While initial implementation has focused on acute hospitals, we are adopting a locally tailored approach within the trust, building on our existing policies for second opinions and the management of physical health deterioration. This will ensure that concerns about both mental and physical health are recognised early, escalated promptly, and responded to by senior clinicians, reinforcing our commitment to safe, responsive, and patient-centred care.

5. National Staff Survey Results

NHS Alliance has produced a summary of the national-level findings of the Staff Survey results. The results give valuable insight into the experiences of 760,000 people working in the NHS in 2005

Link to the report: [NHS Staff Survey results 2025: what you need to know](#)

Lead: Executive Director of People and Organisational Development:

The Trust welcomes the publication of the 2025 National Staff Survey results and recognises the continued value of the survey in providing insight into the experiences of our workforce. We will use both national insights and our local results to further strengthen our focus on staff experience, particularly in areas of identified challenge.

Our approach will prioritise targeted action planning, strengthened leadership visibility, and improved feedback loops to ensure colleagues see tangible outcomes from their input.

This work will be aligned to delivery of our enabling People Strategy, with a clear emphasis on improving engagement, wellbeing, and inclusion across all staff groups.

6. NHS Workforce – International Recruitment

The House of Commons Library has produced a briefing which summarises numbers and trends in international recruitment of the NHS workforce.

The NHS has many staffing vacancies that it struggles to fill. In December 2025, around 6.7% of roles in the workforce were vacant (100,000 full-time equivalent posts). Although the NHS workforce has been growing, demand for NHS services has been growing faster. Over the years, the NHS has increasingly relied on international recruitment to fill vacancies.

Link: [International recruitment in the NHS workforce - House of Commons Library](#)

Lead: Executive Director of People and Organisational Development:

The Trust recognises the national context outlined within the briefing, particularly the sustained vacancy challenge across the NHS and the increasing reliance on international recruitment to support workforce supply. International colleagues continue to make a highly valued contribution to our services and patient care, and we remain committed to ethical recruitment practices and providing a supportive and inclusive environment for all internationally recruited staff.

Locally, our approach will balance the benefits of international recruitment with a strengthened focus on developing and retaining our substantive workforce. This includes delivering our People Strategy priorities around attraction, retention, and employee experience, alongside reducing reliance on temporary staffing through sustainable workforce models.

We will continue to monitor workforce trends and ensure our recruitment approach aligns to both national policy and our longer-term ambition to build a resilient, skilled, and engaged workforce.

7. Considerations for creating effective strategic partnerships to deliver the Ten Year Plan

NHS Alliance has published guidance which shares insights of leaders from at-scale primary care organisations and NHS trusts on how strategic partnerships can improve patient outcomes, strengthen neighbourhood delivery models and use collective resources more efficiently. Through expert presentations, panel discussions and thematic workshops, participants reflected openly on the cultural, operational and structural factors that make or break partnership working today

Link: [Forging strategic partnerships: considerations for delivering the 10 Year Health Plan](#)

Lead: Executive Director of Finance/Chief Executive

This document will be reviewed by the Executive Management Team (EMT); the Trust are already well placed given its strong track record on partnership working.

8. Integrated Health Organisations

NHS Alliance has published a briefing summarising trusts leaders' views on the advanced foundation trust (AFT) programme. The briefing discusses how AFT flexibilities can support population health improvement and neighbourhood level integration, while offering recommendations for NHS England and the Department of Health and Social Care.

Link: [Trust leaders' perspectives on advanced foundation trust freedoms and population health](#)

Lead: Executive Director of Finance/Chief Executive

The Trust hope to be in the next round of AFT accreditation and are in contact with Phase 1 Trusts for learning, updates will be provided to EMT and Committee/Board as learning evolves.

9. Digital Transformation Strategies

NHS Providers has published a report which examines why an outcome-focused board is necessary to ensure that every digital investment can be translated into measurable impact whether that be quality, safety or productivity.

The report has been produced by the Digital Boards programme which is delivered in partnership with Public Digital and funded by NHS England as part of their Digital Academy programmes

Link: [Digital insights: Outcomes are at the heart of patient care, so why not your digital transformation?](#)

Lead: Executive Director of Finance

The Trust have commissioned a review of digital governance to ensure appropriate oversight at board level, this will result in a number of recommendations to Board to ensure our digital strategy is outcome focussed, the updated Digital Plan is due to be presented to the Trust Board in July.

10. NHS England statement on information on health inequalities

NHS England has produced a statement which supports relevant NHS bodies to fulfil their legal duties and take an evidence-led improvement approach to tackling health inequalities, for adults and children and young people.

It also provides guidance on how health inequalities information should be used to inform local action and how this should be reflected in annual reports.

Link: [NHS England » NHS England's statement on information on health inequalities](#)

Lead: Executive Medical Director

The report provides assurance that the Trust is making good progress in addressing health inequalities, with a wide range of initiatives embedded across services, workforce, partnerships and community programmes. It demonstrates a strong organisational commitment, with inequalities integrated into major transformation work and supported through effective collaboration with partners and local communities.

However, in line with NHS England expectations, further work is needed to strengthen the systematic use of data and to more clearly demonstrate measurable impact. The next phase will focus on improving data quality, aligning reporting with national frameworks such as Core20PLUS5, and evidencing how these actions are translating into reduced inequalities in access, experience and outcomes.

11. The Future of Freedom to Speak Up

From 1 July 2026, following a recommendation in July 2025 by the [Dash review](#) of patient safety across health and care, NHS England will deliver some activities previously undertaken by the National Guardian's Office (NGO). Trusts, primary care organisations, integrated care boards (ICBs) and independent providers will be taking on greater responsibility and accountability for embedding effective Freedom to Speak Up arrangements.

Link: [NHS England » The future of Freedom to Speak Up](#)

Lead: Freedom to Speak Up Guardian

This report follows a wide consultation with organisations regarding the future arrangements for speak up, following the closure of the National Guardians Office.

From 1 July 2026, provider organisations will need to evidence the following:-

- Take sole responsibility for ensuring information on how to contact the FTSU Guardian is accurate, accessible and publicly available.
- Continue to submit data through the NHS England system.
- Ensure guardians complete the national mandatory training.
- Ensure psychological support is available for the Guardian from 31 December 2026.

The Care Quality Commission will assess whether providers have effective speaking up arrangements in place and that the Guardians have the right skills and training.

12. Supporting young people to transition into adolescent and adult services

NHS England has published guidance which is designed to support services to provide developmentally appropriate care for 0 to 25-year-olds. It sets out proposed actions for integrated care boards (ICBs), providers and clinical teams to enable safe and effective transition between services. It is anticipated that if adopted by systems, this approach will improve continuity of care, health outcomes and young people's experience.

Link: [NHS England » Supporting young people to transition into adolescent and adult services](#)

Lead: Chief Operating Officer

This guidance responds to what young people, families and NHS staff have said: there is a lack of clarity and accountability for healthcare transition. It sets out recommendations and examples of good practice. In doing so, it supports the ambitions of the [10 Year Health Plan](#), as well as the Strategic Commissioning Framework which asks ICBs to take a holistic view of population health.

The guidance applies to young people transitioning from our child and adolescent mental health services and those within our learning disability service. The Trust already has guidance in place to support these pathways and our relevant clinical governance networks are reviewing those in line with this publication.

13. Good Practice in Caring for People with Dementia

The Care Quality Commission commissioned IFF Research and Professor Sarah Smith at the Centre for Dementia Research (Leeds Beckett University) to do a review of good practice in supporting those living with a dementia in the UK and around the world. The review aimed to identify the things that make care good quality and ensure people have a good experience of the care they receive, including the conditions that help them succeed. The results will help CQC create clear guidance for care services and set a consistent definition of "what good looks like" across care for those living with a dementia and their family/carers.

Link: [13350-Dementia-Care-Literature-Review-Report-V4-Clean.pdf](#)

Lead: Executive Medical Director/Executive Director of Nursing, Quality and Professions

The report will be considered by the Quality Standards Group.

Agenda Item 09

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026			
Title of Report:	Board Assurance Framework			
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: <i>Please make any decisions required of Board clear in this section:</i>	The report provides the Trust Board with the most recent version of the Board Assurance Framework (BAF) allowing for the monitoring of progress against the Trust's six strategic goals.			
Key Issues within the report:				
Positive Assurances to Provide: - Progress against the identified risks to each of the Trust's strategic goals is reflected within the framework to allow for consideration to be given to assurances in place, which enables focused review and discussion of the challenges to the delivery of the organisational objectives. - Each of the Board Assurance Framework sections continue to be reviewed by the assigned assuring committee alongside the recorded risks, to provide further assurance around the management of risks to achievement of the Trust's strategic goals. - Overall assurance rating for each of the strategic goals is applied based on the review of the positive assurance, negative assurance and gaps in assurance identified against the individual goal. The overall rating is applied based on the overall assurance available to the Executive Lead at the time of review.		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT): Following review of the Board Assurance Framework template as part of the recent internal audit and presentation to EMT in April, the document has now been presented in the revised format.		
Key Risks/Areas of Focus: Trust Board is asked to review the current iteration of the Board Assurance Framework and to identify any further elements for consideration as part of the ongoing		Decisions Made: Current assurance ratings for each section of the Board Assurance Framework are detailed below following review by EMT:		

development of the Board Assurance Framework.		Strategic Goal – Innovating for Quality and Patient Safety - Current rating 8 – High. Strategic Goal – Enhancing prevention, wellbeing, and recovery. - Current rating 12 – High. Strategic Goal – Fostering integration, partnerships, and alliances. - Current rating 8 – High. Strategic Goal – Promoting people, communities, and social values. - Current rating 6 – Moderate. Strategic Goal – Developing an effective and empowered workforce. - Current rating 8 – High. Strategic Goal – Optimising an efficient and sustainable organisation. - Current rating 8 – High.			
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>			Date		Date
	Audit Committee		05/2026	Remuneration & Nominations Committee	
	Quality Committee		04/2026	People & Organisational Development Committee	05/2026
	Finance Committee		04/2026	Executive Management Team	05/2026
	Mental Health Legislation Committee		04/2026	Operational Delivery Group	
	Collaborative Committee			Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals (please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)				
√ Tick those that apply				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
√	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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 Framework

Quarter 4 2025/26

Humber Teaching NHS Foundation Trust Strategic Goals / Objectives

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

RISK APPETITE

Strategic Goal	Executive Lead	Risk Appetite (Agreed by Trust Board June 2025)	Threshold Risk Score
Innovating for quality and patient safety	Executive Director of Nursing	SEEK	15
Enhancing prevention, wellbeing, and recovery	Chief Operating Officer	MATURE	15+
Fostering integration, partnerships, and alliances	Chief Executive	MATURE	15+
Promoting people, communities, and social values	Executive Medical Director	MATURE	15+
Developing an effective and empowered workforce	Executive Director of People and OD	MATURE	15+
Optimising an efficient and sustainable organisation	Executive Director of Finance	SEEK	15

RISK APPETITE DEFINITIONS

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

BOARD ASSURANCE FRAMEWORK SUMMARY

Strategic Goal	Risk	Executive Lead	Assuring Committee	Initial Risk Rating (Before Mitigation)			Current Risk Rating (After Mitigation)			Risk Appetite	Status (In / Out of Appetite)	Quarterly Update Summary to Trust Board from Executive Lead
				I	L	Rating I X L	I	L	Rating I X L			
Innovating for quality and patient safety	Quality and patient safety underpins all that we do. Failure to innovate for quality improvement and patient safety could result in service delivery not meeting required quality standards resulting in substandard care which could impact on patient safety and outcomes, trust reputation and CQC rating.	Executive Director of Nursing	Quality Committee	4	3	12 HIGH	4	2	8 HIGH	SEEK	IN	The Trust has progressed its programme of internal mock CQC inspections and self-assessment against CQC Key Lines of Enquiry supported by Quality Standards Group oversight and Well-Led monitoring. Townend Court CQC inspection report published with rating of “Good.”
Enhancing prevention, wellbeing, and recovery	Failing to enhance prevention, wellbeing and recovery could result in patients not accessing support and services that will address their health and care needs leading to poorer health outcomes and adversely widening health inequalities for our populations.	Chief Operating Officer	Quality Committee	4	4	16 SIGNIFICANT	4	3	12 HIGH	MATURE	IN	The Trust continue to work with ICB and partners to reduce out-of-area placements and improve discharge flow. Access and recovery data are monitored for inequalities. Recovery College resources continue to support prevention and recovery.
Fostering integration, partnerships, and alliances	Failure to foster integration, partnerships and alliance could result in the Trust not being able to influence the delivery of health and social care regionally, which could impact on the development of system-wide solutions that enhance ability to deliver excellent services.	Chief Executive	Audit Committee	4	3	12 HIGH	4	2	8 HIGH	MATURE	IN	Controls include active collaboration with ICB and Place partners on community service models, population health training, and pathway redesign. Data-sharing agreements and use of the Yorkshire & Humber Care Record strengthen integrated working, while joint planning supports neighbourhood hubs and specialist service developments.
Promoting people, communities, and social values	Failure to promote people, communities and social values may result in Trust services not having a measurable social impact which could affect the health of our population and cause increased demand for services.	Executive Medical Director	Quality Committee	3	3	9 HIGH	3	2	6 MODERATE	MATURE	IN	The Trust uses a health inequalities dataset, accessibility tools, and improved DNA data to target inequity. Cultural inclusion initiatives, careers pathways, peer support roles, and co-production networks are in place to strengthen community engagement. Estate and sustainability plans ensure investments benefit local communities and support social value.
Developing an effective and empowered workforce	Failure to recruit and retain high-quality workforce could result in service delivery not meeting national and local quality standards resulting I substandard care being delivered which could impact on patient safety and outcomes	Executive Director of People and OD	People and OD Committee	4	3	12 HIGH	4	2	8 HIGH	MATURE	IN	A Trust-wide workforce plan, leadership development programmes, strengthened induction, and targeted recruitment and retention initiatives are in place. Sickness management, wellbeing support, flexible working, and ESR optimisation underpin workforce stability, while WRES/WDES/GPG actions and the Respect framework are driving inclusion.
Optimising an efficient and sustainable organisation	Failure to optimise efficiencies in finances, technology and estates will inhibit the longer-term efficiency and sustainability of the Trust which will reduce any opportunities to invest in services where appropriate and put at risk the ability to meet financial targets set by our regulators.	Executive Director of Finance	Finance Committee	4	3	12 HIGH	4	2	8 HIGH	SEEK	IN	Digital transformation, improved data quality, and financial controls continue to support operational efficiency. Estate modernisation, capital delivery, and sustainability initiatives are in place to ensure safe, modern environments. Collaborative financial planning with system partners be completed to strengthen long-term organisational sustainability.

Innovating for quality and patient safety



Lead Director:
Ex Dir. Nursing

Lead Committee:
Quality Committee

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

Risk Score: 8 HIGH

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

Controls – (Current Inputs)

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

- (A) Peer review process in place aligned to CQC fundamental standards.
- (B) Quality Standards Group oversees CQC inspection preparation including oversight of the divisional and directorate self-assessments.
- (C) Programme of mock inspections in place – reviews undertaken to date (Hull CMHT), Whitby Ward and Older Peoples inpatients wards
- (D) Well led compliance overseen by EMT and Trust Board
- (E) In line with Trust suicide prevention plan there is a reduction in completed suicides within Trust services.

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

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

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

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

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

Positive Assurance – (Current Outputs)

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

- (A.B.C) The Trust's current CQC rating is 'Good' (2019 assessment)
- (A.B.C.) Inspection of Orion (Inspire) services rated as 'Good' 2025.
- (A.B.C.) Townend Court inspection – rated as Good 2026
- (B) Self-assessments completed by divisions on CQC domains and quality standards
- (B) Quality and Safety performance report to QPAS / Quality Committee / Trust Board
- (C) Updated schedule of mock CQC inspections – reports and progress through QPaS and EMT
- (E) Annual Learning from deaths review
- (E) Incident reporting on suspected suicide via Quality Dashboard

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

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

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

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

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Attain a CQC rating of outstanding for safety to inform our ultimate aim of achieving a rating of outstanding in recognition of our success in delivering high-quality, safe, responsive and accessible care (1) Trust CQC rating for 'Safe' domain remains requires improvement (2019 assessment). (2) Internal assessment against key inspection domains and evidence against quality standards. Linked Risk(s): NQ66 - Failure to fully prepare for CQC inspection resulting in a poor inspection rating, which may lead to reputational impact for the Trust. Strategic Objective 3 - Work in partnership with our staff, patients, service users, carers and families to co-produce integrated services which take a collaborative, holistic and person-centred approach to care. Use patient experience and other forms of best available evidence to inform practice developments and service delivery models for the services we provide and commission. (1) CYP and Adult ADHD and CYP Autism waiting lists are currently outstripping demand due to significant rise in referrals. Due to the size of the current ADHD medication waiting lists for CYP the current children's and adult services are not able to start anyone on medication as the services are at capacity. Linked Risk(s): OPS31 – Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO1. 1 - Patient Safety Priorities 2025/2026 monitoring.	Next Check point: June 2026	Kate Baxendale	Leads identified for each priority. Working group established and all have a project group underpinned by charter. Agreed for two-year period and work underway around reporting.
SO1. 2 - Programme of mock inspections in place.	Next Check point: June 2026	Kate Baxendale	Ongoing programme underway across Trust services.
SO3. 1 Neuro diversity services work at ICB level to determine how processes can be standardised / streamline to reduce system pressures	Next Check point: June 2026	Lynn Parkinson	ICB aware of top priorities around waiting time and considering system pathways to remedy pressures.
SO3. 1 - Waiting list Capacity and Demand work ongoing to identify areas for further support. (Neuro diversity and Adult ADHD)	Next Check point: June 2026	Lynn Parkinson	Adult ASD/ADHD Assessment waiting times are improving

Enhancing prevention, wellbeing, and recovery



Lead Director:
Chief Operating Officer

Lead Committee:
Quality Committee

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

Risk Score: 12 HIGH

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

Controls – (Current Inputs)

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

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

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

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

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

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

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

Positive Assurance – (Current Outputs)

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

- (A, B, C) Supporting improvements in the quality and safety of all-age inpatient care, by finalising and publishing system 3-year plans to localise and realign inpatient care in line with the mental health inpatient commissioning framework.
- (A, B, C) The Trust has consistently delivered over 700 patients a month who complete 2+ contacts at discharge.
- (A, B, C) The Trust have consistently delivered above the 48% reliable recovery objective over the last year
- (A, B, C) The Trust also demonstrates a 67% reliable improvement rate over the last year
- (A, B, C) The Trust continues to work with the Integrated Care Board & Public Health to achieve 6 week and 18-week access targets.
- (A, B, C) Waiting lists in Dietetics are reducing due to recent investment.
- (A, B, C) Core CAMHS are almost <18 week compliant.
- (A) As at year end there was an improvement in the number of Out of Area patients. 10 in adult/OP and 4 for PICU which was a significant reduction compared to Q3 (16 and 7 respectively)

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

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

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

- (A) Trauma in Care Strategy Task and Finish group action plan for key pieces of work.

Strategic Objective - Work collaboratively with our stakeholders to co-produce models of service delivery and deliver transformation programmes that meet the needs of the communities we serve and address health inequalities, both in our provider role and in our role as lead commissioner.
(A) QI training increased with 338 total places delivered 2024/25. (B) The Trust continues to host our six-monthly Humber Co-production Network meetings chaired by the Chief Executive. The last meeting took place on Thursday 11 September where a presentation was delivered to the group from Community Vision (Voluntary Infrastructure Support Involving Organisations and Networks). Community Vision informed the group on the work they are leading to support voluntary sector organisations. (C) Trust Patient Care and Performance Accountability Review Process aligns information on clinical and non-clinical operational performance, activity, finance, and quality and Patient Safety, to give an accurate organisational overview and have been applied to the Divisions in the Operations Directorate
Strategic Objective - Continually strive to improve access to our services and minimise the impact of waiting times for our patients, their carers and families.
(A) Waiting Times Procedure in place (B) Waiting times review is key element of Divisional performance and accountability reviews.

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective 1 - Focus on putting recovery at the heart of our care. This means supporting people using our services to build meaningful and satisfying lives, based on their own strengths and personal aims. We will offer holistic services to optimise health and wellbeing including our Recovery College, Health Trainers, Social Prescribing and Peer Support Workers. (1) The Recovery College full review of courses and prospectus (2) There are system challenges around patient flow and a lack of places to discharge patients is leading to a bottleneck which is increasing out of are placements due to reduced flow Linked Risk(s): OPS33 - As a result of system pressures / increased demand and complexity / acuity of care, there has been impacted patient flow within Trust community inpatient services which may lead to reduced patient experience and quality of service provision Strategic Objective 4 - Embed a trauma informed approach to supporting the people who use our services. In doing this, we will acknowledge people’s experiences of physical and emotional harm and deliver our services in a way that enables them to feel safe and addresses their physical, psychological and emotional needs. (1) Mental Health Division to apply the principles to the Trauma Service.

Strategic Objective - Work collaboratively with our stakeholders to co-produce models of service delivery and deliver transformation programmes that meet the needs of the communities we serve and address health inequalities, both in our provider role and in our role as lead commissioner.
(A) 38% QI activities have indicated that they have collaborated with organisations outside the Trust (B) The Patient and Carer Experience team and divisional engagement leads are meeting with Community Vision to identify future opportunities for partnership working. (C) Children and Learning Disabilities – Segment 1. The Division had maintained and sustained improvement and were commended on their leadership. Community and Primary Care - Segment 2, with a moderate concern for Whitby Ward and a minor concern for finance. Forensics – Segment, with a moderate concern for sickness.
Strategic Objective - Continually strive to improve access to our services and minimise the impact of waiting times for our patients, their carers and families.
(A.B) Review completed of all services with high levels of waiting times and service-level recovery plans developed.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO1.1, 2 The Recovery College is currently going through a full review of courses and prospectus, with a transition back to more face-to-face sessions.	Next Check point: June 2026	Lynn Parkinson	Future reporting will capture both face-to-face and online attendance, and feedback will be captured more accurately. A new focus group is also being set up to help develop and co-produce future courses/sessions.
SO4. 1 - Development of Trauma in Care Strategy and implementation in Mental Health	Next Check point: June 2026	Lynn Parkinson	

Fostering integration, partnerships, and alliances



Lead Director:
Chief Executive

Lead Committee:
Audit Committee

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

Risk Score: 8 HIGH

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

Controls – (Current Inputs)

Strategic Objective - Use our system-wide understanding of our local population's health needs and our knowledge of the impact and effectiveness of interventions to plan services.

(A) Working with the ICB and North Yorkshire Place to support the definition of an effective core offer for community services.

Strategic Objective - Work closely with all six Place-based partnerships across Humber and North Yorkshire to facilitate collaboration and empower local systems. Place-based partnerships have responsibility for improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities at a local level.

(A) We are working with colleagues from East Riding to develop content for the ER Place population health training programme, which will initially be delivered to staff in primary care and the VCSE across East Riding.

(B) Working with East Riding Place on the successful transfer of our three primary care practices to established service providers in the East Riding.

Strategic Objective - Collaborate with system partners to maximise the efficient and effective use of resources across health and care services.

(A) Currently supporting the ICB with clearing arrangements.

Strategic Objective - Work alongside our partners in health, social care, the voluntary, community and social enterprise sector, Healthwatch, local government and other fields to develop integrated services as part of the Humber and North Yorkshire Health and Care Partnership.

(A) The Community Hubs Working Group

(B) Hull MH clinical leads continue to participate in the Neighbourhood Health and Care Group

(C) In Hull and ERY MH Services the background work around mapping needs and then location options is underway in relation to Neighbourhood Mental Health Centres agenda.

(D) A business case has been created in partnership with patients with lived experience on developing the PICU business case.

Strategic Objective - Empower Humber staff to work with partners across organisational boundaries, embracing a 'one workforce' approach to enable patients to access the right support, in the right place, at the right time.

(A) Reporting data has been improved for partners and it now provides users and information accessed information.

(B) Data sharing agreements have been updated to provide patient information using the national record locator.

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

Positive Assurance – (Current Outputs)

Strategic Objective - Use our system-wide understanding of our local population's health needs and our knowledge of the impact and effectiveness of interventions to plan services.

(A) This will support equitable service provision, whilst still allowing tailored services locally, as well as defining the role of community services within neighbourhood health.

Strategic Objective - Work closely with all six Place-based partnerships across Humber and North Yorkshire to facilitate collaboration and empower local systems. Place-based partnerships have responsibility for improving the health and wellbeing outcomes for the population, preventing ill health and addressing health inequalities at a local level.

(A) As of year-end 2025/26 the VCSE contract value of working in partnership across 19 partners was £15,812,619

(B) This supports the ICB strategy of neighbourhood-based primary care services at scale and ensuring the long-term sustainability and provision of services.

Strategic Objective - Collaborate with system partners to maximise the efficient and effective use of resources across health and care services.

(A) Workforce, Finance and Operational plans now being submitted to region with ICB engagement.

Strategic Objective - Work alongside our partners in health, social care, the voluntary, community and social enterprise sector, Healthwatch, local government and other fields to develop integrated services as part of the Humber and North Yorkshire Health and Care Partnership.

(A) Collaboration with stakeholders in Driffield to develop plans for an older people's mental health and wellbeing hub at Alfred Bean Hospital.

(B) Workshop held in November to identify priorities and workplan.

(C) The Public Health and ICB data sets are being utilised to reconcile finding against our actual activity data.

(D) This proposal will see the development of two separate male and female high dependency units. There will be continued dialogue with stakeholders and patients as we progress.

Strategic Objective - Empower Humber staff to work with partners across organisational boundaries, embracing a 'one workforce' approach to enable patients to access the right support, in the right place, at the right time.

(A, B) Data Sharing using the Yorkshire & Humber Care Record is currently live with numerous organisations including Hospital Trusts and Community Healthcare, GP practices, Yorkshire Ambulance Service, Local Authorities and Hospital and Foundation Trust across the wider region including Hull and Yorkshire and North Lincolnshire.

(A, B) Humber continues to provide data to the ICB population health management team. This information is used with other providers data to create and management JSNA, ICB, ICS plans. Assurance is provided by the HTFT Be Digital board.

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Collaborate with system partners to maximise the efficient and effective use of resources across health and care services. (1) As at year end there was a marked increase the number of patients with a delayed transfer of care. 17.6% for Adult/OP and 16.8% if you include PICU. Q3 results were 14.1% and 13.1%, and a significant increase compared to Q2 (5.3% and 4.8%). The availability of complex care housing and funding processes between external stakeholders provide challenges to early discharge. (2) State of flux with system partners at present due to ICB consultation <u>Linked Risk(s):</u> OPS29 - As a result of system pressures, increase acuity / complexity of care, issues with access to suitable accommodation via social care and a lack of a 'no right to reside' discharge pathway linked MoJ decision making, there has been impacted patient flow within Trust mental health inpatient services which may lead to reduced patient experience and quality of service provision

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



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

Risk Score: 6 MODERATE

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

Controls – (Current Inputs)

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

- (A) A health inequalities dataset was developed for the Trust Annual Report, analysing access and waiting times for Core20 communities and other marginalised groups, alongside ongoing service engagement.
- (B) An accessibility checklist has been created to support services in improving the accessibility of patient-facing documents and letters.
- (C) Progressing a project to manage DNAs alongside addressing health inequalities.

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

- (A) Reignite Respect: Renewing Our Commitment to No Excuse for Abuse
- (B) The Trust launched its Sexual Misconduct Policy with an all-staff event that reiterated the Trust commitment to safer culture.

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

- (A) A vibrant Explore Humber Clinical Careers Day took place in July where students explored the world of healthcare and got a closer look at the many rewarding roles within our NHS, and we received excellent feedback from students, school representatives and Humber staff. Due to July, August and September being the Q2 period, school engagement is limited but we continued to support 7 young people with work experience across a variety of teams and services but we are now re-engaging with schools throughout September and have inducted the new cohort of T level students from Wyke college to ensure they ready for their work experience with us, over the next two years. Our focus this year is supporting students from disadvantaged backgrounds and encouraging young men into female predominant roles in Health.

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

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

Positive Assurance – (Current Outputs)

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

- (A) Work has included contributing lived-experience insight to the East Riding Population Health Training Programme launched in April 2026, developing an incident-reporting inequalities analysis, promoting targeted workforce wellbeing support during Men's Health Week, planning an MH Division pilot to explore inpatient inequalities using neighbourhood data, and progressing CAMHS pathway mapping to better understand referral routes and access.
- (B) We are working with teams to understand the impact of Dialog+ on our insights into patients' wider conditions of living. Additionally, there is ongoing work to support the Community MH Grants Scheme and gather insights from community organisations applying.
- (C) Cancellations reasons codes are under development and include a category to identify cancellations relating to personal or financial circumstances.

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

- (A) Reignite Respect: Renewing Our Commitment to No Excuse for Abuse - In October, we relaunched our Respect and No Excuse for Abuse anti-discrimination frameworks.
- (A) The event: Reignite Respect- Renewing Our Commitment to No Excuse for Abuse, featured an exclusive opportunity to see our new video guidance, new posters, links to information on our intranet, and a presentation demonstrating how we address bullying and harassment at the Trust.
- (B) Defence Employer Recognition Scheme whereby the Trust was awarded silver in the recent Employer Recognition Scheme accreditation.

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

- (A) During the quarter there were 7 x Band 2 Peer Support Workers (6.2 wte) and 3 Band 3 Peer Support Workers (1.8wte). There was one Band 7 Expert by Experience Programme Facilitator on the Trust bank.

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

(A) The Trust continues to host our six-monthly Humber Co-production Network meetings chaired by the Chief Executive. (B) Following the last meeting that took place, the Patient and Carer Experience team and divisional engagement leads met with Community Vision (a voluntary infrastructure support organisation for local voluntary sector groups and organisations) to identify future opportunities for partnership working. (C) The Trust continues to work on building strong connections with Voluntary Services and the VCSE.
Strategic Objective 5 - Work alongside economic development and health and care system partners to ensure that our investments in facilities and services benefit local communities.
(A) The Trust's Five-Year Estate Strategy 2022-2025 continues and is shared with ICB members and informs the ICB Estate Strategy. Priorities include redesigning MH Inpatient Services. Estate Plans are refined on a locality basis. Current areas of focus are Hull, Beverley and Driffield. The Estate Strategy and CDG provides a forum at which progress is monitored and reviewed against service need. The Estate Strategy is influenced by the organisational Green Plan which focuses on carbon reduction and use of local suppliers where appropriate and within procurement guidelines.
Strategic Objective 6 - Provide opportunities to people with lived experience of mental and physical ill health, autism and learning disabilities and people from communities experiencing deprivation.
(A) Currently there are 6 x Band 2 Peer Support Workers (5.2 wte) and 3 Band 3 Peer Support Workers (1.8wte). There were 8 Band 7 Experts by Experience Programme Facilitator on the Trust bank. This remains the same as reported in Q3.

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Take action to address health inequalities and the underlying causes of inequalities, both in our role as a provider of integrated health services and our role as a developing anchor institution, supporting the long-term aim of increasing life expectancy for our most deprived areas and for population groups experiencing poorer than average health access, experience, and outcomes. (1) Stakeholder input into Trust involvement with Place and ICS level strategy

(A) Next Humber Co-production Network meeting to take place March 2026. In Q3 there were a total of 15 voluntary organisations working in collaboration with the Trust which is a slight decrease on Q2 (17). (B) Links made between our Trust and Community Vision to facilitate future partnership working on service initiatives and projects and contact details were shared between all. Additionally, Community Vision have agreed to sit on the Trust's working group when we embark on the next Patient and Carer Experience Five Year Forward Plan (2028 to 2033). During Quarter 4, the Trust worked in collaboration with 14 voluntary organisations which is a reduction of just one compared to Quarter 3.
Strategic Objective 5 - Work alongside economic development and health and care system partners to ensure that our investments in facilities and services benefit local communities.
(A) The Trust aids the ongoing delivery of healthcare to the region including coordinating as a landlord organisation for partner Trusts and third sector organisations. This is evident in the ongoing Hull Place Pilot, following the One Public Estate projects.
Strategic Objective 6 - Provide opportunities to people with lived experience of mental and physical ill health, autism and learning disabilities and people from communities experiencing deprivation.
(A) For Q4, work continues to strengthen Experts by Experience (EbE) pathways, supporting workforce growth. Updated guidance, including time-limited NHS.net access, awaits governance approval. An impact survey has launched (30+ responses), informing Patient and Carer Experience priorities. Comparing Quarter 3 with Q4; EbE registrations increased by 8%, actively paid EbEs by 7%, while paid hours decreased by 10%. Over the past year, the Experts by Experience (EbE) programme has grown significantly, with approved applications increasing by 58% and EbE-supported work rising by 65%. A total of 32 projects were approved for EbE involvement. Forty-five EbEs were paid for 900 hours of contribution. Ongoing evaluation through surveys evidences the positive impact of lived experience on service development and improvement.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO1. 1- Internal and external stakeholder surveys to look at the Trust's involvement in joint strategies and actions to address health inequalities at Place and ICB level.	Next Check point: June 2026	Michele Moran	.

Developing an effective and empowered workforce



Lead Director:
Executive Dir. of People
and OD

Lead Committee:
P&OD Committee

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

Risk Score: 8 HIGH

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

Controls – (Current Inputs)

Strategic Objective - Grow a community of leaders and managers across Humber with the capability, confidence, and values to create a highly engaged, high performing and continually improving culture.

- (A) Implementation and oversight of an organisation-wide workforce plan that aligns leadership capacity, capability and succession planning with strategic priorities and agreed values and behaviours.
(B) Internally delivered PROUD Leadership Programme; Alumni programme, Being Humber culture and values programme, Humber Talent Programme and revised induction processes.

Strategic Objective - Ensure all colleagues are highly motivated to achieve outstanding results by creating a great employer experience, so that they feel valued and rewarded for doing an outstanding job; individually and collectively.

- (A) Deliver the People Strategy through grounded leadership development, wellbeing and retention initiatives.
(B) Embed compassionate and inclusive leadership via PROUD, talent, mentoring and coaching programmes.
(C) Strengthen employer experience through targeted wellbeing, flexible working, sickness intervention and Stay Conversations.

Strategic Objective - Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber.

- (A) Ongoing monitoring of hard to recruit roles in the recruitment and retention task and finish group.
(B) Strengthen local and system pipelines through targeted recruitment campaigns, apprenticeships, university partnerships and system collaborations.
(C) Actively review and invest in retention through leadership development, career pathways, wellbeing interventions, flexible working and proactive Stay Conversations.

Strategic Objective - Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual’s experience of working at Humber.

- (A) Health & Wellbeing Offer: A comprehensive programme of wellbeing support is in place. Delivery and impact are overseen by the Health & Wellbeing Steering Group, with regular assurance reporting to EMT and the People & OD Committee.
(B) Sickness Absence: A structured, data-led approach is embedded through Towards a Healthier Workforce Model, targeting services with sickness absence of ≥8% to support early intervention and workforce resilience.

Strategic Objective - Enable new ways of working and delivering health care, anticipating future demands and planning accordingly.

- (A) Workforce and Medical Workforce Plans embedded within medium-term service and financial planning, focused on sustainable supply, vacancy trajectories and *grow-your-own* pipelines.
(B) Plans under development to optimise use of ESR in readiness for the new workforce solution
(C) Job Evaluation and Job Matching Preparedness - In preparation for national job matching activity underway to meet national requirements

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

Positive Assurance – (Current Outputs)

Strategic Objective - Grow a community of leaders and managers across Humber with the capability, confidence, and values to create a highly engaged, high performing and continually improving culture.

- (A) Medium term WFP submitted and is compliant. Internal Pan due for completion in May
(B) The Trust delivers a consistent, values-led leadership and culture approach through the PROUD Leadership. New cohort of the Humber Talent Programme underway. National Staff Standards being mapped across Being Humber and similarly with NHS Leadership and Management Framework principles. Trust Leadership and Management Hub launched.

Strategic Objective - Ensure all colleagues are highly motivated to achieve outstanding results by creating a great employer experience, so that they feel valued and rewarded for doing an outstanding job; individually and collectively.

- (A) People Strategy progress report to EMT and P&OD Committee (Feb 26) showing progress across measures. Quarterly People Insight report and monthly scorecard reports on progress against strategy
(B) See above SO1B
(C) Launch of Your HWB, Flex and Leave Plus schemes, Proactive wellbeing conversation training and now embed the Rapid Intervention sickness model.

Strategic Objective - Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber.

- (A, B, C) 7.22% Trust vacancy rate, Registered Nurse vacancy rate 6.82%, consultant vacancy rate 21.68% (March 2026) (open risk WF38)
(A, B, C) Staff recommending the Trust as a place to work has improved year on year since 2019 reported at 70% in 2025 – above the benchmark and national averages. The Trust continues to demonstrate strong advocacy, ranking 7th out of 49 Mental Health, Learning Disability and Community providers, with sustained year-on-year improvement at a time when several higher-ranked organisations have declined
(B) 145 apprenticeships, 87 T-levels, 25 Work experience placements since April 2025.

Strategic Objective - Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual’s experience of working at Humber.

- (A) Proactive Health & Wellbeing Support: 147 Physical MOTs delivered since January 2026.

Strategic Objective - Enable new ways of working and delivering health care, anticipating future demands and planning accordingly.

- (A) Local workforce plans embedded in the Medium-Term Plan. Improving consultant vacancy trajectory (reduced from ~30% to ~21%). Starters exceed leavers, with planned intake peaks aligned to NQN pipelines. Grow-your-own supply routes established
(B) Commencement of Manager Self Service implementation in June 2026, with Appraisals mapped to ESR.
(C) The Trust has successfully completed the national Job Evaluation Readiness Assessment and submitted recent audit.
(D) Chat bot being trialled and Digital ID proposed to be launched in spring 2026.

Strategic Objective - Maximise a diverse and inclusive workforce representative of the communities we serve.
(A) No Excuse for Abuse and Respect Framework relaunched, with targeted approach to identify challenged areas (B) WRES, WDES, Gender Pay Gap delivered annually with work plans to support improvement initiatives.
Strategic Objective - Develop a culture of learning, high engagement, continuous improvement, and high performance that builds on our values and enables us to realise the potential of our people.
(A) OD programme and leadership - expansion of Trust mentoring and coaching offer, delivering a minimum of 3 themed PROUD Alumni sessions per year to support ongoing leadership development (B) Career development conversations are being embedded across the organisation through the Trust's appraisal process

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Maximise a diverse and inclusive workforce representative of the communities we serve. 2025 staff survey saw a significant rise in racial abuse from patients towards ethnically diverse staff, rising to 40%, and focused, collaborative work with target reducing this. - We have seen a decline in staff reporting they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, when compared to national comparator figures. A smaller rise has been seen for ethnically diverse staff reporting experience of harassment, bullying or abuse from staff in the last 12 months, but still represents an improving trend since 2021.
Strategic Objective - Attract, recruit, and retain the best people by being an anchor employer within the locality; with roles filled by staff that feel happy and proud to work for Humber. Consultant vacancy rate for March 2026 – 21.68% Linked Risk(s): WF38 – As a result of the current level of consultant vacancies, agency solutions are being used to ensure that services are kept safe which has financial impact for the Trust, and may also affect our ability to maintain an effective and engaged workforce
Strategic Objective - Prioritise the health and wellbeing of our staff by understanding that staff bring their whole self to work, so we place mental and physical wellbeing at the heart of the individual's experience of working at Humber. The Workforce Scorecard (March 2026) reported a rolling sickness rate figure of 5.55% (Trust target 5%), and above national and regional benchmarks. With long term sickness increasing to 90 live cases. The highest reason for sickness absence within the organisation remains stress, anxiety and mental ill health The National Staff Survey identifies this as an area of focus. The NSS 'We are Safe and Healthy' theme score declined in 2025 compared to 2024 results, however, remains better than national and benchmark averages. With the biggest decline for the question relating to MSK issues Linked Risk(s): WF57 - Persistent and elevated sickness absence rates across Trust staff groups -currently averaging 5.6% (Dec 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.
Strategic Objective - Enable new ways of working and delivering health care, anticipating future demands and planning accordingly. There is a requirement to ensure ESR Manager Self-Service and readiness for the new workforce solution will be delivered to plan and within required timescales Work to continue regarding the internal Band 5 job evaluation review.

Strategic Objective - Maximise a diverse and inclusive workforce representative of the communities we serve.
(A, B) Workforce representation - ethnic diversity has increased to 10.43% (Jan 2026) exceeding regional demographic of 5.1%, LGBTQ+ has increased to 4.76% (Jan 2026) exceeding the local demographic of 3.8%. Disability representation has increased to 10.36% Jan 2026) this remains below the regional demographic of 16–20% regionally but the organisation continues to make significant improvements. (A, B) Since 2022, the Trust has been working to improve the representation of underrepresented groups in clinical and non-clinical roles at band 7 and above. There has been a 58% rise in ethnically diverse staff and 38% rise in staff with a disability or long-term condition occupying these roles.
Strategic Objective - Develop a culture of learning, high engagement, continuous improvement, and high performance that builds on our values and enables us to realise the potential of our people.
(A) Reporting of OD progress into EMT on a quarterly basis. (A) 67 colleagues are currently enrolled on the PROUD Leadership Programme. Mentoring engagement has increased to 9 staff receiving 16 hours of support since January 2026.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO7. 1 - EDI	Next Check point: June 2026	Karen Phillips	Actions refreshed as part of the NSS, WRES, WDES and Gender pay gap action planning process and ratified at Board. EDI assurance/insight report presented to EMT providing assurance against actions. EDI insight report presented to each P&OD Committee.
SO3. 1 - Medical Vacancies	Next Check point: June 2026	Kwame Fofie	Based on information for March 2026 - 8 vacancies, 1 vacancy has been appointed to and will commence in post in April 2026. 7 covered by agency, reduced to 6 agency doctors by April 2026.
SO4. 1 - Sickness absence	Next Check point: June 2026	Karen Phillips	Deep dives into sickness reported into EMT and P&OD Committee twice yearly, which identified trends and actions. Divisional accountability reviews monitoring and exploring absence routinely. Reports continue to feed into EMT and People & OD Committee. The Trust reports improved position sustained over three consecutive months and reduced LTS cases. Significant divisional improvement noted across Mental health, Children's & LD and Forensic services. Focus on burnout, psychological and MSK support as part of the Trust NSS plan.
SO5 – 1 - ESR Optimisation SO5 – 2 - National Role Profiling – Band 5-6	Next Check point: June 2026	Karen Phillips	Plans developed to fully optimise ESR in readiness for the new workforce solution. 2026 will see the roll out of the three final functionality elements implemented – appraisals in ESR, Manager Self Service and full establishment control. Plan in place to review and consolidate all band 5 job descriptions with activity managed through an internal working group.

Optimising an efficient and sustainable organisation



Lead Director:
Executive Dir. Finance

Lead Committee:
Finance Committee

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

Risk Score: 8 HIGH

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

Controls – (Current Inputs)

Strategic Objective - Embrace new, safe and secure technologies to enhance patient care, improve productivity and support our workforce across the health and social care system.

- (A) Trust has moved the tenant for Power BI and now has 20 users up and running.
- (B) The mobile phone contract has been awarded in 2024.

Strategic Objective - We will design technologies around the person’s needs and will make sure that people are not excluded from accessing services due to digital poverty or poor rural connectivity.

- (A) Trust has reviewed its Digital Governance Structures in 2025 to ensure appropriate oversight and assurance at Executive and Board Level

Strategic Objective - Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshire Health and Care Partnership in our role as lead provider.

- (A) The Trust is building on its role as Specialist Lead Provider and is currently exploring opportunities for core mental health services to follow a similar collaborative approach with the Trust identified as the preferred Host.

Strategic Objective - Continue to develop our estate to provide safe, environmentally sustainable, and clinically effective environments that support operational delivery.

- (A) The Trust continues to prioritise its capital investment priorities based on available information to maximise impact across the Trust’s Estate

Strategic Objective - Work with our partners and communities to minimise our effect on the environment to meet the NHS climate change target.

- (A) Trust Green Plan developed.

Strategic Objective - Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources.

- (A) Planning Guidance requires the system to deliver a balanced net financial position for 2025/26.
- (B) Agency Reduction Target of 30% for 2025/26 has been set
- (C) The Trust has a breakeven financial plan that meets the ICS planning target set for it.

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

Positive Assurance – (Current Outputs)

Strategic Objective - Embrace new, safe and secure technologies to enhance patient care, improve productivity and support our workforce across the health and social care system.

- (A) Trust Data Quality Maturity Index (DQMI) score at 99% above national average (95%).
- (A) Patient communication, electronic referral service, electronic prescription service, voice requisition and hand-held device app to be fully implemented in 25/26.
- (A) Implementation of the new data lake/lake house business intelligence system which include artificial intelligence capabilities.
- (A) Create a centre of excellences within the Interweave team to lead on user centred design the Yorkshire & Humber Care Record
- (B) Mobile phone contract provides 50% reduction in spend and access to different mobile phone networks providing the best connectivity for our mobile workforce.

Strategic Objective - We will design technologies around the person’s needs and will make sure that people are not excluded from accessing services due to digital poverty or poor rural connectivity.

- (A) The Trust has successfully implemented a new Electronic Patient Record

Strategic Objective - Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshire Health and Care Partnership in our role as lead provider.

- (A) Overall, the Trust has a high level of sustainability with a good cash position.
- (A) Trust has delivered a balanced position as part of the ICS 2024/25 Plan and has a breakeven 2025/26 plan
- (A) Trust has delivered a 30% Agency cost compared to pay bill in 2024/25, current modelling suggests Agency Reduction of 2.1m in 2025/26, this equates to a 39% year on year reduction.

Strategic Objective - Continue to develop our estate to provide safe, environmentally sustainable, and clinically effective environments that support operational delivery.

- (A) 2024 PLACE scores of 99.77% for Cleanliness (Avg 98.31%) and 97.39 for Food (Avg 91.32%)
- (A) The Trust has plans for the redevelopment of Granville Court in 2025 and a longer-term plan for the reprovision of Westlands Inpatient Unit as part of its wider Inpatient Redesign project

Strategic Objective - Work with our partners and communities to minimise our effect on the environment to meet the NHS climate change target.

- (A) Provision of virtual private network technology allow staff to work from any location (including home) enabling a reduction of the estate required for corporate staff and reducing our CO2 emissions from staff travel.
- (A) The Trust is currently exceeding the carbon reduction targets outlined in the Green Plan (2022–2025), achieving an approximate 33% reduction in T/CO₂e from the baseline year

Strategic Objective - Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources.

- (A, B, C) Humber Financial Times is issued to all staff

Negative Assurance / Gaps in Assurance – Required Outputs
Strategic Objective - Work with our partners to optimise the efficiency and sustainability of the Humber and North Yorkshire Health and Care Partnership in our role as lead provider. (1) Wider ICS Financial Position is showing to be on track to deliver the financial plan but has an overall unmitigated risk of £78. <u>Linked Risk(s):</u> FII247 – As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.
Strategic Objective 6 - Empower all staff to contribute to the efficiency and sustainability of the organisation by making informed decisions about the efficient use of resources. (1) Details of staff understanding of Trust finance measures and controls <u>Linked Risk(s):</u> FII223 – Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base.

Mitigating Actions to Address Gaps	Target Date	Action Lead	Update on Actions
SO3. 1 Medium Term Financial Planning has been initiated across the ICB	Next Check point: June 2026	Pete Beckwith	National Guidance has been circulated, and initial plans have been shared with the ICB
SO3. 1 Deliver a balanced net system financial position for 2025/26.	Next Check point: June 2026	Pete Beckwith	Trust has submitted a balanced plan to the ICS. Month 8 financial position shows the Trust is on plan to deliver a Balanced Position at Year end Year End financial position shows an underspend of £3.008m for the Trust
SO6. 1 Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2025/26.	Next Check point: June 2026	Pete Beckwith	Current plan delivers the expected reduction, Agency is monitored at Finance Committee, EMT, ODG and forms part of the Accountability Review process Agency reduction of £2.390m or 44% in 2025/26. A further 30% reduction is required for 2026/27

RISK SCORING MATRIX

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

RISK TERMINOLOGY DEFINITIONS

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

Agenda Item 10

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Risk Management Enabling Strategy Annual Report														
Author/s:	Executive Lead - Sarah Smyth, Executive Director of Nursing, Quality and Professions Oliver Sims Corporate Risk and Incident Manager														
Recommendation:	<table border="1"> <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>			To approve		To discuss		To note	√	To ratify		For assurance			
To approve		To discuss													
To note	√	To ratify													
For assurance															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	The report provides an update on the implementation of the Trust Risk Management Enabling Strategy, and the delivery of its risk management ambitions, as well as actions identified for year two of the strategy for Trust Board consideration.														
Key Issues within the report:															
Positive Assurances to Provide: - An update has been included with this report regarding the achievement of the identified risk management ambitions outlined in the strategy document. - Several areas have progressed well in year one and specific actions identified to further strengthen implementation of the strategy and the Trust's risk management arrangements in year two.		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT): It is proposed that next year's annual Risk Register Report will be merged with the Annual Risk Management Strategy Report to ensure that there is no duplication of the information contained and that all elements around risk management process, alignment to the strategy and implementation of actions identified through the review of the strategy and internal audit can be considered through one report and reported into Executive Management Team, Audit Committee and Trust Board to provide additional assurance.													
Key Risks/Areas of Focus: No key risks / areas of focus to highlight. Specific actions have been detailed within the report for further developments in year 2 of the strategy.		Decisions Made: An update on the implementation of the Risk Management Enabling Strategy ambitions has been included within the report to detail further actions for 2026/27 which will further embed and strengthen risk management processes within the Trust. This has also been used to develop a Risk Management Improvement Plan for 2026/27 appended to this report.													

Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date
	Audit Committee	05/2026	Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	04/2026 05/2026
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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 Management Enabling Strategy Annual Report

1. Risk Management Enabling Strategy

The Trust is committed to embedding an integrated approach to managing risk and recognises that the proactive and continuous management of risk, is essential to the efficient and effective delivery of its strategic vision. The risk management enabling strategy document describes the Trust approach to the identification, reporting and management of all risks facing the Trust.

The Trust's continued ambition to have excellent systems and processes fully embedded across the organisation that supports the delivery of the Trust's Strategic Goals requires that we support better decision making through a comprehensive understanding of potential risks and their likely impact on the Trust should they be realised.

In this respect the Trust is committed to maintaining a systematic approach to the identification and management of all risks surrounding our activities. This strategy is based on achieving the ambitions identified below.

By April 2029 the Trust will achieve the following Risk Management Ambitions:

1. Continued devolution of decision-making and accountability for the recognition and management of risk across the organisation from Trust Board to point of delivery (Board to Ward) in system and partnership working.
2. To continually refine existing systems and processes throughout the Trust to ensure they remain aligned to service delivery and support effective risk management, ensuring the management of risk is dynamic and integral to the day-to-day activities of Trust services including its commissioning responsibilities.
3. To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality and compliance requirements.

2. Risk Management Ambitions Update

Risk Management Ambition One		Alignment to strategic goals	
Continued devolution of decision-making and accountability for the recognition and management of risk across the organisation from Trust Board to point of delivery (Board to Ward) in system and partnership working.		Strategic Goal 1 – Innovating quality and patient safety	
		Strategic Goal 2 – Enhancing prevention, wellbeing and recovery	
		Strategic Goal 6 – Promoting people, communities and social values	
Why is this important?			
It is important to create a culture in which all staff are able influence decisions, support process improvements and outcomes, to reduce risk and improve the quality of services. Bringing decision making as close as possible to the service delivery.			
What do we want to do?		How will we do it?	

To promote a culture whereby staff are able to identify risks and make decisions and improvements to ensure risks to the delivery of the trust's ambitions are identified, managed dynamically and resolved in a timely manner.	1. Continued implementation of risk management training sessions for all staff to further support risk management culture. 2. Develop of a risk management annual report to further mature associated processes and to ensure that they are responsive and dynamic in their nature regarding the identification and management of all organisational risks. 3. Development of risk appetite rationales in conjunction with Executive Leads which links to assurance mechanisms and already established early warning systems based on embedded processes. 4. Development of process for utilising risk appetite as part of the Trust standard board and committee paper cover document.

Year One Actions Completed

1. Dates for monthly risk register training sessions are scheduled until March 2027 for Trust Staff and have been communicated via divisional governance arrangements. Training sessions also offered to specific staff groups and individuals newly appointed to the Trust, to further strengthen risk identification and management processes. Six training sessions have been delivered since approval of the Risk Management Enabling Strategy at Trust Board in September 2025. 2. A risk management improvement plan template has been developed following the internal audit annual review of the Board Assurance Framework and Risk Management which will be produced annually and further developed in line with Trust requirements and feedback received through future annual internal audit reviews for the life cycle of this strategy.

Year Two Planned Actions

Risk Management Ambition Action	Lead	Timescale
Delivery of Board Assurance Framework training session to ODG membership to promote understanding and ownership of document / Trust risk appetite.	Oliver Sims	31/05/2026
Development of bespoke risk appetite rationales to support 2026/27 review process.	Oliver Sims / Exec Leads	30/06/2026
To determine how the Trust's 2026/27 risk appetite statements when agreed, can be utilised as part of the Trust's board and committee cover sheet	EMT	31/07/2026

Risk Management Ambition Two	Alignment to Strategic Goals	
To continually refine existing systems and processes throughout the Trust to ensure they remain aligned to service delivery and support effective risk management, ensuring the management of risk is dynamic and integral to the day-to-day activities of Trust services including its commissioning responsibilities.	Strategic Goal 1 – Innovating quality and patient safety	
	Strategic Goal 4 – Developing an effective and empowered workforce	

Why is this important?

It is important that the risk management process is dynamic, has a clear purpose, reliable inputs, well-designed activities and value-added outputs. A well-articulated systematic approach to risk management allows us to provide a benchmark and ensure we are responsive to the Trust's risk management needs.

What do we want to do?

Define a Risk Management standard throughout the organisation ensuring a robust systematic approach to risk management.

How will we do it?

1. Undertake refreshed training needs analysis for risk management within the Trust and re-launch training package.
2. Development and implementation of a risk management e-learning training package available to all staff.
3. Undertake quarterly review of any risks linked to regional teams, regulators and partner organisation and incorporate pertinent risks into the Trust established risk management arrangements.
4. Targeted work with inpatient settings for full implementation of robust risk management arrangements and regular reporting / discussion at team meetings to include all frontline staff and ensure their full awareness of current risks and associated mitigations.
5. Review format of annual risk appetite review to include rationale summary, work undertaken in year in line within appetite rating and planned / proposed actions for next financial year.
6. Review Trust-developed resource for risk appetite summaries and update to reference all elements of financial / sustainability priorities.

Year One Actions Completed

1. Quarterly arrangements have been implemented for the review of risks linked to regional teams, regulators and partner organisation that are pertinent to the Trust, and regular contact in place to ensure provider collaborative risks pertinent to the Trust-wide risk register are fully considered by EMT and incorporated into the document where required.
2. Targeted work has been undertaken with the Trust's inpatient settings to ensure that risk management arrangements are implemented. This is being monitored via the Nursing and Quality directorate risk register and operational risks are considered on a regular basis by ODG and QPAS.

Year Two Planned Actions		
Risk Management Ambition Action	Lead	Timescale
Development of a refreshed training needs analysis for risk management by staff group in conjunction with the Trust's divisional management.	Oliver Sims / Divisional General Managers	30/06/2026
Development of a risk management e-learning training package. Action being taken forward during year 2 following updates to the Trust's Datix system so that resources are full representative of the system's new user interface and functionality.	Oliver Sims / L&D	31/03/2027
Development of 2026/27 risk appetite review format to be inclusive of bespoke risk appetite rationales and to allow for capturing of specified actions for the next financial year.	Oliver Sims	30/06/2026
Further development of Trust resource for risk appetite summaries to support 2026/27 risk appetite review.	Oliver Sims	30/06/2026

Risk Management Ambition Three	Alignment to Strategic Goals	
To support the Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislation responsibilities, including standards of clinical quality and compliance requirements.	Strategic Goal 1 – Innovating quality and patient safety	
	Strategic Goal 2 – Enhancing prevention, wellbeing and recovery	
	Strategic Goal 5 – Maximising an efficient and sustainable organisation	
Why is this important?		
The system of internal control within the Trust is an important component in the successful management of its risks. Internal controls are concerned with the methods, procedures and checks that are in place to ensure that the organisation is able to meet its ambitions.		
What do we want to do?	How will we do it?	
Integrate risk management and ensure processes are in place to allow staff to identify, monitor and communicate risks that may affect the delivery of strategic ambitions.	1. Further development / refinement of the Board Assurance Framework and supporting review process via Trust Board and its assuring committees. 2. Reference to Trust-wide risk register to be cited within Board Assurance Framework template as part of development. 3. Review of Trust Board and Committee risk register extract reporting template to reflect changes since last review and ensure that date opened is included for all entries to demonstrate length of time risk has been open to support review. This will include changes to linked actions and any associated timescales with rationale for change. 4. All committee to commence with cyclical deep dives of aligned strategic goals and associated sections of the BAF alongside	

	regular review arrangements of each iteration of the document.
Year One Actions Completed	
1. The Board Assurance Framework has been subject internal audit annual review, and the document template has been updated to address each the recommendations made. 2. An update has been made to BAF template for Q4 use onwards, to allow for specific references to the trust-wide risk register to be cited where required in relation to the gaps in assurance and supporting actions, to align the two documents and further strengthen assurance arrangements. 3. A review has been completed of the risk register extract reporting template to reflect changes since last review and ensure that date opened is included for all entries to demonstrate length of time risk has been open to support review. 4. We have commenced with cyclical deep dive arrangements of aligned strategic goals and associated sections of the BAF for the Quality Committee in year 1 and Audit Committee has continued with its oversight and review of its aligned strategic goal.	

Year Two Planned Actions		
Risk Management Ambition Action	Lead	Timescale
Implementation of cyclical deep-dive arrangements of aligned strategic goals and associated sections of the BAF at the Trust's Finance and People and OD Committees	Oliver Sims / Exec Lead	31/12/2026

3. Recommendations

The Audit Committee is asked to note the content of this strategy update and approve the proposed actions to further embed the systematic approach to the identification and management of all risks surrounding the Trust's activities.

Appendix 1

Risk Management Improvement Plan 2026/2027			
Area of Focus	Planned Actions	Lead	Timescale
Risk Management / BAF Staff Training	Delivery of Board Assurance Framework training session to ODG membership to promote understanding and ownership of document / Trust risk appetite.	Oliver Sims	31/05/2026
Risk Appetite Development and Refresh	Development of bespoke risk appetite rationales to support 2026/27 review process.	Oliver Sims / Exec Leads	30/06/2026
Risk Appetite Application	To determine how the Trust's 2026/27 risk appetite statements when agreed, can be utilised as part of the Trust's board and committee cover sheet.	EMT	31/07/2026
Risk Management / BAF Staff Training	Development of a refreshed training needs analysis for risk management by staff group in conjunction with the Trust's divisional management.	Oliver Sims / Divisional General Managers	30/06/2026
Risk Management / BAF Staff Training	Development of a risk management e-learning training package. Action being taken forward during year 2 following updates to the Trust's Datix system so that resources are full representative of the system's new user interface and functionality.	Oliver Sims / L&D	31/03/2027
Risk Appetite Development and Refresh	Development of 2026/27 risk appetite review format to be inclusive of bespoke risk appetite rationales and to allow for capturing of specified actions for the next financial year.	Oliver Sims	30/06/2026
Risk Appetite Development and Refresh	Further development of Trust resource for risk appetite summaries to support 2026/27 risk appetite review.	Oliver Sims	30/06/2026
Risk Management / BAF Governance Arrangements	Implementation of cyclical deep-dive arrangements of aligned strategic goals and associated sections of the BAF at the Trust's Finance and People and OD Committees.	Oliver Sims / Exec Lead	31/12/2026

Agenda Item 11

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Insightful Board, CQC Well-Led Quality Statements and preparing for a CQC Well Led Quality Statements Review															
Author/s:	Sarah Smyth, Executive Director of Quality, Nursing & Professions Stella Jackson, Head of Corporate Affairs Kate Baxendale, Deputy Director of Nursing, Quality & Professions															
Recommendation:	<table border="1"> <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>	To approve		To discuss	✓	To note		To ratify		For assurance						
To approve		To discuss	✓													
To note		To ratify														
For assurance																
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	This paper contains an update regarding compliance against the Insightful Board domains and the CQC Well Led Quality statement actions. It also provides details of work underway to prepare for a CQC and/or external Well-Led review. The Board is asked to: • Note relevant committees continue to monitor gaps in compliance against the Insightful Board domains allocated to them for assurance. • Consider whether the actions which have not yet closed should be added as separate items to Committee workplans and the Insightful Board report retired. • Note the update regarding progress made since the Board considered the CQC Well-Led Quality Statements • Note the intention of the CQC to reframe their quality statements as supporting questions, similar to their previous key lines of enquiry (KLOES). • Note the work underway to prepare for a CQC and/or external Well-Led review and consider whether any further work needs to take place.															
Key Issues within the report:																
Positive Assurances to Provide: • The Board can demonstrate good governance arrangements against many of the areas in the Insightful Board guidance. • An Insightful Board briefing has taken place with senior managers at the Trust, particularly regarding the quality of information provision. • The Board considered the guidance at the Strategic Board Development meeting held on 25 February 2025 and agreed the Committees should seek assurance regarding the relevant sub-sections/domains within the guide.		Key Actions Commissioned/Work Underway: • The domain areas have been assigned to the relevant committees for consideration.														

- All committees have reviewed the evidence and gaps and will continue to receive updates regarding the assurances and gaps. - The Board reviewed the Strategy domain at the July Board meeting - The Board, EMT, ODG has reviewed all 8 quality statements.	
Key Points/Risks: - An external review of governance will need to commence this year. - Briefings will be delivered to the Board and Governors to equip them for the interviews that will occur as part of this process.	Decisions Made: - The Board agreed the relevant committees should seek assurance regarding the relevant domains/sub-sections within the Insightful Board guide. The Board has considered compliance against the Strategy domain and the areas within this domain have been assigned to the relevant committees. - EMT supports the approach and action plan. - EMT also supports the actions which have not yet closed being added as separate items to Committee workplans and the Insightful Board report retired.

Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	8.7.25 9.9.25 12.5.26
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	EMT/ODG Time Out 28.11.24 Trust Board 25.2.25 & 25.6.25 EMT 9/9/25 Trust Board 25.2.26

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
✓ Tick those that apply				
✓	Innovating Quality and Patient Safety			
✓	Enhancing prevention, wellbeing and recovery			
✓	Fostering integration, partnership, and alliances			
✓	Developing an effective and empowered workforce			
✓	Maximising an efficient and sustainable organisation			
✓	Promoting people, communities, and social values			
Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	✓			
Quality Impact	✓			
Risk	✓			
Legal	✓			To be advised of any future implications as and when required by the author
Compliance	✓			
Communication	✓			
Financial	✓			

Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Insightful Board and CQC Well Led Quality Statements Update

1. Introduction

This paper contains an update regarding compliance against the Insightful Board domains and the CQC Well Led Quality statement actions. It also provides details of work underway to prepare for a CQC and/or external Well-Led review.

2. Insightful Board Context

On 12th November 2024, NHS England (NHSE) published The Insightful Provider Board. This non-mandatory guidance aims to support provider boards to turn data into useful insight. Effective governance practice around board reporting and assurance-seeking is also considered. Suggested measures are incorporated into the guidance that boards might wish to consider using for planning, monitoring, and seeking assurance about progress.

The guidance aims to properly equip boards, making sure they have got the right information at the right time, and can use it in the right way to both lead and track improvement, as well as respond quickly to problems.

The guidance is in three sections covering:

- The board's role in governance and organisational culture
- Suggestions for ensuring that information boards receive, and review is meaningful.
- Domains for consideration by boards, with related key questions they might wish to consider, and measures and indicators that might enable them to gain adequate assurance about performance.

2.1 Trust's Response Insightful Board

Senior managers at the Trust received a briefing regarding the Insightful Board guidance at Operational Delivery Group and through the Quality Standards Group.

The Board considered the Insightful Board guidance at a Strategic Board Development meeting held on 25 February 2025 and 25 June 2025 and agreed the committees should review the relevant questions and measures detailed within the six domain areas and, in doing so, consider whether there is any more the Trust should be doing to monitor and gain assurance. This has been timetabled into Committee work plans and effectiveness reviews.

A paper regarding compliance against the best practice within the Strategy section of the guidance was forwarded to July Board where it was agreed that compliance against the areas should be assigned to and considered by the relevant committees and this subsequently occurred.

Trust Board received a further update regarding compliance against the Insightful Board domain areas and the Quality Statements at the Strategic Board meeting held on 25 February 2026.

2.2 Action Plan - Insightful Board Actions and Gaps

Gaps in compliance against the Insightful Board domain were pulled together into an action plan and these have, and continue to be, monitored by relevant committees. The combined action plan is attached at Appendix 1.

It's important to note that there is overlap of the standards that have been reviewed by Quality Committee and the Mental Health Legislation Committee and then People and OD Committee and Finance Committee. This is however positive because there is further triangulation and assurance.

Since the committees started monitoring gaps in compliance, a number of actions have now been closed and are highlighted in green in the action log. It is proposed that the small number of actions which are still open are moved to the relevant committee workplan as separate items and that the Insightful Board report is retired.

3. NHS England - Capability Assessment Framework Self-Assessment

Following publication of the Insightful Board guidance, providers were informed they need to complete a Capability Assessment Framework self-assessment. Providers now need to self-assess against six functional domains from "The insightful Board" to identify strengths and challenges, which are then reviewed by NHS England to assign a rating (e.g., Green, Amber-red, Red) to inform their relationship and any required support actions.

NHS provider capability assessments use a multi-faceted approach involving self-assessment by the provider, third-party information (like CQC ratings), and national oversight to determine a capability rating. Providers self-assess against the six Insightful Board functional domains to identify strengths and challenges, which are then reviewed by NHS England to assign a rating (e.g., Green, Amber-red, Red) to inform their relationship and any required support actions.

The process aims to strengthen assurance for NHS England by providing a holistic view of provider boards' awareness of challenges and their track record of addressing them.

The Trust's capability rating has been assessed as Green.

4. CQC Well Led Quality Statements

On 8 April 2024 the Care Quality Commission and NHS England jointly developed and published new well led guidance for Trusts under the Single Assessment Framework. The guidance details eight quality statements which are detailed below: -

- 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, improvement and innovation
- Environmental sustainability

Assessment against these quality statements is the current methodology being undertaken by the CQC to determine how well-led an NHS provider is.

However, on 16 October 2025, the Care Quality Commission published a consultation regarding proposed changes to how health and social care providers are assessed and rated. The consultation proposed a more proportionate, data-driven, and collaborative approach to inspection, aiming to reduce bureaucracy and make ratings more responsive.

In particular, the consultation proposed that the quality statements would be reframed as supporting questions, similar to the previous key lines of enquiry (KLOEs). These proposed

changes will allow the CQC to be more precise about what good looks like, giving clarity to providers on what the CQC needs, and to the public on the standard of care they should expect.

The consultation closed on 11 December 2025, and it is anticipated that the new assessment frameworks and supporting guidance will be published in Summer 2026, with full implementation of the redesigned regulatory process taking place by the end of 2026.

Even though the statements are similar to the Insightful Board best practice requirements, the Insightful Board focusses on data whereas the quality statements focus on feedback and insights. Consequently, the areas identified as requiring improvement differ. Therefore, whilst the work is aligned, separate action plans have been developed to ensure a detailed approach to both frameworks.

4.1 CQC Well Led Quality Statements self-assessment

The divisions and directorates have undertaken a self-assessment against the eight CQC Well Led Quality statements.

- The quality statements self-assessment findings have been presented at Strategic Board.
- The quality statements have been reviewed through the Quality Standards Group, Organisational Delivery Group and the Executive Management Team.

4.2 Preparing for a CQC Well-Led Review

The CQC undertook a well-led review of the Trust in 2019 and an overall rating of 'Good' was awarded. Inspections of those Trust services which haven't been inspected for a number of years are currently being undertaken and it is envisaged a well-led review will occur this year or next.

Additionally, toward the end of 2021, an external review of governance commenced (undertaken by Grant Thornton) and this concluded in 2022. The Trust received very good feedback from the review and the actions identified have been implemented. A further review was undertaken 12 months ago to ensure the actions were still embedded.

Provision 4.7 within Section C of the Code of Governance for NHS Provider Trusts provides that all trusts should undertake an external developmental review of their leadership and governance using the Well-Led framework every three to five years. Consequently, a further review is due this year.

In preparation for a CQC/external Well-Led review, the following work is underway:

- Task and Finish Group established
- Comprehensive briefing pack (for the Board and Council of Governors) to be developed by the Task and Finish Group
- Information from other CQC inspections being gathered and learning taking place through the Quality Standards Group. The learning will inform briefings for the Board and Governors.
- Key lines of enquiry (once published) to be mapped against the quality statements
- Mock interviews to take place with Board members, particularly Committee Chairs, and Governors (it is likely these will commence in the Summer 2026)
- Briefings to be delivered to the Board and Governors (it is anticipated these will commence in Spring 2026, with the first one being safer staffing).

7. Recommendations

The Board is asked to:

- Note relevant committees continue to monitor gaps in compliance against the Insightful Board domains allocated to them for assurance.
- Consider whether the actions which have not yet closed should be added as separate items to Committee workplans and the Insightful Board report retired.
- Note the update regarding progress made since the Board considered the CQC Well-Led Quality Statements
- Note the intention of the CQC to reframe their quality statements as supporting questions, similar to their previous key lines of enquiry (KLOES).
- Note the work underway to prepare for a CQC and/or external Well-Led review and consider whether any further work needs to take place.

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale
Quality	Quality	Experience	Triangulation of set patient experience and staff experience questions	To develop greater critique of staff experience vs patient experience linked to specific staff survey questions. February 2026 Triangulation will take place once the 2025 NSS data is published. The People Experience Team has been engaging with Trusts that have successfully embedded this approach and will work with the PACE team to implement it in early 2026. April 2026 In April, work continued to bring patient experience and people experience metrics closer together, building on the shared recognition that both are strongly interconnected and offer greater insight when triangulated. Following initial workshops earlier in the year between the People Experience, OD and Patient Experience teams, a data-triangulation exercise using newly released National Staff Survey results and patient experience dashboards (including FFT and sentiment analysis) will now take place. A proposal will also be submitted to EMT to establish a multidisciplinary People Experience Working Group, aimed at coordinating People Promise activity, strengthening communication through local champions, and ensuring patient and people experience data is routinely aligned across Trust forums.	KP/ KF	March 2026

Strategy	Quality	Statutory duties, regulatory ratings, and compliance with regulatory requirements	Violence, Prevention and Reduction Standard	Violence Prevention and Reduction Enabling Strategy to be produced in collaboration with staff, patients and their families. November 25 Self-assessment being undertaken and will be reported to EMT with action plan.	PB	March 26
Quality	Quality	Advocacy	Advocacy is received by Mental Health legislation Committee. Where do we report advocacy for all clinical areas? November 25 update We work in close partnership with two advocacy services in Hull and East Riding: Cloverleaf Advocacy in Hull and VoiceAbility in East Riding. Both organisations provide Independent Mental Health Advocacy (IMHA) and Independent Mental Capacity Advocacy (IMCA). These services are available to both children and adults, and they also offer support with complaints. The Steering Group receives quarterly reports from both VoiceAbility and Cloverleaf on IMHA activity and emerging issues, as well as an annual report from Cloverleaf on advocacy at the Humber Centre. Mental Health Legislation Managers hold regular meetings with the Local Authority and their respective advocacy services to review performance and address any concerns.	To develop advocacy reporting in all areas in addition to MH: November 25 update A similar reporting process will be established for IMCA and complaint-related activities. IMCA reports from the advocacy services will be submitted to and discussed within the Safeguarding Assurance Group, while complaint activity—typically low (around 1–2 cases per year)—will be incorporated into the overall complaints reporting framework. We do receive quarterly report from the advocacy service, and we have a good working relationship with them. March 2026 - MHA advocacy update: The Mental Health Legislation Committee (MHLC) provides strategic leadership and oversight of Mental Health Act (MHA) and Mental Capacity Act (MCA)-related advocacy. A summary assurance report will be incorporated into the Insight Report and presented to MHLC with ongoing reporting to subsequent MHLC meetings for assurance and oversight. The Steering Group receives quarterly reports from both VoiceAbility and Cloverleaf on IMHA activity and emerging issues, as well as an annual report. Key learning and actions arising from the annual advocacy report will be shared with MHLC. This reporting cycle is included within the MHLC workplan.	KF/SS	November 25 March 26 Complete

				March 2026 – Non- MHA and Advocacy Quality Committee (QC) provides oversight of non-MHA advocacy, primarily via complaints data, where volumes are typically low. This will be included in the Annual Complaints Report and QC insightful report.		
		Learning From Deaths	We currently don't have a learning from deaths report. However, we include learning from deaths within our annual patient safety report	To enhance our reporting, understand best practice and develop future reporting, a learning from deaths report will be produced which will link our local and regional suicide work. November 25 To strengthen organisational reporting, embed recognised best practice, and inform the development of future reporting processes, a Learning from Deaths report will be produced. This report will align and integrate our local and regional suicide prevention work, ensuring consistency and transparency. The report will be submitted to QPaS for initial review in January 2026 and subsequently presented to the Quality Committee on 05 March 2026 for assurance and oversight. April 2026 Update The Learning from Deaths report for Q2 and Q3 was completed and presented to QPaS on 23 April 2026. The report will be presented to the next Quality Committee (QC) meeting to provide assurance and oversight. Mortality dashboard data continues to be included within the Board's regular performance reporting, ensuring ongoing visibility of trends, themes and actions. Learning from Deaths reporting is now included within the QC Work Plan, with six-monthly updates to support sustained assurance and oversight.	KF	November 25 March 26 Complete
		Mortality Data	Mortality data is received by CRMG, the Quality Committee insights report and in the annual patient safety report	November 25 update To further strengthen governance and ensure systematic learning, mortality data will now be	KF	November 25 March 26 Complete

				explicitly incorporated into the Learning from Deaths reporting process. This purpose will include: • Provide consistent triangulation of data across governance committees • Deliver a single, transparent narrative of patient safety outcomes • Link mortality reviews directly to governance oversight to drive improvement Expected Outcomes • Reinforced accountability at all levels of governance • Clear identification of trends and emerging risks • Assurance that lessons learned from mortality reviews are acted upon and monitored. Governance Pathway The enhanced Learning from Deaths report will be submitted to QPaS for initial review on 22 January 2026 and subsequently presented to the Quality Committee on 05 March 2026 for assurance and oversight. This integration ensures that mortality data is not only reported but actively used to inform governance decisions, strengthen patient safety culture, and embed continuous learning across the organisation. April 2026 Update The Learning from Deaths reports for Q2 and Q3 have been completed and were presented to QPaS on 23 April 2026. These reports will be submitted to the next Quality Committee (QC) meeting to provide formal assurance and oversight. Mortality dashboard data continues to be reported routinely through the Board's regular performance reports, supporting visibility of trends, themes and outcomes. In addition, a Mortality Data Review Group has now been established to strengthen oversight of mortality information, with a specific focus on data quality, emerging themes, and organisational learning.		

				Learning from Deaths reporting is now included within the QC Work Plan, with six-monthly updates for oversight and assurance.		
Quality	Quality	LeDeR	Improved awareness of LeDeR reporting November 25 Humber Teaching NHS Foundation Trust maintains active engagement with the Humber and North Yorkshire Integrated Care Board (ICB) through monthly participation in the LeDeR Steering Group. The Trust is represented by the Divisional Clinical Lead for Learning Disability Services, alongside colleagues from the Neuro Team and Safeguarding. The Steering Group agenda routinely covers regional updates, performance and assurance, quality assurance, governance, audit, and improvement activities. The Trust has contributed to several key initiatives led by the Steering Group, including the epilepsy project, hospital experience study, implementation of the Reasonable Adjustment Flag, support for annual health checks, and a cancer screening project. In alignment with the Steering Group's directive, all providers are required to produce a report detailing actions taken to address priority areas identified through LeDeR reviews specifically health inequalities, reasonable adjustments, and causes of death. Learning from LeDeR reviews is facilitated through a monthly review panel, with Humber staff in attendance. These reviews are anonymised, and thematic learning is extracted to inform practice across providers. This learning is disseminated internally via the LeDeR newsletter produced by the reviewing team. This is embedded into the agendas	This is reporting into the Safeguarding group, including the regional report. This will be included in the Learning from Deaths report as above. Oversight from Quality Committee. November 25 As part of the revised governance arrangements for the Safeguarding Assurance Group findings from both the reviews and regional reports will be presented to the Safeguarding Assurance Group to promote cross-divisional learning and continuous improvement. LeDeR will be included in the Learning from Deaths report. April 2026: LeDeR Update LeDeR has been included in the <i>Learning from Deaths</i> report, which was presented to QPaS on 23 April 2026 and subsequently escalated to QC. Key workstreams already in place: - Reasonable Adjustment Flag programme and associated working group. - Monthly LeDeR ICB meeting, attended by HTFT staff, with themes and learning shared through the local Learning Disability (LD) clinical network. - Dissemination of learning via the LeDeR newsletter. LeDeR included within the QC Work Plan under Learning from death report.	KF	As above ~~November 25~~ March 26 Complete

			of Learning Disability Services MDT meetings and their clinical networks.			
Quality	Quality	CDOP	Regional CDOP reporting	To include in Quality Committee insight report	SS	Complete
Quality	Quality	Feedback from visits	Reporting of visits by EMT and Board	Feedback reports from Board and Executive Team visits to be shared with EMT to ensure triangulation of data and feedback.	SS	September 25 Complete
Quality	Quality	Patient safety	Reporting of patient safety partners and impact	Review of patient safety partners – options appraisal paper for EMT Update November 25 – paper received by EMT, supported in principle but funding will need to be agreed through the planning process Feb 26 We now have 2 patient safety partners as a trust and therefore meet the minimum requirements. Updates will be provided via the insights report and patient safety priorities	SS	October 25 January 26 Complete
Strategy	Quality	Organisational Development – Health Inequalities Plan	Demonstrating Inequalities	The Trust has a health inequalities delivery plan which is reported through EMT, Quality Committee and Board. No further action	N/A	N/A
Quality	Quality	Mental Health and people with a LD and autism	There is a list of performance metrics which need to be considered by the Quality Committee – these already feature in the performance waiting list report that goes to Quality committee and performance is reported to Board,	The performance questions to be included in the Quality Committee self-assessment.	SJ	September 25 - Complete
				Review performance metrics against the current report. November 25 The new metrics will be available for the committee in the Q3 Waiting Times and Performance Report.	LP	November 25 Complete

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale
People	People and OD	Agency spend	Eradicate agency spend	Operational Planning guidance asks for 50% reduction in Agency and 10% reduction in Bank which is committed through our plans. Up to this, we have already shown a 47% reduction in agency and 8% reduction in Bank. Update January 2026: MTP submitted targets for 26/27 to commit to a 30% agency reduction and a 7.5% bank reduction. A bank and agency reduction plan will go to ODG which will focus on the specific action required to achieve this target. This action will remain ongoing with progress reported through the finance agency report, the people insight report and the workforce, finance and productivity report that goes to EMT and the P&OD Committee. April 2026 The Trust continues to prioritise the reduction of temporary staffing expenditure. Year-to-date figures demonstrate a 9% reduction in agency usage and a 15% reduction in bank usage, evidencing the impact of targeted workforce interventions. The medium-term plan submission committed the Trust to a 30% agency reduction and 7.5% bank reduction for 2026/27, with current progress on track. All locum medics have now been transitioned to Agency Direct Engagement, which results in significant cost savings and enhanced financial control.	KP	Ongoing with aims for achievement by March 2027.
People	People and OD	National Education and Training Survey	From the data there may be some areas for improvement in the areas of discrimination and sexual safety	Medical Education Team to undertake a deep dive <i>Update October 2025</i> <i>Two deep dives were conducted—one post-NETS and one post-GMC NTS—in collaboration with NHS England's Quality Team, including the Quality</i>	KF	December 25 Complete

				<i>Intelligence Manager. No concerns were identified regarding discrimination or sexual safety.</i> • <i>Bullying/Harassment:</i> - o <i>100% of Resident Doctors (above national average) reported no bullying or harassment by staff during placements.</i> • <i>Sexual Safety:</i> - o <i>Over 70% (below national average) reported no experience of inappropriate sexual behaviour from patients; 23% reported incidents 'once or twice'. NHS England attributed this to the mental health setting and raised no concerns.</i> • <i>Discrimination:</i> - o <i>70% (below national average) reported experiencing discrimination by patients; 28% reported it occurred.</i> - o <i>Again, NHS England did not raise concerns, attributing findings to the mental health context.</i> • <i>GMC NTS Feedback:</i> - o <i>NHS England confirmed no patient safety or undermining concerns were reported by Resident Doctors at Humber Teaching NHS Foundation Trust.</i> • <i>Education & Engagement:</i> - o <i>GMC colleagues delivered sessions on the updated Good Medical Practice in 2024 and 2025, open to all doctors including Resident Doctors.</i>		
		Quality Improvement in Medical Training	Consideration of minimal level of training if participating in charters	To establish a minimal level for doctors <i>Update October 2025</i> <i>The Trust's Doctors' QI Approach, established over five years ago, supports medical staff in improving patient care. Central to this is the Let's Talk QI session—covering Clinical Audit, Continuous Improvement, Innovation, and Research—delivered during induction and Wednesday teaching.</i> <i>Doctors also have access to regular QI drop-ins for idea sharing and support. The programme is backed by the Executive Medical Director, Clinical Audit Facilitator, and QI Manager. Certificates and presentation opportunities are available for those undertaking projects.</i>	KF	November 25 Complete

				<i>To embed QI further, four QI Doctor Champions actively support colleagues. The approach is regularly reviewed to ensure continued relevance and impact.</i>		
		Apprenticeships	Understanding our direction with optimising the apprenticeship levy spending in line with the future business need	Assessment of current position and actions to address gaps underway Update January 2026: The Trust supports 136 apprentices across 40+ pathways, with strong growth, funded through a 0.5% wage bill levy that enables strategic workforce development, internal talent growth, and support for system partners. Optimisation will be tracked through metrics such as levy utilisation rate, number of apprenticeships started per quarter, division-level uptake, and percentage of internal progression into substantive roles. This will be reported into the People Insight report that reports to P&OD Committee.	KP	November 25 Complete
		Lived experience	Lived experience workforce – evaluate impact and continuous improvement	This action is being picked up with the PACE team.	KP	Complete

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale	Update
		System Financial Performance	Medium Term Financial Plan/MHIS	Medium Term Financial Plan to be developed. See above Assurance of the MHIS at ICS level to be undertaken. This has now been superseded by the new planning framework	PB	January – March 26	As above
Strategy	Finance	Organisational Development - SNOMED	SNOMED Recording Compliance	SNOMED recording is in progress, but we are not yet fully compliant with this. It then needs to be embedded in our health inequalities recording and underpin our operational service plans. On going monitoring through digital and data group with individual actions plan developed for each division.	PB/KF	Dec 25	SystmOne is configured to record health equalities from the completion of the go live in February 2025. Protected characteristic (which include health inequalities) and general data quality reports are provided to all Trust staff. The performance and productivity group are managing the performance of operational staff to complete health inequality and other SNOWED code. The focus is currently on operational staff to record SNOWED codes and to provide support as identities by operational teams. Update May 2026 Work remains ongoing:- - Enablers for data quality and reporting and capture are in place - Operational Compliance is monitored at

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale	Update
							Performance and Productivity Group - Trajectories for each division to be agreed and form part of accountability reviews
Finance	Finance	Workforce Drivers	Corporate Benchmarking.	Return due 11 th July 2025, results to be analysed and reported to EMT and Finance Committee.	PB	October 25	Corporate Benchmarking results received Finance results reported to EMT and October Finance Committee. Workforce results reported to EMT and January Finance Committee. All Areas of Corporate Services included in the Corporate Benchmarking will be reviewed by EMT and Finance Committee Update May 2026 <i>2026 exercise commences in July 2026</i>
			Need to extract sickness by staff group.	To be picked up with the BI team	PB/KP	October 25	Update May 2026 Sickness for Nurses and Medical included in the Model Hospital Productivity Report to EMT Monthly and to Finance Committee Quarterly. Complete
		Business Unit Information	Cashflow	Future finance reports to include a cashflow forecast	PB	September 25	A cashflow forecast is now included in the Finance Report

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale	Update
		Capital	2025/26 Capital Programme and associated financing	To be approved by Capital and Estates Group and then EMT	PB	August 25/ September 25	Capital Programme reported to EMT and also forms part of finance committee report.
		Capital	3 Year financial plan	To be approved	PB	January – March 26	2 year plan submitted in December, 3 year plan to be submitted in February 2026. The BRS already plans across a 3 year period. There is dependency on funding from The ICB which the Trust is in regular discussion Update May 2026 A compliant 3 year financial plan was submitted in February 2026. Complete
		Productivity	Methodology	Report to be taken to EMT and Finance Committee Awaiting National Guidance on methodology for MH Trusts	PB/LP	October 25	Productivity now standing items on Finance Committee. This includes - Model Hospital Productivity Metrics - NHSE Productivity Packs - National Cost Collection Update All the above reported to EMT and Finance Committee and well received by Finance Committee Update May 2026

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale	Update
							Measuring productivity gains was reported at the February Strategic Bord Session.
		Estates and Facilities Management	ERIC Return/Model Hospital	The results from the 24/25 return will be analysed and key metrics will be taken to the Estates Strategy and Capital Delivery Group and then EMT, this will include comparative data from Model Hospital.	PB	August 25 and Ongoing	Headlines from the 2024/25 ERIC submission reported to the Estates Strategy and Capital Programme Group in August, the dashboard was also part of the assurance report to EMT. ERIC is a standing item at the Estates Strategy and Capital Programme Group and referenced in assurance reports to EMT.
Strategy	Finance	Organisational Development – Model Hospital	Utilisation of Model Hospital Data	Further focus needs to be given to the utility of Model Hospital data and demonstration of all available benchmarking data in our productivity and efficiency programme of work.	LP/PB	Nov 25	Model Hospital Productivity and Efficiency Metrics are reported to EMT Monthly and are now a standard item on the Finance Committee Agenda. Update May 2026 Model Hospital data is also used to inform reports against the National Oversight Framework Dashboard and Corporate Benchmarking Work.
Strategy	Finance	Key Trends and Forecasts	Cashflow Reporting	Cash is reported monthly to EMT, cashflow forecast to be developed and form part of future finance reports.	PB	Sept 25	A 3 year cashflow forecast is now included in the Finance Report and will be reported to EMT
Strategy	Finance	Compliance and Risk ERIC and PAM	The results from the 24/25 ERIC return will be analysed and key metrics will be taken to the Estates Strategy and Capital Delivery Group and then EMT, this will include comparative data from Model Hospital.	Update reports on the PAM to be a standing item (with a paper) to future Health and Safety Group meetings.	PB	August 25 and Ongoing	ERIC Dashboard part of the Estates assurance report to EMT on 9 th September 2025. Highlights from the PAM submission reported to the Trust Health and Safety Group in September, this was in the

Insightful Board Domain	Committee	Standard	Gap	Action	Lead	Timescale	Update
							assurance report to EMT on the 14th October 2025. PAM is a standing item on the Health and Safety Group and an update on the revised reported methodology was received on 18th March 2026.

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Antimicrobial Stewardship (AMS) Progress Update															
Author/s:	Lead Executive – Dr Kwame Opoku-Fofie Author: Dr Weeliat Chong (Chief Pharmacist)															
Recommendation:	<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>				To approve	√	To discuss	√	To note		To ratify		For assurance	√		
To approve	√	To discuss	√													
To note		To ratify														
For assurance	√															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	This paper provides the Board with an update on the actions arising from the NHS England letter (November 2025), “<i>Act now: protect our present, secure our future.</i>” The Board is asked to note the AMS progress made and take assurance that the required actions on AMS have been fully implemented, with appropriate oversight and monitoring arrangements in place.															
Key Issues within the report:																
Positive Assurances to Provide: - All actions outlined in the NHS England letter, “Act now: protect our present, secure our future” (November 2025), have been completed. - Robust arrangements are in place for ongoing monitoring, review, and continuous improvement through the HTFT Antimicrobial Stewardship Plan 2024–2027.		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT): - Trust’s Executive lead of AMR is the Executive Medical Director. - Trust’s Antimicrobial Stewardship Policy and Plan (M-030) was approved by EMT and ratified by the Trust Board on 26.03.2025. - Our Antimicrobial Stewardship Plan 2024-27 was approved by the Trust Board in March 2025. An update of progress against this plan was presented and approved by the Healthcare Associated Infection Group (HAIG) on 19.11.2025. This report provides further update on the plan. - The Infection Prevention and Control Board Assurance Framework (section 3) serves as a self-assessment tool within the Trust with all clinical areas having completed a local assessment of performance against all performance indicators within the last year. - Prescribing audits on antimicrobials are carried out annually. The reports are reviewed by both the Drug and Therapeutics Group and HAIG.														
Key Risks/Areas of Focus: The key areas of focus Board-level review and executive oversight: ensuring sustained leadership visibility and accountability.		Decisions Made: AMS for board assurance and oversight.														

• Risk and capability assessment: maintaining an up-to-date understanding of organisational risks and capacity to respond. • Setting priorities and delivering improvement: embedding continuous improvement and ensuring alignment with national expectations.			
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date	Date
	Audit Committee		Remuneration & Nominations Committee
	Quality Committee		People & Organisational Development Committee
	Finance Committee		Executive Management Team
	Mental Health Legislation Committee		Operational Delivery Group
	Collaborative Committee		QPaS
			12.05.2026
			23.04.2026

Monitoring and assurance framework summary:

Links to Strategic Goals (please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)				
√ Tick those that apply				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
	Developing an effective and empowered workforce			
	Maximising an efficient and sustainable organisation			
	Promoting people, communities and social values			
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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Antimicrobial Stewardship

Progress Update

27 May 2026

BACKGROUND

In response to the letter from NHS England in November 2025 entitled **Act now: protect our present, secure our future**, this paper provides a brief update on the actions listed in the letter:

1. Board-Level Review & Executive oversight
2. Risk and Capability Assessment
3. Set Priorities and Deliver Improvement

UPDATE

1. Board-Level Review & Executive Oversight

ACTION: Schedule a joint presentation to your board from IPC and AMS (Antimicrobial Stewardship) teams covering:

- Current performance against national AMR (Antimicrobial Resistance) targets
- Key concerns and immediate actions required

HTFT Progress Update

Our *Antimicrobial Stewardship Policy and Plan (M-030)* [antimicrobial-stewardship-policy-and-plan-m-030.pdf](#) was approved by EMT and ratified by the Trust Board on 26.03.2025. It sets out the Trust's strategic plan for making a sustained and ongoing progress towards achieving the government vision and ambitions for optimising the use of antimicrobials. This contains the *Trust Antimicrobial Stewardship Plan 2024-27*. An update of progress against this plan was presented and approved by the Healthcare Associated Infection Group (HAIG) on 19.11.2025. Please see Appendix for the latest update on 27.05.2026.

2. Risk and Capability Assessment

ACTION: Complete the national infection prevention and control **Board Assurance Framework** to

- Evaluate current performance and compliance
- Identify gaps in leadership, workforce capability and resource allocation and
- Inform risk registers and strategic planning.

HTFT Progress Update

The *Infection Prevention and Control Board Assurance Framework* is currently utilised as a self-assessment tool within the Trust, with all clinical areas having completed a local assessment of performance against all performance indicators within the last year.

A formal review of the overall Trust performance against this framework has been completed by the IPC Team. This will be presented at the April 2026 QPaS and EMT in May 2026 prior to the submission to a subsequent meeting of the Trust Board.

3. Set Priorities and Deliver Improvement

ACTION: By April 2026, agree and publish three priority areas for AMR improvement within your organisation. For each priority:

- Define specific, measurable objectives.
- Assign executive-level accountability.
- Establish timelines and reporting mechanisms.

HFTF Progress Update

Our executive lead of AMR is our Executive Medical Director.

As indicated above, our *Antimicrobial Stewardship Plan 2024-27* was approved by the Trust Board in March 2025. An update of progress against this plan was presented and approved by the Healthcare Associated Infection Group (HAIG) on 19.11.2025. The latest update (27.05.2026) is in the Appendix.

Prescribing audits on antimicrobials are carried out annually. The reports are reviewed by both the Drug and Therapeutics Group and HAIG.

SUMMARY

All relevant actions listed in the letter from NHS England in November 2025 entitled ***Act now: protect our present, secure our future*** have been completed, with ongoing monitoring and review of our local actions as set in HTFT Antimicrobial Stewardship Plan 2024-27.

Appendix - Trust Antimicrobial Stewardship Plan 2024-2027

(PROGRESS UPDATE 27 MAY 2026)

Key Trust Priorities

- Ensure effective antimicrobial stewardship and governance arrangements are in place.
- to improve staff awareness and understanding of antimicrobial resistance through effective communication, education and training.
- to strengthen the knowledge and evidence base through surveillance
- to reduce the incidence of infection through the effective implementation of appropriate infection prevention measures.

1.Innovating Quality and Patient safety		
“We will embed a culture of continuous quality improvement in all antimicrobial stewardship activities undertaken on behalf of the Trust”		
How we will achieve this	How we will know we have achieved this	Progress made
Review and evaluate the current antimicrobial stewardship governance arrangements to ensure it remains in alignment with current national guidance requirements	• Antimicrobial stewardship arrangements in place and outlined within the IPC Arrangements Policy. • Antibiotic stewardship related matters discussed at the Trust Board, Drug & Therapeutics Group, Divisional Clinical Network and Governance meetings.	• Antimicrobial stewardship arrangements outlined within the IPC Arrangements Policy. Approved by the Trust Board March 2025 https://intranet.humber.nhs.uk/media/nippi5e2/antimicrobial-stewardship-policy-and-plan-m-030.pdf • Antimicrobial stewardship performance included within the IPC Annual reports. Presented at the Trust Board November 2025 • All performance data presented at the HAIG/ Drug and Therapeutics meetings/ relevant Clinical Governance meetings. Minutes available
• Utilise the National Infection Prevention and Control (IPC) Board Assurance Framework (BAF) to monitor and evaluate Trust antimicrobial stewardship	• Full compliance demonstrated against all the effective antimicrobial stewardship key criteria 3.1-outlined within the Health and Social Care Act 2008 code of practice on the prevention and control of	• Compliance requirements reviewed within the document. Self-assessment undertaken and deemed to be compliant against all the antimicrobial stewardship key criteria outlined

compliance against the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance (updated 13 December 2022).	infections and related guidance (updated 13 December 2022).	
Enhance the mechanisms in place for monitoring compliance to Infection Prevention and Control (IPC) standards and policies to improve IPC practices and outcomes.	- A Trust wide antimicrobial prescribing stewardship audit programme in place across each clinical area - Annual review of the contents of the audit programme evidenced. - Compliance monitored and rated as 'good' in all clinical areas.	- Annual audit programme in place across each clinical inpatient area - Annual review of the content of the audit programme completed. - Compliance monitored and rated as 'good' in all clinical areas. Feedback provided when practice falls below the expected standard
All antibiotic guidelines to ensure they remain current and address clinical and operational needs.	- All current Trust antimicrobial policy and guidelines reviewed to ensure they reflect current national guidance. - All guidance accessible on the Trust Intranet	- Trust antimicrobial policy was reviewed in March 2025 and all relevant antimicrobial formulary/guidelines are reviewed by HNY ICB Area Prescribing Committee. - Medicines optimisation policy in place https://intranet.humber.nhs.uk/media/1dbpybku/medicines-optimisation-policy-m-006.pdf - The follow HNY APC Prescribing guidelines, which are accessible on the Trust Intranet - Regular Pharmacy focus newsletters produced.

2. Fostering integration, partnership and alliances		
We will work collaboratively with local and regional partners to drive forward further reductions in the number of healthcare associated infection		
How we will achieve this	How we will know we have achieved this	Progress made
We will continue to commit to avail ourselves of every opportunity to share and learn with colleagues across the local health economy.	Shared learning with regional partners will be demonstrated by evidence of regular attendance and active participation at local and regional meetings.	- Regular IPC Team attendance at the Humber IPC & AMR Collaborative Forum - Pharmacy attendance at the local HNY ICB Antimicrobial Stewardship Group meetings.
We will work with partners locally to develop and implement a Trust Antimicrobial Plan.	- A Trust Antimicrobial Stewardship Plan has been developed and approved for 2024-2027 . - The Trust Board receives annual reports on antimicrobial stewardship activities. - A Trust audit programme of adherence with antimicrobial prescribing is in place. - The audit programme demonstrates both. - a high level of compliance - an effective response to identified areas for improvement.	- Trust Antimicrobial Stewardship Plan was approved by the Board in March 2025. - Antimicrobial stewardship performance and activities included within the Infection Prevention and Control Annual Report, which was presented in November 2025 at the Trust Board meeting. - Regular scheduled audit programme in place - Good levels of compliance noted for antimicrobials prescribed within the Trust. - Regular Pharmacy oversight in place within all clinical units ensuring effective scrutiny and feedback on prescribing.

3. Developing an effective and empowered workforce		
“We will improve staff awareness and understanding of antimicrobial resistance through effective communication, education and training”.		
Fully embed the use of the newly designed Hand Hygiene and Personal Protective Equipment (PPE) Clinical Competency assessment tool to enhance practice.	Evidence is available via the Electronic Staff Record ‘ESR’ that the Hand Hygiene and PPE Clinical Competency has been successfully attained by each member of staff within the pharmacy team who have been deemed to require Tier 2 IPC Training.	Fully compliant (updated 31 December 2025)
Resources are in place to support and measure adherence to good practice and quality improvement in AMS.	All antimicrobials prescribed within the Trust are monitored regularly by the Pharmacy Team to ensure they are all prescribed safely and effectively.	- Regular scrutiny of all prescribed antimicrobials and documentation within the Trust is in place - Any medicine-related adverse incidents are reported via the Trust approved DATIX reporting system in accordance with the Trust Incident Reporting Policy
To enhance staff awareness and understanding of antimicrobial resistance through effective communication, education and training;	- The Trust Medical Training Programme includes antimicrobial prescribing and effective antimicrobial stewardship. - The Trust Non- Medical Training Programme to include antimicrobial prescribing and effective antimicrobial stewardship within its yearly training schedule	Antimicrobial stewardship included within the Trust Medical and Non-Medical Prescribers’ Training Programme.

4. Maximising an efficient and sustainable organisation		
We will continue to support the improvement of our healthcare environments to ensure they are safe and facilitate the prevention and control of infection.		
How we will achieve This	How we will know we have achieved this	Progress Made
Work in collaboration with our Facilities colleagues to ensure that the storage and safe management of medicines is considered in all construction	- All Trust sites meet the required national technical specifications for the safe storage and management of medicines. - Evidence is available that all capital schemes and preventative maintenance schemes	- All Trust sites meet the required national technical specifications for the safe storage and management of medicines. - Pharmacy team are involved in all planned works. Work continues to ensure that their views and input are consistently sought in the initial stages of all projects.

projects.	have involved the Pharmacy team from the initial stages of the project where the storage and safe management of drugs will be required.	

5. Promoting people, communities and social values		
We will avail ourselves of every opportunity to promote the importance of infection prevention and control community wide		
How we will achieve this	How we will know we have achieved this	Progress Made
The Pharmacy Team will support Trust participation in local, national and global IPC promotional campaigns raising IPC safety and good antimicrobial stewardship awareness.	All national and international promotional events ie World AMR awareness week will be celebrated with a programme of antimicrobial stewardship activities planned.	AMR awareness week celebrated annually with a number of promotional activities included. Plans currently in place to celebrate the event again this year
We will enhance the quality and availability of all Trust antimicrobial stewardship promotional resources.	The usage of a variety of key media, including the internet, intranet and social media platforms in the promotion of effective antimicrobial stewardship.	A number of promotional materials available on the Trust intranet. The use of social media platforms will be enhanced to promote effective antimicrobial stewardship.

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026																											
Title of Report:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report																											
Author/s:	Lynn Parkinson/Alexandra Smith Accountable Emergency Officer/EPRR and Business Continuity Manager																											
Recommendation:	<table border="1"> <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>				To approve		To discuss		To note		To ratify		For assurance	✓														
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:	<table border="1"> <thead> <tr> <th></th><th>Date</th><th></th><th>Date</th></tr> </thead> <tbody> <tr> <td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr> <tr> <td>Quality Committee</td><td></td><td>People & Organisational Development Committee</td><td></td></tr> <tr> <td>Finance Committee</td><td></td><td>Executive Management Team</td><td>12.05.26</td></tr> <tr> <td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td>27.04.25</td></tr> <tr> <td></td><td></td><td>Other (please detail)</td><td></td></tr> </tbody> </table>					Date		Date	Audit Committee		Remuneration & Nominations Committee		Quality Committee		People & Organisational Development Committee		Finance Committee		Executive Management Team	12.05.26	Mental Health Legislation Committee		Operational Delivery Group	27.04.25			Other (please detail)	
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Mental Health Legislation Committee		Operational Delivery Group	27.04.25																									
		Other (please detail)																										
Key Issues within the report:	The attached 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 2025 to 31st March 2026. The report provides an overview of EPRR activities during the last 12 months including its continued response to resident doctor's industrial action and the outcome of the EPRR annual assurance assessment. This report also sets out EPRR priorities for 2025/26.																											
Positive Assurances to Provide: - That we continue to meet the standards set by the EPRR national teams and obligations under the Health and Care Act (2022) - That we continue to improve care and service safety, resilience and response through a programme of EPRR training, testing and learning from incidents internally and through networks and partners.		Key Actions Commissioned/Work Underway: - Continue the work to improve on the EPRR core standards compliance rating for 2026-27. - To ensure audit recommendations are actioned.																										

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

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	✓			To be advised of any future implications as and when required by the author
Quality Impact	✓			
Risk	✓			
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



Caring, Learning
& Growing Together

**BEING
HUMBER**
Our culture, our difference

Emergency Preparedness, Resilience and Response

Annual Report

1st April 2025 – 31st March 2026

FOREWORD

The Emergency Preparedness, Resilience and Response (EPRR) team have assessed risks, developed and reviewed a range of plans and delivered a range of training and exercising to ensure the Trust is resilient. The work undertaken by the team in conjunction with service areas and external stakeholders have enabled the Trust 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 2025/26 with the command-and-control arrangements being stood up to manage potential disruptions to service.

The annual EPRR core standards self-assessment for 2025-26 was again undertaken by the Trust using the new process and compliance requirements previously introduced in 2023-24.

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

I am pleased to present the EPRR 2025-26 Annual Report which identifies the work undertaken to address key priorities, identifies Trust compliance with statutory duties and acknowledges its achievements over the last twelve months.

Lynn Parkinson

Chief Operating Officer/Deputy Chief Executive and Accountable Emergency Officer

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1. Introduction

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.

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 2025 to 31st March 2026. This report provides an overview of EPRR activities over the last 12 months and has set out EPRR priorities for the next 12 months.

3. Statutory Framework and National Policy Drivers

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

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

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

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

4. Accountable Emergency Officer

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

5. Emergency Preparedness, Resilience and Response Discharge of Responsibilities in 2025/26

5.1 EPRR Assurance Process

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

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

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

The annual EPRR core standards self-assessment for 2025-26 was again undertaken by the Trust using the new process and compliance requirements previously introduced in 2023-24.

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

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

Assurance rating principle

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

Compliance Level	Definition
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partially	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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

Humber Teaching NHS Foundation Trust completed its self-assessment against this year's applicable core standards uploading evidence as required, the timeline for the 2025/26 process is outlined below:

- Initial indicative compliance submitted to the ICB by the end of September 2025.
- Peer reviews to be undertaken during September with a similar organisation. Our peer review took place with Navigo on 29th September 2025 with their EPRR team.
- All final evidence was uploaded to the portal by 31st October 2025.
- Final self-assessment was signed off by the Trust AEO and submitted to the ICB by 31st October 2025.
- ICB to provider (HTFT) meeting including EPRR Team and Trust AEO, took place on 3rd November to discuss the final submission.
- LHRP Confirm and Challenge on 20th November 2025.
- Final submission to go to Trust Board on 26th November 2025.

The table below illustrates the final overall compliance of 86% and what compliance looks like within each domain. Hazmat/CBRN was our biggest challenge due to lack of guidance for mental health and community trusts. This is something the EPRR leads across the region are driving more robustly for 2026/27.

Overall assessment:

Partially compliant

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	4	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	10	4	6	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	50	8	0

6. Risk Assessment

The Trust has an EPRR risk register which is reviewed quarterly within the EPRR team; entries onto the EPRR risk register are aligned to the Northeast & Yorkshire NHS England EPRR risk register and Humber Local Resilience Forum community risk register. The EPRR risk register is reported monthly to the Trust Operational Delivery Group via the Risk Managers report.

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

7. Partnership Working

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

Groups attended over the last year include:

- Humber Local Resilience Forum and general working group (multi-agency)
- North of England Mental Health Forum EPRR Leads
- Humber and North Yorkshire ICB system calls
- Humber and North Yorkshire ICB Local Health Resilience Operational Subgroup
- Quarterly Local Health Resilience Partnership
- Humber and North Yorkshire ICB Assurance Group
- Humber and North Yorkshire ICB Resilience
- Humber and North Yorkshire ICB Industrial Action system calls
- Yorkshire and Humber Mental Health and Community EPRR Group

8. Training, Exercising & Testing

8.1 Training & Exercising

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

An EPRR all staff awareness e-learning package has also been created by the team with the Trusts instructional designer and rolled out as part of the Trust's mandatory training in the last 12 months, this is a requirement of the EPRR core standards and gives all staff in the Trust a basic understanding of EPRR, the current compliancy for this E-learning training is standing at 95%.

The EPRR Manager holds a MSc in Emergency Planning, Resilience and Response. The EPRR Officer has completed their Diploma in Health Emergency Planning. The Senior Administration Assistant is undertaking their Diploma in Health Emergency Planning.

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

2025	Training		Exercises	
	Internal	Multi-agency	Internal	Multi-agency
April	RaidR training for MoC	Health Commander portfolio training	Communication Exercise	
May	Incident Response & Recovery awareness	Health Commander portfolio training		NHSE Business Continuity workshop

June	Incident Response & Recovery awareness	Health Commander portfolio training		
July		Health Commander portfolio training		
August		Health Commander portfolio training	Forensics BC exercise Winter Plan testing	
September	Incident Response & Recovery awareness	Health Commander portfolio training		Exercise Pegasus
October		Health Commander portfolio training	Miranda House evacuation Exercise	
November		Health Commander portfolio training		
December		Health Commander portfolio training		
January		Principles of Health Command Training Humber TCG training		
February		Principles of Health Command Training Humber TCG training		
March		Principles of Health Command Training Humber TCG training		

All these exercises had debriefs completed and work is ongoing with recommendations from these. Learning from the exercises have been incorporated into the EPRR plans and policies for this year, and Business Continuity plans have been updated where required. The EPRR team are part of this process and ensure that learning is embedded.

Planned exercises for 2026 are:

2026	Training		Exercises	
	Internal	Multi-agency	Internal	Multi-agency
April		Principles of Health Command Training Humber TCG training	Communication Exercise	Exercise Kaus Australis
May	Incident Response & Recovery awareness (including ICC)	Principles of Health Command Training Humber TCG training	Trust Wide Cyber Exercise Community divisional exercise	
June	Incident Response & Recovery awareness (including ICC)	Principles of Health Command Training Legal awareness training Humber TCG training	Mental health divisional exercise	
July	Incident Response & Recovery awareness (including ICC)	Principles of Health Command Training	Children and Learning Disabilities divisional exercise	Heatwave Exercise
August	Incident Response & Recovery awareness (including ICC)	Principles of Health Command Training	Winter Plan testing	
September		Principles of Health Command Training Legal awareness training	Forensics divisional exercise	
October		Principles of Health Command Training	Communication Exercise	
November		Principles of Health Command Training		
December		Principles of Health Command Training		

8.2 Testing

Communication tests to on call teams have also continued to take place every six months in line with current requirements. These tests enable the Trust to have an understand of the ability to respond to an incident in the out of hours period and is becoming an embedded process for those who provide on call cover across all areas of the Trust particularly in the out of hours period.

Communications Tests were held on:

10th April 2025

27th October 2025

The tests went well and demonstrated that our procedures were followed correctly.

9. Responding to incidents

9.1 NHS Alert Levels

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

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

9.2 Incidents the Trust have supported

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

Incident Type	Date From	Date To	LRF Incident? (NY / Humber)	Description
Power Outage	13/05/25	15/05/25	N/A	Power outage on evening of 13th May affecting Willerby area, due to NPg cutting a cable which didn't show our Willerby site on the CAD drawing to restore power to Willerby area, our power was cut off.
Infectious Disease	18/07/25	05/08/25	Health Coordination Group	This incident involved a health visitor worked for HDFT, worked in Whitby and lived in Middlesborough. TB incident. HTFT supported with clinic rooms at Whitby hospital to support
Industrial Action (Resident Drs)	25/07/25	30/07/25	N/A	Resident Drs took industrial action between 7am Friday 25th July to 7am Wednesday 30th July.
Langdale Wildfire	26/08/25		NY	Wildfire affecting the Langdale area, and smoke seen drifting to the Whitby, then Scarborough areas.
SHYPS LIMS	01/09/25	05/09/25	Health Coordination Group	SHYPS LIMS system being switched on 1st September, so ask to all providers to support in decreasing referrals during this period.
Hull Protest	16/08/25	16/08/25	Humber	Hull protest from 11am to 2pm on Saturday 16th August, movement from Three Tuns pub to Cenotaph (road with HRI on).
Potential Explosion Watts Road, Beverley, East Yorkshire	29/08/25	31/08/25	Humber	Potential explosion, requiring evacuation of the area. Coltman Avenue was therefore evacuated, affecting our Hull and East Riding CAMHS Eating Disorder Team
Denial of building due to flood	27/08/25	Ongoing	N/A	The mental health team at Princes Court have had to relocate due to a flood in the building. They only rent part of the building, phone diverts, and flexible working have been put in place.

Incident Type	Date From	Date To	LRF Incident? (NY / Humber)	Description
Loss of staff	14/10/25	26/01/26	N/A	The CMHT is currently experiencing a significant increase in staff sickness and a higher-than-usual number of staff leaving over the previous 6-month period. This has resulted in reduced team capacity and growing pressure on remaining staff to maintain safe and effective service delivery. Waiting lists and reallocation lists have also increased, and the team is struggling to sustain routine reviews and planned interventions.
York meningitis incident	31/10/25	31/10/25	N/A	York meningitis incident - 3 York students had contracted meningitis. Therefore, IMT tasked a sub-group with coordinating vaccines for around 80 students. HTFT were then asked if we have vaccinators that could be the backup plan.
Loss of staff	13/11/25	13/11/25	N/A	The Children's Occupational Therapy have activated their Business Continuity Plan due to staff issues. This has been compounded by a disciplinary investigation/redeployment, maternity leave and vacancies. This has caused an unsustainable caseload for existing staff and the requirement to review caseloads and reprioritise service delivery.
Industrial Action (Resident Drs)	14/11/25	19/11/25	N/A	Resident Drs took industrial action between 7am Friday 14th November to Wednesday 19th November 2025.
Industrial Action (Resident Drs)	17/12/25	22/12/25	N/A	Resident Drs took industrial action between 7am Wednesday 17th to Monday 22nd December 2025.

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

10. Business Continuity Management System

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

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

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

11. EPRR plans and policies

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

EPRR policies & plans	Document name	Lead	Current version	Review
Plans	Incident Response Plan	EPRR	July 2025	July 2026
	Pandemic Plan	EPRR/IPC	2024	May 2026
	Adverse Weather	EPRR	2025	June 2026
	Trust Evacuation and Shelter Plan	EPRR	2024	April 2026
	EPRR Communication Plan	EPRR/Communications	2024	May 2026
	CBRN Plan	EPRR	July 2025	May 2026
	Fuel Plan	EPRR	January 2026	2029
Policies	EPRR Policy	EPRR	September 2025	July 2026
	Trust Business Continuity Policy	EPRR	July 2025	June 2026
	Outbreak of Communicable Diseases	IPC	July 2025	July 2026
	Risk Management	Risk	2024	2027
	Physical Security of Premises	Security	2024	2027
Others	Strategic BIA	EPRR	September 2025	September 2026
	Business Continuity Escalation Process	EPRR	September 2025	September 2026

12. Operational Support

The Trust continues to work closely with the ICB leads for winter and surge planning and regularly responds to requests for assurance on its ability to deliver operationally during times of increasing pressure in the health system, supporting patient flow and the planning for bank holidays/events. HNY ICB specifically mentioned the positive work the Trust is undertaking to mitigate against flu and the Infection Prevention and Control measures that are in place.

The RaidR system has now been rolled out across Community and Mental Health Trust's. This was a national requirement, and Trusts were supported by NHSE to work through and develop their internal processes to enable this to be implemented by February 19th, 2025. This system captures the Trust's Opel score through several data parameters, narrative and Opel actions taken. The RaidR submission is completed by the EPRR team during weekdays and the bed management team, community band 7's and on-call managers during the weekends. We have received notification that the RaidR system will be replaced nationally during 2026/2027 and this will be incorporated into our planning.

The Trust maintains a robust on-call manager and director rota system as well as a well-established evening site manager rota which is managed by the EPRR team. The on-call managers rota consists of a first and second on-call manager ensuring more resilience out of hours for the Trust.

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

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

13. Assurance and Governance Arrangements

13.1 Internal Audit

A Business Continuity and Resilience Audit carried out by Audit Yorkshire in 2025 with a final report being published in August 2025. The report had 2 moderate and 4 minor recommendations. All recommendations have been completed and evidence submitted to Audit Yorkshire. A further audit around Business Continuity arrangements to a digital disruption commenced in February 2026 with the report being awaited.

13.2 Operational Delivery Group

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

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

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

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

14. Summary

2025/26 has been another busy and challenging year for Humber Teaching NHS Foundation Trust in terms of its EPRR response. The EPRR team has been dedicated to meeting the demands faced in terms of responding to the GP collective action whilst continuing to ensure the out of hours rotas have been managed, weekend and bank holiday plans have been distributed and ensuring system assurance deadlines have been met. Testing of plans has been undertaken, flooding and severe weather has been accounted for, training has continued and a programme of work for 2026/27 has been planned.

15. EPRR Priorities for 2026/2027

As new guidance is developed, introduced and learning from each response is collated the teams' key priorities for the 2026/27 are as detailed below:

- Support the level of compliance against the NHS England Core Standards at Partial through work programmes that address the Trust's improvement requirements and continue to strive to improve on those areas currently achieving partial or non-compliance.
- Ensure the updating of the Trust's suite of plans, including the Incident Response Plan, policies and procedures to ensure that they reflect national guidance; best practice and learning from live and test situations.
- Improve care and service safety, resilience and response through a programme of EPRR training, testing and learning from incidents internally and through networks and partners.
- Further embed the importance of Business Continuity Management with operational services by delivering support and training and ensure an evidence-based approach is taken.
- Continue to improve on the system and monitoring mechanisms with our MH and community partners and stakeholders. Including the change over from Opel reporting from RaidR and the replacement of this system later in the year.

Agenda Item 14

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	National Staff Survey 2025 – IQVIA Presentation														
Author/s:	Karen Phillips – Executive Director of People & OD														
Recommendation:	<table border="1"> <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>			To approve		To discuss	✓	To note		To ratify		For assurance			
To approve		To discuss	✓												
To note		To ratify													
For assurance															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	To enable Trust Board to receive a benchmarked presentation from IQVIA, the independent provider of the NHS National Staff Survey, on the Trust's 2025 Survey results. The presentation will provide: • Comparative insight against national and peer organisations • Key strengths and areas of improvement across the People Promise themes • A deeper understanding of trends in staff experience, engagement and culture The session will support Board in: • Gaining independent assurance on workforce experience • Understanding the Trust's relative performance and trajectory • Informing strategic oversight of workforce priorities and organisational development														
Key Issues within the report:															
Positive Assurances to Provide: • The Trust continues to perform above the national and benchmark averages across all People Promise themes, as well as staff engagement and morale. • The Trust continues to demonstrate strong advocacy, ranking 7th out of 49 Mental Health, Learning Disability and Community providers, with sustained year-on-year improvement at a time when several higher-ranked organisations have declined. • Strong performance in compassionate culture, inclusion, teamworking and flexible working, supported by relatively low levels of bullying, harassment and discrimination. • Advocacy indicators remain positive, with colleagues reporting high confidence in		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT): EMT has agreed four Trust-wide priority areas: ○ Quality of appraisals ○ Health and wellbeing, with a focus on musculoskeletal issues and burnout ○ Raising concerns and speaking up ○ A structured listening exercise to understand more about colleagues feeling valued • A Trust-wide listening exercise, including a CEO-led narrative, MS Forms survey and manager-led team discussions, is being rolled out to capture deeper insight into colleagues' experience of feeling valued.													

patient care and strong pride in their work. Improved participation, with the highest response rate to date at 64 percent, strengthening the reliability of the findings.		- Divisions are analysing their own results and presenting local actions through their Accountability Reviews, supported by HR Business Partners. - Further detailed analysis is underway in key themes including wellbeing, development, burnout and appraisal experience.		
Key Risks/Areas of Focus: - Declines in appraisal quality, feelings of being valued, and happiness at work present risks to engagement, retention and morale. - Significant deterioration in musculoskeletal health and increased burnout indicators could impact sickness absence and workforce capacity. - Small declines in confidence to speak up and belief that concerns will be addressed highlight a need to reinforce psychological safety. - There is a risk of staff perceiving previous initiatives as having limited impact, reinforcing the importance of visibility, action and feedback loops.		Decisions Made: - To Note the independent presentation from IQVIA - To Discuss the findings, implications and organisational response		
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	27/05/26
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)</i>				
✓ 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	✓			To be advised of any future implications as and when required by the author
Quality Impact	✓			
Risk	✓			
Legal	✓			
Compliance	✓			
Communication	✓			
Financial	✓			
Human Resources	✓			
IM&T	✓			
Users and Carers	✓			
Inequalities	✓			
Collaboration (system working)	✓			
Equality and Diversity	✓			
Report Exempt from Public Disclosure?			No	

Agenda Item 15

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026			
Title of Report:	NHS England 10 Point Plan to Improve Resident Doctors' Working Lives: Updates and Board Assurance Framework (BAF)			
Author/s:	Dr Kwame Fofie, Executive Medical Director Gillian Wicks, Head of Medical – Education, Business & Staffing			
Recommendation:	To approve		To discuss	√
	To note		To ratify	
	For assurance	√		
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	The purpose of this paper is to present the Trust's progress in implementing the NHS England 10 Point Plan to Improve Resident Doctors' Working Lives and the associated Board Assurance Framework.			
Key Issues within the report:				
Positive Assurances to Provide: 96% compliance achieved with no areas of non-compliance and strong performance across most domains - Robust governance, leadership, and co-production with Resident Doctors embedded - Effective systems in place for rota management, training, engagement, and reimbursement		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT): - Development of a dedicated Resident Doctor annual leave policy - Embedding new rota and exception reporting system (Lantum/DRS5) - Strengthening payroll governance and reporting oversight - Ongoing delivery and review of the Local Action Plan through EMT and Committees		
Key Risks/Areas of Focus: - Annual leave policy gap (governance completion required) - Exception reporting system not yet fully embedded - Payroll reporting assurance and consistency		Decisions Made: - Approval and implementation of the Trust-wide action plan - Appointment of Executive Lead, NED, and Resident Doctor Peer Leads - Adoption of the Board Assurance Framework for ongoing oversight - Agreement to continue programme governance and reporting through Board committee		
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	Nov 25 & Feb 26
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

10 Point Plan to improve resident doctors' working lives

"Fixing unacceptable working practices: getting the basics right for resident doctors", NHS England, 29th August 2025.

Context as Described by NHS England:

"The 75,000 resident doctors working across the NHS are the backbone of the service – but too often they are let down on basic issues like payroll errors, poor rota management, lack of access to rest facilities and hot food, and unnecessarily repeating training.

While some progress has been made, it has been too slow, and many still face unfair and inconsistent working conditions.

Supported by our commitment to staff under the recently published 10 Year Health Plan for England, NHS England is setting out 10 ways in which we are improving resident doctors working conditions over the next 12 weeks."

This plan sets out actions for NHS England and individual trusts. To ensure meaningful progress, it will be formally incorporated into the new NHS Oversight Framework.

However, it has been prescribed that *"Trusts should proceed on the basis that it is already in effect and take appropriate action without delay"*.

Summary of the 10 Point Plan:

1. Trusts should take action to improve the working environment and wellbeing of resident doctors.
2. Resident doctors must receive work schedules and rota information in line with the Code of Practice.
3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing.
4. All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
5. Resident doctors should never experience payroll errors due to rotations.
6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating.
7. Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours.
8. Resident doctors should receive reimbursement of course related expenses as soon as possible.
9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery.
10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate.

NHS England - Why are we doing this?

- Supporting resident doctors improves the quality of care offered to Many of these steps will also improve the lives of other staff groups across the NHS.
- Our educators work hard to ensure that resident doctors' education and training is world class, but too often they have been let down on basic issues. The 10 Point Plan will help us respond to what resident doctors have been telling us.
- We have long recognised the need to improve the working lives of resident doctors, but we know we need to go further, faster to build on what we have already done.

NHS England - Why the focus on resident doctors?

- Resident doctors are different from other staff because they provide care while training in different parts of the NHS, which means they move employer regularly for several years.
- All NHS staff are important, and we will continue to support improvements in working conditions, retention, health and wellbeing and facilities through the 10 Year Health Plan and the forthcoming NHS Workforce Plan.

HTFT Progress and Positive Assurances

The Trust has delivered significant progress:

- 96% overall compliance, with no domains rated non-compliant
- 16 areas compliant, 2 partially compliant
- Strong Board-level leadership, including:
 - **Executive Senior Lead for Resident Doctor Experience - Dr K Opoku-Fofie**
 - **Named Non-Executive Director – Dr Phillip Earnshaw**
 - **Four Resident Doctor Peer Leads**
- Fully compliant rota management, with timely issuing and strong transparency
- Effective engagement model, including forums, consultation, and co-production
- Robust training governance, including a signed MoU and oversight structures
- Efficient expense reimbursement processes, meeting required standards
- Positive feedback from Resident Doctor Peer Leads, recognising Trust commitment and collaborative culture

These collectively provide high confidence in both delivery and sustainability of improvements.

Improving Doctors Working Lives Programme - The 10 Point Plan

Provider: HUMBER TEACHING NHS FOUNDATION TRUST

Amenities	Baseline survey	12-week progress
Access to Lockers	No	Yes, >50%
Rest facilities	Yes	Yes, >50%
Designated on-call parking access	No	Yes
Access to hot and cold food 24/7	Yes	Yes
Access to cold food 24/7	Yes	Yes
Inductions specifically designed to meet the needs of Resident Doctors	Yes	Yes
Beds/sleeping pods available free of charge	Yes	Yes, >50%
Are Resident doctors able to work from home for portfolio and self-directed learning?	Yes	Yes
Access to free psychological support treatment?	Yes	Yes
Positive feedback mechanisms in place to reward and promote staff?	Yes	Yes
Protected breaks?	Yes	Yes
Do you promote the Safe Learning Environment Charter?	Yes	Yes
Sexual safety/harassment training and awareness?	Yes	Yes

Appointing senior leads to take action on Resident Doctor issues

	Baseline survey	12-week progress
Has your Trust Board appointed a senior named, accountable Resident Doctor Lead?	Yes	Yes
Has your Trust Board appointed a Resident Doctor Peer Lead?	No (consult with LNC/ equiv. bodies)	Yes
At what levels of your organisation have you reviewed and discussed the following surveys? (None, Executive team, Trust Board, People Committee, Two out of Three, or All)		
GMC Training survey	All	Two of the Three
NETS survey	All	Two of the Three
National Staff Survey		All
National Student Survey		People Committee

Annual Leave	Baseline survey	12-week progress
Is there a local policy to encourage good annual leave management which references resident doctors?	Yes	Yes
Good annual leave practice covered at resident doctor induction?	Yes	Yes
Allow resident doctors to carry over annual leave between rotations?	Yes (internal & external rotations)	Yes (internal & external rotations)
Do rostering systems for Resident Doctors allow for self/preferential rostering?	Yes	Yes

Payroll and Expenses	Baseline survey	12-week progress
Implemented local SLAs and introduced board-level governance for tracking/reporting payroll errors?	Plan to	Plan to
Changes in payroll errors over the last 12 months?	No change	No change
Processing of course related expenses?	After course attendance	When course is booked

Office on the web Frame

Mandatory Training & Learning	Baseline survey	12-week progress
Do you accept resident doctors' mandatory training from other sites and follow the People Policy Framework (May 2025)?	Yes, MOU only	Yes, both

Does the Resident Doctor Peer Lead support the findings as set out in this survey?	Fully supports

* 12-week progress survey

96%

(Improvement of 15pp)

* The survey score is calculated by averaging the percentage scores of each scored question. . Please refer to the points scheme for specific scoring criteria.



Caring, Learning
& Growing Together

Areas of Partial Compliance / Improvement Focus

- **Annual Leave Arrangements:**

While processes are working well operationally, there is no dedicated Resident Doctor annual leave policy, representing a minor governance gap.

- **Exception Reporting:**

New systems (Lantum/DRS5) have been introduced and are functioning but require full embedding and ongoing monitoring to achieve full assurance.

Board Assurance Framework (BAF)

A dedicated BAF entry has been developed, providing:

- Clear articulation of risks, currently low.
- Defined controls and mitigating actions
- Strong internal and external assurance sources
- Alignment with NHS England expectations

The BAF confirms that:

- Systems and processes are largely fully compliant
- Gaps are limited, understood, and actively managed
- Assurance mechanisms are robust and triangulated

Board Assurance Statement

The Board can take high assurance from the Board Assurance Framework that the Trust has successfully implemented the NHS England *10 Point Plan to Improve Resident Doctors' Working Lives*, achieving **96%** compliance within the required timeframe.

There is strong evidence of effective leadership, robust governance, and meaningful engagement with Resident Doctors, with the majority of domains rated fully compliant and no areas of non-compliance identified.

The small number of partially compliant areas (annual leave policy and exception reporting system embedding) are well understood, low risk, and subject to clear mitigating actions and ongoing oversight.

Overall, the framework demonstrates that the Trust has established sustainable systems, controls, and assurance mechanisms, providing confidence that improvements in Resident Doctors' working lives are being delivered, monitored, and maintained.

Feedback to NHS England directly from our Resident Doctor representatives in relation to our process of engagement on the 10 Point Plan:

"After a great collaborative effort with myself and other resident doctor representatives, we have reviewed the 10-point plan proposed. We'd like to commend our trust for valuable efforts made. We note there are many items the trust already performs well in, such as its propensity to act on feedback and suggestions, often gathered through regular meetings/ forums with resident doctor representatives and the wider resident doctor body. We hope such factors can be maintained and celebrated for such standards. We note the ongoing process required for other items and look forward to further progress and commitment.....With regards to the 10-point plan, thank you for including us in this important work. We look forward to further collaboration and committed community building. "

Dr Jemima Cohen, CT3, Resident Doctor Representative.

Recommendation

The Board is asked to take assurance from the progress made and approve the ongoing governance and oversight arrangements to ensure sustained improvement in Resident Doctors' working lives.

1. Note the Trust's overall performance of 96% compliance and significant improvement from baseline.
2. Note the Board Assurance Framework entry and associated current low risk profile.
3. Endorse the continuation of the improvement programme to address remaining gaps.
4. Agree ongoing governance and reporting arrangements via Board sub-committees – People & Organisational Development Committee.
5. Support the inclusion of progress and outcomes within the Trust's Annual Report.

Resident Doctor Board Assurance Framework v1.0

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance Rating
1. Workplace wellbeing – Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead.						
Organisational or board systems and process should be in place to ensure that:						
1.1	Completed baseline audit	Baseline Audit, Summary Action Plan, EMT papers, Trust Board papers.	No gaps in assurance	Not required	Consultation with Resident Doctors (RD) commenced 18th Sept 2025. Through consultation, and with full engagement with RD's baseline audit, and subsequent local Action Plan was agreed on 7th Oct 2025. Baseline Audit presented to EMT by Dr Kwame Fofie on 9th Oct 2025. Summary Action Plan produced and presented at Public Trust Board by Dr Kwame Fofie on 26th Nov 2025.	3. Compliant
1.2	Approved improvement plan in place	Baseline Audit & Summary Action Plan. 12- week NHS England Progress Survey 29th Dec 2025.	No gaps in assurance	Not required	Consultation with Resident Doctors (RD) commenced 18th Sept 2025. Through consultation, and with full engagement with RD's baseline audit, and subsequent local Action Plan was agreed on 7th Oct 2025. This action plan is reviewed and updated on a regular basis. NHS England 12-week progress survey ranked the Trust at 96%.	3. Compliant
2. Rota transparency – Compliance with 8-week schedules, 6-week rotas with improvement plans in place where performance needs to improve.						
System and process are in place to ensure that:						

2.1	Compliant with 6- and 8-week rota standards	Assurance from Medical Staffing Manager. Guardian of Safe Working (GoSW) Report on Safe Working Aug – Oct 2025. GoSW Report of 26th Jan 2026 to Workforce & OD Committee. GoSW report May 2026.	No gaps in assurance	Not required	3rd Nov 2025 GoSW reported: “Work schedules were issued in a timely manner, with no reported delays. Trainees received their personal rota at least eight weeks in advance of their rotation and continued to have access to the live rota via the shared V drive. This ensured transparency and allowed trainees to anticipate and plan around their clinical duties effectively”. GoSW Report of 26th Jan 2026 to Workforce & OD Committee, “Work schedules were issued in a timely manner, with no reported delays”. Switch from Allocate to Lantum/DRS 5 in progress following successful pilot - full engagement and input from Resident Doctors.	3. Compliant

2.2	Clear monitoring of compliance and reported at Board sub-committee level	Assurance from Medical Staffing Manager. Guardian of Safe Working (GoSW) Report on Safe Working Aug – Oct 2025. GoSW Report of 26th Jan 2026 to Workforce & OD Committee. GoSW report May 2026.	No gaps in assurance	Not required	3rd Nov 2025 GoSW reported: “Work schedules were issued in a timely manner, with no reported delays. Trainees received their personal rota at least eight weeks in advance of their rotation and continued to have access to the live rota via the shared V drive. This ensured transparency and allowed trainees to anticipate and plan around their clinical duties effectively”. GoSW Report of 26th Jan 2026 to Workforce & OD Committee, “Work schedules were issued in a timely manner, with no reported delays”. Switch from Allocate to Lantum/DRS 5 in progress following successful pilot - full engagement and input from Resident Doctors.	3. Compliant
3. Annual leave reform – Adoption of national best practice initiatives						
System and process are in place to ensure that:						

4.1	Appointed Resident Doctor Senior Board Lead and a Non-Executive Director for Resident Doctors'	7th Oct 2025 - Email confirmation - Dr Kwame Fofie officially designated SLRDE (Senior Lead for Resident Doctor Experience) by Michele Moran, Trust Chief Executive. 23rd March 2026 - Email confirmation - Dr Phillip Earnshaw nominated Non-Executive Director.	No gaps in assurance	Not required	Summary: Dr Kwame Fofie, Executive, nominated SLRDE/Senior Board Lead & Dr Philip Earnshaw nominated NED for Resident Doctors.	3. Compliant

4.2	Appointed Resident Doctor Peer Lead and they are engaged in line with national guidance	Emails confirming appointment of Resident Doctor/s by peers as Peer Leads for 2025/26. Attendance at Strategic Trust Board (held on 29th Oct 2025) by SLRDE. Engagement with Executive Management Team. Local Action Plan update on 9th Dec following confirmation from RDPL's that they felt this action had been met.	No gaps in assurance	Not required	7th Oct 2025 - 4 Resident Doctors (x2 Core & x2 Higher) appointed by peers as Peer Leads (RDPLs). Feedback from RDPL <i>"After a great collaborative effort with myself and other resident doctor representatives, we have reviewed the 10-point plan proposed. We'd like to commend our trust for valuable efforts made. We note there are many items the trust already performs well in, such as its propensity to act on feedback and suggestions, often gathered through regular meetings/ forums with resident doctor representatives and the wider resident doctor body. We hope such factors can be maintained and celebrated for such standards. We note the ongoing process required for other items and look forward to further progress and commitment.</i> <i>With regards to the 10-point plan, thank you for including us in this important work. We look forward to further collaboration and committed community building".</i> <i>Executive team engagement directly with RD's to understand local working conditions and priorities. 9th Dec 2025 – All 4 Resident Doctor reps agreed this action had been met and RAG rating should be changed to green.</i>	3. Compliant

4.3	Robust progress updates in place which involve Resident Doctor	Resident Doctor Forum/s (chaired by Guardian of Safe Working). Regularly updated Local Action Plan. NHS England 12-week Progress Survey. Emails confirming ongoing consultation and engagement process	No gaps in assurance	Not required	Sharing of Local Action Plan (in which RD's agreed RAG ratings) with Resident Doctor representatives as part of engagement/consultation process for thoughts, views, comments and agreement: 22nd Sept 2025, 2nd October 2025, 19th Nov 2025, 3rd Dec 2025 (updated following feedback), 9th Dec 2025 (engagement in National NHS England survey sign-off and submission), 23 January 2026 (RD Reps met with Board reps and SLRDE). Attendance at Resident Doctor Forums (chaired by GoSW) by Medical Staffing Manager, DME, Head of Medical - Education, Business & Staffing.	3. Compliant
4.4	Clear support plan in place to assist the RDPL	Support via Medical Staffing Team, Medical Education Department (including Director of Medical Education), GoSW, SLRDE/Senior Board Lead, Resident Doctor Forums, Medical Education Committee).	No gaps in assurance	Not required	Support is available from a number of sources as described. 4 RDPL's appointed to ensure all RD's voices were heard and to ensure the role was doable.	3. Compliant
5. Payroll accuracy – Trusts have commenced payroll improvement activity and are monitoring						
System and process are in place to ensure that:						
5.1	Implementing payroll improvement methodology					

5.2	Reduction in payroll errors				The Finance Director has committed to include a statement in the financial report on Resident Doctors payroll errors.	
5.3	Monthly error reporting compliance undertaken				The current report shows no payroll errors for Resident Doctors	
6. Mandatory Training – no unnecessary duplication and MLOGs in place and working with RDs						
System and process are in place to ensure that:						
6.1	Signed MoU and processes in place for monitoring that no unnecessary training is being repeated	Signed Memorandum of Understanding (MoU)	No gaps in assurance	Not required	MoU signed in January 2025 (assurance provided by Head of Learning & Development)	3. Compliant
6.2	Mandatory Training Local Oversight Group (MLOG) in place	MLOG Terms of Reference. Meeting minutes/action logs.	No gaps in assurance	Not required	This activity is in place through the Training and Education Group which meets 6 weekly - TOR is reviewed annually (assurance provided by Head of Learning & Development)	3. Compliant
6.3	The MLOG involves Resident Doctors in ensuring that local STATMAN requirements are necessarily and proportionate	Learning and Staff Development Policy	No gaps in assurance	Not required	Continue to apply the approach i.e. when mandating training, it is foremost done based on role and position at Humber, this includes all medic roles in ESR. Process established in instances where training is challenged i.e. involve professional lead and operational lead ahead of making any changes to the required compliance (assurance provided by Head of Learning & Development).	3. Compliant
7. Exception reporting – Adoption of new national framework						
System and process are in place to ensure that:						

7.1	Clearly communicated new approach and local processes to all Resident Doctors	Resident Doctor Committee Minutes (chaired by GoSW). GoSW quarterly Board Reports.	Switch from Allocate to new rota software, management and exception reporting system (Lantum/DRS5) on 11th May 2026, no reported issues re: exception reporting to date but under continuous review until full embedded.	Not required	Exception Reports now go directly to HR and Payroll. This ensures a more streamlined process and eliminates the element of clinical discussion/ CS involvement. Exception Reports regarding Postgraduate Teaching now go directly to Medical Education.	2. Partially compliant
7.2	Implemented local and national data reporting requirements	Changes to exception reporting implemented on the 6 th of February 2026 (GoSW Board Report). Confirmation from Medical Staffing (as recorded in RDC minutes) that new exception reporting system working well.	No gaps in assurance	Not required	Switch from Allocate to new rota software, management and exception reporting system (Lantum/DRS5) on 11th May 2026, no reported issues re: exception reporting to date but under continuous review until full embedded.	3. Compliant
8. Expense reimbursement – Adoption of fast-track course costs						
System and process are in place to ensure that:						
8.1	Adopted new reimbursement process	Accent Leave Manager (ALM) reports	No gaps in assurance	Not required	All RD expenses are submitted on the ALM system, the majority require external approval by the Training Programme Director. Any expenses submitted by the RD is approved on Easy expenses as soon as received, this amount is then reimbursed by NHS England.	3. Compliant
8.2	Meeting target reimbursement time of 6 weeks.	Accent Leave Manager reports. No complaints received from RD's.	No gaps in assurance	Not required	Any delay in reimbursement would be caused by late submission of expenses on Easy, RD's are	3. Compliant

					however fully aware of Trust deadlines.	
8.3	Doctor satisfaction meeting ≥80% target	No concerns raised through RDC or via any other route. No concerns raised through the Medical Education Committee (MEC) by RD representatives.	No gaps in assurance	Not required	As above	3. Compliant

Agenda Item 16

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Trust Compliance with the Fit and Proper Person Test Framework 2025/26															
Author/s:	Caroline Flint Trust Chair		Stella Jackson Head of Corporate Affairs													
Recommendation:	<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>				To approve		To discuss		To note	✓	To ratify		For assurance	✓		
	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 for Non-Executive Directors will be shared with the Council of Governors. • The annual declaration will be forwarded to NHS England by 30 June 2026 in accordance with Framework requirements.															
Key Issues within the report:																
Positive Assurances to Provide: • The Trust continues to comply with the Fit and Proper Person Test requirements. • The Trust has a robust process in place to ensure those people undertaking Board level roles at the Trust are fit and proper.		Key Actions Commissioned/Work Underway: • Some learning/areas for improvement were identified regarding the completion of the 2023/24 annual checks and these were addressed for the 2024/25 checks (mainly relating to logging in issues). No further issues have been identified since then.														
Key Risks/Areas of Focus: No matters to escalate		Decisions Made: • N/A														

Governance:		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail) 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Trust Compliance with the Fit and Proper Persons Test Framework 2024/25

1. Introduction

The Kark Review (2019) was commissioned by the Government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applied under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The review highlighted areas that needed improvement to strengthen the existing regime and a Fit and Proper Person Test Framework was developed and launched by NHS England which NHS organisations are required to abide by.

The Framework is applicable to anyone undertaking Board level roles including Executive Directors, Non-Executive Directors, Associate Non-Executive Directors and Associate Directors. Organisations are able to extend the assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The assessment has, therefore, also been undertaken for the Head of Corporate Affairs but the annual submission requirement is limited to Board members only.

The regulations (Section 1, Paragraph 5, or 'Regulation 5' as CQC refers to them in its guidance) place a duty on trusts to ensure that their directors, as defined above, are compliant with the FPPT.

According to the regulations, trusts must not appoint a person to an executive or non-executive director level post unless they meet the following criteria:

- are of good character
- have the necessary qualifications, competence, skills and experience
- are able to perform the work that they are employed for after reasonable adjustments are made
- have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- can supply information as set out in Schedule 3 of the Regulations

While it is the Trust's duty to ensure that it has fit and proper directors in post, the CQC has the power to take enforcement action against the Trust if it considers that the Trust has not complied with the requirements of the FPPT. This may come about if concerns are raised to CQC about an individual or during the annual well-led review of the appropriate procedures.

The Trust Chair is responsible for ensuring that the Trust conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role.

2. Trust Position

The Trust has a robust system, managed by the Head of Corporate Affairs, to ensure FPPT's are undertaken for those people undertaking Board levels roles on appointment and on an annual basis. This includes ensuring any identified issues are escalated, that the Board and Council of Governors are informed of the outcome of the checks undertaken and that declarations are made in accordance with the framework requirements.

3. Compliance

Annual declarations were requested and provided by all Board members for 2025/26 (the checks undertaken for Kathryn Smart, Caroline Wollerton and Andrew Brown were undertaken at recruitment and not repeated as part of the annual checks due to the recency of the checks and appointment) and the Chair concluded all remained fit and proper and that a robust process had been followed. The Senior Independent Director (SID) concluded the Chair was fit and proper.

An external company was commissioned to undertake a number of the checks, but DBS checks continue to be undertaken in-house in accordance with company policy.

The outcome of the checks and supporting evidence were documented on a checklist for each Board member. The checklist template in Appendix 7 of the Fit and Proper Person Test Framework (below) was completed for each person that the FPPT was undertaken for.

Checks were undertaken for the following Board members:

- Caroline Flint (Chair)
- Stephanie Poole (Non-Executive Director)
- Phillip Earnshaw (Non-Executive Director)
- Keith Nurcombe (Non-Executive Director)
- Caroline Wollerton (Non-Executive Director)
- Andrew Brown (Non-Executive Director)
- Kathryn Smart (Non-Executive Director)
- Michele Moran (Chief Executive)
- Lynn Parkinson (Chief Operating Officer and Deputy Chief Executive)
- Peter Beckwith (Executive Director of Finance)
- Kwame Fofie (Executive Medical Director)
- Sarah Smyth (Executive Director of Nursing, Quality and Professions)
- Karen Phillips (Executive Director of People and Organisational Development)
- Stella Jackson (Head of Corporate Affairs and non-Board member)

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 2026 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.

Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Committee Effectiveness Reviews 2025/26														
Author/s:	Stella Jackson Head of Corporate Affairs														
Recommendation:	<table border="1"> <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>			To approve	√	To discuss		To note		To ratify		For assurance			
To approve	√	To discuss													
To note		To ratify													
For assurance															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	The Board is asked to: - Note the results of the committee effectiveness reviews undertaken for the period 1 April 2025 to 31 March 2026. - Approve the terms of reference for each of the Board committees.														
Key Issues within the report:															
Positive Assurances to Provide: - The effectiveness reviews demonstrate good governance with committees meeting the requirements of their terms of reference throughout the year. - All committees have undertaken an annual effectiveness review and the results are contained in this report. The terms of reference for each Committee are attached as appendices for Board approval. - The Executive Management Team has also undertaken an effectiveness review and no key areas of development were identified.		Key Actions Commissioned/Work Underway: The findings from the Board effectiveness review have been forwarded to the Board as a separate paper.													
Matters of Concern or Key Risks: No issues raised.		Decisions Made: Terms of Reference (ToR) have been reviewed by respective Board committees and amendments agreed for ratification by the Board.													

Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee	2.3.2026	Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
✓ 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	✓			To be advised of any future implications as and when required by the author
Quality Impact	✓			
Risk	✓			
Legal	✓			
Compliance	✓			
Communication	✓			
Financial	✓			
Human Resources	✓			
IM&T	✓			
Users and Carers	✓			
Inequalities	✓			
Collaboration (system working)	✓			
Equality and Diversity	✓			
Report Exempt from Public Disclosure?			No	

Trust Board and Committee Effectiveness Reviews 2024-2025

1. Introduction

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

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

Committee	Non-Executive Director Committee Chair
Quality Committee	Phillip Earnshaw
Finance Committee	Keith Nurcombe
People & Organisational Development Committee	Carrie Wollerton
Collaborative Committee	Stephanie Poole
Mental Health Legislation Committee	Stephanie Poole
Audit Committee	Kath Smart
Remuneration and Nomination Committee	Trust Chair
Trust Board	Trust Chair

This paper contains the results of the effectiveness reviews undertaken by the committees during 2025/26. It also contains the terms of reference of each Committee for approval.

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

2. Committee Effectiveness Review Results

2.1 Delivery of functions delegated by the Board

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

2.2 Attendance and Quoracy

The committees reviewed attendance at their meetings when considering the results of the effectiveness reviews. All committee meetings were quorate. Attendance at meetings throughout the year was good.

2.3 Reporting Groups

In March 2025, the Board agreed that the operational reporting groups which reported into Board committees should, in future, report into EMT and that any key issues should be escalated to the relevant committee. This practice has been in place for 12 months and appears to be working well.

2.4 Conduct of meetings

Each committee had a workplan for 2025/26 and considered this at its meetings. Items on the workplan informed the content of each agenda. Each committee also has a workplan for 2026/27 which is updated as appropriate following consideration at committee meetings.

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

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

Audit

2.5 Review of Terms of Reference (ToR)

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

- Appendix 1: Audit Committee (it is proposed that the word 'effectiveness' is added to the sentence 'produce an annual *effectiveness* report for the Trust Board'; that reference to the minutes being submitted to the Trust Board is removed as the Board receives a Committee Chair Assurance Report instead of minutes; and that the Committee's oversight role regarding insurance arrangements, procurement activity, Scheme of Delegation/Standing Financial Instructions and declarations of interest is added).
- Appendix 2: Collaborative Committee (Reference to the Schoen Clinic has been removed from the governance schematic. Amendments have also been made to the narrative to reflect current Provider Collaborative terminology and arrangements).
- Appendix 3: Finance Committee (it is proposed that the Committee's focus on productivity is referenced within the terms of reference as well as information regarding the receipt of benchmarking information as appropriate and the review of model hospital collection results)
- Appendix 4: Mental Health Legislation Committee (it is proposed that reference to the Committee having oversight of mental health procedures and policies is removed as this operational activity is overseen by the Executive Management Team. It is also proposed that information is added regarding the Committee's oversight of changes in legislation, advocacy and benchmarking)
- Appendix 5: People and Organisational Development Committee (it is proposed that the terms of reference are strengthened regarding the Committee's assurance seeking role relating to sexual safety, workforce risks and key employment matters and that the membership section is updated to reflect correct titles and attendance).
- Appendix 6: Quality Committee (the proposed changes are designed to focus the Committee increasingly on improving outcomes and triangulations).

Appendix 7: Remuneration and Nominations Committee (it is proposed that the Associate Director of People and OD job title is amended to Executive Director of People and OD).

2.6. Actions Arising from the Effectiveness Review?

Generally, the committees functioned effectively throughout the financial year 2025/26. A small number of recommendations were made regarding the future focus of some committees and these will be reflected in the relevant workplans as appropriate.

3. Summary

- The Trust Board and all sub committees have undertaken a committee effectiveness review for 2025-2026 and have reviewed their Terms of Reference.
- The Trust Board and all sub committees have a work plan for the 2026/27 year ahead and these are available on request.

4. Recommendations

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

Terms of Reference Audit Committee

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

Board on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk management arrangements, and the robustness of the self-assessment against Healthcare Financial Management Association (HMFA) audit committee checklist.

Key Responsibilities

The Audit Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference. Its key responsibilities are to:

- keep an overview of the key elements of the Trust's governance and finance.
- monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;
- review the Trust's internal controls;
- review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;
- monitor risks that are identified by the systems of internal control;
- make recommendations to the Council of Governors regarding the appointment, reappointment of the External Auditor and removal of the external auditor, including tender procedures;
- develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;
- monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;
- approve the appointment and/or removal of the internal auditors;
- 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 **effectiveness** report for the Trust Board

	review arrangements by which staff within the Trust may raise confidentially concerns over financial control and reporting, clinical quality and patient safety and other matters.
Scope and Duties	The Audit Committee's duties are detailed below under the following headings: - The Chair - The Audit Committee - Governance, Risk Management and Internal Control - External Audit - Internal Audit - Other Assurance Functions - Counter Fraud - Management - Financial Reporting - Administrative Support <u>The Chair</u> The Chair is responsible for the following: - Approving agendas for meetings - Chairing pre meetings with the auditors and counter fraud specialists - Chairing meetings - Reporting to the Trust Board (highlighting any issues requiring further disclosure or executive action) - Reporting immediately those items of a significant nature regarding the Board Assurance Framework and the Risk Register; - Providing an executive summary report following each Committee meeting for the Trust Board meeting - Notifying the Chair(s) of any other Committee(s) of specific actions arising from the Audit Committee that affect the other Committee(s) and ensuring these actions are detailed in the minutes ~~Approving the minutes of the Audit Committee before they are submitted to the Trust Board~~ - Ensuring there is unhindered access to the Heads of External and Internal Audit for any matters of internal control or risk requiring urgent advice or action.

The Audit Committee

Governance, Risk Management and Internal Control

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

In particular, the Committee will review the adequacy of:

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

gift/hospitality.

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

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

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

External Audit

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

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

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

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

This will be achieved by:-

- consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.
- review and agree, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan

- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- review of all audit reports that are specifically drawn to the attention of the Audit Committee by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

The Head of External Audit will have unhindered and confidential access to the Chair of the Audit Committee.

Internal Audit

The Audit Committee shall ensure that there is an effective Internal Audit function established by management that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved
by:-

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework
- where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the Audit Committee for approval
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit in such manner as is appropriate and agreed by the Audit Committee, including a review of the successful operation of the contract between the Trust and Internal Audit.

The Head of Internal Audit will have unhindered and confidential access to

the Chair of the Audit Committee.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

In addition, the Audit Committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work.

Counter Fraud

The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and bribery, in accordance with Service Condition 24 of NHS Standard Contract. The Audit Committee will review the outcomes of work in these areas against the standards set by NHS Counter Fraud Authority (as referenced in Standard Condition 24).

Management

The Audit Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request reports from individual functions within the Trust (e.g. clinical audit) as may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them.

The Audit Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

- changes in, and compliance with, accounting policies and practices and estimation techniques

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

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

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

Administrative Support

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

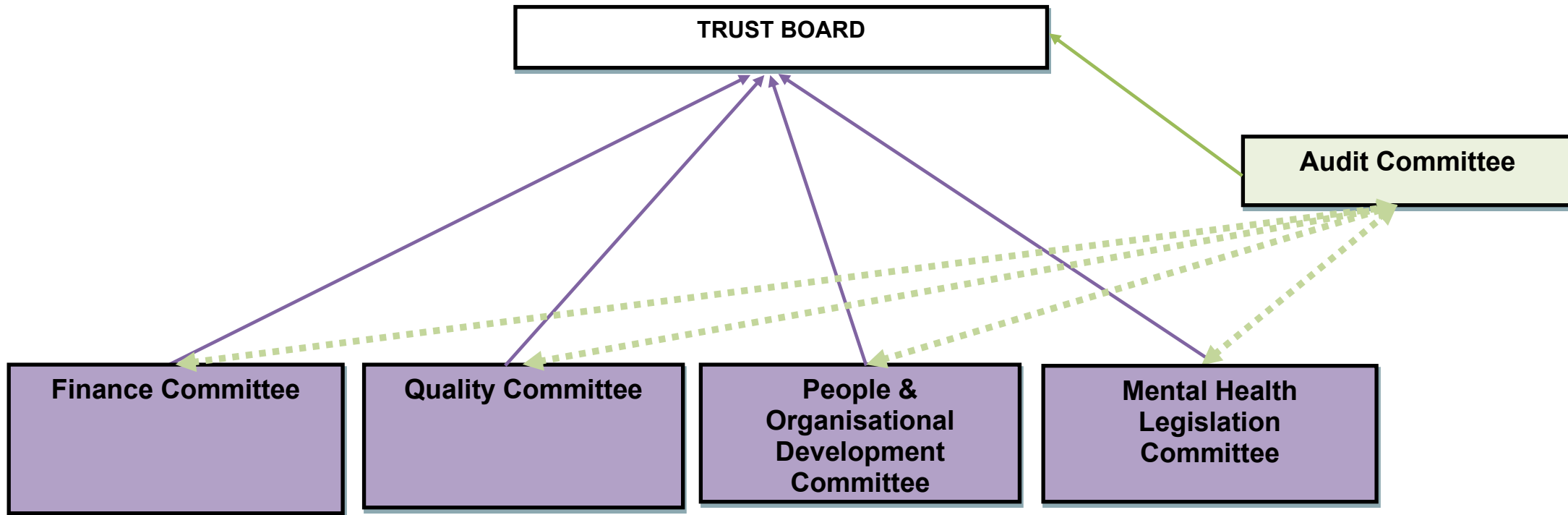
- agreement of the agenda with the Chair and attendees and collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- minute-taking and keeping a record of matters arising and issues to be carried forward
- helping the Chair to prepare reports to the Board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

	• supporting any ongoing training requirements for Non-Executive Directors as appropriate for their membership of the Audit Committee. Reference should be made, as appropriate to the Trust's Standing Orders, Reservations and Delegation of Powers and Standing Financial Instructions
Membership	The Audit Committee shall be composed of not less than 3 Non-Executive Directors of the Trust. • There will be appropriate cross-membership with other Board committees. • One member of the Audit Committee should have significant, recent and relevant financial experience as outlined in the Combined Code. • Members are required to attend at least 50% of meetings. Named substitutes may attend with the agreement of the Committee Chair. Attendance by others at Meetings External and Internal Auditors, and a representative of the Counter Fraud specialists are required to make themselves available when required for a private meeting with the Audit Committee Chair. The Director of Finance is the Executive lead for this Committee. The Director of Finance, Head of Corporate Affairs and Internal and External Audit and Counter Fraud representatives shall normally attend Audit Committee meetings. Other Executive Directors may be invited to attend, particularly when the Audit Committee is discussing areas of risk or operation that are the responsibility of that Director. The Chief Executive will have a standing invitation to attend Audit Committee meetings. The Chief Executive will usually attend the Audit Committee meeting where the end of year reporting, auditor's opinions, the Annual Governance Statement, the Annual Report and Annual Accounts are delivered. The Finance Directorate Administrator shall be Secretary to the Audit Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members. Representatives from other organisations (for example, NHS Counter Fraud Authority) and other individuals may be invited to attend on occasion. <i>The Trust Chair shall not be a member of the Audit Committee.</i>
Quorum	A quorum shall be 2 members.
Chair	One of the Non-Executive Directors will be appointed as Chair of

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

	any issues that require disclosure to the full Trust Board, or require executive action. Specific actions arising from one committee affecting the work of another Committee will be detailed in the minutes and notified to the Chair of the other Committee. The Audit Committee will report to the Trust Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the extent to which risk management is fully embedded in the organisation, the integration of governance arrangements and the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts. An annual review of effectiveness will be undertaken and included in the annual report. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference. The Audit Committee shall report to the Board, identifying any matters within its remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.
Agreed by Committee	19 May 2025
Board Approved	228 May 2025
Review Date	May 2026

AUDIT COMMITTEE REPORTING STRUCTURE



Caring, Learning
& Growing Together



Humber Teaching NHS Foundation Trust
Specialised Collaborative Committee

Terms of Reference Updated for 2026

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

	The Collaborative Planning and Quality Team (CPaQT); reporting to PCOG and the Collaborative Committee, is an enabler based in HTFT which supports all partners in the SPC to ensure appropriate health care services are planned, provided, quality assured and reviewed. CPaQT works with all partners to develop proposals to improve care and meet the needs of the HNY population. In so doing, the partners in the SPC seek to: improve the efficiency, effectiveness, economy, and quality of services; reduce inequalities; and promote the involvement of patients, stakeholders, and the public in the development of our services. The Collaborative Committee has the authority to establish sub-groups as necessary to fulfil its objectives. However, it may not delegate any powers delegated by the HTFT Board and will remain accountable for the work of any such sub-group.
Role / Purpose	~~The purpose of the Collaborative Committee is to provide assurance to the HTFT Board on matters of planning, finance, contracting, performance and quality assurance of the SPC, thus supporting the overall strategic aim of the SPC to improve care pathways and outcomes for patients.~~ ~~Day to Day provision of patient care is the responsibility of Providers within the SPC. Services will be planned and funded utilising NHS Standard Contracts with clear Key Performance Indicators (KPIs) and Outcomes. Via the PCOG, the Collaborative Committee will support the partnership approach between the Providers of the SPC.~~ ~~The SPC aims to reduce reliance on in-patient care, reduce out of area treatments, increase provision of care closer to home and reduce the expenditure on bed based care; in doing so it will aim to generate financial savings. These savings will be reinvested in other parts of the Adult Secure, CAMHS and Eating Disorders mental health, learning disability and autism pathways following agreed governance process for the review, new service proposal and formal contracting.~~ The Collaborative Committee provides assurance to the HTFT Board on planning, finance, contracting, performance, and quality for the Specialised Provider Collaborative, supporting its overarching goal of improving patient care pathways and outcomes. Individual SPC providers are responsible for day-to-day patient care, with services commissioned through NHS Standard Contracts and measured against clear Key Performance Indicators (KPIs) and outcomes. Through the Provider Collaborative Oversight Group (PCOG), the Committee fosters a partnership approach across providers, ensuring coordinated delivery and shared accountability. The SPC seeks to reduce inpatient dependency, minimize out-of-area placements, and increase care closer to home, generating efficiencies and cost savings. These savings will be reinvested into Adult Secure, CAMHS, Eating Disorder, and wider mental health, learning disability, and autism pathways, in line with agreed governance and contracting processes.

Scope & Duties	The objectives and duties of the Committee are to: ~~• Provide assurance to the HTFT Board as Host Provider that it is fulfilling its duties and obligations within the SPC.~~ ~~• Be assured that appropriate arrangements are in place in respect of Serious Incidents, Safeguarding, and to ensure quality of care and continuous learning and improvement.~~ ~~• Working closely with PCOG and CPaQ, link with other Provider Collaboratives and local and national commissioners, with the aim of improving services along whole pathways of care and manage pressures within the wider health and care system.~~ ~~• Monitor overall contract management, including quality assurance across the NHS and independent sectors. The Committee may act as the next line of arbitration/mediation between partners if matters cannot be resolved at PCOG.~~ • Assuring the HTFT Board that it is meeting its obligations and responsibilities as the Host Provider within the SPC. • Ensuring that robust arrangements are in place for Serious Incidents, Safeguarding, and quality of care, promoting continuous learning and service improvement. • Collaborating closely with PCOG and CPaQT, as well as linking with other Provider Collaboratives and local and national commissioners, to enhance services across entire care pathways and manage pressures within the broader health and care system. • Monitoring overall contract management, including quality assurance across both NHS and independent providers. The Committee may also serve as a forum for arbitration or mediation where issues cannot be resolved at the PCOG level. <u>Specific responsibilities</u> <i>Financial planning</i> ❖ Provide assurance to the HTFT Board that the SPC's programme of work is well planned and supported by an appropriate risk management system. ❖ Gain assurance, via PCOG, that performance against financial plans is reviewed, financial risks and gain shares are agreed, and mitigated and/or realised, and that any remedial action plans are effective. ❖ Provide assurance to the HTFT Board as Host provider on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money. <i>Transactional</i> ❖ Following review and approval at PCOG, scrutinise and ratify business cases (for both new service proposal and reduction of service delivery) and investments and/or disinvestments,

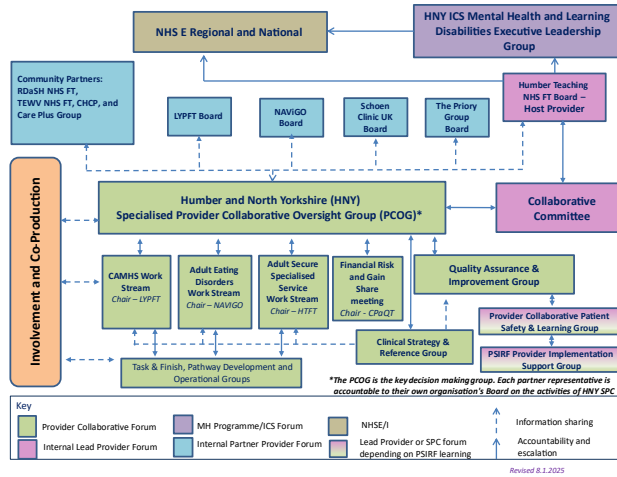
	which will then be translated into contractual agreements which are held by the Host Provider <i>Contracting</i> ❖ Gain assurance that contracts are in place to address risk in relation to the quality and performance of commissioned services and thereby undertake the duties as expected of the Host Provider. ❖ Following discussion and approval at PCOG, ratify and enact Contract Variations and necessary formal Commissioning Intentions dialogue within the SPC. <i>Risk Management:</i> ❖ Each work stream is responsible for its own specific Risk Register. A summary of each work stream risk register will be shared at each PCOG and Collaborative Committee. ❖ The Collaborative Committee will review Risk Registers and will suggest modifications to the risk registers, including ownership and delivery of action plans against defined timescales. ❖ Discuss and review of any issue likely to require inclusion on the HTFT Risk Register. <i>Quality Assurance</i> ❖ To be assured that quality, clinical governance, patient and public engagement issues are appropriately addressed in all service developments/reconfiguration of services and are in line with statutory requirements, national policy and guidance. The Collaborative Committee will receive Chairs log and/or relevant reports from PCOG for review and overall assurance. ~~The Collaborative Committee will have relationships as necessary with other groups and committees that will inform its work including links with:~~ ~~• Transforming Care Alliance Network/Forum to ensure the needs of patients with learning disability and autism are understood and service developments are in line with wider system developments. Further work will be necessary to define and agree definitive links once engagement with the Forum commences.~~ ~~• HNY Integrated Care System and place-based health and care partners to ensure widest development of patient pathways to reduce admission to hospital care but also reduce length of stay.~~ ~~• Local Authorities within the geographical footprint~~ ~~• NHS England Regional and National Team~~ The Collaborative Committee will maintain relationships with relevant groups and committees to inform its work, including: • HNY Integrated Care System and place-based health and care partners – to support the development of patient pathways that reduce hospital admissions and length of stay. • Local Authorities within the Humber and North Yorkshire footprint.

	• Transforming Care Alliance Network/Forum – to ensure the needs of patients with learning disabilities and autism are understood, and that service developments align with wider system initiatives. Specific links will be defined once engagement with the Forum is fully established. • NHS England Regional and National Teams – to ensure alignment with national standards, guidance, and commissioning priorities.
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~~ • Executive Director of Nursing, Quality and Professions • Collaborative Planning Director • Clinical and Quality Assurance Director
Attendance	HNY Provider Collaborative Planning and Quality team • Assistant Director of Clinical and Quality Assurance • Head of Secure Planning • Head of CAMHS and Adult Eating Disorder Planning • Finance Manager • Head of Lived Experience and Involvement Clinical Work Stream Leads (as per specific agenda items) • Clinical Lead, Adult Secure • Clinical Lead, Adult Eating Disorders and CAMHS
Quorum	The quorum necessary for the transaction of business and decision making shall be three (3) members including. 1 Non-Executive Director and 1 Executive Director – one of whom must be the Chair or Vice Chair Decisions will be reached by consensus. If a decision cannot be reached by consensus, then it will be escalated to the Humber Teaching NHS FT Board for resolution.
Chair	The meeting will be chaired by a HTFT Non-Executive Director.

	~~Vice Chair will be Chief Executive, HTFT, and will deputise for the Chair when necessary.~~ Vice-Chair will be a Non-Executive Director of HTFT and will deputise for the Chair when necessary.
Frequency of meetings	Meeting will be held quarterly. Frequency may increase during the annual planning cycle to ensure that the work undertaken by the Collaborative Planning and Quality Team is timely, reflecting the fast-paced nature of contract negotiations. Meetings may be held in person or utilising technology (Microsoft Teams)
Accountability and Reporting Arrangements	A written assurance report will be provided to the Trust Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings. Members will be invited to declare any conflicts of interest.
Agenda & Papers	The CPaQT administration will be responsible for arranging meetings. An agenda for each meeting, together with relevant papers, will be forwarded to members to arrive 1 week before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the CPaQT administration.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Collaborative Committee Terms of Reference.
Agreed by Collaborative Committee (Date)	March 2025 date / highlight to be updated following Collaborative Committee
HFT Board Approved (Date)	November 2024 date / highlight to be updated following Collaborative Committee
Review Date	January 2027

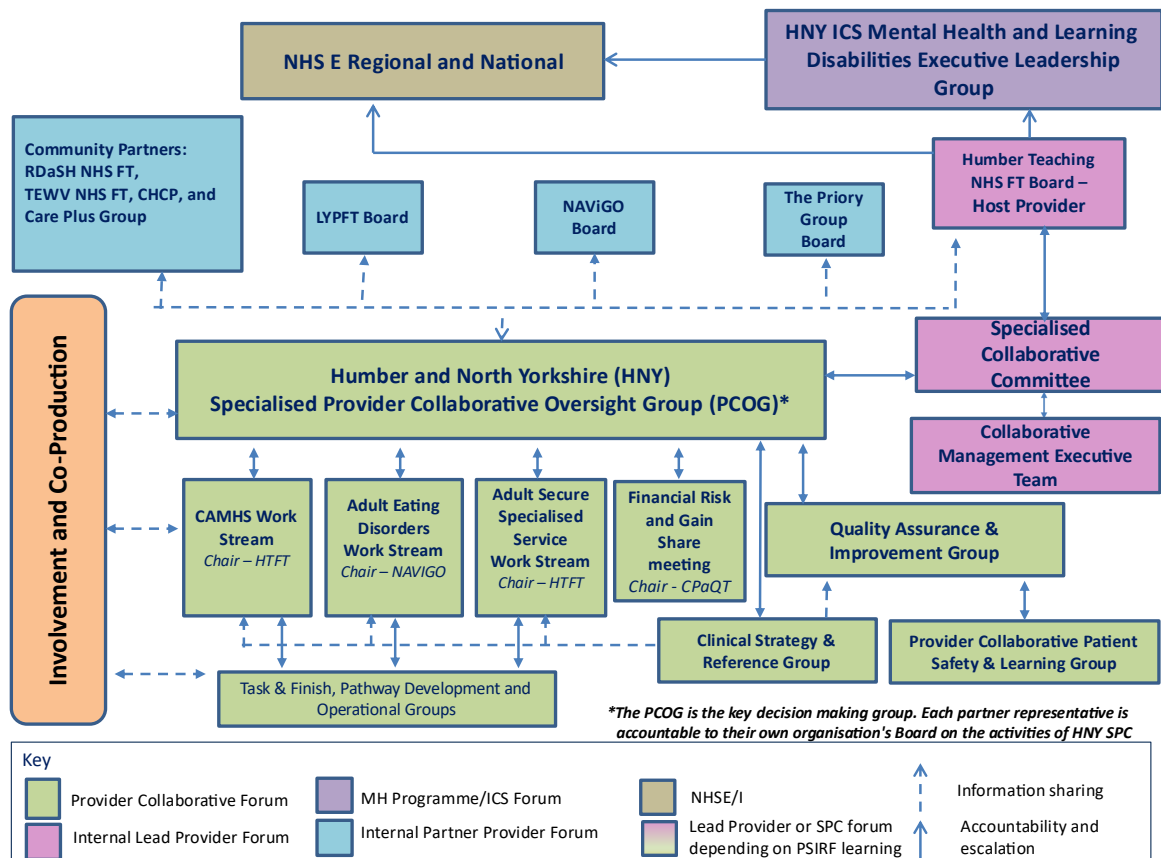
Reporting Schematic:

Overall Provider Collaborative Governance Framework

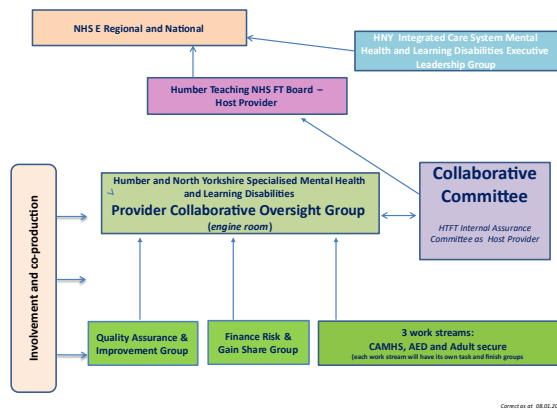


Old Schematic above to be removed

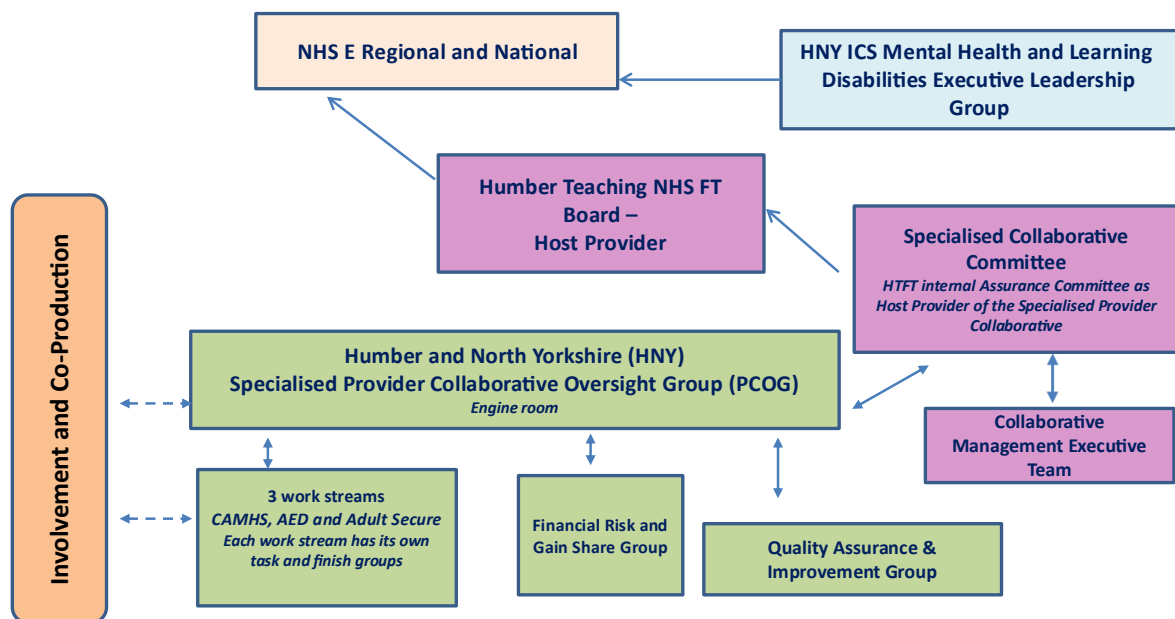
New Schematic from 1 March 2026



Lead Provider Delineation Governance Framework



New Schematic from 1 March 2026



Revised 01.03.2026

Appendix 1

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

The Trust Mission:

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

Our Trust Vision:

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

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

Caring for People while ensuring they are always at the heart of everything we do.

Learning and using proven research as a basis for delivering safe, effective, integrated care.

Growing our reputation for being a provider of high-quality services and a great place to work.

Our Goals (how we will get there)

- Innovating quality and patient safety
- Enhancing prevention, wellbeing, and recovery
- Fostering integration, partnership, and alliances
- Promoting people, communities, and social values
- Developing an effective and empowered workforce
- Optimising an efficient and sustainable organisation

The Characteristics of Being Humber

We Put Patients First

We Are Courteous and Civil

We Are Compassionate

We Are Inclusive

We Act with Integrity

We Communicate Effectively

We Prioritise Safety

We Work Together

Terms of Reference

Finance Committee

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

- Receive assurance from the Operational and Corporate Directors in respect of performance against annual budgets, capital plans and the BRS, activity and key performance indicators, corporate governance activities and responsibilities.
- Monitor effective balance sheet management, including asset management and cash planning
- Monitor financial performance indicators, including compliance with Better Payment Practice Code.
- Monitor the development, application and delivery of financial recovery plans.
- Monitor the development, application and delivery of financial contingency plans.
- Review the robustness of the risk assessments underpinning financial forecasts
- Review the Trust Wide Risk Register and Board Assurance Framework relevant to the work of this Committee.
- Work with the Audit, People and OD and Quality Committees advising on the non- clinical aspects of risk management.
- Identify opportunities for improvement and encourage innovation
- Monitor contract negotiation and performance noting the position of contracts and raising any concerns; receiving assurance from the Executive Directors in respect of the organisation meeting the contractual requirements and expectations of commissioners, meeting the legislative / regulatory requirements of regulators and other bodies.
- Receive and Review Efficiency and Productivity information from the Model Health System.
- Review results from benchmarking exercises including corporate benchmarking.
- Receive updates in relation to the work of the Trusts Performance and Productivity Group
- Receive and Review both the process and Results for the National Cost Collection exercise.
- Review and challenge the Estates & Facilities Work Programme, and the delivery of the Trust's Estate Strategy and Green Plan
- Review and challenge the Digital Delivery work programme and any emerging digital innovations.
- Scrutinise all business cases for new business and investment, in line with the Trusts Scheme of Delegation and Standing Financial instructions and review all tenders presented to the Committee taking on board the views provided by the Executive Management Team. This will be achieved by:–
 - ~~reviewing and approving the business development and investment framework to support and govern all investments, contracts and projects as set out in the ToR.~~
 - ~~evaluating post implementation, the financial performance of approved investments, contracts and development projects, and report the findings to the Board.~~
 - ~~considering the Trust's medium and long term strategies in relation to both revenue and capital investment expenditure, and make recommendations to the Board on a regular basis.~~
 - ~~Reviewing and assessing the business cases for:~~
 - ~~Capital expenditure over £500k~~
 - ~~New business development projects with an annual value in excess of £500k in total~~
 - ~~Any reconfiguration project which has a financial and/or resource implication over £500k per annum~~
 - ~~Leases, contracts or agreements with revenue, capital and/or resource investment/commitment in excess of £500k per annum~~
 - ~~The purchase or sale of any property~~

	○ ~~The purchase or sale of any equipment above £250k~~

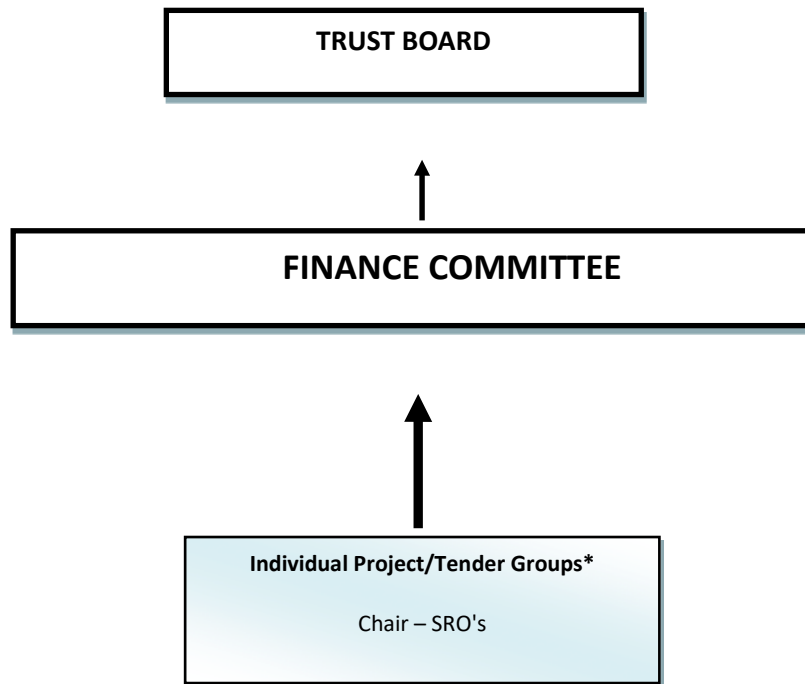
	~~○ All borrowing or investment arrangements~~ ~~○ Horizon scanning regarding business opportunities.~~ ~~○ To periodically consider strategic risks to business and ensure these are reflected and mitigated within any business cases.~~ ~~○ Ensure that Digital support the delivery of patient care~~ ~~○ Receive assurance to ensure the Trust's digital maturity improves on an annual basis~~ ~~○ Receive assurance the Trust is compliant with the digital section of the revised NHS Provider Licence~~ ~~○ Ensure the Trust has the right infrastructure, governance and support in place to provide safe and secure services to patients.~~ • Have due regard to the public sector equality duty and the Trust's equality objectives • Refer issues arising to other Trust committees or groups • Maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency, across the financial year. The Committee shall be proactive in agreeing the most appropriate reporting format and style to suit the particular needs of the following users and stakeholders in accordance with best practice: • the Board (who may at any time request additional information, or information in a different format) and committees • commissioners, including CCGs and NHS England • public, patients and staff • budget holders • other stakeholders, e.g., other Trusts, local authorities
Membership	Membership of the committee shall be comprised of the following: • 3 x Non-Executive Directors (1 of whom shall chair the committee) • Director of Finance (Executive Lead) • Chief Operating Officer In attendance at the Committee will be the following: • Deputy Director of Finance • Head of Partnerships and Strategy • Chief Information Officer • Head of Corporate Affairs General Managers and Deputy Directors will not be members but will attend for all or any part of a meeting as appropriate. The Medical Director will not be a member but will be invited to attend with a specific focus on digital assurance. Senior Clinical Leadership will be requested / invited to attend the Committee, a reciprocal arrangement will take place for Finance attendance at the Quality Committee Non-Executive Directors are entitled to attend any Trust committee meeting.

	The Chief Executive has a standing invitation to attend any meeting. The Chair of the Trust has the right to come to any committee at any time. Declarations of interest Members are required to state for the record any interest relating to any matter to be considered at each meeting, in accordance with the Trust's Conflict of Interest policy. Members will be required to leave the meeting at the point a decision on such a matter is being made, after being allowed to comment at the Chairs' discretion. Declarations shall be recorded in the minutes.
Quorum	A quorum shall be three of the above, comprising at least two Non-Executive Directors.
Chair	• The Committee shall be chaired by a Non-Executive Director with appropriate experience who will be appointed by the Trust Chair and confirmed annually in a Board minute. • In the absence of the Committee Chair, one of the remaining Non-Executive Directors present at that meeting shall act as Chair for that meeting. Deputies may attend by agreement with the Chair.
Frequency	• The Committee shall meet quarterly, however additional meetings will be diarised and held as necessary. • There is a requirement for flexibility when working to new business deadlines and virtual meetings may be required for investment decisions.
Agenda and Papers	• Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Committee not less than 5 days before the date of the meeting. • Minutes of all meetings of the Committee shall be taken by an appropriate and identified admin and kept by the admin. • A record shall be kept of matters arising and/or issues to be carried forward at each meeting. • A record shall be kept of all investment decisions for the purposes of performance monitoring and reporting. • All investment papers submitted must be considered by the Executive Management Team prior to consideration by the Committee in line with the flow of investment decision making. • All meetings of the Committee shall be called at the request of the Chair. • Meeting agenda will be agreed with the Committee Chair before circulation and when circulated it will confirm the venue, time and date.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which assurance reports have not been produced.
Monitoring	An annual effectiveness review will be undertaken which will include a review of

and Review	attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	21 st April 2026
Board Approved Date	May 2026
Review Date	April 2027

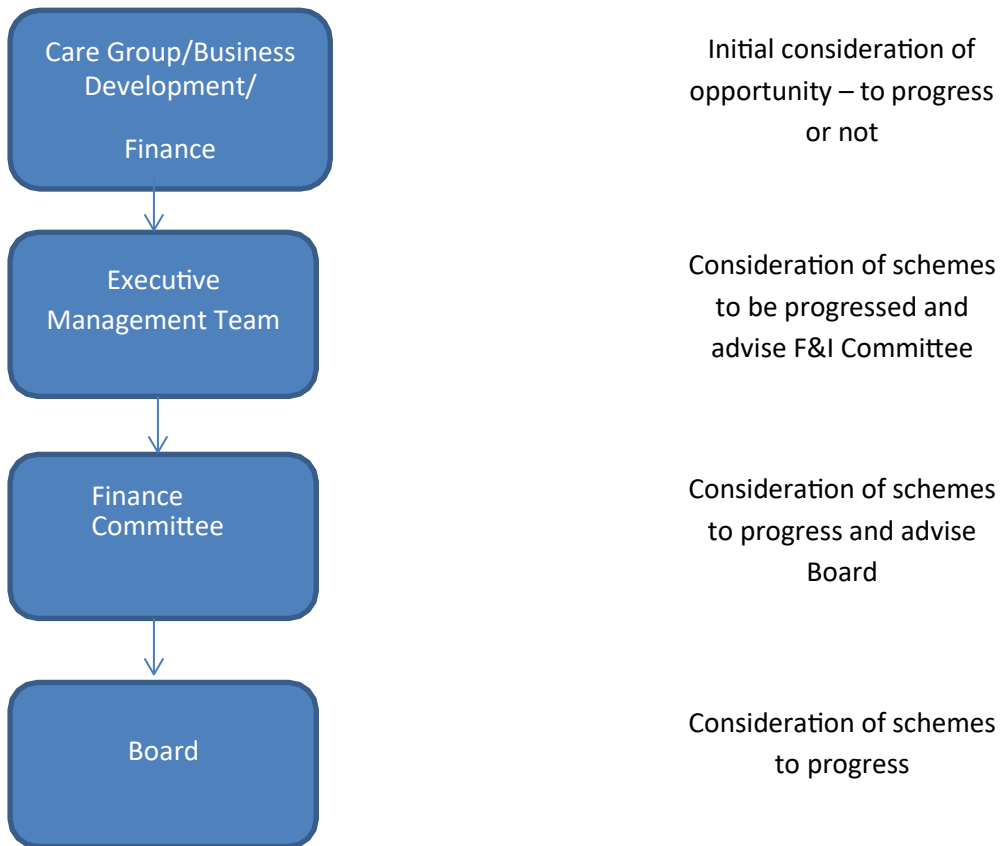
Schematic below:

FINANCE AND INVESTMENT COMMITTEE REPORTING STRUCTURE



** Not a formal subgroup of the Finance and Investment Committee, relevant groups established based on each tender requirement.*

Flow of decision-making process re Investments



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 <u>and benchmarking</u> on key indicators underpinning delivery of the Trust's duties and responsibilities under Mental Health Legislation. • To receive regular updates on recent CQC MHA visits, including themes, associated actions, learning and progress. • To receive a summary of key issues arising from the Associate Hospital Managers Forum • <u>To receive quarterly reports regarding the reduction of restrictive practices. These will be presented by the RRI Lead.</u> • <u>To receive regular updates on the governance of the referral and access arrangements for the provision of Independent Mental Health Advocacy.</u> • To regularly review the Board Assurance Framework (BAF). • <u>To have oversight in any changes of mental health legislation.</u> • 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 • Director of Nursing, Allied Health & Social Care Professionals The following will be required to attend the meetings: • Clinical Director and Clinical lead for RRI • Mental Health Legislation Lead (Mental Health Legislation Manager to act as deputy in absence) • Hull AMHP Lead The following will be invited to attend the meetings: • Local Authority representation covering the Humber area Core members are expected to attend each meeting. However where this is not possible deputies can attend by agreement of the Chair.

	Other individuals may be called to attend for all or part of any meeting, as and when appropriate. The Chief Executive has a standing invitation to attend any meeting. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.
Quorum	The quorum necessary for the transaction of business shall be five including • two Non-Executive Directors, • the Medical Director (or authorised deputy – senior Consultant Psychiatrist) • one other Executive Director At least one of the Executives should be a qualified clinician Members of the Committee must attend at least 3 meetings in each financial year but should aim to attend all scheduled meetings.
Chair	The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair. In the absence of the Chair a Non-Executive Director shall Chair the meeting.
Frequency of Meetings	The Committee shall meet at least every quarter. Additional meetings may be held on an exceptional basis at the request of the chair or any five members of the MHL Committee.
Agenda and Papers	The Mental Health Legislation Lead (with appropriate support), will ensure that: • There is agreement of the agenda with the Chair of the Committee, and that the necessary papers are produced, collated and circulated; • Minutes are taken of the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance. • Minutes shall be circulated promptly (within 20 working days) to all members of the Committee; • A record is kept of matters arising and issues to be carried forward; • An annual cycle of business is established
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and a Committee Chair assurance report will be forwarded to the Public Board.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	~~01 May 2025~~ <u>07 May 2026</u>
Board Approved	~~28 May 2025~~
Review Date	May 202 <u>7</u> ~~6~~

People and Organisational Development Committee Revised Terms of Reference

Authority	The People and Organisational Development Committee is constituted as a standing committee of the Trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors' meetings.
Overall Aim/Purpose	The purpose of the People and OD Committee is to assure the Trust Board that appropriate processes are in place to give confidence that: • Workforce performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks. • Performance in relation to Workforce Equality and Diversity requirements is monitored effectively with appropriate actions being taken to address any performance issues and risks. • The workforce impact of proposed business change proposals (i.e., new models, budget reductions) are fully reviewed for their impact on people. • To provide assurance on the delivery of the relevant strategic objective assigned to the People and Organisational Development Committee - Developing an effective and empowered workforce. • Provide assurance to the Trust Board that robust arrangements are in place to prevent, identify and respond to sexual harassment, sexual misconduct and other inappropriate behaviours affecting staff and volunteers.
Duties	• To provide the strategic overview of and assurance against workforce (including bank and volunteers) issues in the Trust. • To provide assurance to the Trust Board that workforce-related risks, including cultural, conduct, capacity, capability and compliance risks, are identified, assessed and managed effectively, with clear escalation where risk appetite may be exceeded.

- Be assured of the Trust's response to all relevant employment legislation, Directives, Regulations, national standards, policies, reports and best practice, including horizon scanning for changes in employment law and assessment of associated workforce risks and mitigations.
- 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 Resident Doctors
- Scrutinise the effectiveness of arrangements for Freedom to Speak Up, safeguarding, and the investigation of concerns relating to staff safety, inappropriate behaviour and conduct.
- To provide oversight and assurance of the Trust's arrangements for preventing and addressing sexual harassment, sexual misconduct and other inappropriate behaviours, including the effectiveness of reporting mechanisms, investigation processes, safeguarding arrangements, and the support provided to staff.
- The Committee will seek assurance on emerging People-related risks of national or regulatory significance and adapt its assurance approach accordingly.

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 • Executive Director of People & OD • Chief Operating Officer • Medical Director • Executive Director of Nursing, Quality and Professions Caldicott Guardian The following will be routine attendees at the committee: • Deputy Director of People & OD • Head of People Operations • Director of Finance • Head of Corporate Affairs All those that attend the meetings are required to attend a minimum of three meetings a year. Nominated deputies can attend meetings on behalf of Committee members and will count towards the quorum. The Chief Executive and the Chair each have a standing invitation to attend. The Chair of Audit Committee has a standing invitation to attend. Other relevant officers will be invited to attend as required by the Committee.
Quorum	2 Non-Executive Directors, 1 Executive Director and 1 other board member. The agenda will be agreed by the Chair, via the Executive Director of People and OD.
Chair	The Chair of the Committee will be a Non-Executive Director.
Frequency of meetings	The Committee will meet as a minimum 4 times a year.

Agenda & Papers	An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive 5 working days before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the Committee Secretary.
Minutes & Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which assurance reports have not been produced.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	6 May 2026
Approved by Trust Board	
Review	



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: - The trust has systems in place which ensure the quality of care to its patients is maintained and that health outcomes are improved over time. - Assuring the board that our services are safe, effective, responsive, caring and well-led. The committee will seek assurance that associated risks are monitored effectively, and that appropriate and timely actions are taken to address any deficit in acceptable standards and mitigations in place to manage identified risks. - To oversee compliance with statutory, regulatory and professional quality standards. - To ensure a culture of continuous quality improvement, learning and compassionate care. - To oversee compliance with statutory, regulatory and professional quality standards. - To ensure a culture of continuous quality improvement, learning and compassionate care. - 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. - To triangulate data and intelligence across all areas of Quality
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/ Service User 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 in line with Insightful Board requirements and functions delegated by the Board. - To provide assurance to the Trust Board that risks, and governance

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	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 and associated Annual Review documents. • Drive improvements in the approach to quality improvement, research 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, investigating and learning from 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 and demonstrating improvement following feedback and engagement. • The Quality Committee will ensure that there is an integrated approach to quality and effectiveness, and patient and staff safety throughout the Trust, ensuring there is triangulation of data and information.:- • 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 • The quality impact of proposed business change proposals (i.e., new models, budget reductions) are fully reviewed for their impact on quality



Humber Teaching NHS Foundation Trust

	• <u>Quality of care (safety, effectiveness, experience)</u> • <u>Patient/service user safety including RRI</u> • <u>Clinical and professional standards</u> • <u>Safeguarding (adults and children)</u> • <u>Learning from incidents, complaints, freedom to speak up, claims, inquests and patient feedback</u> • <u>Mortality, suicide prevention and learning from deaths</u> • <u>Quality improvement methodology and impact</u> • <u>Medication safety</u>
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 • Executive Director of Nursing, Quality and Professions (Management support to the Committee) • Executive Medical Director • Chief Operating Officer In attendance • Clinical Director • Head of Corporate Affairs • Deputy Director of Nursing, Quality & Professions -and Staff Champion Patient Experience • Head of Nursing - Patient Safety Specialist • Administrator All those that attend the meetings are required to attend a minimum of three meetings a year. Nominated deputies can attend meetings on behalf of Committee members and will count towards the quorum.

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Caring, Learning
& Growing Together

BEING
HUMBER
Our values in action



Humber Teaching NHS Foundation Trust

	The Chief Executive, the Trust Chair and the Chair of Audit Committee have a standing invitation to attend. Other relevant officers will be invited to attend as required by the Committee <u>and observers may attend with the permission of the Chair.</u>
Quorum	2 Non-Executive Directors, 1 Executive Director and 1 other board member. The agenda will be agreed by the Chair, via the <u>Executive Director of Nursing, Quality and Allied Health and Social Care Professions</u>.
Chair	Non-Executive Director
Frequency	The Quality Committee will meet as a minimum 4 times a year.
Agenda and Papers	An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive 5 working days before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the Committee Secretary.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which minutes have not yet been approved. The Quality Committee will provide an annual Quality Account to the Trust Board.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Date Agreed by Quality committee	<u>8th April 2026</u>
Date Approved by Trust Board	
Review Date	<u>April 2026</u>



Humber Teaching
NHS Foundation Trust

CLINICAL & QUALITY GOVERNANCE REPORTING STRUCTURE

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Trust
Board

Quality
Committee



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Remuneration and Nomination Committee

Terms of Reference

Constitution and Authority	The Remuneration and Nomination Committee is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board meetings. The Committee is authorised by the Board to act, in accordance with Standing Orders, Scheme of Delegation and Standing Financial Instructions, and within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its' functions. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
Role / Purpose	To provide a forum for agreement of remuneration and terms of service for Trust Executive's and Trust Very Senior Managers (VSM) in accordance with national requirements.
Scope and Duties	The Remuneration Committee has delegated responsibility for setting remuneration for all Executive Directors (and also for those senior managers on the Very Senior Managers contract of employment) including pension rights and any compensation payments The Remuneration and Nomination Committee's duties are detailed below under the following headings: • National Requirements • Appointments Role • Remuneration Role <u>National Requirements</u> 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. <u>Appointments Role</u> The Committee will: • Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations

	to the Board and Appointment, Terms and Conditions Committee of the Council of Governors, as applicable with regard to any changes • Give full consideration to and make plans for succession planning for the Chief Executive taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. The same consideration will be given to other Executive Directors on the advice or recommendation of the Chief Executive. • Receive assurance reports from the Chief Executive as required to ensure the executive level leadership needs of the Trust are kept under review to ensure the continued ability of the Trust to operate effectively in the health economy. • It is a requirement of the 2006 Act that the Chair, the other Non-Executive Directors and – except in the case of the appointment of a Chief Executive – the Chief Executive, are responsible for deciding the appointment of Executive Directors. The appointments panel will consist of the Chair and one non-executive director from the Remuneration and Nomination Committee and the Chief Executive, except in the case of the appointment of a Chief Executive. The panel has responsibility for identifying suitable candidates to fill executive director vacancies, including shortlisting, assessment and selection and they make recommendations to the Remuneration and Nomination Committee. • It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors. The Governors are responsible for the appointment, re-appointment and removal of the Chair and the other Non-Executive Directors. • To approve appointments of all Executive Director positions on the Board determining their remuneration and other terms of service and monitoring their performance. • When appointing the Chief Executive, the Committee shall be the Committee described in Schedule 77, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the Committee shall be the Committee described in Schedule 7, 17(4) of the Act. • When a Board level Executive vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation ensure that a description of the role and capabilities required for the particular appointment is prepared. In identifying suitable candidates the Committee shall ensure the use of open advertising or the services of external advisers are used to facilitate the search. The Committee will ensure the Trust considers candidates from a wide range of backgrounds and consider candidates on merit against objective criteria. • Ensure that a proposed Executive Director's "other significant commitments" (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise. • Ensure the proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported. • Be advised of and consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. • In considering appointments, receive assurance to ensure that all Directors meet the "fit and proper" person test of the general conditions of Monitor's provider licence. • An Appointments Advisory Committee (AAC) will be established by the Trust when required to progress consultant recruitment and appointments.

Consultant appointments will be reported to the public board meeting via the Chief Executive's report.

- Approval of annual Recruitment and Retention payments over £25k (these should not exceed a period of 4 years without review);
- Noting of Recruitment and Retention payments of up to £25k per annum and (these should not exceed a period of 4 years without review).

Remuneration Role

The Committee will:

- Have delegated responsibility for setting remuneration for all Executive Directors (and also for those senior managers on the Very Senior Managers contract of employment) including pension rights and any compensation payments. Those managers within this definition who are not on the Very Senior Managers Contract or Executive Directors are on national pay and terms and conditions and their posts are subject to job evaluation in line with the national scheme. *NB: The rights of all staff on the VSM contract who are in the NHS pension are bound by the national pension rules.*
- To receive proposals from the Chief Executive relating to the remuneration of the other Executives.
- In accordance with relevant laws, regulations, Trust policies and Standing Financial Instructions (SFIs) decide and keep under review the terms and conditions of office of the Executive Directors and those senior managers on the Very Senior Managers contract of employment, including:
 - Salary, including any performance related pay or bonus.
 - Provision for other benefits, including pensions and cars *NB rights of all staff on the VSM contract who are in the NHS pension are bound by the national pension rules.*
 - Allowances.
 - Payable expenses.
 - Compensation payments.

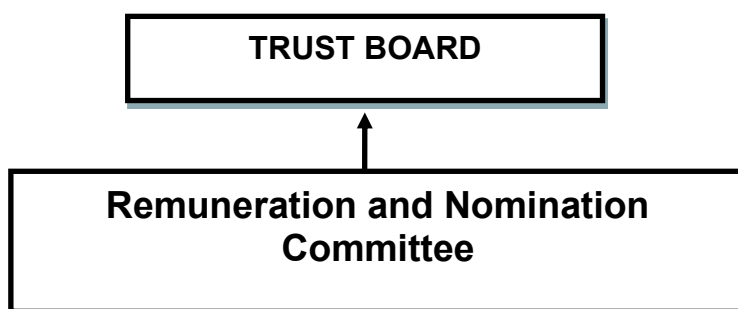
In adhering to all relevant laws, regulations and Trust policies:

- Approve levels of 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 <u>Associate-Executive</u> Director of People and Organisational Development. Other persons may be invited by the Committee to attend a meeting to assist in deliberations. Any non-member, including the Secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.
Quorum	The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors plus the Chair (or person deputising for the Chair). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.
Chair	The Trust Chair shall chair the Committee.
Frequency of Meetings	Meetings shall be held not less than twice a year and at such other times as the Chair of the Committee shall require.
Agenda and Papers	The Board Support Unit Manager shall be the Secretary to the Committee and prepare and distribute papers and keep minutes of the Committee.
Minutes and Reporting	Formal minutes shall be taken of all Committee meetings. An assurance report summarising key discussions and decisions will be presented to the Board of Directors following each meeting.
Monitoring and Review	The Committee shall monitor and review its performance through • An annual effectiveness review against its terms of reference. The annual effectiveness review will be provided to the Board of Directors. • The Terms of Reference of the Committee shall be reviewed annually.

Agreed by Committee	~~30 April 2025~~ 29 April 2026
Board Approved	~~28 May 2025~~ May 2026
Review Date	April 2027 6

REMUNERATION AND NOMINATION COMMITTEE REPORTING STRUCTURE



Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Trust Board Effectiveness and Terms of Reference Review 2026														
Author/s:	Rt Hon Caroline Flint FRCGP (Hon) Trust Chair														
Recommendation:	<table border="1"> <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>			To approve	✓	To discuss		To note		To ratify		For assurance			
To approve	✓	To discuss													
To note		To ratify													
For assurance															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	Trust Board is asked to: - Note the Board effectiveness review report for 2025/26 - Approve the proposed amendments to the Trust Board Terms of Reference (attached at Appendix 1) and as detailed below - References to the 'Finance and Investment Committee' amended to the Finance Committee - The Attendance section has been updated to highlight that any concerns shall be reported to the Chair - Reference to 'him/her' has been replaced with a gender-neutral sentence. - The role of the Chair in ensuring Fit and Proper Person checks are undertaken for Board members has been added. - Details of the people Board members may wish to raise concerns with has been updated, with the Head of Corporate Affairs replacing the Executive Director of Finance as a contact point. - The Membership section has been updated to reflect changes in job titles and voting members on the Board - The Committee titles have been amended on the schematic to reflect current Committee names.														
Key Issues within the report:															
Positive Assurances to Provide: The effectiveness review demonstrates good governance with the Board effectively meeting the requirements of the terms of reference throughout the year.		Key Actions Commissioned/Work Underway: No actions identified													

- All committees have also undertaken an annual effectiveness review, and the results are contained in a separate paper. - The Board discussed improvements to papers at its Strategic Development Board meeting on 15 September 2025 and made suggestions for Board and Board sub-Committees. - The Executive Management Team has undertaken an effectiveness review, and no key areas of development were identified.				
Matters of Concern or Key Risks: No issues raised.		Decisions Made: N/A		
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>				
	Audit Committee	Date	Remuneration & Nominations Committee	Date
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	Trust Board 27.5.26

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	N/A	Comment

		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	

Trust Board
Annual Review of Trust Board Effectiveness and Terms of Reference
1 April 2025 to 31 March 2026

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
- Ensure compliance with statutory requirements and duties
- Shape a positive culture for the Trust
- Take decisions that it has reserved to itself.

The Chief Executive is the Accountable Officer for the Trust.

1. Executive Summary

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

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

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

Strategic Board Development sessions enable the Board to have detailed in-depth discussions about key strategic matters facing the Trust. A work programme has been produced to capture items to be considered at the Strategic Development meetings and the notes from the Strategic Development meetings are forwarded to Board meetings in private.

The Board discussed improvements to papers at its Strategic Development Board meeting on 15 September 2025 and made suggestions for Board and Board sub-Committees. In December 2025, the Board reviewed the items discussed at these meetings, the outcomes and action taken to progress each key area of work. The Board has also reflected on the effectiveness of these meetings and agreed they are 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. A further external review of governance will be scheduled during 2026/27.

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 continued to be good resulting in the Board focussing on and being clear about the key issues it needed to discuss
- In addition, half of the Non-Executive Directors trained to become Associate Hospital Managers.

2. Delivery of functions delegated by Board

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

3. Attendance

3.1 The Board met on six occasions during 2025/26, and attendance is detailed below:

Members:	No of meetings attended
Chair, Caroline Flint	6/6
Chief Executive, Michele Moran	6/6
Non-Executive Director, Dean Royles	4/5
Non-Executive Director, Phillip Earnshaw	6/6
Non-Executive Director, Keith Nurcombe	5/6
Non-Executive Director, Stephanie Poole	6/6
Non-Executive Director, Kathryn Smart	1/1
Non-Executive Director, Stuart McKinnon-Evans	5/5
Associate Non-Executive Director, Priyanka Perera	2/3
Executive Director of Finance, Peter Beckwith	6/6
Executive Medical Director, Kwame Fofie	6/6
Executive Director of Nursing, Quality and Professions, Sarah Smyth	6/6
Chief Operating Officer, Lynn Parkinson	6/6
Executive Director of People and Organisation Development, Karen Phillips	6/6

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

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

3.3 Include any recommendation for change to membership & reasons why

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

4. Quoracy

The Board meetings were quorate on all occasions.

5. Reporting Committees to Board

The following committees reported to the Board during 2025/26: -

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

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

Yes.

The annual review of committee effectiveness and terms of reference for these committees for 2025/26 will be presented to the Board in May 2026 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 2025/26?

At the March 2025 Board meeting, the Board agreed that those operational groups which report into Committees should report into the Executive Management Team in future, with any exceptions highlighted through those groups escalated to the relevant committee in the usual way. This new arrangement is working well and has freed up more time for the Board to consider business items of strategic importance

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.

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

Yes.

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

- Is the quality and timeliness of the minutes satisfactory?

Yes

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

Yes

7. Review of Terms of Reference

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

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

- References to the 'Finance and Investment Committee' amended to the Finance Committee
- The Attendance section has been updated to highlight that any concerns shall be reported to the Chair
- Reference to 'him/her' has been replaced with a gender-neutral sentence.
- The role of the Chair in ensuring Fit and Proper Person checks are undertaken for Board members has been added.
- Details of the people Board members may wish to raise concerns with has been updated, with the Head of Corporate Affairs replacing the Executive Director of Finance as a contact point.
- The Membership section has been updated to reflect changes in job titles and voting members on the Board
- The Committee titles have been amended on the schematic to reflect current Committee names.

8. Workplan for 2026/27

Has a workplan for the year ahead, 2026/27 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.

Comments were made by some Board members regarding the length of Board papers and there was an acknowledgement that discussions have taken place during the year about how papers might be improved.

Comments were also made regarding the balance of Formal and Strategic Board meetings which was considered to be effective.

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 to better 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 others to support and grow health and social care systems. In addition, members of the Board must ensure compliance with NHS England's Fit and Proper Person Test Framework requirements, which takes account of the requirements of the Care Quality Commission in relation to directors being fit and proper for their roles.
Duties	The duties set out below shall not preclude the Board of Directors from reserving powers and duties to itself. These powers and duties shall be set out in the Standing Orders, Scheme of Delegation and Standing Financial Instructions and for the avoidance of doubt where there is a conflict, Standing Orders, Scheme of Delegation and Standing Financial Instructions will take precedence over these Terms of Reference. The duties of the Board of Directors are to: • Set the values and strategic direction of the Trust; and ensure the Trust's Strategy is reviewed as necessary.

	• Provide leadership to the Trust to promote the achievement of the Trust's Principal Purpose as set out in the Constitution (i.e. the provision of goods and services for the purposes of health services in England), ensuring at all times that it operates in accordance with the Constitution and the terms of the license as issued by Monitor (now part of NHS England) • Promote teaching, research and innovation in healthcare to a degree commensurate with the Trust's "teaching hospital" status • Engage as appropriate with the Trust's membership and Council of Governors. • Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction. • Oversee the implementation of the Trust's strategic goals and monitor the executive team's delivery of the strategic objectives ensuring consistency with the role/purpose of the Board of Directors • Agree the Trust's financial and strategic objectives, including approval of the Strategic Plan. • Ensure that the Trust has adequate and effective governance and risk management systems in place • Monitor the performance of the Trust and ensure that the Executive Directors manage the Trust within the resources available in such a way as to: ▪ Ensure the safety of service users and the delivery of high-quality 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 • Finance ~~& Investment~~ Committee • Mental Health Legislation Committee • Quality Committee • Remuneration and Nomination Committee • People and Organisational Development Committee • Commissioning Committee Members of the Board of Directors must ensure that wherever possible they attend every Board meeting (including additional Board meetings when convened). An explanation of non-attendance should be made to the Chair. Attendance at meetings will be monitored by the Head of Corporate Affairs and <u>any concerns</u> shall be reported to the Chair on a regular basis and <u>attendance</u> 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

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	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. 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 ~~them~~ <u>him/her</u> 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 • <u>Ensure the Board of Directors has adequate support and necessary data on which to base informed decisions and monitor that such decisions are implemented.</u> • <u>Ensure Fit and Proper Person checks are undertaken for directors both on appointment and on an annual basis.</u> • 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, <u>Head of Corporate Affairs</u>~~Director of Finance~~ or Chief Executive is inappropriate

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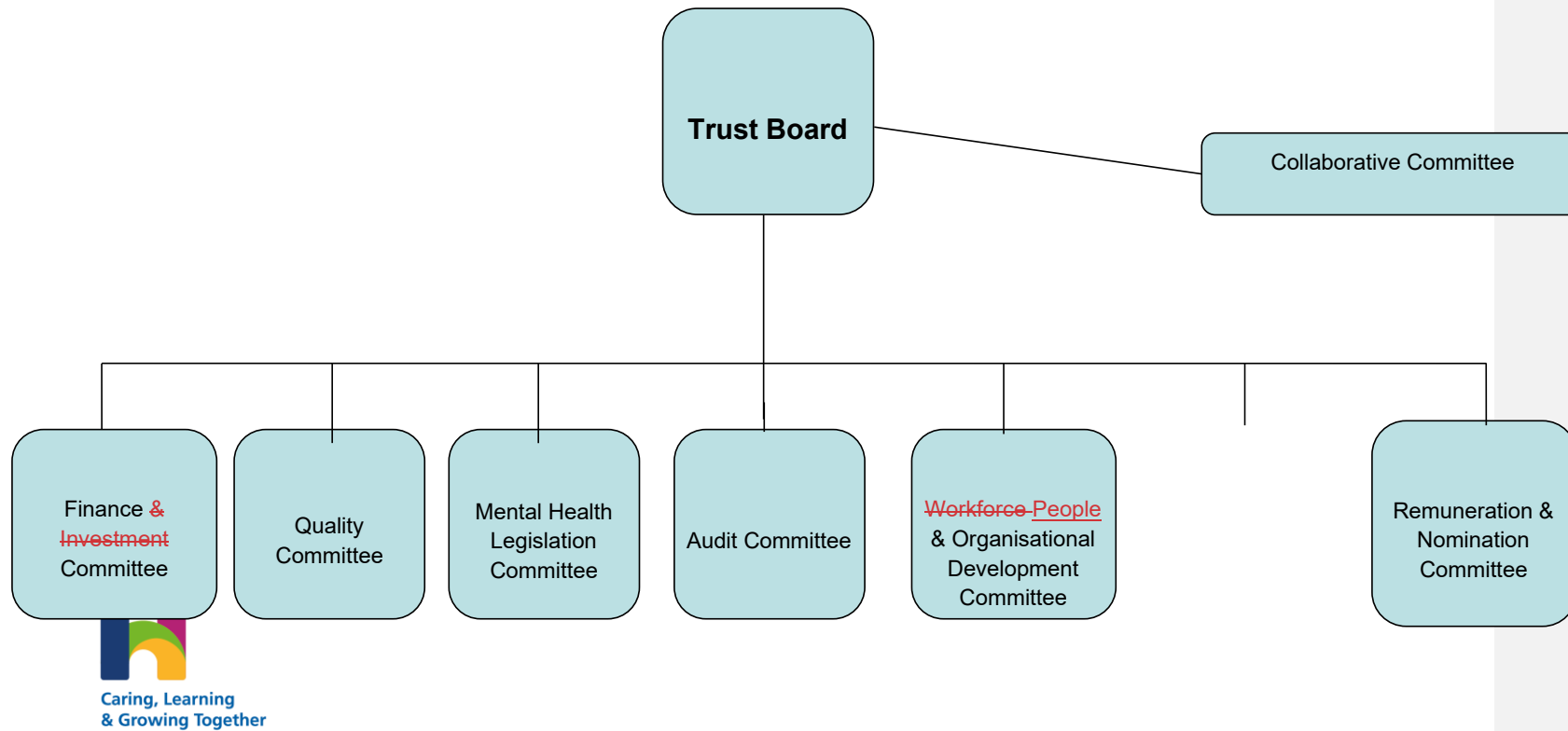
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	Discussing the Chair's performance appraisal, remuneration or allowances The SID is also a contact point for staff who wish to raise concerns under the Freedom to Speak Up process. The Non-Executive Directors are accountable to the Council of Governors 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 ~~e~~Executive and Non-Executive Directors. Membership shall be as follows: - A Non-Executive Chair - Up to 6 other Non-Executive Directors - Up to 6 Executive Directors ~~Associate Director of People and Organisational Development (non-voting) *~~ - Up to 2 Associate Non-Executive Directors (non-voting) * *Associate Non-Executive ~~and Executive Director~~ appointments will be non-voting and not count towards the ~~other Non-Executive or Executive Director~~ positions. At all times at least half of the Board of Directors, excluding the Chair shall be Non-Executive Directors. For clarity the Executive Directors who are members of Board of Directors are: - Chief Executive (voting) ~~Executive~~ Director of Finance (voting) ~~Executive~~ Medical Director (voting) ~~Executive~~ Director of Nursing, ~~Allied Health and Social Care Professionals & Caldicott Guardian~~ <u>Quality and Professions</u> (voting) - Chief Operating Officer (voting) ~~Associate~~ Director of People and Organisational Development (~~non-voting~~)

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

	<i>nature of the business to be transacted, publicity on which would be prejudicial to the public interest'</i> 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 PA to the Chair and Chief Executive shall take the minutes and shall ensure these are presented to the next Board of Directors' meeting and signed by the person who presided at the meeting. Minutes from meetings of the Board of Directors will be presented to the Council of Governors when practicable, in accordance with a process agreed by the Council of Governors. The public agenda, papers and minutes of each meeting shall be displayed on the Trust's website.
Monitoring	A review of attendance and effectiveness will be undertaken annually. To comply with NHS Resolution Risk Management standards (which now incorporates the functions of the organisation formerly known as the NHS Litigation Authority (NHSLA), the Trust must include certain details in all its terms of reference documents. The Trust must also collect evidence of compliance with these areas.
Approval Date	27 ~~8~~ May 202 ~~6~~ ⁵
Review Date	May 202 ~~7~~ ⁶

Sub Committee Structure



Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Finance Report, April 2026															
Author/s:	Michele Moran Chief Executive															
Recommendation:	<table border="1"> <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>				To approve		To discuss		To note	✓	To ratify		For assurance			
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 2026 (Month 1). The report provides assurance regarding financial performance, key financial targets and objectives.															
Key Issues within the report:																
Positive Assurances to Provide: - At Month 1 a financial position consistent with the Trust plan has been recorded - Cash balance at the end of April was £24.405m.		Key Actions Commissioned/Work Underway: 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 2026, and comment accordingly.														
Governance:		Date		Date												
	Audit Committee		Remuneration & Nominations Committee													
	Quality Committee		People & Organisational Development Committee													
	Finance Committee		Executive Management Team													
	Mental Health Legislation Committee		Operational Delivery Group													
	Collaborative Committee		Other (please detail) Annual report													

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

FINANCE REPORT – April 2026

1. Introduction

This report is being circulated to the Trust Board to present the financial position for the Trust as at the 30th April 2026 (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

The Trust has submitted a break-even plan for 2026/27, and a budget consistent with the financial plan has been uploaded onto the Trust Ledger.

The monthly profile of the budget maintains a breakeven position throughout 2026/27, delivery against this profile will achieve a score of 1 against the finance indicators on the National Oversight Framework.

3. Background and Month 1 Position

Formal reporting requirements to NHSE at Month 1 have been relaxed due to year end accounting priorities.

The Trust have submitted 'Heads Up' information to NHSE to confirm the Trust is on target for both year to date and forecast outturn, as per the table below:

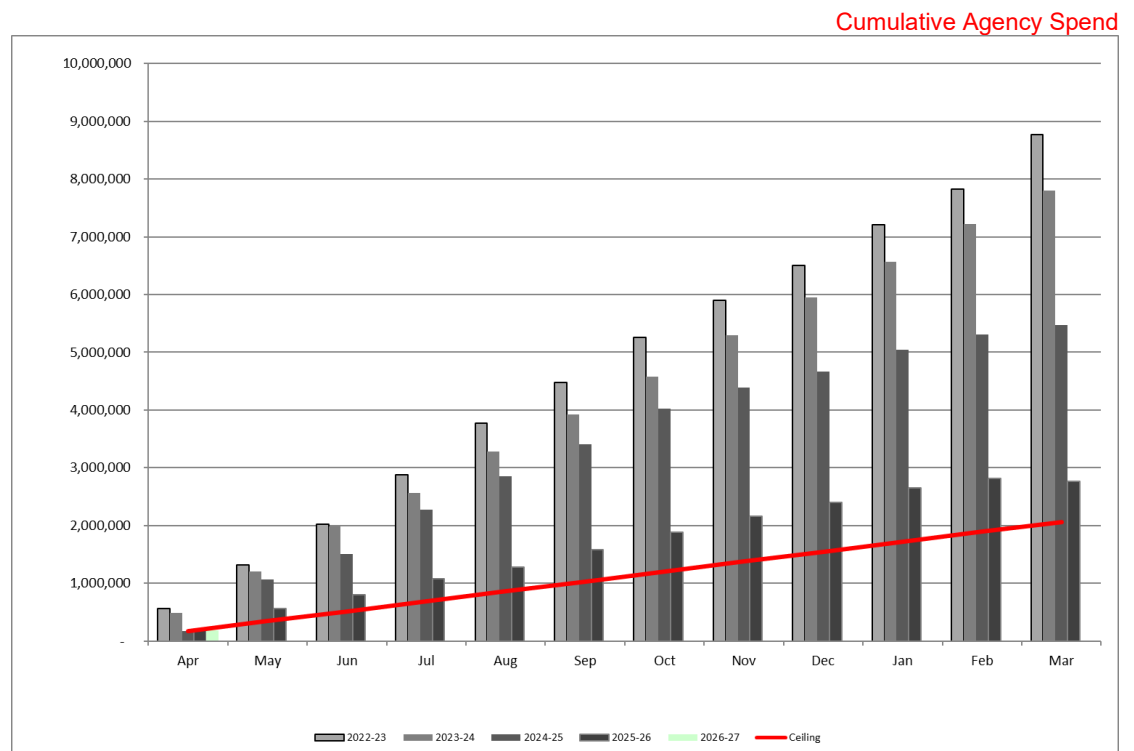
Month 1 Heads Up Return

	Plan YTD £000s	Actual YTD £000s	Variance YTD £000s	Plan £000s	FOT £000s	Variance £000s
Surplus / (Deficit) including DSF	0	0	0	0	0	0

4. Agency

NHSE have mandated Trusts to reduce Agency expenditure by a further 30% in 2026/27. The effect of this is a target of £2.064m, EMT will be agreeing targets for professional groups and divisions.

Spend recorded in the ledger at the end of Month 1 was £0.186m, this was slightly above a prorate ceiling target of £0.172m.



The current target means that agency expenditure will account for 1.1% of the total pay costs of the Trust.

5. Cash

As at the end of April 2025 the Trust held £24.405m in its Cash Balances.

6. Better Payment Practice Code

Under the Better Payment Practice Code (BPPC) the Trust has a target to pay 95% of undisputed invoices on time.

The current BPPC performance figures are shown in Table 3 below, work continues to maintain this level of performance.

Better Payment Practice	YTD Number	YTD £'000
NON NHS		
Total bills paid	1,726	13,723
Total bills paid within ta	1,717	13,681
Percentage of bills paid	99.5%	99.7%
NHS		
Total bills paid	98	631
Total bills paid within ta	90	609
Percentage of bills paid	91.8%	96.5%
TOTAL		
Total bills paid	1,824	14,354
Total bills paid within ta	1,807	14,290
Percentage of bills paid	99.1%	99.6%

7. Recommendations

The Trust Board are asked to note the Finance report for April 2026, and comment accordingly.

Agenda Item 20

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Performance Report – April 2026															
Author/s:	Peter Beckwith, Executive Director of Finance Michele Moran, Chief Executive Officer															
Recommendation:	<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>				To approve		To discuss		To note	✓	To ratify		For assurance			
To approve		To discuss														
To note	✓	To ratify														
For assurance																
Purpose of Paper:	This purpose of this report is to inform the Trust Board on the current levels of performance as at the end of April 2026, EMT are considering the format of future reports to ensure appropriate oversight and the attached may be subject to further changes. The updated report (Appendix 1) is presented using statistical process charts (SPC) for a select number of indicators with upper and lower control limits resented in graphical format. All indicators have been aligned to the Trusts Strategic Goals with summary narrative for each section in the report (<i>Quality, Workforce, Operational</i>) Performance against the current National Oversight Framework is attached at appendix 2. Proposed metrics for 2026/27 are attached at Appendix 3.															
Key Issues within the report:																
Positive Assurances to Provide: - Strong oversight framework position, with the Trust segment score of 1, rank of 7th out of 61 providers. - Mental Health Urgent Response (F2F) within 24hours performance has continued to improve. - Safer staffing reviews confirm that staffing levels continue to meet required safe staffing establishments across inpatient services, with CHPPD remaining in a strong position across most wards. - Mandatory training compliance is at 88.3%, remaining above the Trust target of 85%, - Clinical supervision is performing well at 93.3%,		Key Actions Commissioned/Work Underway: - More detailed commentary has been provided within the body of the report for Quality Operational and Workforce Sections. - Adult and CYP 4ww % - work is being led by the Clinical Director with a focus on embedding use of valid outcome measures which will report the 4ww standard.														

Key Risks/Areas of Focus: - Sickness absence is reported at 5.1%, marginally above the typical Trust target (5%). - Adult and CYP 104ww %, the focus remains on meeting the target outlined in the Medium-Term Plan submission (by the end of this financial year,- the position currently stands at 743>104weeks.		Decisions Made: Trust Board are asked to note the current performance as at the end of April and that work is taking place via Executive Management Team to further refine the performance report which comes to Trust Board	
Governance:		Date	Date
	Audit Committee		Remuneration & Nominations Committee
	Quality Committee		People & Organisational Development Committee
	Finance Committee		Executive Management Team
	Mental Health Legislation Committee		Operational Delivery Group
	Collaborative Committee		Other (please detail) Annual report

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
✓ 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	✓			To be advised of any future implications as and when required by the author
Quality Impact	✓			
Risk	✓			
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

This purpose of this report is to inform the Trust Board on the current levels of performance as at the end of April 2026, EMT are considering the format of future reports to ensure appropriate oversight and the attached may be subject to further changes

2 Trust Performance Report

EMT have been reviewing the Trust Performance Report, an updated version of the Trust Performance Report is attached at appendix A, this is reporting performance to the end of April 2026.

The updated version of report continues to use statistical process charts (SPC) for a select number of indicators with upper and lower control limits resented in graphical format.

All indicators are aligned to the Trusts Strategic Goals, a proposed change to the current format of the report discussed at EMT proposes a narrative sheet for indicators that fall under the remit of either committee or operational delivery group (noting performance is reported to EMT monthly), this is to enable richer narrative and for each section of the report to be provided to committee quarterly to enable more detailed scrutiny with any recommendations for further performance information to be included in future board reports.

3 Clock Stops

NHSE has moved away from counting measures based on care contacts and instead measures when meaningful activity has begun. The Clock starts at start of the referral-spell and only stops when a meaningful set of actions has happened.

The full clock stop occurs when all required elements have been recorded for that referral spell (*Once all have been recorded a full clock stop occurs*)

- A baseline outcome
- A Care plan
- An intervention
- An Assessment

4 National Oversight Framework

Attached at Appendix B is the current performance (April 2026) against the current iteration of the National Oversight Framework.

The Quarter Three results for NHS Oversight Framework were published in December 2025, with the Trust moving from segment 2 into segment 1 with the Trust now ranked 7th among similar Trusts in the league table (total of 61 Trusts).

Scores by segment across each sector are summarised in the table below:

Domain	Q1	Q2	Q3
Access to Services	3.27	2.83	1.49
Effectiveness and Experience	1.39	1.35	1.35
Patient Safety	2.23	2.10	1.90
People and Workforce	2.35	2.47	2.33
Productivity and Value for Money	2.25	2.77	2.77
Overall Score	2.22	2.21	1.91
Segmentation	2	2	1
Rank	22nd	19th	7th

Key points to note from the above table are:

Access to services scores have improved significantly in Q3, the most significant influence on this movement is the eradication of community over 52 week waits.

Movement on the **Patient Safety domain** relates to the improved % of urgent referrals to crisis care seen within 24 hours, as previously reported to board performance against this indicator was impacted by the move of EPR.

The score on **Productivity and Value for Money** has been influenced by the profiling of the Trusts Plan (capped the score at 2) and the 2024/25 NCC scores. Work is taking place through the trust performance and productivity group and there is a high level of confidence the 2025/26 NCC score will see significant improvement.

NHS England has confirmed that metrics are being reviewed for 2026-27, the Trust has had early sight of the proposed metrics (Appendix 3) and work is taking place to map current trust performance against available data to understand any potential impact on segmentation in 2026/27.

5 Finance Information

Currently a separate finance reports appears in the board pack and will continue to do so, however to ensure the Board Performance Report is seen as integrated it is recommended some key finance metrics are included in the report, current consideration for indicators includes but is not limited to:

- Cash in Bank
- Better Payment Practice Code
- Bank Spend (Against Target)
- Agency Spend (Against Target)
- Year to Date Variance to Budget

6 Recommendation

Trust Board are asked to note the current performance as at the end of April and that work is taking place via Executive Management Team to further refine the performance report which comes to Trust Board

Financial Year
2026-27

TRUST PERFORMANCE REPORT

This report provides a high-level overview of the NHS Trust's current performance levels, drawing on key indicators from the Integrated Quality and Performance Tracker.

The purpose of the report is to present the Board with a thematic review of performance across a selected set of indicators over the past 24 months. The analysis includes Statistical Process Control (SPC) charts, illustrating trends and variation in performance against established upper and lower control limits.

Reporting Month:
Apr-26

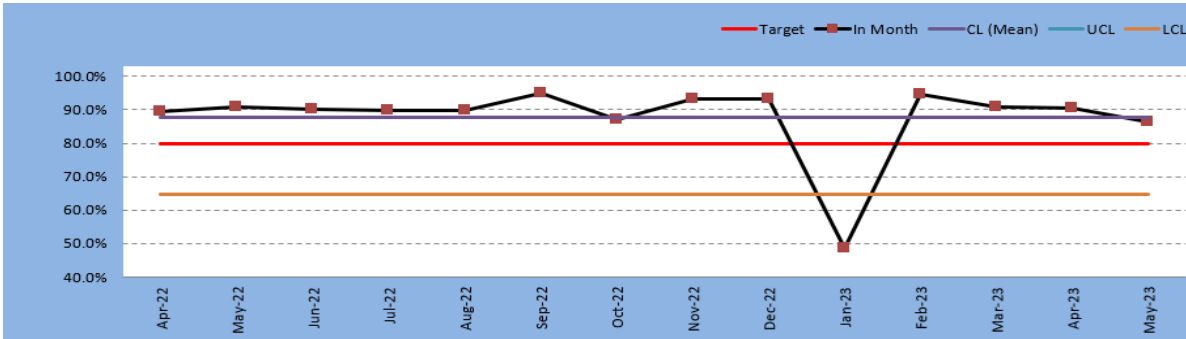
Chief Executive: Michele Moran
Prepared by: Business Intelligence Team

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending:

April 2026

Purpose	This paper provides a summary on the progress being made against a basket of NHS performance indicators together with executive summary and underpin the Trust's Strategy 2017-2022. A sample of the strategic goals are represented in this report. Particular attention is drawn to the use of Statistical Process Control Charts (SPC).																																																																																													
What are SPCs?	SPCs contain upper and lower control limits which are in the most part based on 2 standard deviation points above and below the average. SPC averages are best plotted over a minimum of 12 data points. The majority of charts, if not all, within the TPR are based over 24 data points and include targets where these have been set. The charts can help us understand the scale of any problem, gather information and identify possible causes when used in conjunction with other investigative tools such as process mapping. SPC tells us about the variation that exists in the systems that we are looking to improve. SPCs should be used to help to set baselines and evaluate how we are currently operating within these thresholds. They can also help us to assess whether service changes have made a sustainable difference. They give an indication as to whether there is relatively stable variation over time or whether there are special causes creating exceptional variance. This is done by analysing the chart looking at how the values fall around the average and between or outside the Upper Control Limit (UCL) and the Lower Control Limit (LCL). These lines fall either side of the mean/average. They do not indicate whether the indicator is achieving the target that has been set, but they allow us to better understand how stable the performance is and whether or not it is changing. Attention would be specifically drawn to peaks and troughs outside of the control limits and initiate further investigation as to what the causes of these may be. SPCs are not always useful with low numbers, short periods of time or where data would normally be expected to be more erratic or seasonal unless this is plotted over a substantial amount of time. An example of an SPC chart with an exception is below:																																																																																													
Example SPC Chart	S – statistical, because we use some statistical concepts to help us understand processes. P – process, because we deliver our work through processes ie how we do things. C – control, by this we mean predictable.	 <table><caption>Approximate data points from the Example SPC Chart</caption><thead><tr><th>Month</th><th>In Month (%)</th><th>Target (%)</th><th>CL (Mean) (%)</th><th>UCL (%)</th><th>LCL (%)</th></tr></thead><tbody><tr><td>Apr-22</td><td>90.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>May-22</td><td>92.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Jun-22</td><td>91.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Jul-22</td><td>90.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Aug-22</td><td>91.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Sep-22</td><td>95.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Oct-22</td><td>88.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Nov-22</td><td>92.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Dec-22</td><td>92.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Jan-23</td><td>50.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Feb-23</td><td>95.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Mar-23</td><td>91.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>Apr-23</td><td>90.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr><tr><td>May-23</td><td>88.0</td><td>80.0</td><td>88.0</td><td>92.0</td><td>65.0</td></tr></tbody></table>			Month	In Month (%)	Target (%)	CL (Mean) (%)	UCL (%)	LCL (%)	Apr-22	90.0	80.0	88.0	92.0	65.0	May-22	92.0	80.0	88.0	92.0	65.0	Jun-22	91.0	80.0	88.0	92.0	65.0	Jul-22	90.0	80.0	88.0	92.0	65.0	Aug-22	91.0	80.0	88.0	92.0	65.0	Sep-22	95.0	80.0	88.0	92.0	65.0	Oct-22	88.0	80.0	88.0	92.0	65.0	Nov-22	92.0	80.0	88.0	92.0	65.0	Dec-22	92.0	80.0	88.0	92.0	65.0	Jan-23	50.0	80.0	88.0	92.0	65.0	Feb-23	95.0	80.0	88.0	92.0	65.0	Mar-23	91.0	80.0	88.0	92.0	65.0	Apr-23	90.0	80.0	88.0	92.0	65.0	May-23	88.0	80.0	88.0	92.0	65.0
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Strategic Goal 1	Innovating Quality and Patient Safety		Strategic Goal 4	Developing an effective and empowered workforce																																																																																										
Strategic Goal 2	Enhancing prevention, wellbeing and recovery		Strategic Goal 5	Maximising an efficient and sustainable organisation																																																																																										
Strategic Goal 3	Fostering integration, partnership and alliances		Strategic Goal 6	Promoting people, communities and social values																																																																																										
Key Indicators	The following is a list of indicators highlighted within this report and the Goal to which they are set against. Other than the Safer Staffing dashboard, each indicator uses SPC charts																																																																																													

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending:

April 2026

Dashboard	Safer Staffing	A dashboard to provide overview on a number of clinical indicators for the Trust's inpatient units across all services	Quality
Dashboard	Mortality	Learning from Patient Deaths as required under the Patient Safety Incident Response Framework	Quality
Goal 1	Incidents per 10,000 Contacts	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Quality
Goal 2	72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from Inpatient hospitals	ODG
Goal 2	CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months	ODG
Goal 2	52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks. (Excludes ASD & ADHD Services for both Adult and Paediatrics)	ODG
Goal 2	52 Week Waits - Adult (18+) ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Adults (18+) and have been waiting more than 52 weeks	ODG
Goal 2	52 Week Waits - Paediatric ASD/ADHD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service and ADHD for Children and have been waiting more than 52 weeks	ODG
Goal 2	MH Urgent Response	New Urgent Referrals to Crisis Care teams in the reporting period with first face to face contact within 24 hours of referral	ODG
Goal 2	CYP_4WW_StoppedClocks	CYPMH - Proportion of Children and Young people referral-spells that have had a full meaningful help clock stop within four weeks.	ODG
Goal 2	ADULT_4WW_StoppedClocks	Adult CMH - Proportion of Adult referral-spells that have had a full meaningful help clock stop within four weeks.	ODG
Goal 2	CYP MH 104WW	CYP MH - number of referral-spells that are waiting a full meaningful help clock stop	ODG
Goal 2	Community Waiting list over 52 weeks	Community Services (Adult and CYP) - Number of patients who have yet to be seen for care and have been waiting more than 52 weeks.	ODG
Goal 2	Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	ODG
Goal 2	NHSER Talking Therapies - 6 and 18 week waits	Percentage of patients who were seen within 6 weeks and 18 weeks of referral	ODG
Goal 2	NHSER Talking Therapies - Moving to Recovery	Recovery Rates for patients who were at caseness at start of therapeutic intervention	ODG
Goal 2	CMHT Access	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illness. Rolling 12 months.	ODG
Goal 2	CYP MH Access	Number of CYP aged under 18 accessing support by NHS funded community services and school or college based Mental Health Support Teams (receiving at least one contact). Rolling 12 months. <i>Includes Neuro Services, no team types are excluded.</i>	ODG

Humber Teaching NHS Foundation Trust

Trust Performance Report

For the period ending:

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Goal 2	Perinatal Access	Number of women with at least one attended contact (F2F or video) with a specialist community perinatal mental health service in the last 12 months.	ODG
Goal 2	IPS Access	Number of referrals that accessed Individual Placement Support (IPS) - rolling 12 months	ODG
Goal 2	MHST Access	Number of referrals that accessed MHST - rolling 12 months	ODG
Goal 2	Liaison 1 hour response	New referrals to liaison psychiatry teams from A&E in the reporting period with first face to face contact within 1 hour	ODG
Goal 2	UCR 2 hr response	The percentage of 2-hour Urgent Crisis Response (UCR) referrals that achieved the 2-hour standard in the reporting month	ODG
Goal 2	Virtual Ward	Virtual Ward Bed Occupancy Rate	ODG
Goal 3	Out of Area Placements	Number of days that Trust patients were placed in out of area wards including split across Adult, Older Adult and PICU	ODG
Goal 4	Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care	ODG
Goal 1	Mandatory Training	A percentage compliance based on an overall target of 85% for all mandatory and statutory courses	People & OD
Goal 1	Vacancies (WTE)	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.	People & OD
Goal 1	Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	People & OD
Goal 4	Sickness Absence	Percentage of staff sickness across the Trust (not including bank staff)	People & OD
Goal 4	Staff Turnover	Percentage of leavers against staff in post (excluding employee transfers)	People & OD

Quality Committee

Positive Assurances to Provide:

- Trust wide patient safety indicators remain strong, with harm-free care at 99.6% in April 2026, indicating consistently high levels of safe care delivery.
- Safer staffing reviews confirm that staffing levels continue to meet required safe staffing establishments across inpatient services, with CHPPD remaining in a strong position across most wards. A number of units have had a reduction in sickness red flags compared to Q3
- Clinical supervision compliance is generally positive, with most areas achieving or maintaining performance above the Trust target, supporting safe clinical practice and oversight.

Matters of Concern or Key Risks to Escalate:

- Trust-wide safer staffing reviews completed in May, including detailed review of all key quality and patient safety metrics.

Key Actions Commissioned/Work Underway:

- BLS/ ILS below trust trajectory due to absence in the training team. Recovery plan in place and compliance will be achieved by the end of June 26.

Decisions Made:

- Trust Board are asked to note the current performance as at the end of April and that work is taking place via Executive Management Team to further refine the performance report which comes to Trust Board.

PI RETURN FORM 2026-27

Safer Staffing Inpatient Dashboard

For the period ending: March 2026



KEY	Units					Bank / Agency Hours		Average Safer Staffing Fill Rates						High Level Indicators																Indicator																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																														
	Ward	Speciality	WTE	OBDe (Inc Leave)	CHPPD Hours (Registered)	Bank % Filled	Agency % Filled	Day		Night		Current Month				YTD				Clinical Supervision	Mandatory Training (ALL)	Mandatory Training (ILS)	Mandatory Training (BLS)	Sickness Levels (Clinical)	WTE Vacancies (RN Only)	Feb-26	Mar-26																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																	
								Registered	Unregistered	Registered	Unregistered	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Aggression	Complaints (Upheld / Partly upheld)	Failed S17 Leave	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Aggression	Complaints (Upheld / Partly upheld)	Failed S17 Leave																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
Adult MH	Avondale	Adult MH Assessment	27.8	✓ 58%	✓ 14.4	26.6%	2.3%	✓ 94%	✓ 99%	✓ 97%	✓ 103%	0	14	0	0	1	83	2	0	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.7%	✗ 68.8%	✗ 5.7%	3.0	✓ 1	78.6%	✓ 93.2%	✓ 91.

PI RETURN FORM 2026-27

Safer Staffing Inpatient Dashboard

For the period ending: March 2026



Humber Teaching
NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : March

There are 11 units flagging red for sickness in March which continues to improve when compared to the overall position in Q3 and down from 15 in January, and 12 in February. The number of units with a sickness rate above 10% was 4 in March, also an improved position when compared to Q3 and similar to January (n=3) and February (n=4).

Four units have sustained an average under the Trust target of 5% over the six month period Oct 25 – Mar 26 (Derwent, Swale, Ullswater, Pine View, and Malton).

11 units are now above the 85% target for ILS, up from 10 in February. Ullswater has continued to increase ILS compliance from 66.7% in January to 90.9% in March.

Westlands and Maister Lodge had fallen to 68.8% and 71.4% in February but have improved to 75% and 78.6% in March. Ouse had recovered ILS compliance to 90% in February however this is currently just under the target threshold at 80%. Two units are flagging red (under 75%) in March (Whitby and Pine View). Unexpected and unforeseen cancellation of BLS training sessions have impacted some compliance rates with 5 units under 75% (Avondale, Mill View Court, PICU, Townend Court and Whitby). ILS and BLS training compliance was reviewed as part of the safer staffing reviews in May, and work is on-going to address access to training via ESR, optimising training capacity, and delivery of training on site to improve accessibility.

Statutory/Mandatory training overall has continued to remain above the Trust target of 85% for all wards.

TEC had discrepancies within their planned versus actual hours and has now been addressed with the E-roster team. Staffing levels have remained at safer staffing requirements.

Whitby had 6 red flags in March, impacted by high OBDs, a nil return for clinical supervision, drop in ILS and BLS compliance and sickness above 5%.

CHPPD remains in a strong position across the majority of inpatient wards. Malton are consistently under target however following the recent safer staffing reviews it was noted that the shift pattern supports safer staffing requirements. Due to a number of HCA vacancies, RNs are at times used to backfill HCA shortages. Two HCAs have been recruited and are due to commence.

10 units achieved above 85% for clinical supervision in March, similar to previous months. There were 2 nil returns noted in March for Townend Court and Whitby ward.

All Safer Staffing reviews have taken place in May, and areas of challenge or low compliance have been addressed with senior leadership teams.

The CHPPD RAG ratings are following discussions with and agreed by EMT in Nov 2022. Breakdowns are as follows:

Red RAG falls below the lowest rating, Green RAG is greater than the highest rating. Amber RAG falls between

Red Rag	Green Rag	Units Applied
<=5.3	>=6.3	Pine view, Ouse
<=7	>=8	New Bridges, Westlands, Mill View Court, Swale, Whitby, Malton
<=8	>=9	Avondale
<=9.3	>=10.3	Maister Lodge, Maister Court, Derwent, Inspire, Granville
<=10.5	>=11.5	Mill View Lodge
<=11.0	>=12.0	Ullswater
<=15.6	>=16.6	PICU
<=27.0	>=28.0	Townend Court

Slips/Trips and Falls (Rolling 3 Months)			
	Jan-26	Feb-26	Mar-26
Maister Lodge	2	7	7
Millview Lodge	0	1	1
Malton IPU	1	3	1
Whitby IPU	2	2	2

Registered Nurse Vacancy Rates (Rolling 12 months)											
Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
5.2%	4.8%	7.6%	8.6%	10.0%	11.2%	11.8%	4.1%	4.3%	4.3%	4.0%	4.5%

PI RETURN FORM 2026-27

Safer Staffing Community Dashboard

For the period ending: March 2026



Humber Teaching
NHS Foundation Trust

		Workforce Indicators						Quality Indicators						Trend	
	Team	Speciality	WTE in post	Vacancies (WTE)	Sickness	Bank Spend £	Agency Spend £	Mandatory Training	Clinical Supervision	Friends & Family Responses	Friends & Family %	Serious Incidents	Complaints (Upheld / Partly upheld)	Feb-26	Mar-26
Adult MH Services	Mental Health Response Service	Adult Crisis	59.6	13.6%	✓ 3.4%	£43,094	£0	✓ 91.9%	⚠ 80.6%	3	✓ 100.0%	0	0	⚠ 2	✓ 0
	Hull Mental Health Team	Hull Adult MHT	25.2	33.1%	✗ 6.4%	£6,519	£11,582	✓ 85.5%	✗ 61.3%	1	✓ 100.0%	0	0	✓ 1	⚠ 2
	Beverley Mental Health Team	ER Adult MHT	6.7	1.0%	✗ 8.0%	£0	£0	✓ 94.0%	✓ 100.0%	6	✓ 100.0%	0	0	✓ 1	✓ 1
	Goole Mental Health Team	ER Adult MHT	9.8	-5.0%	✓ 1.5%	£162	£0	✓ 94.5%	✓ 100.0%	6	✗ 66.7%	0	0	✓ 0	✓ 1
	Haltemprice Mental Health Team	ER Adult MHT	9.7	0.8%	✗ 9.6%	£0	£0	✓ 94.6%	✓ 100.0%	0	✗ NS	0	1	✓ 1	✓ 1
	Holderness Mental Health Team	ER Adult MHT	12.4	-4.9%	✓ 0.6%	£0	£0	✓ 94.6%	✓ 100.0%	1	✗ 0.0%	0	0	✓ 0	✓ 1
	Bridlington & Driffield MHT	ER Adult MHT	13.1	16.3%	✗ 5.3%	£667	£0	✓ 97.5%	✓ 100.0%	8	⚠ 87.5%	0	0	✓ 1	✓ 1
	STaRS Community	Rehab & LTC	21.1	14.9%	✗ 17.1%	£760	£0	✓ 89.6%	✗ 77.3%	2	✓ 100.0%	0	0	✓ 1	⚠ 2
Older People MH Services	Crisis Intervention Team for Older People (CITOP)	OP Crisis	27.2	12.3%	✓ 3.2%	£8,379	£0	✓ 93.5%	✓ 100.0%	4	✓ 100.0%	0	0	✓ 0	✓ 0
	Hull Intensive Care Team for Older People (HICTOP)	Hull OP CMHT	21.7	11.0%	✗ 5.8%	£0	£0	✓ 98.3%	✓ 96.2%	9	⚠ 88.9%	0	0	✓ 0	✓ 1
	Beverley and Haltemprice OP CMHT	ER OP CMHT	8.4	3.8%	✓ 1.3%	£0	£0	✓ 99.5%	✓ 100.0%	7	✓ 100.0%	0	0	✓ 0	✓ 0
	Bridlington & Driffield OP CMHT	ER OP CMHT	6.4	21.2%	✓ 2.7%	£648	£0	✓ 98.8%	✓ 100.0%	8	✓ 100.0%	0	0	✓ 1	✓ 0
	Goole & Pocklington OP CMHT	ER OP CMHT	5.0	25.5%	✓ 2.4%	£0	£0	✓ 98.3%	✓ 100.0%	4	✓ 100.0%	0	0	✓ 0	✓ 0
	Holderness OP Community Team	ER OP CMHT	3.9	26.2%	✓ 4.0%	£0	£0	✓ 98.5%	✓ 100.0%	6	⚠ 83.3%	0	0	✓ 1	✓ 0
Universal	Early Intervention in Psychosis	14-65 MHT	31.1	-12.1%	✓ 1.3%	£0	£0	✓ 90.8%	✓ 93.3%	2	✓ 100.0%	0	0	✓ 0	✓ 0
	Hospital Mental Health Team	Liaison Services	34.9	13.7%	✗ 11.9%	£10,003	£18,551	✓ 96.2%	✓ 90.9%	3	✓ 100.0%	0	0	⚠ 2	✓ 1
Community Services	Ryedale Team	Comm Services	21.2	-2.9%	⚠ 5.2%	£913	£0	⚠ 82.4%	✓ 89.3%	0	✗ NS	0	0	✓ 0	✓ 0
	Scarborough Hub	Comm Services	63.7	9.3%	✗ 5.5%	£37,707	£0	✓ 89.4%	✓ 87.1%	2	✗ 50.0%	0	0	⚠ 2	⚠ 2
	Whitby Community Nurses	Comm Services	27.2	22.0%	✗ 12.7%	£2,281	£0	✓ 88.0%	✗ N/R	0	✗ NS	0	0	✓ 1	✓ 1
	Pocklington Nurses	Comm Services	16.6	14.9%	✗ 5.5%	£3,289	£0	⚠ 84.6%	✓ 100.0%	0	✗ NS	0	0	✓ 1	✓ 1

Points of Note :

Complaints - Zero figures indicate at least one complaint was made but not upheld. Figures above zero indicate these complaints were either Upheld or Partly Upheld. These incur a Red flag.

No returns for clinical supervision will incur a Red Flag

FFT % results based on the number of responses received with a satisfactory outcome

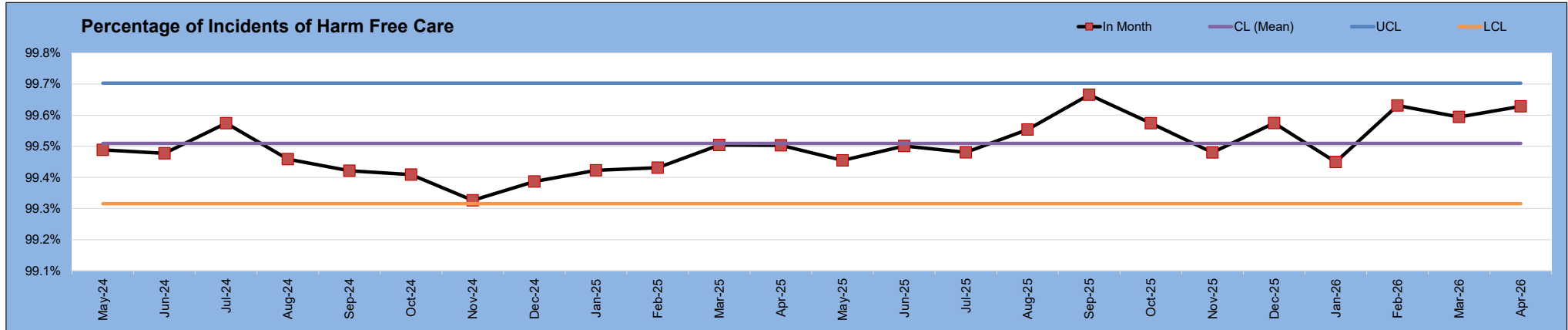
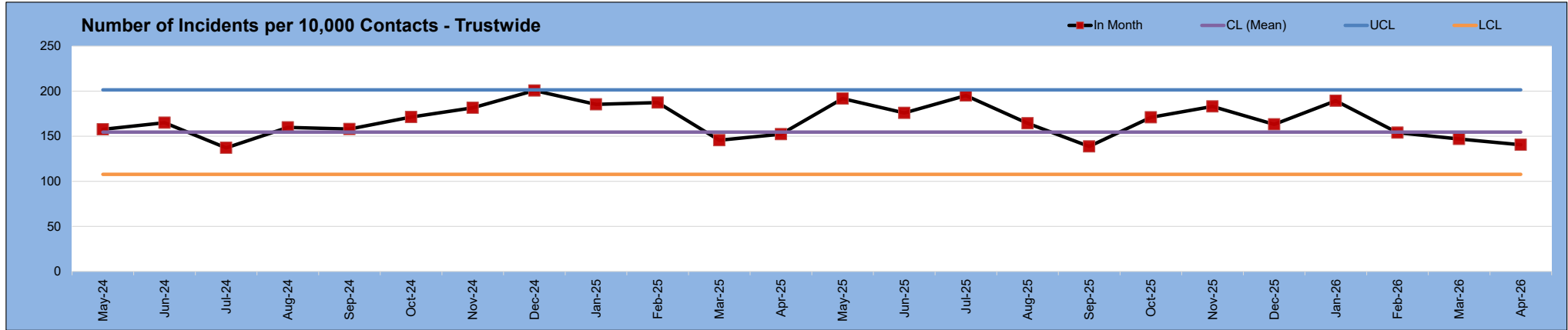
PI RETURN FORM 2026-27

Goal 1: Innovating Quality and Patient Safety

For the period ending: April 2026

	Number of Incidents	% Harm Free Care
Current month:	140	99.6%

Indicator Title	Description/Rationale	Executive Lead:
Incidents per 10,000 Contacts	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Sarah Smyth



PI RETURN FORM 2026-27

Goal 1: Innovating Quality and Patient Safety

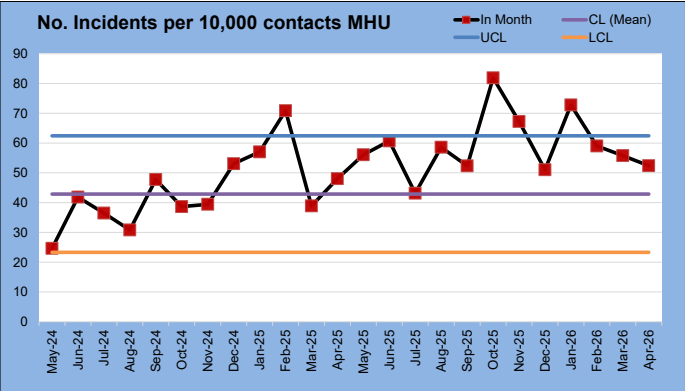
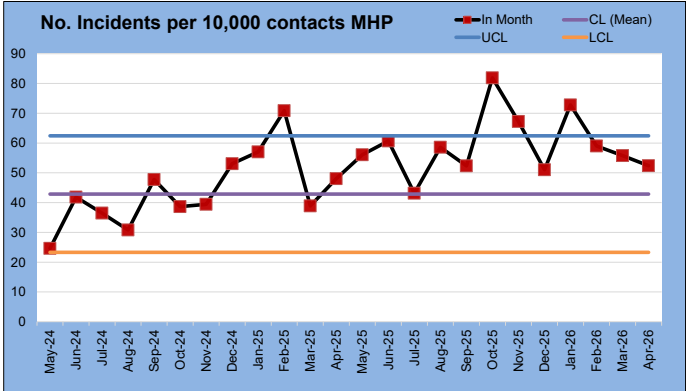
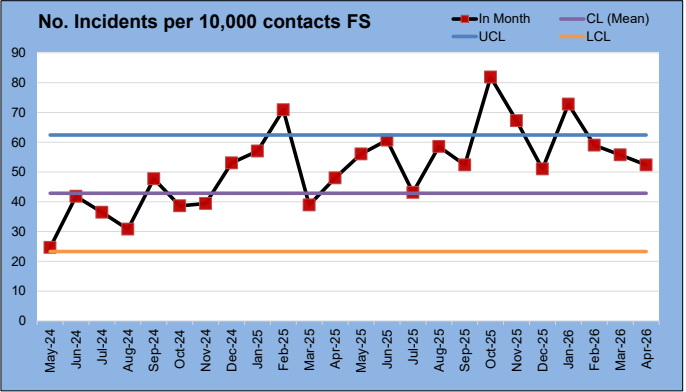
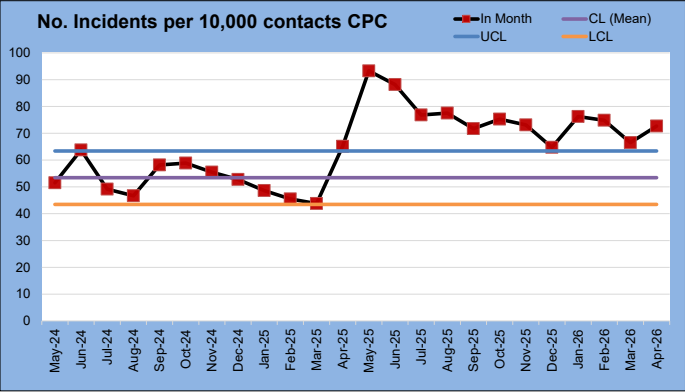
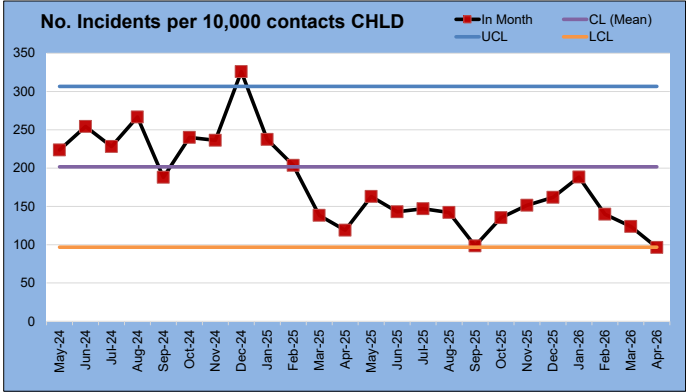
For the period ending:

April 2026

Trustwide
current month:

140

Indicator Title	Description/Rationale	Executive Lead:
Incidents by Division	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Sarah Smyth



Current Month per Division

Children & Learning Disability (CHLD)	96
Community & Primary Care (CPC)	73
Forensic Services (FS)	562
Mental Health Planned (MHP)	52
Mental Health Unplanned (MHU)	471

Incident Analysis

	Mar-26	Apr-26
Never Events	0	0
% of Harm Free Care	99.6%	99.6%
% Incidents reported in Severe Harm or Death	0.6%	0.5%

Operational Delivery Group Committee

Positive Assurances to Provide:

- >52wws for Chronic Fatigue Service have been adversely impacted by a medical staffing, this has recently been resolved and a new medic has commenced in post, the service have a focus on ensuring these longest waits are prioritised and now resolved.
- Mental Health Urgent Response (F2F) within 24hours. The performance position has continued to improve since August 25 though dipped slightly in April. A strong focus remains in this area with daily validation of the exception reports to ensure referrals have been correctly prioritised.
- Physical Health Community Waiting lists continue to maintain a zero >52ww position. Strong focus remains in this area across all services.
- EIP (Early Intervention in Psychosis) seen within 14days has achieved 100% performance since December 25.
- Talking Therapies Reliable Recovery is performing above of national and local targets.
- IPS (Individual Placement Support) access has shown month on month improvement from February to April.
- CAMHS 18 ww position is currently at 96% compliant
- MHST (Mental Health Support Teams) access continues to show month on month improvement.
- UCR (Urgent Community Response) 2 Hour Response – has consistently performed well though April saw a slight decline, data quality checks are being undertaken as operationally there is no change in service delivery to account for this.
- PICU/HDU (Psychiatric Intensive Care Unit and High Dependency) Unit) development underway for completion by Q3 to support the elimination of inappropriate Out of Area placements alongside other quality improvement benefits expected as a consequence of the change and reconfiguration of this service.
- Mental Health Adult and Older Adult Length of Stay continue to benchmark well nationally.

Key Actions Commissioned/Work Underway:

- ADHD Taskforce Implementation Group now in place, this is implementing a Hull and ERY system wide approach to assessing the recommendations made by the national taskforce. This work will have associated positive impacts for the ASD pathway..
- Adult and CYP 4ww %. PROMS (patient reported outcome measures) and CROMS (clinically reported outcome measures) workstream led by Clinical Director. Focus on embedding use of valid PROMS and CROMs which will support the 4ww standard.
- New proposal being developed for location of step-up older peoples beds to support elimination of inappropriate older peoples out of area placements.
- Further review and escalation of discharge delays for focussed improvement
- Review of PICU pathways, clinical and medical models nearing completion to support the elimination of PICU out of area placements.

Matters of Concern or Key Risks to Escalate:

- >52wws for Memory Assessment Service and are impacted by delays in access to imaging and reporting delays. .
- >52wws for children's ASD and ADHD continue to increase due to ongoing demand and capacity challenges. Work continues with the ICB to agree a sustainable solution to reducing waiting times and demand.
- >52wws for Adult Autism will continue to present as a result of CYP (Children and Young People) transitions. Excluding transitions, the waiting list and waiting times are reducing. The service is working closely with the children's service to streamline the transition process.
- Adult and CYP 104ww %. The focus remains on meeting the target outlined in the Medium-Term Plan submission (by the end of this financial year, the 104ww position will reduce and be met). The position currently stands at 743>104weeks. The PROM/CROM (patient reported outcome measures and clinically reported outcome measures) Task Group is established and patient level information is now available for the Divisions to improve outcome recording for these patient groups.
- Talking Therapies 18ww Standard, the service is working with increasingly complex patients to prevent referral to secondary services where this is appropriate. Further analysis of the current caseload is underway to understand the trend/impact and develop a reliable improvement trajectory.
- Perinatal Access, the service is required to increase access by approximately 100 new f2f/video contacts to achieve the 8.6% prevalence target. A number of initiatives are being examined further to address this. The service is also challenged by a 17% decrease in birthrate compared to the 2016 rate which the access target is currently predicated on.
- Liaison Psychiatry 1 hour response, following a period of significant improvement, April shows an in month decline due to very high demand which is usual seasonal variation, this is expected to recover in May.
- Local Authority delays for East Riding Older Adult Inpatients are increasing and are further impacted by no further funding for mental health liaison/inreach to Care Homes leading to risk of increased admissions.

Decisions Made:

- All performance metrics are closely monitored and reviewed by the Performance and Productivity Group, chaired by the Deputy Chief Operating Officer, which reports to the Organisational Delivery Group (ODG) and then to the Executive Management Team. Any metrics which are not meeting a performance requirement are supported by detailed improvement trajectories and plans. Capacity and demand analysis is applied to those services challenged by excessive waiting times and this is updated regularly. Performance requirements are a significant aspect of the quarterly Patient Care, Performance and Accountability Reviews and targeted support by the relevant executive directors is put in place where performance is not improving as required or expected.

PI RETURN FORM 2026-27

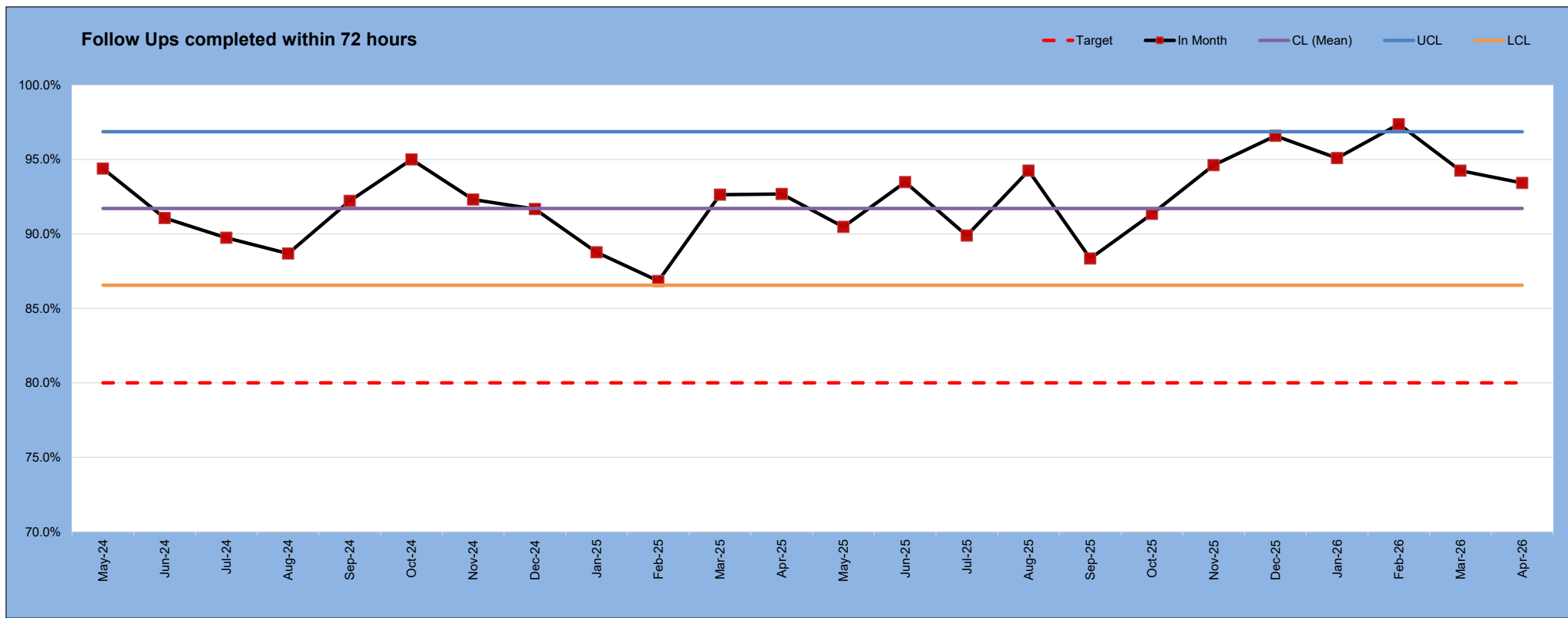
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

93.4%

Indicator Title	Description/Rationale	Executive Lead:
72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from Inpatient hospitals	Lynn Parkinson



PI RETURN FORM 2026-27

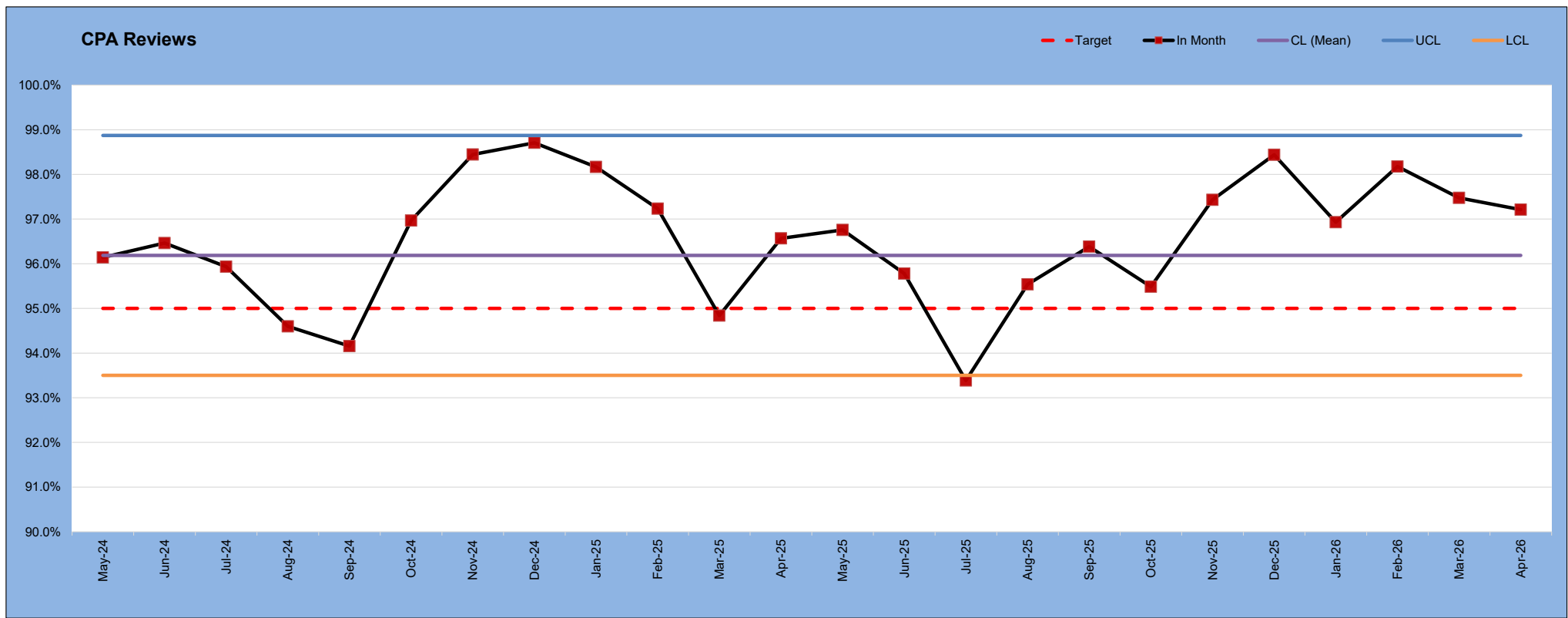
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

97.2%

Indicator Title	Description/Rationale	Executive Lead:
CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months	Lynn Parkinson



PI RETURN FORM 2026-27

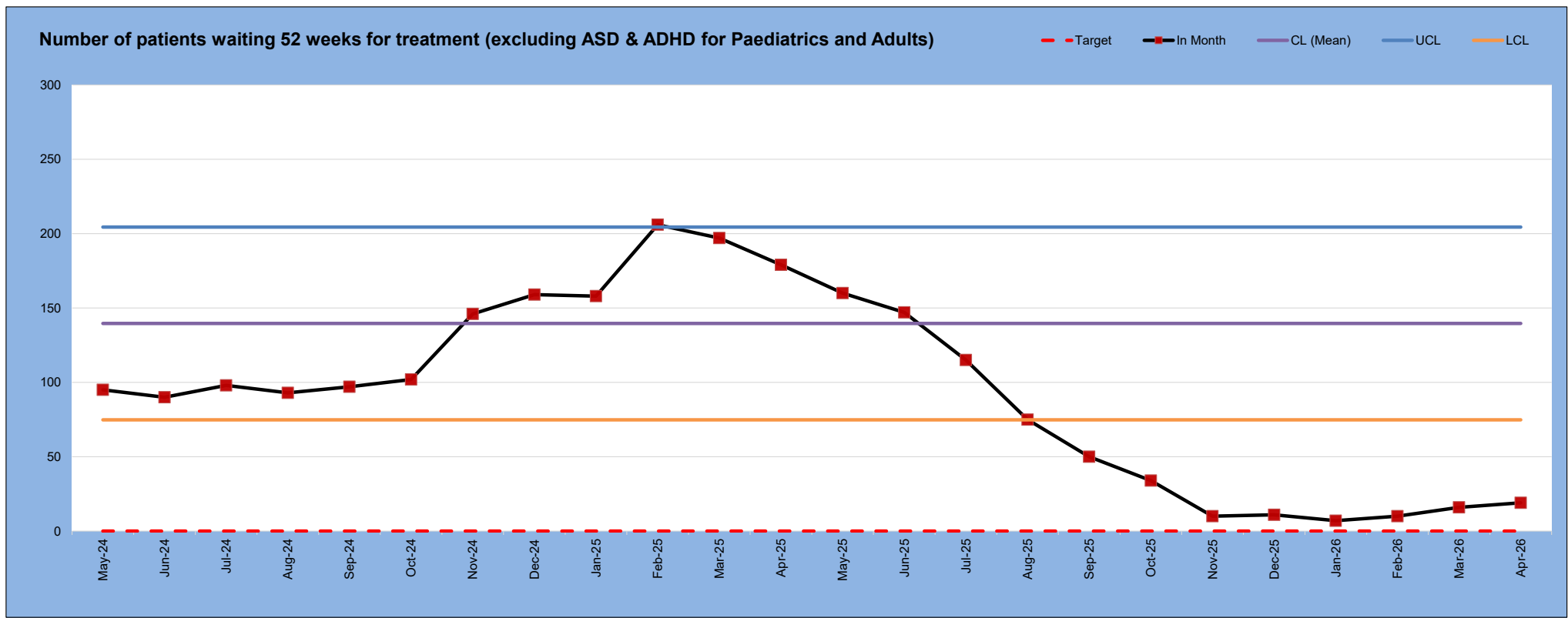
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

19

Indicator Title	Description/Rationale	Executive Lead:
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)	Lynn Parkinson



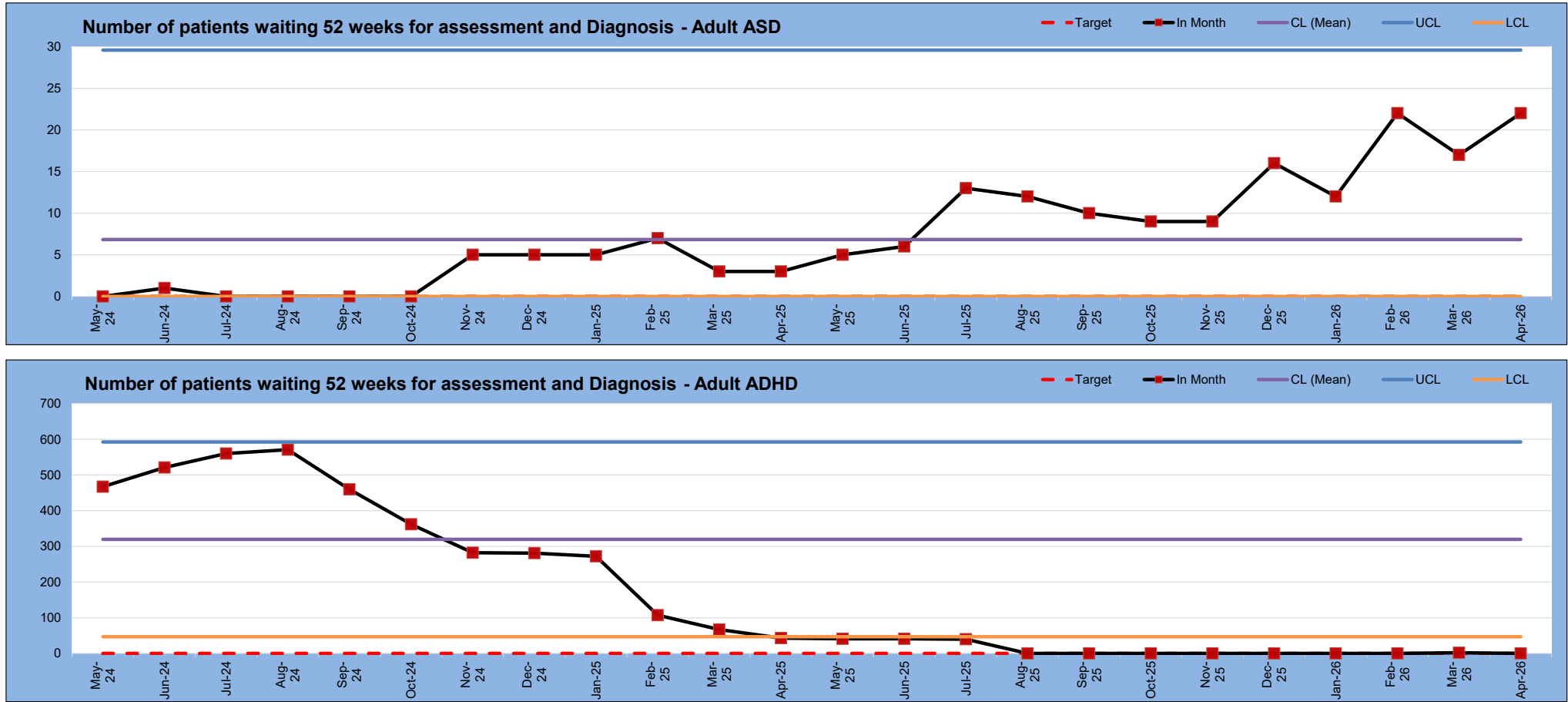
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

	Adult ASD	Adult ADHD
Current month:	22	0

Indicator Title	Description/Rationale	Executive Lead:
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	Lynn Parkinson



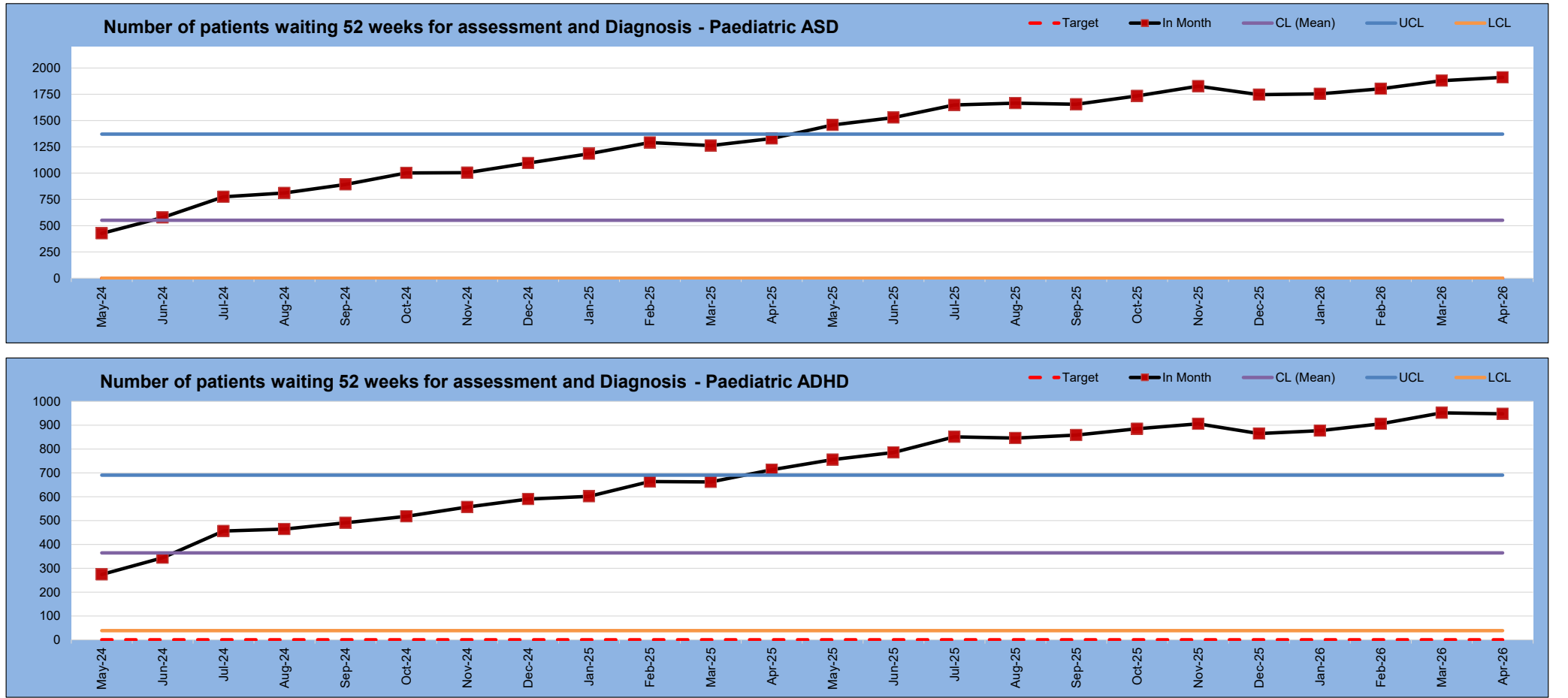
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

	Paediatric ASD	Paediatric ADHD
Current month:	1911	948

Indicator Title	Description/Rationale	Executive Lead:
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



PI RETURN FORM 2026-27

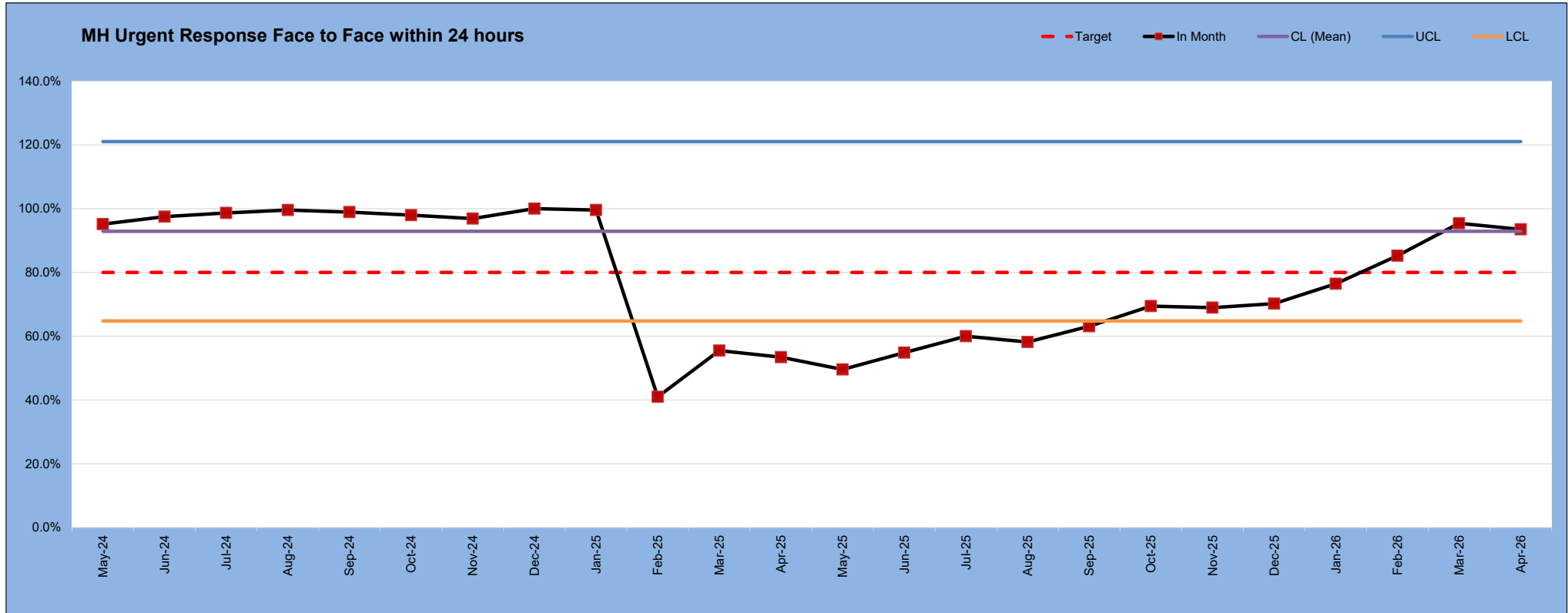
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

93.5%

Indicator Title	Description/Rationale	Executive Lead:
MH Urgent Response	New Urgent Referrals to Crisis Care teams in the reporting period with first face to face contact within 24 hours of referral	Lynn Parkinson



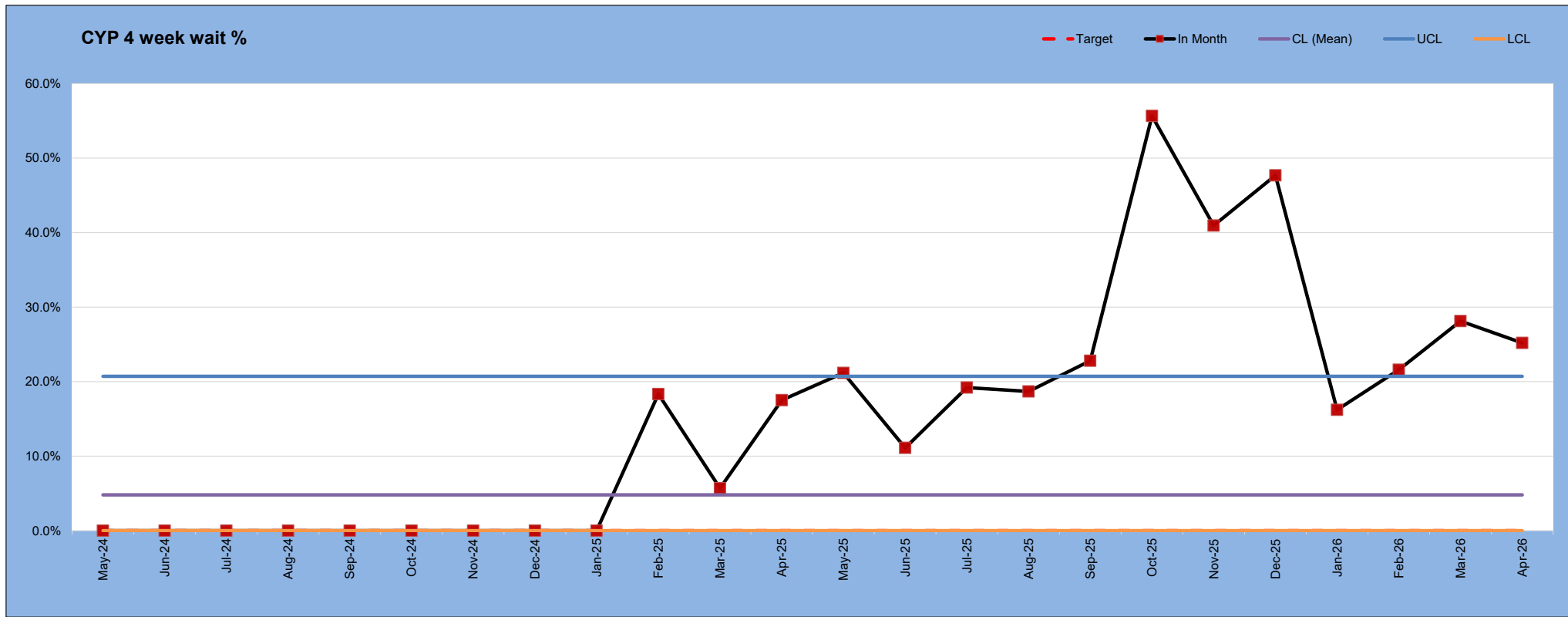
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:
25.2%

Indicator Title	Description/Rationale	Executive Lead:
CYP_4WW_StoppedClocks	CYPMH - Proportion of Children and Young people referral-spells that have had a full meaningful help clock stop within four weeks.	Lynn Parkinson



PI RETURN FORM 2026-27

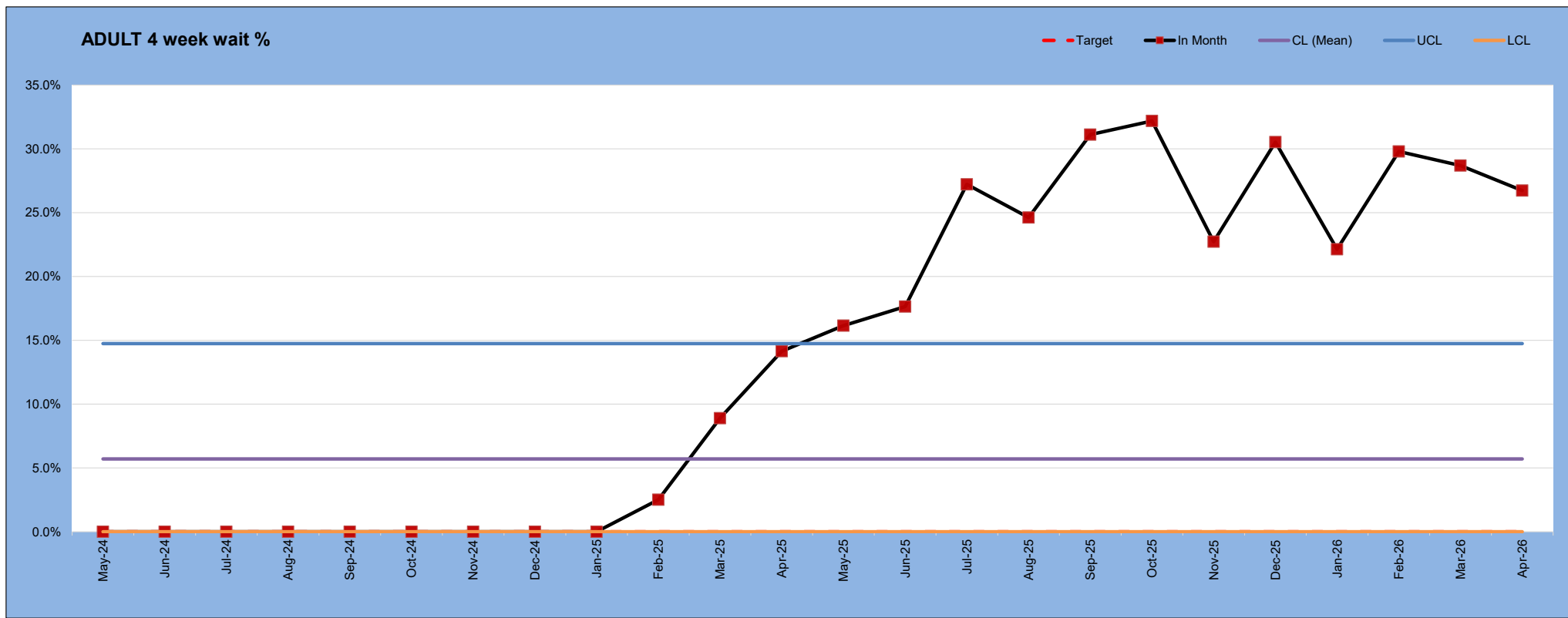
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

26.7%

Indicator Title	Description/Rationale	Executive Lead:
ADULT_4WW_StoppedClocks	Adult CMH - Proportion of Adult referral-spells that have had a full meaningful help clock stop within four weeks.	Lynn Parkinson



PI RETURN FORM 2026-27

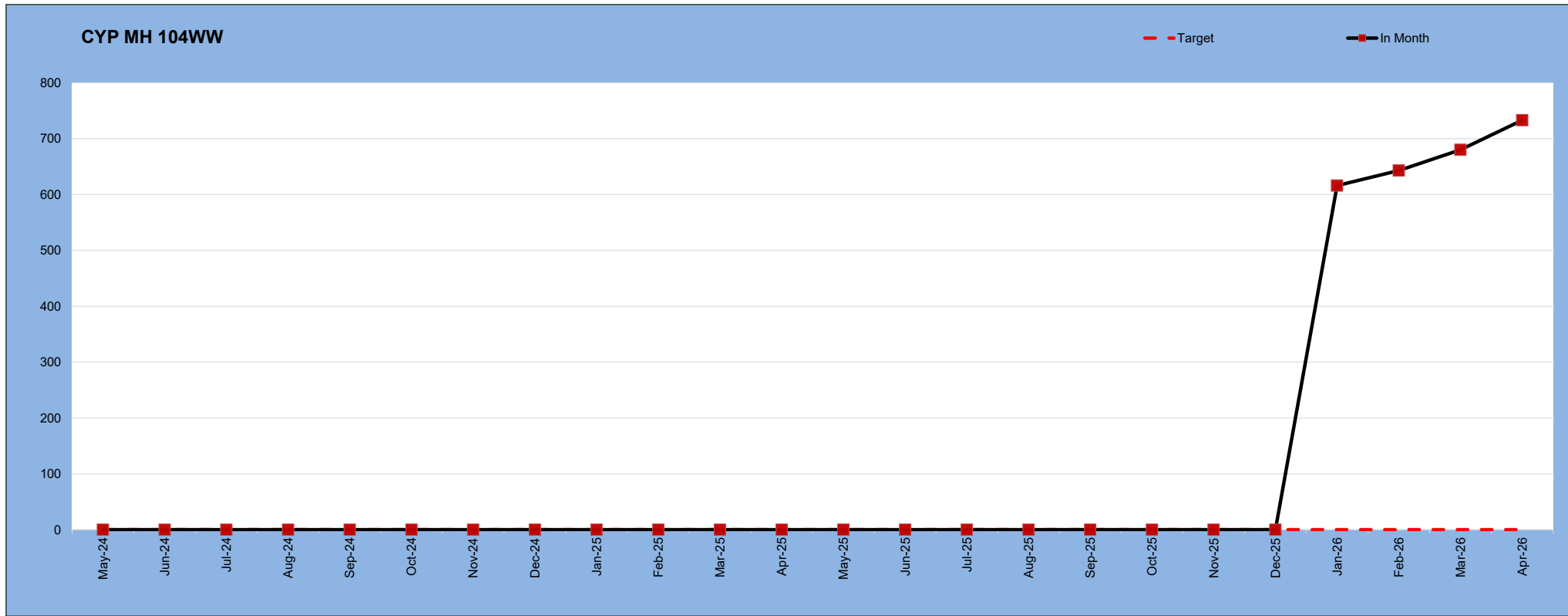
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

733

Indicator Title	Description/Rationale	Executive Lead:
CYP MH 104WW	CYP MH - number of referral-spells that are waiting a full meaningful help clock stop	Lynn Parkinson



PI RETURN FORM 2026-27

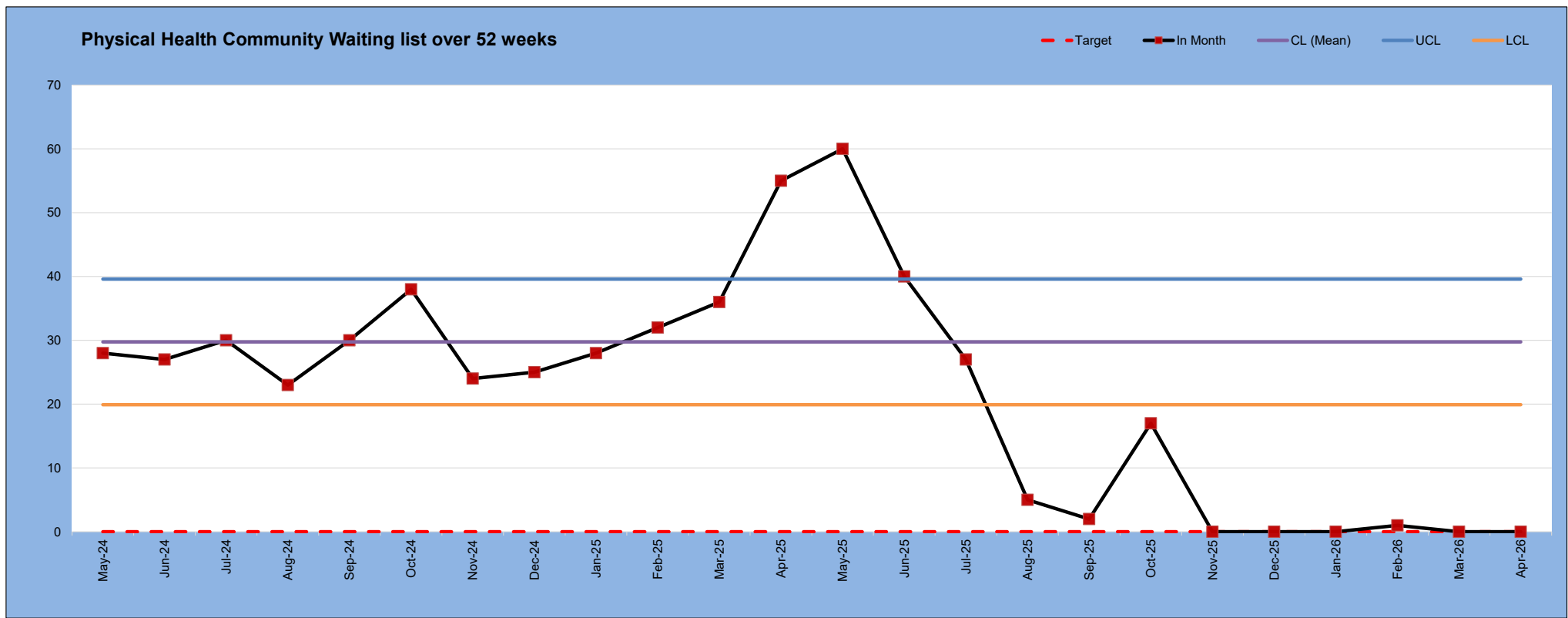
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

0

Indicator Title	Description/Rationale	Executive Lead: Lynn Parkinson
Community Waiting list over 52 weeks	Community Services (Adult and CYP) - Number of patients who have yet to be seen for care and have been waiting more than 52 weeks.	



PI RETURN FORM 2026-27

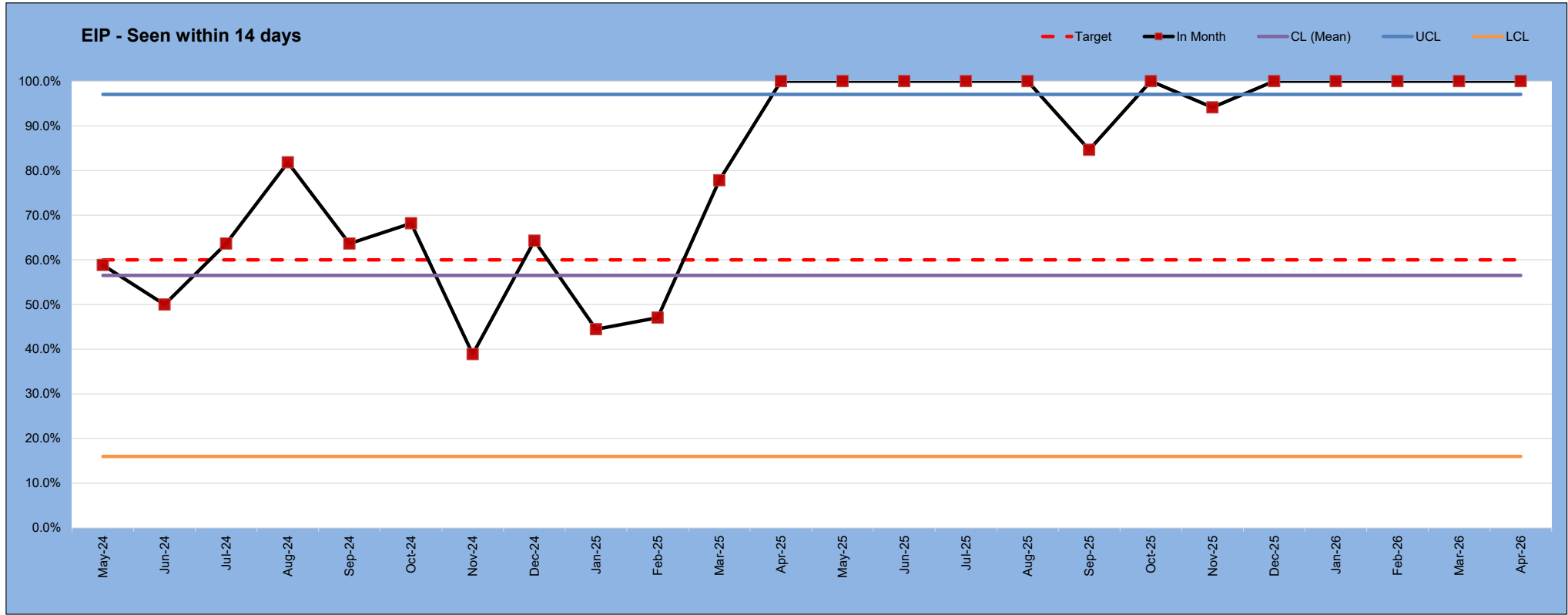
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

100.0%

Indicator Title	Description/Rationale	Executive Lead:
Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	Lynn Parkinson



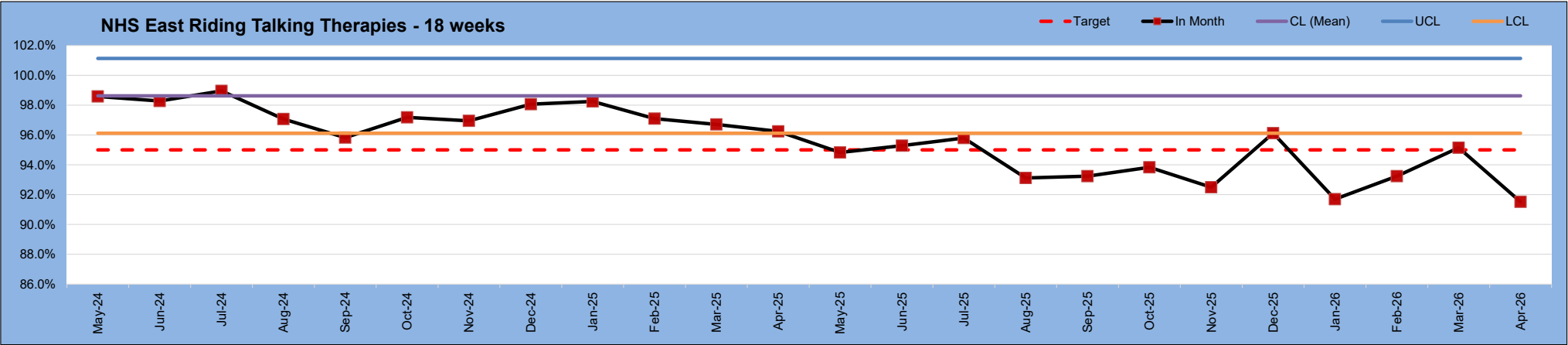
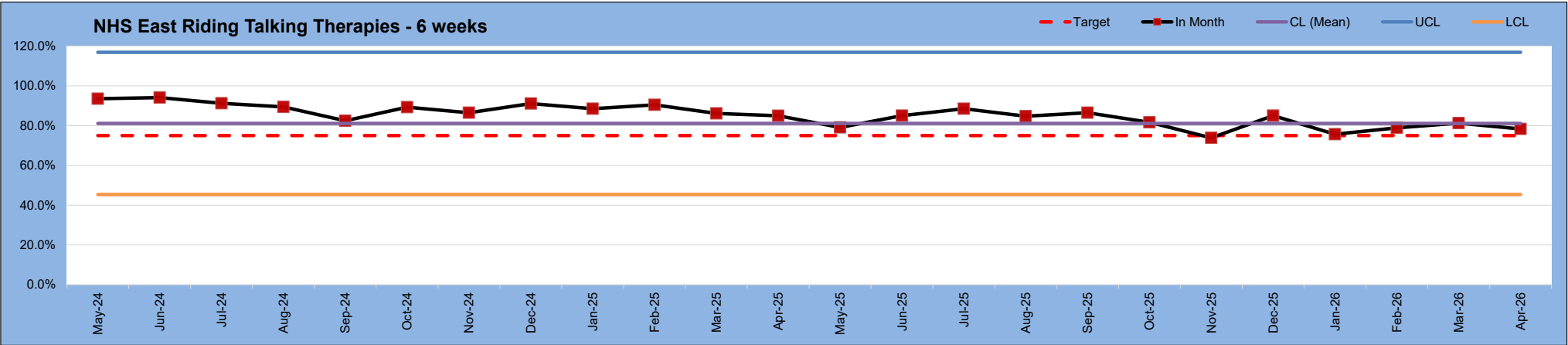
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

	6 week waits	18 week waits
Current month:	78.3%	91.5%

Indicator Title	Description/Rationale	Executive Lead:
NHSER Talking Therapies - 6 and 18 week waits	Percentage of patients who were seen within 6 weeks and 18 weeks of referral	Lynn Parkinson



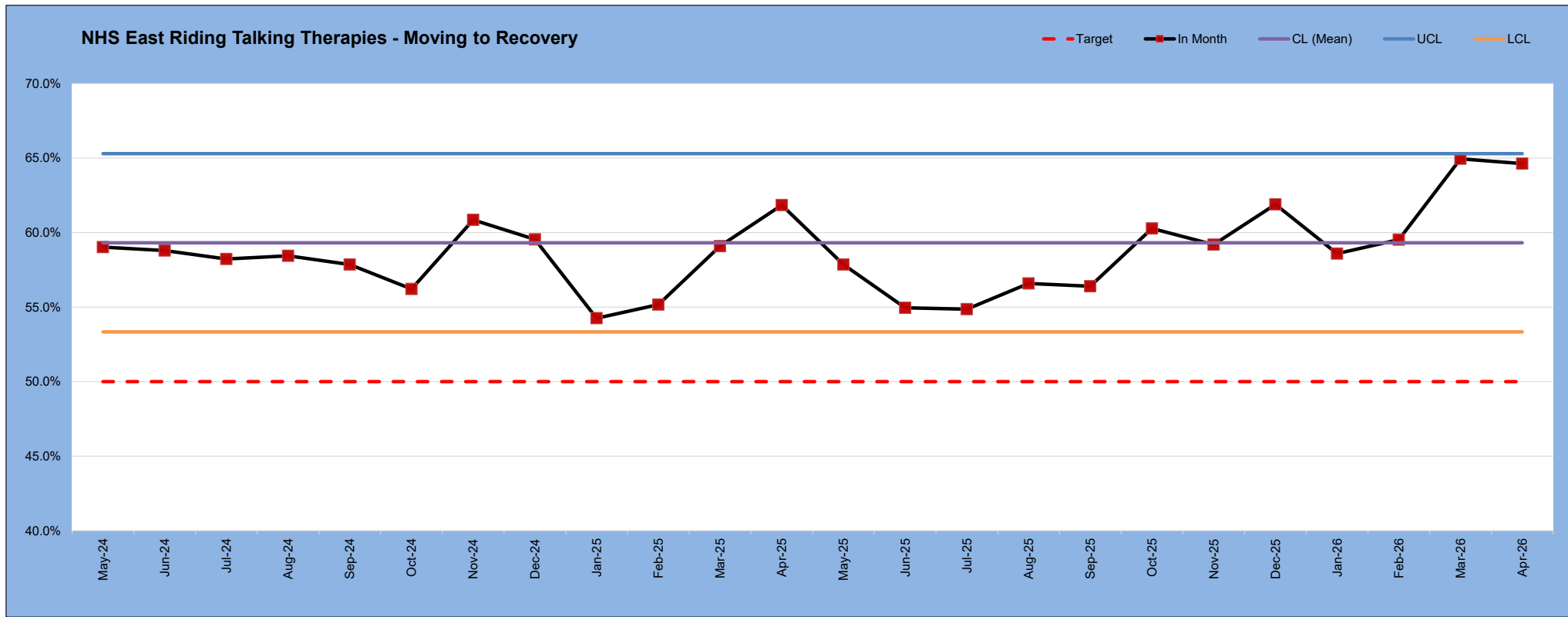
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:
64.6%

Indicator Title	Description/Rationale	Executive Lead:
NHSER Talking Therapies - Moving to Recovery	Recovery Rates for patients who were at caseness at start of therapeutic intervention	Lynn Parkinson



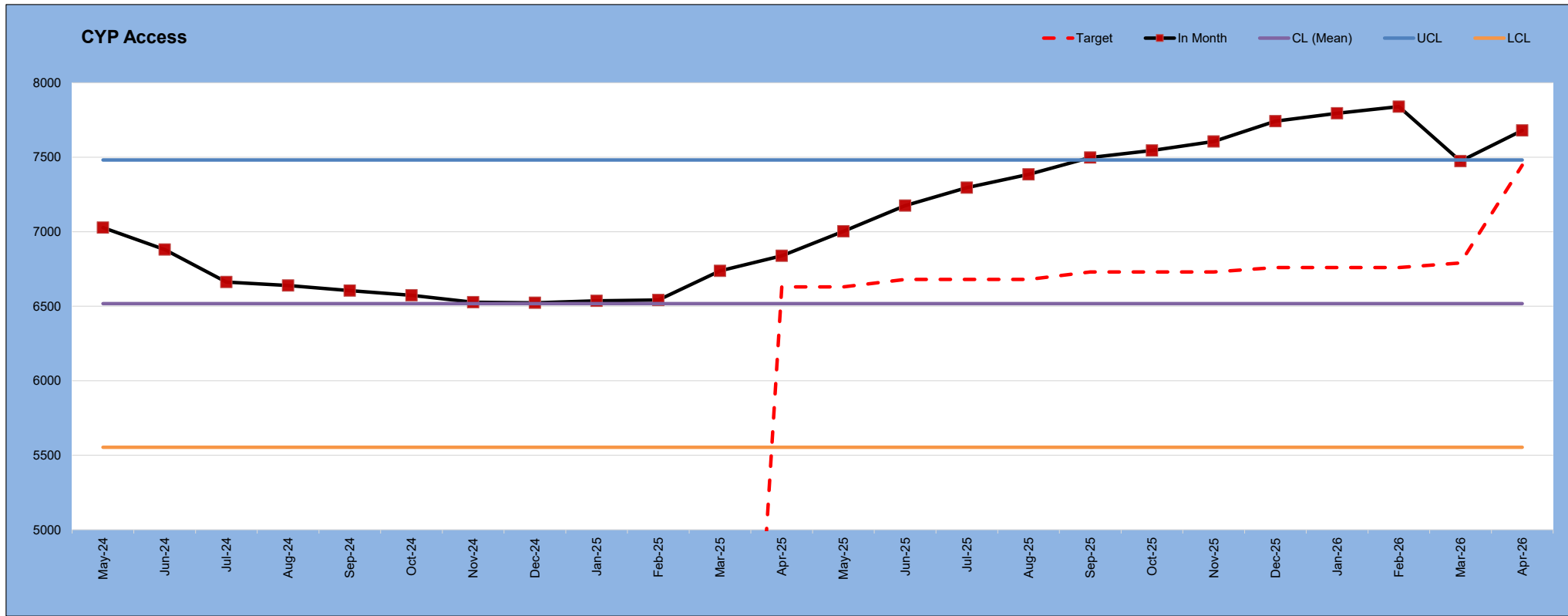
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:
7680

Indicator Title	Description/Rationale	Executive Lead:
CYP MH Access	Number of CYP aged under 18 accessing support by NHS funded community services and school or college based Mental Health Support Teams (receiving at least one contact). Rolling 12 months. Includes Neuro Services, no team types are excluded.	Lynn Parkinson



PI RETURN FORM 2026-27

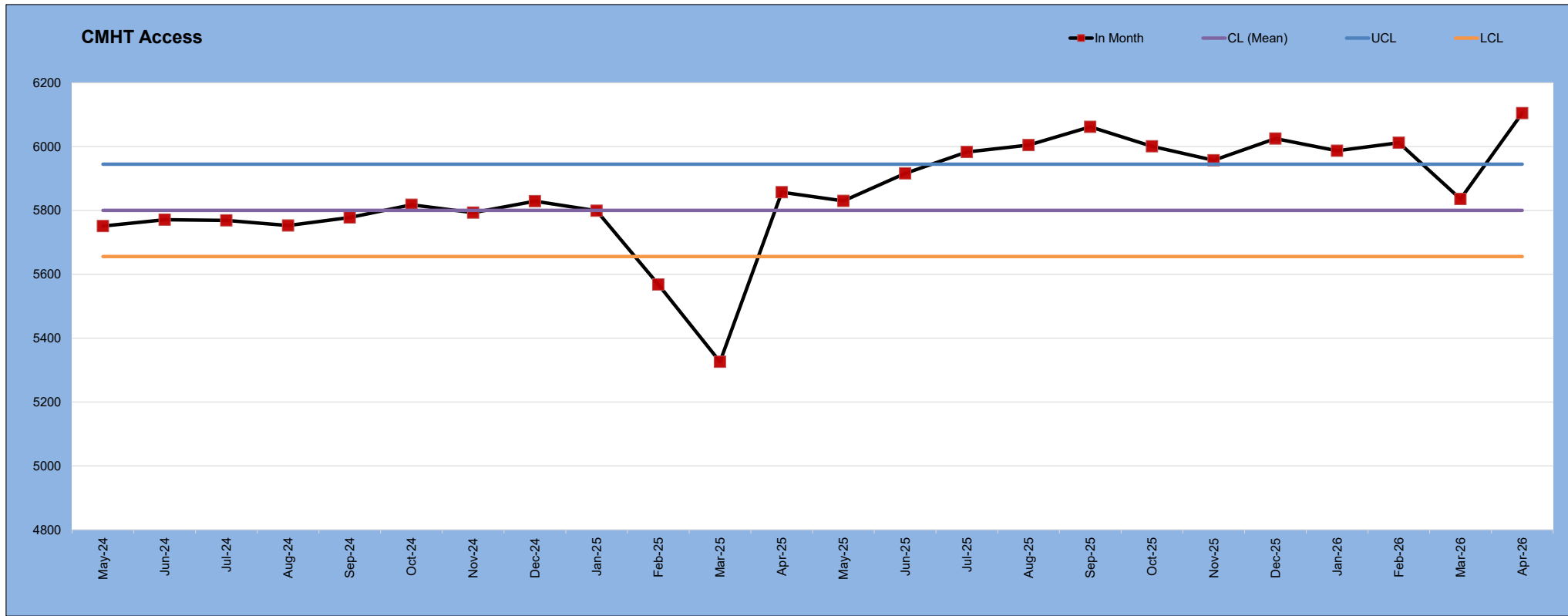
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

6105

Indicator Title	Description/Rationale	Executive Lead:
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.	Lynn Parkinson



PI RETURN FORM 2026-27

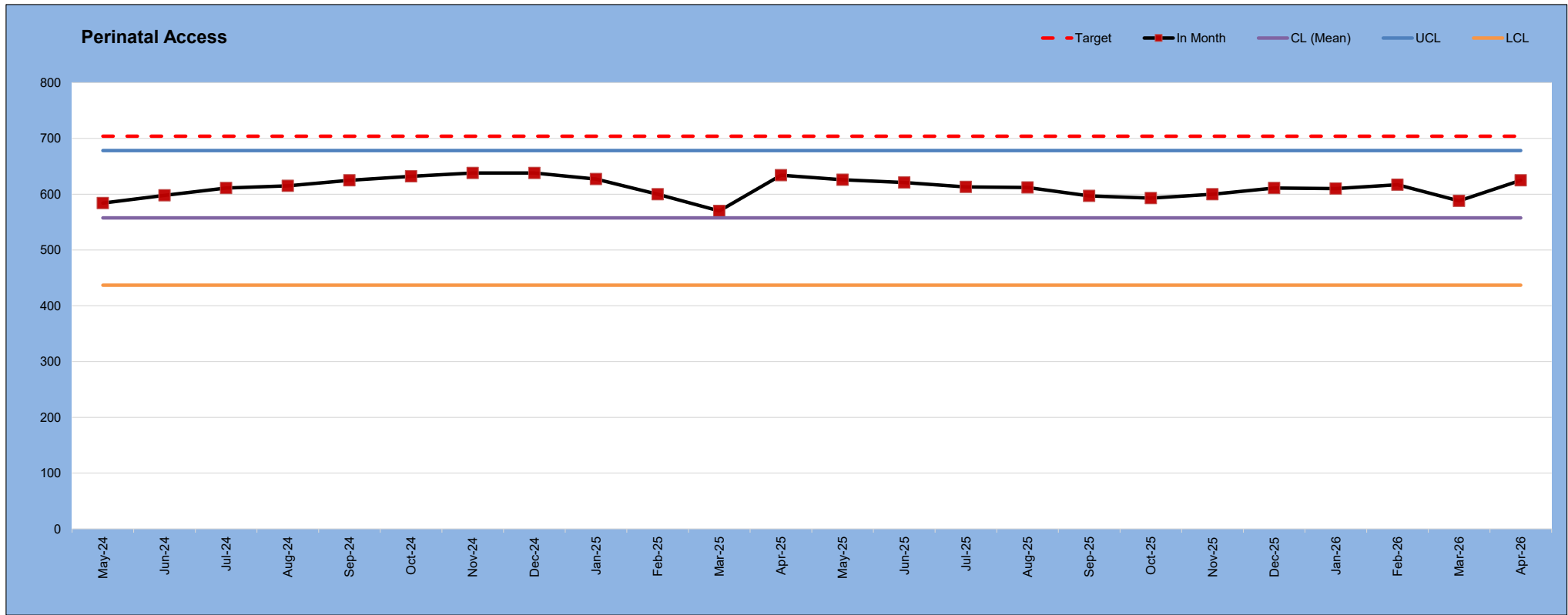
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

625

Indicator Title	Description/Rationale	Executive Lead:
Perinatal Access	Number of women with at least one attended contact (F2F or video) with a specialist community perinatal mental health service in the last 12 months.	Lynn Parkinson



PI RETURN FORM 2026-27

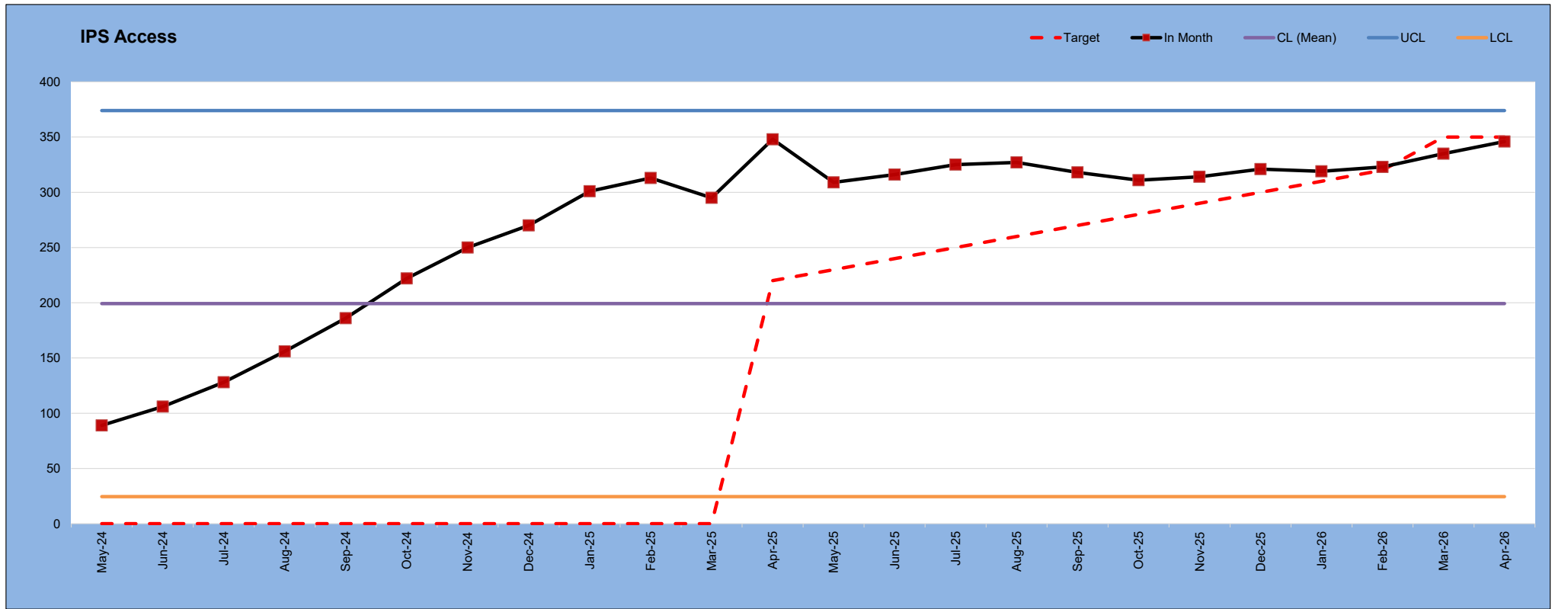
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

346

Indicator Title	Description/Rationale	Executive Lead:
IPS Access	Number of referrals that accessed Individual Placement Support (IPS) - rolling 12 months	Lynn Parkinson



PI RETURN FORM 2026-27

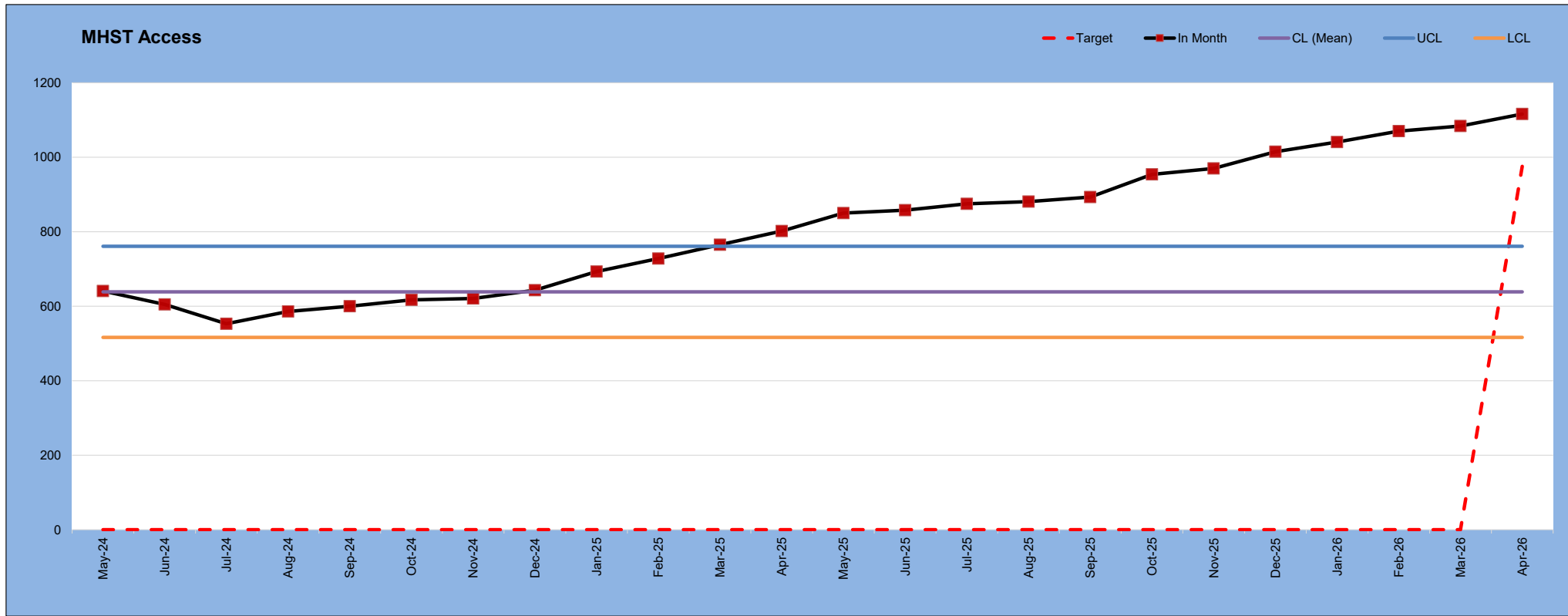
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

1116

Indicator Title	Description/Rationale	Executive Lead:
MHST Access	Number of referrals that accessed MHST - rolling 12 months	Lynn Parkinson



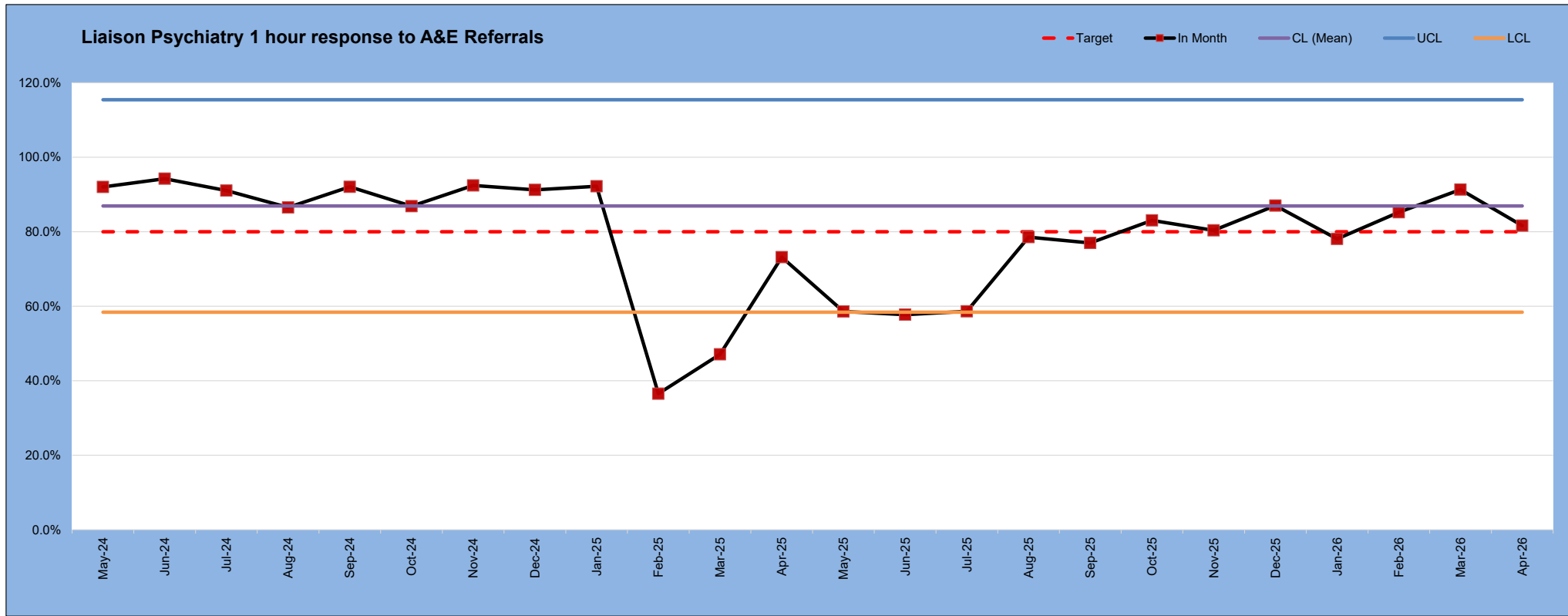
PI RETURN FORM 2026-27

Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:
81.6%

Indicator Title	Description/Rationale	Executive Lead:
Liaison 1 hour response	New referrals to liaison psychiatry teams from A&E in the reporting period with first face to face contact within 1 hour	Lynn Parkinson



PI RETURN FORM 2026-27

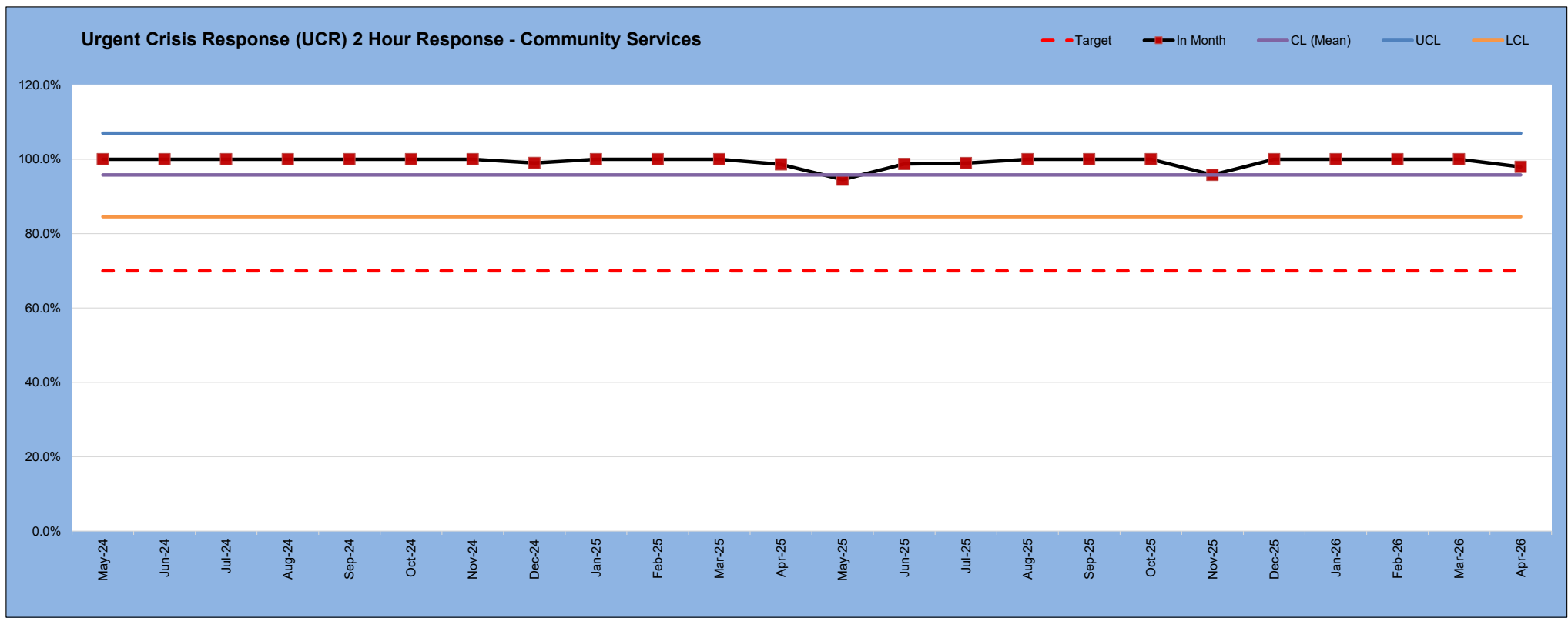
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

98.0%

Indicator Title	Description/Rationale	Executive Lead:
UCR 2 hr response	The percentage of 2-hour Urgent Crisis Response (UCR) referrals that achieved the 2-hour standard in the reporting month	Lynn Parkinson



PI RETURN FORM 2026-27

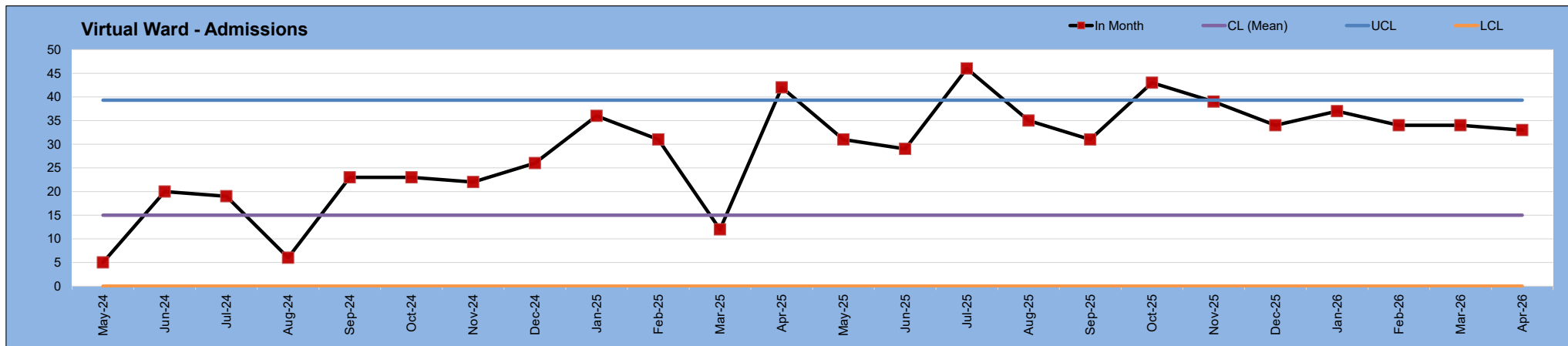
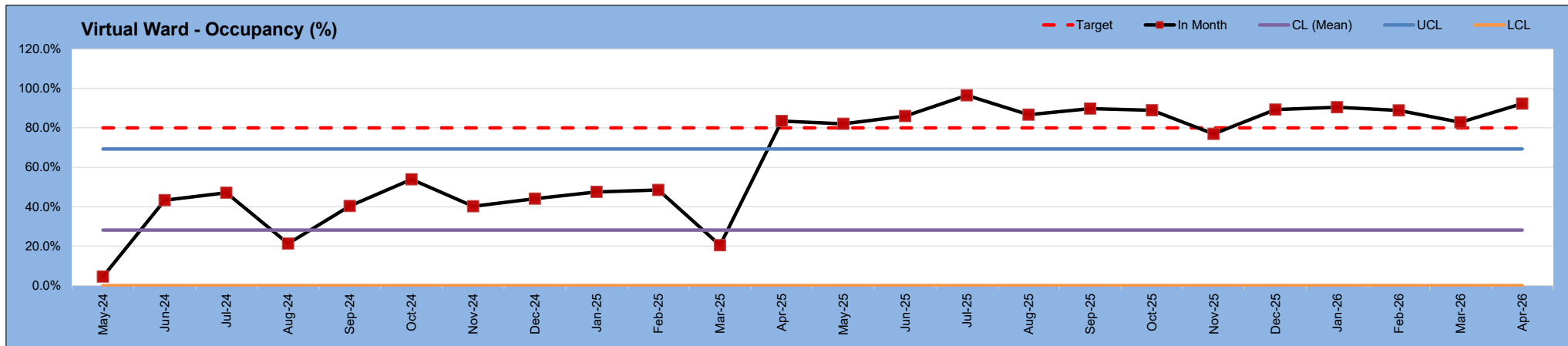
Goal 2: Enhancing prevention, wellbeing and recovery

For the period ending: April 2026

Current month
stands at:

92.3%

Indicator Title	Description/Rationale	Executive Lead:
Virtual Ward	Virtual Ward Bed Occupancy Rate	Lynn Parkinson



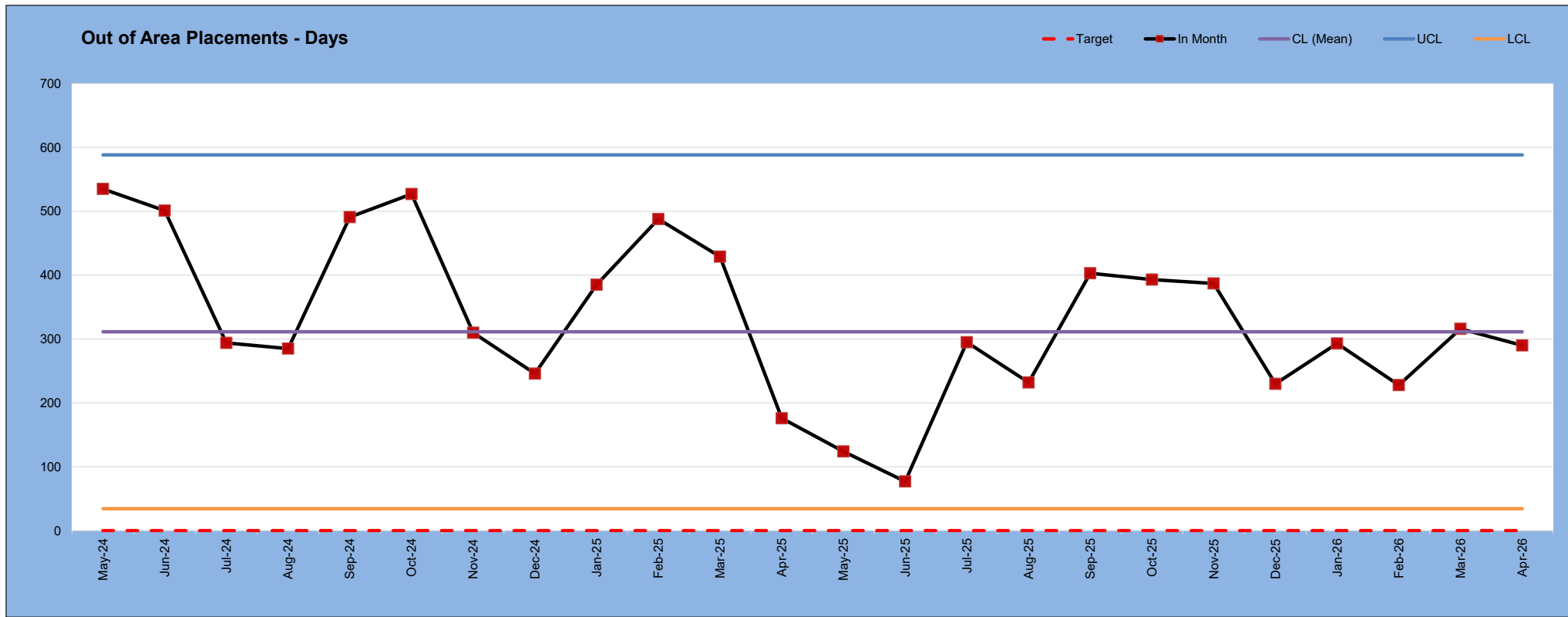
PI RETURN FORM 2026-27

Goal 3: Fostering integration, partnership and alliances

For the period ending: April 2026

Patients OoA
within Month
14

Indicator Title	Description/Rationale	Executive Lead: Lynn Parkinson
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	

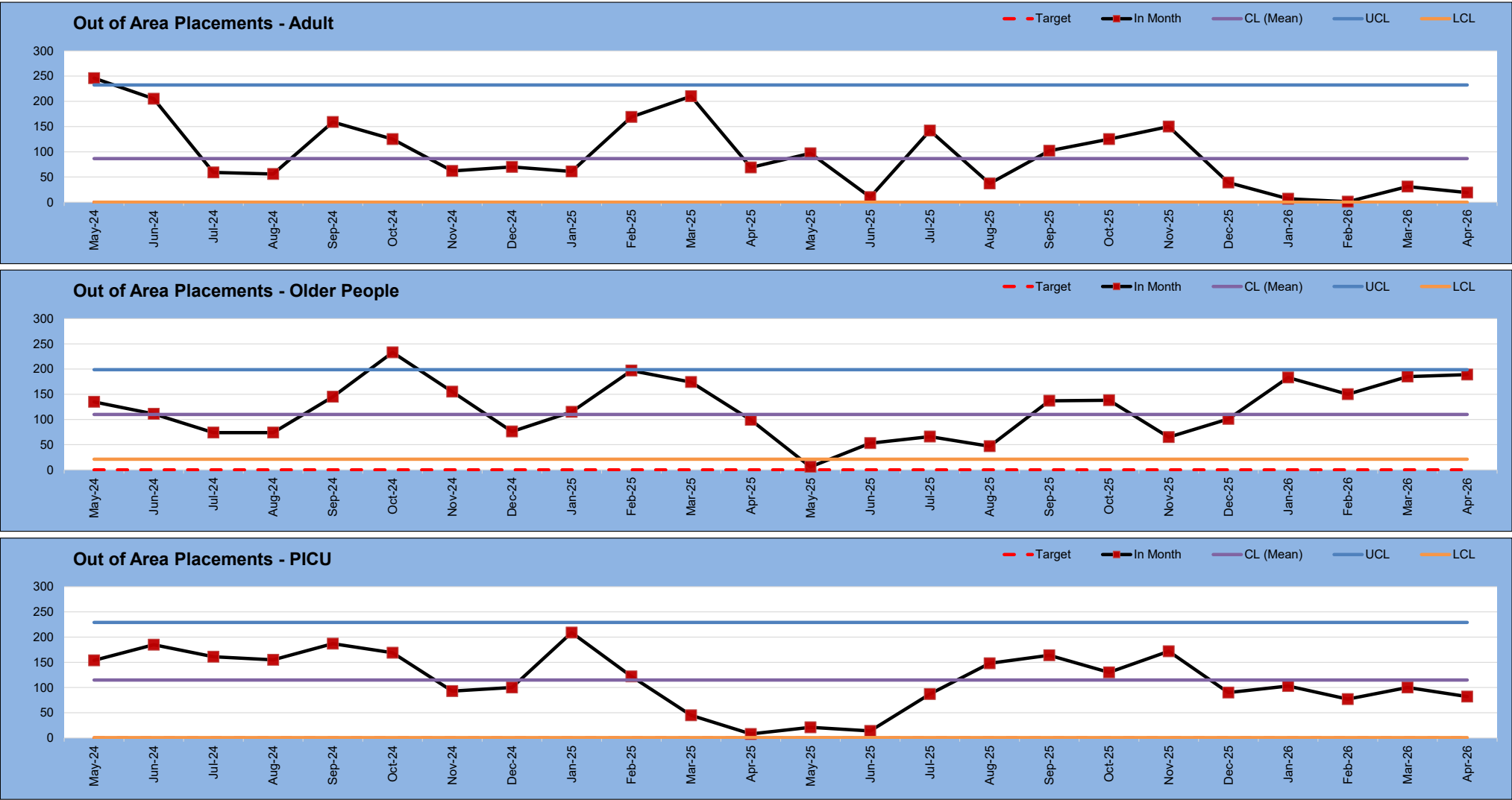


PI RETURN FORM 2026-27

Goal 3: Fostering integration, partnership and alliances

For the period ending: April 2026

Indicator Title	Description/Rationale	Executive Lead: Lynn Parkinson
Out of Area Placements	Number of days that Trust patients were placed in out of area wards - split across Adult, Older Adult and PICU	



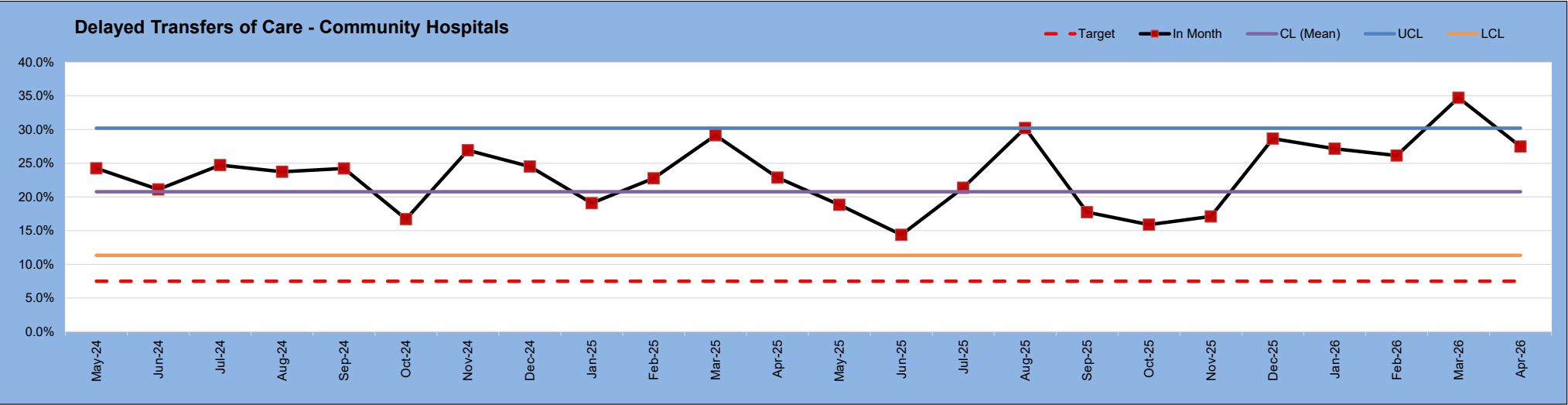
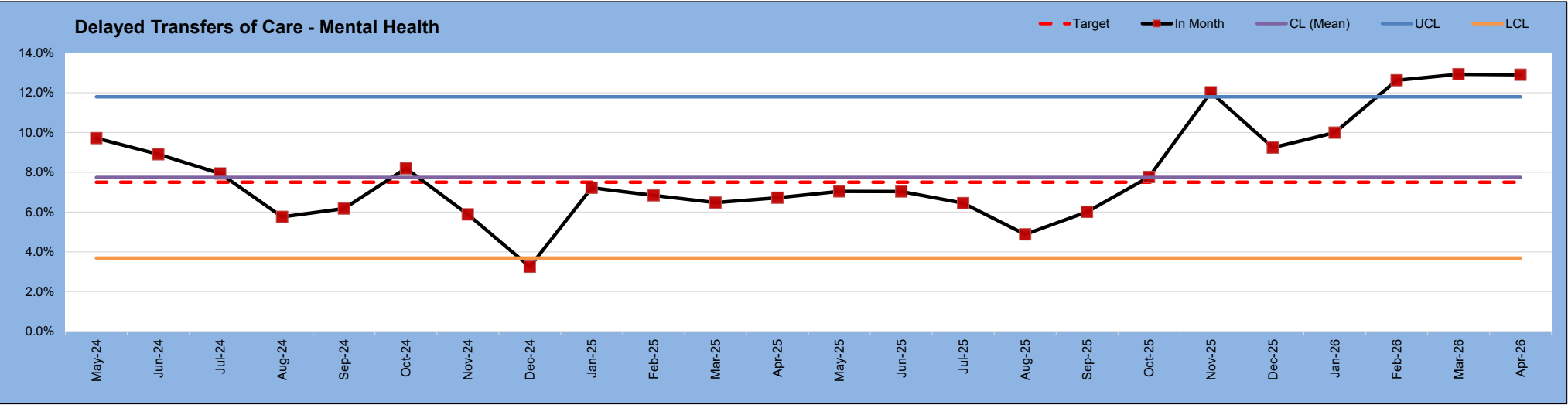
PI RETURN FORM 2026-27

Goal 4: Fostering integration, partnership and alliances

For the period ending: April 2026

	MH DToC %	CH DToC %
Current month:	12.9%	27.5%

Indicator Title	Description/Rationale	Executive Lead:
Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care	Lynn Parkinson



People & Organisational Development Committee

Positive Assurances to Provide:

- Mandatory training compliance is at 88.3%, remaining above the Trust target of 85%, indicating strong organisational compliance with statutory and mandatory requirements.
- Clinical supervision is performing well at 93.3%, demonstrating consistent support, governance and professional oversight across services.
- Vacancy levels are relatively low at 5.6%, suggesting stable workforce establishment and effective recruitment controls.
- Staff turnover remains low at 0.6% (monthly), indicating good workforce stability and retention.
- Overall workforce metrics demonstrate stable performance within expected control limits, with no immediate signs of significant deterioration.

Matters of Concern or Key Risks to Escalate:

- Sickness absence is reported at 5.1%, marginally above the typical Trust target (5%), indicating a continued pressure on workforce capacity and potential impact on service delivery.
- While vacancies are relatively low overall, variation across staff groups (e.g. nursing, consultant workforce) may present localised risks to service resilience.
- Reliance on maintaining high compliance (training and supervision) presents a risk if performance begins to drift, particularly given operational pressures.
- Workforce indicators remain stable but sensitive, with risk of deterioration if absence levels rise or recruitment pipelines slow.

Key Actions Commissioned/Work Underway:

- Continued monitoring and management of sickness absence, with a focus on reducing levels back within target through proactive management and support. Delivery of the Rapid response Sickness Absence Model and Working Towards a Healthier Workforce Plan
- Delivery of a new Sickness Absence Policy to bring more rigor to the process.
- Ongoing recruitment and retention activity to sustain low vacancy levels and address any emerging gaps in key professional groups.
- Sustained focus on mandatory training compliance, and DNA monitoring/reporting ensuring continued access and completion across all staff groups.
- Continued oversight and reinforcement of clinical supervision standards to maintain high compliance levels.
- Medical Workforce Plan in delivery phase to respond to higher rates of consultant vacancies

Decisions Made:

- New Sickness Policy approved, with Board ratification in May
- Agreement to maintain sickness absence as a key workforce priority with continued oversight.
- Endorsement of current workforce performance management approach, including regular reporting and monitoring. Reported to EMT and the People & OD Committee in the People Insight report.

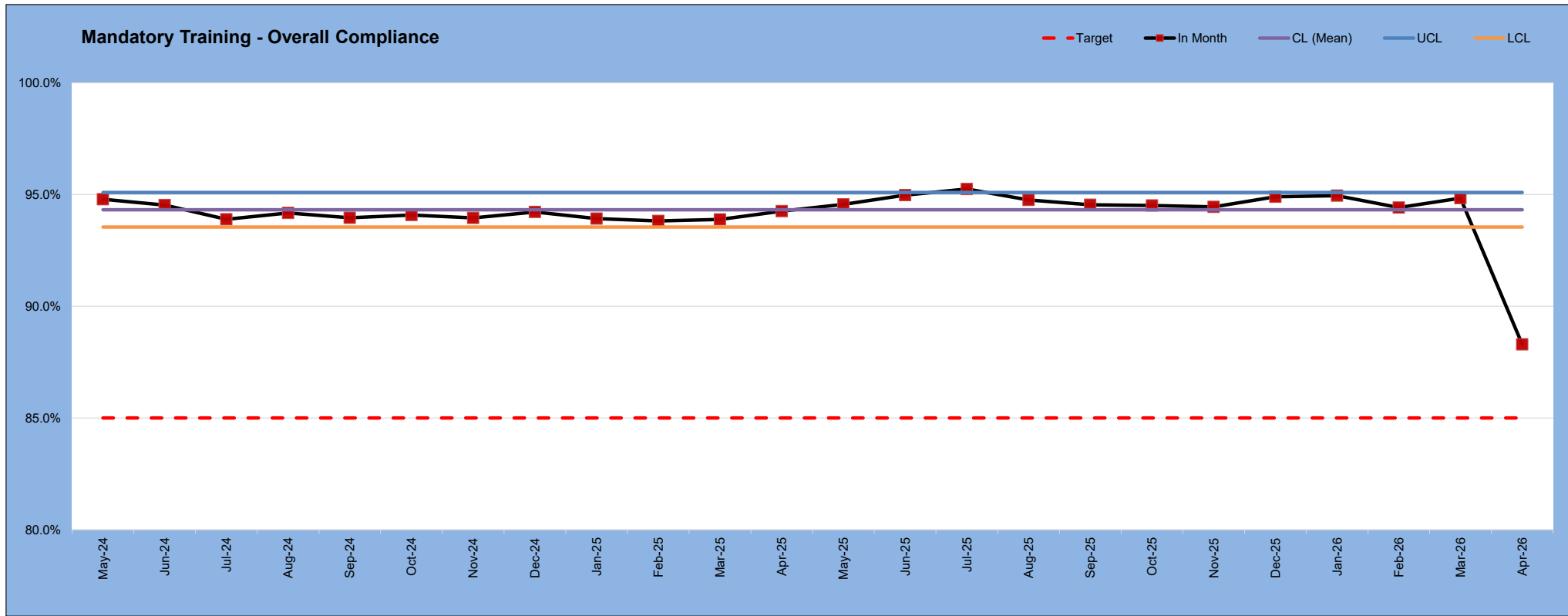
PI RETURN FORM 2026-27

Goal 1: Innovating Quality and Patient Safety

For the period ending: April 2026

Current month
stands at:
88.3%

Indicator Title	Description/Rationale	Executive Lead:
Mandatory Training	A percentage compliance based on an overall target of 85% for all mandatory and statutory courses	Karen Phillips



PI RETURN FORM 2026-27

Goal 1: Innovating Quality and Patient Safety

For the period ending: April 2026

Current month
stands at:
5.6%

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



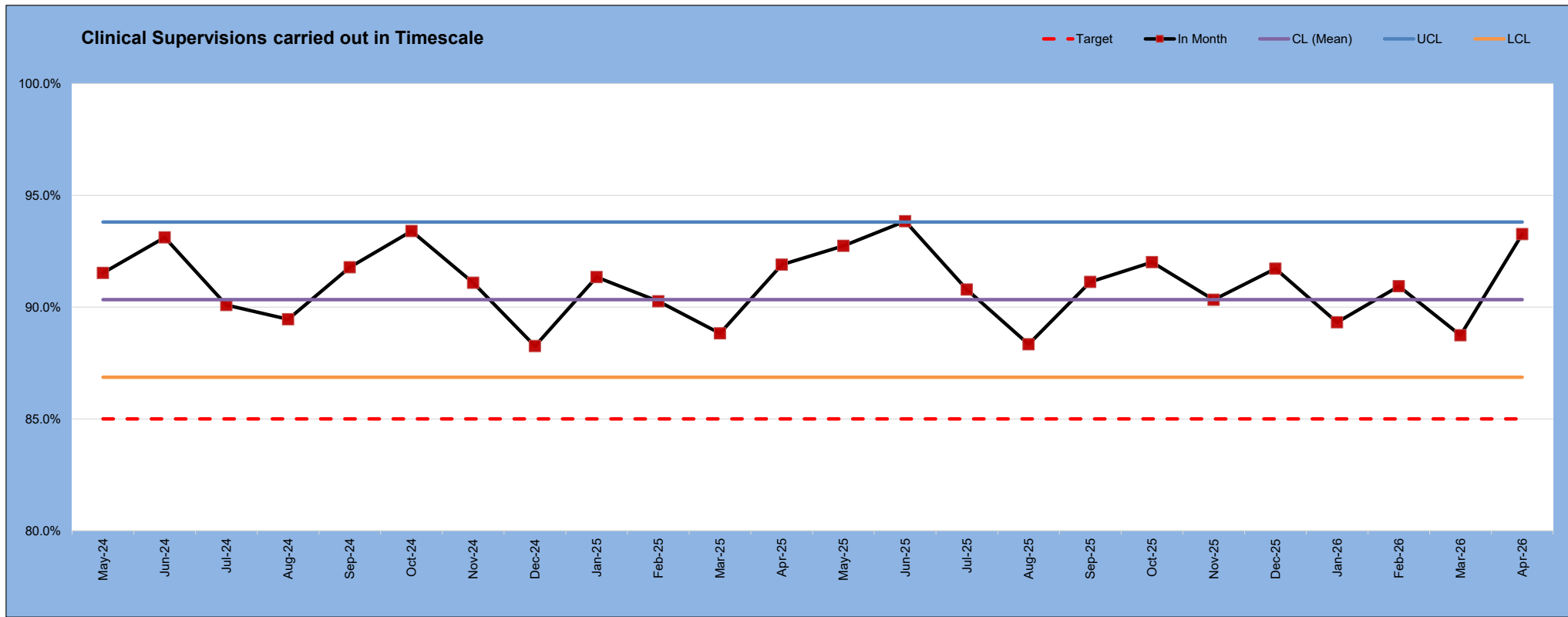
PI RETURN FORM 2026-27

Goal 1: Innovating Quality and Patient Safety

For the period ending: April 2026

Current month
stands at:
93.3%

Indicator Title	Description/Rationale	Executive Lead: Sarah Smyth
Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	



PI RETURN FORM 2026-27

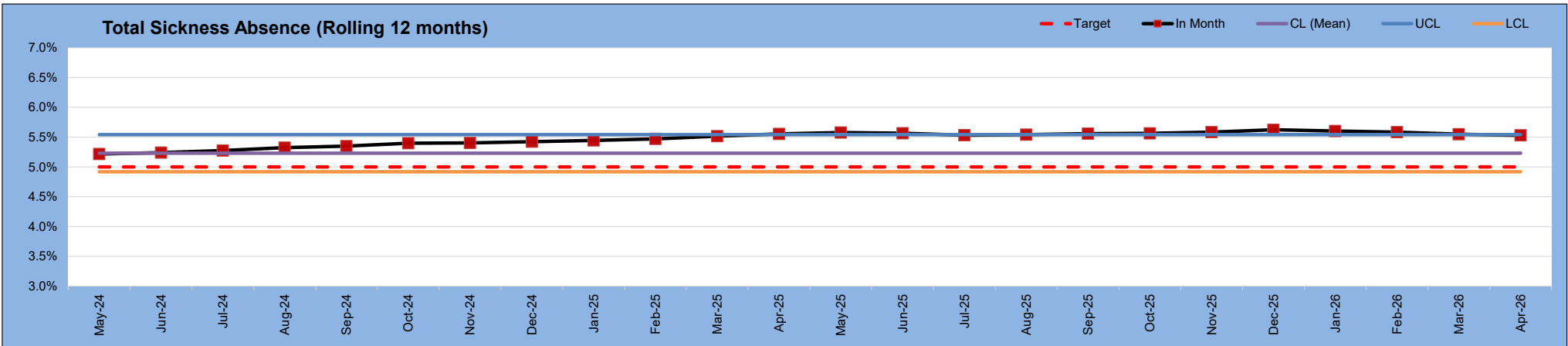
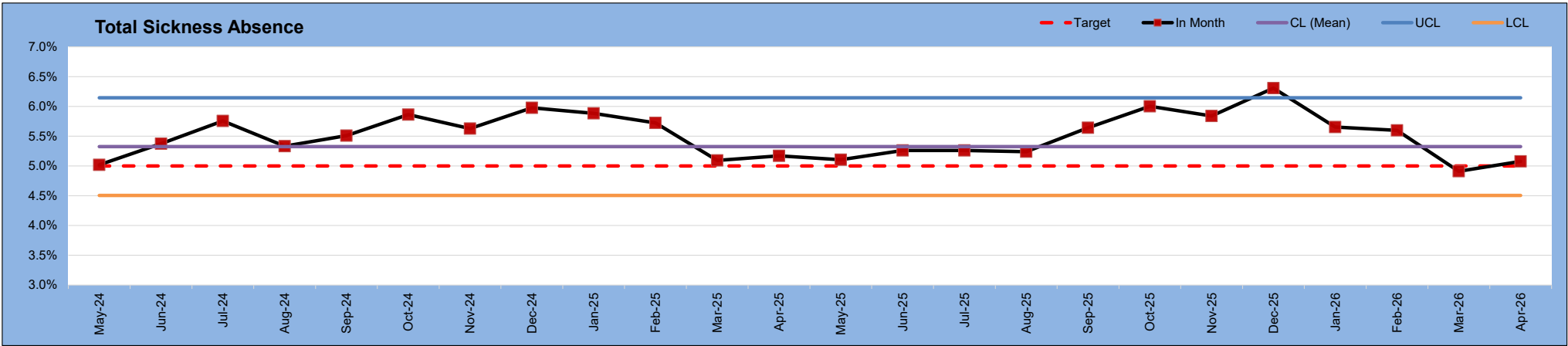
Goal 4: Developing an effective and empowered workforce

For the period ending: April 2026

Current month
stands at:

5.1%

Indicator Title	Description/Rationale	Executive Lead:
Sickness Absence	Percentage of staff sickness across the Trust (not including bank staff)	Karen Phillips



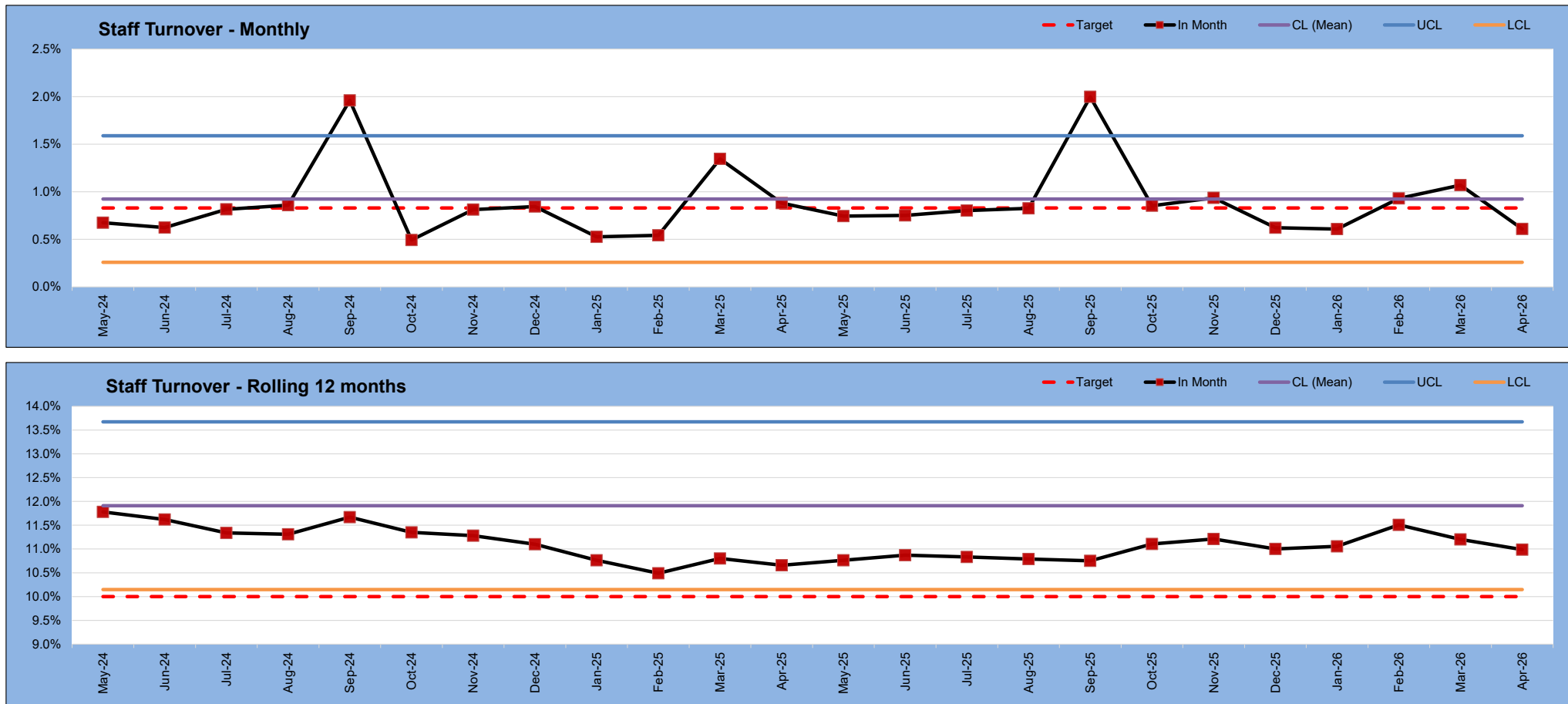
PI RETURN FORM 2026-27

Goal 4: Developing an effective and empowered workforce

For the period ending: April 2026

Current month
stands at:
0.6%

Indicator Title	Description/Rationale	Executive Lead:
Staff Turnover	Percentage of leavers against staff in post (excluding employee transfers)	Karen Phillips



Humber Teaching NHS Foundation Trust

Trust Performance Report

GLOSSARY

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BI	Business Intelligence
BLS	Basic Life Support
CAMHS	Child and Adolescent Mental Health Services
CHPPD	Care Hours per Patient Day
CL	Central Line
CMH	Community Mental Health
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CYP	Children and Young People
CYP MH	Children and Young People's Mental Health
DToC	Delayed Transfer of Care
EIP	Early Intervention in Psychosis
F2F	Face to Face
FFT	Friends and Family Test
ILS	Immediate Life Support

IPS	Individual Placement Support
IPU	Inpatient Unit
LCL	Lower Control Limit
LD	Learning Disability
MH	Mental Health
MHST	Mental Health Support Teams
NHSER	NHS East Riding
OBD	Occupied Bed Days
OBDs	Occupied Bed Days (plural)
ODG	Operational Delivery Group
PICU	Psychiatric Intensive Care Unit
RN	Registered Nurse
RTT	Referral to Treatment
SPC	Statistical Process Control
TPR	Trust Performance Report
UCL	Upper Control Limit
UCR	Urgent Crisis Response
WTE	Whole Time Equivalent
YTD	Year to Date

Executive Team:

Chief Executive: Michele Moran

Chair: Caroline Flint

Chief Operating Officer: Lynn Parkinson

Director of Finance: Peter Beckwith

Associate Director of People and Organisational Development: Karen Phillips

Medical Director: Kwame Fofie

Director of Nursing: Sarah Smyth

Issue Date: 20/05/2026



Caring, Learning
& Growing Together

Financial Year
2026-27

NHS

Oversight Framework

Scorecard

This document provides a high level summary of the performance against the NHS Oversight Framework.

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 NHS Oversight Framework.

Reporting Month:

Apr-26

Chief Executive: Michele Moran

Prepared by: Business Intelligence Team

Caring, Learning and Growing



Oversight Framework Scorecard

Oversight Framework Segment	
Trust Segment Score	1
My Peer Segment Score	3
National Segment Score	3

Trust rank

7 out of 61

Previous quarter's rank: 19 out of 61

NHS England
Humber Teaching NHS Foundation Trust
2025/26
12 May 2026



Oversight framework summary Beta

Overall segment and domain scores									
Headlines			Data period	Provider value	Peer average ⓘ	National value	National value method	Chart	
Adjusted segment					Q3 2025/26	1	NOF Score	Provider value	
Average metric score					Q3 2025/26	1.91	NOF Score	Provider value	
Unadjusted segment					Q3 2025/26	1	NOF Score	Provider value	
Financial override			Q3 2025/26	No	No	Yes	Provider median		
Domain Scores									
			Data period	Provider value				Chart	
⌵	Access to services domain segment				Q3 2025/26	1	NOF Score		
⌵	Effectiveness and experience of care domain segment				Q3 2025/26	1	NOF Score		
⌵	Patient safety domain segment				Q3 2025/26	1	NOF Score		
⌵	People and workforce domain segment				Q3 2025/26	2	NOF Score		
⌵	Finance and productivity domain segment				Q3 2025/26	3	NOF Score		

Oversight Framework Scorecard

Oversight Framework Segment	
Trust Segment Score	1
My Peer Segment Score	3
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Trust rank

7 out of 61

Previous quarter's rank: 19 out of 61

NHS England

Humber Teaching NHS Foundation Trust

2025/26

12 May 2026

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Dec-25	0.00	%	-0.05 ↑	1.00	1 out of 41	0.25	
Access to services	Mental health care	Annual change in the number of children and young people accessing NHS-funded MH services	Jan 25 - Dec 25 vs Jan 24 - Dec 24	12.19	percentage points	19.10 ↑	1.97	16 out of 49	7.09	
Effectiveness and experience	Effective flow and discharge	Percentage of inpatients with >60 day length of stay	Q3 2025/26	10.63	%	2.09 ↓	1.00	1 out of 47	23.24	
Effectiveness and experience	Effective out of hospital care	Urgent Community Response 2-hour performance	Q3 2025/26	97.59	%	-0.62 ↓	1.05	2 out of 38	86.40	70
Effectiveness and experience	Patient experience	CQC community mental health survey satisfaction rate	2024		score		2.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	-0.35	%	0.00 →	2.00	51 out of 61	0.00	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 9 2025	1.42	%	-0.69 ↓	1.00	2 out of 61	0.01	
Finance and productivity	Finance	Combined finance	Q3 2025/26				2.00			
Finance and productivity	Productivity	Relative difference in costs	2024/25	114.68	%	0.00 →	3.53	51 out of 61	104.85	
Patient safety	Patient safety	Percentage of patients in mental health crisis to receive face-to-face contact within 24 hours	Q3 2025/26	69.04	%	9.71 ↑	2.19	20 out of 48	65.99	
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	7.00	out of 10	0.00 →	1.60	13 out of 61	6.81	
People and workforce	Retention and culture	Sickness absence rate	Q2 2025/26	5.38	%	0.17 ↓	2.69	22 out of 61	5.62	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.20	out of 10	0.00 →	1.95	20 out of 61	7.08	

Oversight Framework
Access

NHS England
Humber Teaching NHS Foundation Trust
2026/27
12 May 2026



1.49	Domain Average Score

Data Source	Indicator Definition	NOF Current Score	Frequency of Reporting	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
BI	Percentage of patients waiting over 52 weeks for community services	1	End of period	0.00%											
BI	Annual percentage change in the number of children and young people accessing NHS funded mental health services (local data)	1.97	12-month rolling, year-on-year	12.28%											

Oversight Framework
Effectiveness & Experience

NHS England
Humber Teaching NHS Foundation Trust
2026/27
12 May 2026



1.35	Domain Average Score

Data Source	Indicator Definition	NOF Current Score	Frequency of Reporting	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
CG	Community mental health survey satisfaction rate	2	Annual	6.5/10 (2025)											
BI	Percentage of adult inpatients with a length of stay over 60 days at discharge	1	Monthly	12.7%											
BI	Urgent community response (UCR) 2-hour performance	1.05	Monthly	95.1%											

Oversight Framework
Patient Safety

NHS England
Humber Teaching NHS Foundation Trust
2026/27
12 May 2026



1.90	Domain Average Score

Data Source	Indicator Definition	NOF Current Score	Frequency of Reporting	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
HR	NHS Staff Survey - raising concerns sub-score	1.6	Annual	6.94 / 10 (2025)											
BI	Percentage of patients in crisis to receive face-to-face contact within 24 hours	2.19	Monthly	94%											

Oversight Framework
People & Workforce

NHS England
Humber Teaching NHS Foundation Trust
2026/27
12 May 2026



2.32	Domain Average Score

Data Source	Indicator Definition	NOF Current Score	Frequency of Reporting	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
BI	Sickness absence rate	2.69	Rolling twelve months	5.53%											
HR	NHS staff survey engagement theme score	1.95	Annual	7.15 / 10 (2025)											

Oversight Framework Finance & Productivity

NHS England
Humber Teaching NHS Foundation Trust
2026/27
12 May 2026

2.77	Domain Average Score

Data Source	Indicator Definition	NOF Current Score	Frequency of Reporting	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
FINANCE	Planned surplus (+) \ deficit (-) £,000	2	Monthly	0	0	0	0	0	0	0	0	0	0	0	0
FINANCE	Variance year-to-date to financial plan	1	Year to date	0											
FINANCE	Combined Finance Score	2													
FINANCE	Relative difference in costs (National Cost Index)	3.53	Annual	114.7											

Data Period = Mar 2025

Metric ID	Metric Name	Metric Description	Metric methodology - Denominator	Metric methodology - Numerator	Scoring methodology
OF0005	Percentage of patients waiting over 52 weeks for community services	Of the total community health waiting list, the number of patients who have been waiting more than 52 weeks.	Total count of patients on the waiting list.	Count of patients on the waiting list for more than 52 weeks	Organisations scored between 1.00 and 4.00 based on absolute % ranked high to low (Lower is better)
OF0041	Annual percentage change in the number of children and young people accessing NHS funded mental health services	The percentage change in number of people under the age of 18 who have had at least one contact from NHS funded mental health services vs previous year. This metric only counts a unique patient once. If a patient has multiple referrals in the 12-month period with 1+ contacts recorded, they would only be counted once in the access metric.	Denominator: as above, for the preceding 12 month period. Filters: Included - direct contact with a patient, parent or carer (as a patient proxy) or between professionals (as indirect activity), as long as they are clinically meaningful. Excluded - 05 – Email; 09 - Text Message (Asynchronous); 10 - Instant messaging (Synchronous); 12 - Message Board (Asynchronous); 13 - Chat Room (Synchronous); 98 - Other (not listed).	Number of CYP aged under 18 supported through NHS funded mental health with at least one contact in a rolling 12 month period.	Organisations scored between 1.00 and 4.00 based on % change ranked high to low (Higher is better)
OF0024	CQC community mental health survey satisfaction rate	The banded score relating to satisfaction of patients who use community mental health services for each trust	https://www.cqc.org.uk/sites/default/files/2025-04/20250403_cmh24_QualityMethodology.odt Banded score for section 12 – overall experience	N/A	Proprietary CQC methodology, each org receives a band which we translate to a score (1.00 = better or much better than expected, 2.00 = somewhat better than expected or as expected, 3.00 = somewhat worse than expected, 4.00 = worse or much worse than expected)
OF0063	Percentage of adult inpatients with a length of stay over 60 days at discharge	Percentage of adult inpatients with a length of stay over 60 days at discharge	Total discharges from adult acute beds	of the denominator, discharges from adult acute beds with a length of stay over 60 days	Organisations scored between 1.00 and 4.00 based on % of delayed patients ranked high to low (Lower is better)
OF0057	Percentage of Urgent Community Response patients seen within two hours	Percentage of standard urgent community response referrals seen within 2 hours.	Number of standard urgent community response referrals received.	Number of referrals that had a Referral to Treatment waiting time of under 120 minutes.	All Organisations <70% score 4.00. Remainder ranked from 1.00 – 3.00 based on absolute % (Higher is better)

Metric ID	Metric Name	Metric Description	Metric methodology - Denominator	Metric methodology - Numerator	Scoring methodology
OF0061	Staff survey – raising concerns sub-score	NHS staff survey “raising concerns” sub-score	NHS staff survey sub score for the following measures: Q20a - I would feel secure raising concerns about unsafe clinical practice Q20b - I am confident that my organisation would address my concern Q25e - I feel safe to speak up about anything that concerns me in this organisation Q25f - If I spoke up about something that concerned me I am confident my organisation would address my concern For further details see Section 3.1 of NHS Staff Survey Technical Guide	N/A	Organisations scored between 1.00 and 4.00 based on % positive responses ranked high to low (Higher is better).
OF0016	Percentage of crisis response patients to receive face to face contact within 24 hours	Percentage of new urgent referrals to crisis services with first face to face contact within 24 hours of referral	Denominator: New Urgent Referrals to Crisis Services with first face to face contact Filters: • The Service or Team Type Referred To (Mental Health) is either A02, A18, A19 • Where the Clinical Response Priority Type is 2 (urgent) • Where the Attended Or Did Not Attend is 5 or 6 and the Consultation Medium Used is face to face communication.	New Urgent Referrals to Crisis Services with first face to face contact within 24 hours of referral	Organisations scored between 1.00 and 4.00 based on absolute % ranked high to low (Higher is better)
OF0082	Staff sickness rate	The percentage of days in the previous year where staff are sick and unable to work	FTE number of days available	FTE number of days sick (including non-working days)	Organisations scored between 1.00 and 4.00 based on 12 month rolling rate of sickness ranked high to low (Lower is better)
OF0084	Staff survey engagement theme score	The NHS Staff Survey Staff engagement theme score.	This score is comprised of 3 individual sub-scores covering motivation, involvement and advocacy, aggregated to an overall score. Each sub-score is comprised of a number of questions which are scored on a 0-10 scale and reported as a mean score. A higher score indicates a more favourable result.	N/A	Organisations scored between 1.00 and 4.00 based on % positive responses ranked high to low (Higher is better).

Metric ID	Metric Name	Metric Description	Metric methodology - Denominator	Metric methodology - Numerator	Scoring methodology
N/A	Combined Finance Score	The combined finance score is based on a combination of two individual financial scores as follows	The combined finance score is based on a combination of two individual financial scores as follows Measure one [Plan]: Planned surplus deficit score (OF1079) Measure two [Actual]: Variance year-to-date score (OF1081)	N/A	If [Plan] = 1 and [Actual] = 1 then 1 If [Plan] = 1 and [Actual] = 2 then 1 If [Plan] = 1 and [Actual] = 3 then 2 If [Plan] = 1 and [Actual] = 4 then 4 If [Plan] = 2 and [Actual] = 1 then 2 If [Plan] = 2 and [Actual] = 2 then 2 If [Plan] = 2 and [Actual] = 3 then 3 If [Plan] = 2 and [Actual] = 4 then 4 If [Plan] = 3 and [Actual] = 1 then 2 If [Plan] = 3 and [Actual] = 2 then 3 If [Plan] = 3 and [Actual] = 3 then 3 If [Plan] = 3 and [Actual] = 4 then 4 If [Plan] = 4 and [Actual] = 1 then 2 If [Plan] = 4 and [Actual] = 2 then 3 If [Plan] = 4 and [Actual] = 3 then 4 If [Plan] = 4 and [Actual] = 4 then 4
OF0076 / OF0079	Planned surplus/deficit	The overall level of planned surplus/deficit of the organisation for the financial year once deficit support funding has been removed	Allocation minus deficit support funding	Planned turnover	Scored based on planned level of deficit (1.00 = 0% or surplus, 2.00 = below 1%, 3.00 = between 1% and 2%, 4.00 = beyond 2%)
OF0078 / OF0081	Year-to-date variation from plan	The variance between the planned surplus/deficit at the current month and the actual surplus/deficit figure	Planned surplus/deficit	Actual surplus/deficit	Score based on variation from plan (1.00 = on plan or better, 2.00 = below 0.5% variance, 3.00 = between 0.5% and 1% variance, 4.00 = beyond 1% variance)
N/A	Relative difference in costs score	National Cost Collection Index	Organisations scored between 1.00 and 4.00 based on comparative cost value ranked high to low (Lower is better).	N/A	Organisations scored between 1.00 and 4.00 based on comparative cost value ranked high to low (Lower is better).

Metric ID	Metric Name	Metric Description	Metric methodology - Denominator	Metric methodology - Numerator	Scoring methodology
OF2000	Does the organisation have a financial deficit?	Whether the organisation currently has a financial deficit	Metric returns a value of 1 where a deficit exists based on three sequential checks: 1. Is the organisation in receipt of Deficit Support Funding? (If "Yes" return value of 1 and no further checks) 2. If check one is "No", does the organisation have a planned break-even/surplus plan for the year? (If "No" return value of 1 and no further checks) 3. If check two is "Yes", is the organisation at or better than their year-to-date financial plan? (If worse than plan return value of 1) If the organisation is not in receipt of deficit support funding and has a break-even plan and is currently delivering in line with this plan then all three tests are considered passed and a value of 0 is returned.	N/A	Where the metric methodology returns a value of 1 the organisation's segment is capped at 3
OF2001	Is the organisation in the Provider Improvement Programme?	The Provider Improvement Programme replaces the Recovery Support Programme from 2025/26. Organisations that enter the Provider Improvement Programme will be manually placed into segment five of the oversight framework.	Metric returns a value of 1 where an organisation is on the published Provider Improvement Programme cohort	N/A	Where the metric methodology returns a value of 1 the organisation's segment is set at 5



Humber Teaching
NHS Foundation Trust

Executive Team:

Chief Executive: Michele Moran

Chair: Caroline Flint

Chief Operating Officer: Lynn Parkinson

Director of Finance: Peter Beckwith

Associate Director of People & Organisational Development: Karen Phillips

Medical Director: Kwame Fofie

Director of Nursing: Sarah Smyth

Issue Date: 12/05/2026

Domain area	Subject area	Metric	Humber Teaching
Access to services	Elective care	% of patients waiting less than 18 weeks for community care	Y
Access to services	Elective care	% of patients waiting over 52 weeks for care	Y
Access to services	Mental health care	% of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)	Y
Access to services	Mental health care	% of total Children's and Young Persons mental health patients waiting over 104 weeks for contact	Y
Effectiveness of care	Outcomes	% of acute adult discharges followed up within 72 hours	Y
Effectiveness of care	Outcomes	% of acute mental health admissions with no contact with community mental health services in the previous year	Y
Effectiveness of care	Outcomes	% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery	Y
Effectiveness of care	Effective discharge	14 day readmission rate	Y
Effectiveness of care	Effective discharge	30 day readmission rate band	Y
Experience of care	Patient flow	% of intermediate care beds occupied by patients without criteria to reside	Y
Experience of care	Experience	CQC community mental health survey satisfaction rate	Y
Experience of care	Patient flow	Mean length of stay for adult acute and psychiatric intensive care unit patients	Y
Experience of care	Patient flow	Mean length of stay for older adult acute discharges	Y
Experience of care	Experience	NHS staff survey advocacy rate	Y
Finance productivity and innovation	Innovation	% of clinical trials set up within 90 days	Y

Domain area	Subject area	Metric	Humber Teaching
Finance productivity and innovation	Innovation	Data Quality Maturity Index	Y
Finance productivity and innovation	Finance	Planned surplus/deficit	Y
Finance productivity and innovation	Productivity	Relative cost difference (National Cost Collection Index)	Y
Finance productivity and innovation	Finance	Variance to plan year-to-date	Y
Patient safety	High quality care	% of urgent crisis response patients to receive face to face care within 24 hours	Y
Patient safety	Safe culture	NHS staff survey raising concerns sub-score	Y
People and workforce	People and culture	Healthcare Worker Flu Vaccination Rate	Y
People and workforce	People and culture	National Education and Training Survey satisfaction rate	Y
People and workforce	People and culture	NHS staff standards score	Y
People and workforce	People and culture	NHS staff survey engagement theme score	Y
People and workforce	People and culture	Sickness absence rate	Y
People and workforce	Workforce	Temporary staffing cost as a % of total pay bill	Y
Population health, prevention and reducing inequality	Preventing ill health	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service	Y
N=			28

Agenda Item 21

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Risk Register Update														
Author/s:	Sarah Smyth, Executive Director of Nursing, Quality and Professions Oliver Sims Corporate Risk and Incident Manager														
Recommendation:	<table border="1"> <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>			To approve		To discuss	√	To note	√	To ratify		For assurance			
To approve		To discuss	√												
To note	√	To ratify													
For assurance															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	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 March 2026.														
Key Issues within the report:															
Positive Assurances to Provide: The Trust-wide risk register details the risks facing the organisation scored at a current rating of 15 or higher (significant risks).		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/EMT): OPS31 – Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain: Key actions focussing on work at ICB level to determine standardisation / streamlining of Neuro diversity services as well as appropriate funding. Further consideration underway around waiting list initiatives and Right to Choose. FII223 – Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base: Development of Medium-Term financial plan with funding proposals in conjunction with the ICB. WF57 – Persistent and elevated sickness absence rates across Trust staff groups— currently averaging 5.54% (Sep 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight													

Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery:

Focus on delivery of Trust 'Working Towards a Healthier Workforce plan, with continued work around flu vaccination uptake and embedding of Plus schemes. Continued delivery of health and wellbeing MOTs to Trust workforce and recruitment of Psychologist to Trust Occupational Health department.

- **FII247 – As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery:**

New risk scoped to replace closed entry for 2025/26 (FII239). Ongoing maintenance of relationships with commissioners and continued work to highlight the requirement for funding through MHIS and service development funds. The Trust will continue to bid for national capital resource as and when it becomes available.

Key Risks/Areas of Focus:

- No key risks / areas of focus to highlight further to the content referenced in the appended risk register entries.

Decisions Made:

EMT were assured that appropriate actions are in place to mitigate the risks. EMT has requested that ODG regularly review all risks that are 2 years or older and those where the risk rating has stayed the same for 6 months or more.

Trust-wide Risk Register (15+ significant risks only)

- The Trust-wide risk register extract contains **4 risks** currently rated at 15+:

Risk Description	Current Rating
OPS31 – Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	16
FII223 – Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base.	16
WF57 – Persistent and elevated sickness absence rates across Trust staff groups—currently averaging 5.54% (Sep 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	16
FII247 – As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	15

Governance:

	Date		Date
Audit Committee	05/2026	Remuneration & Nominations Committee	
Quality Committee	04/2026	People & Organisational Development Committee	05/2026

Please indicate which committee or group this paper has previously been presented to:	Finance Committee	04/2026	Executive Management Team	05/2026
	Mental Health Legislation Committee	04/2026	Operational Delivery Group	04/2026
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals (please indicate which strategic goal/s this paper relates to. Please outline in the paper how this links)				
√ Tick those that apply				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
√	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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 May 2026

1. Trust-wide Risk Register

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 March 2026.

There are currently **4** 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
OPS31	Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	20	16	8	↔
FII239	As a result of difficulties within the ICS to meet challenging financial targets for 2025/26, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	20	15	5	↔
WF57	Persistent and elevated sickness absence rates across Trust staff groups—currently averaging 5.54% (Sep 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	20	16	8	↔
FII223	As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery.	20	16	8	New Risk

2. Closed/ De-escalated Trust-wide Risks

There is **one risk** to highlight that was previously held on the Trust-wide risk register and has been closed / de-escalated since last reported to the Trust Board in March 2026.

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

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
FII223	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.	20	5	5

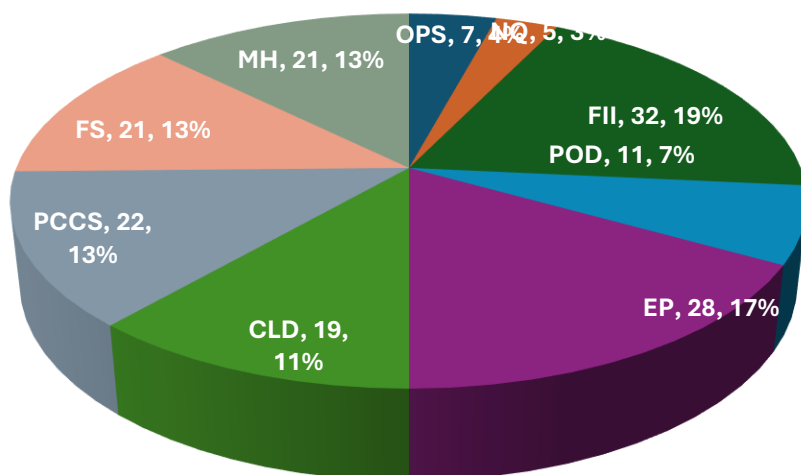
3. Wider Risk Register

There are currently **157** risks held across the Trust's risk registers. The current position represents an overall increase of **11** risks from the **146** reported to Trust Board in March 2026. 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 Risk – March 2026	Number of Risk – May 2026
20	0	0
16	3	3
15	1	1
12	34	33
10	5	4
9	45	48
8	23	23
6	30	37
5	0	0
4	13	14
3	2	2
2	1	1
Total Risks	157	166

Chart 1 – Total Risks by Division/ Directorate



Key:

OPS – Operations Directorate
NQ – Nursing & Quality
FII – Finance, Infrastructure & Informatics Directorate
POD – People & 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

4. Recommendations

The Trust Board is asked to discuss and note the update

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (Initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Date Reviewed	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
1	OPS31	Failure to effectively address waiting times within the Trust's Children's Neurodiversity services which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	Objectives	Almost Certain	Severe	20	Significant	1. Targeted meetings with Division and service areas to address areas of challenge 2. Local Targets and KPIs. 3. Close contact being maintained with individual service users affected by ongoing issues. 4. Waiting Times Procedure in place 5. Waiting times review is key element of Divisional performance and accountability reviews. 6. Review completed of all services with high levels of waiting times and service-level recovery plans developed. 7. Capacity and Demand review includes a focus on productivity and development of plans detailing Recovery requirements 8. Planning round and discussions taking into acute waiting times position 9. Devised process for skill mixing / pathway review to use existing funding to address patient that require treatment that stay in system 10. ICB continuing to review how we can address neurodiversity services challenges and national taskforce implemented to consider these demands.	1. Reports to demonstrate waiting list performance to Trust Board, Quality Committee and Operational Delivery Group. 2. Quality impact on key identified areas monitored via Quality Committee. 3. Weekly divisional meetings with Performance & Access Mgr around waiting list performance. 4. Introduction of Monthly Performance & Productivity Group chaired by COO. 5. Capacity and Demand planning has either taken place or is scheduled to take place in all long waiting areas and improvement trajectories developed or proposals developed for improvement.	1. Opportunities to revise pathways to increase productivity or reduce demand into services. 2. insufficient funding available to support demand / service provision 3. Outcome of option review for ASD/ADHD	1. Children's Autism number of patient waiting >52 weeks - January -1800 2. Children's ADHD number of patient waiting assessment >52 weeks - January - 902 3. Operational planning guidance does not provide instructions in relation to neuro services. 4. Limited over 52-week progress	Likely	Severe	16	Significant	1. Neuro diversity services work at ICB level to determine how processes can be standardised / streamline to reduce system pressures (30/04/2026) 2. CYP ASD /ADHD Options paper approved by EMT to support potential Pause of the Waiting Lists encouraging Right to Choose (30/04/2026) 3. Confirmation on levels of funding available to support demand (30/04/2026)	10/03/2026	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	∞	High
2	FI1223	Risk to longer-term financial sustainability if block contract values are insufficient to cover the Trust Cost base.	Objectives	Almost Certain	Severe	20	Significant	1. Draft Financial Plan in progress. 2. BRS and Efficiency Plan 2026/27 developed 3. Monthly reporting, monitoring and discussion with budget holders. 4. Small contingency / risk cover provided in plan. 5. MTFP in development to inform plans. 6. Service and Operational plans. 7. Regular reviews with NHSE/I and relevant Commissioners 8. Non-recurrent savings identified	1. Monthly reporting to EMT. 2. Bi monthly reporting to Board 3. Quarterly Reporting to Finance Committee 4. Monthly reporting to NHSE/I and feedback 5. ODG monitoring progress of Financial Position and BRS plans. 6. Budget Reduction Strategy policy and procedure agreed by Finance and Investment Committee and Trust Board. 7. External / Internal Audit on financial controls/systems. 8. Regular input through Humber and North Yorkshire ICS 9. Cash Position for the Trust is strong	1. Current underlying position of the ICS is a risk of £78.5m could be £167m gap for 2026/27-Current underlying position of the Trust is a risk of £1.500m - met by Non recurrent Efficiencies 2-There has been no deployment of MHIS which was previously annual investment of £2m 3-There is Risk in the assumption of the receipt of 2024/25 income from the ICS 4- 2. The 2026/27 Pay Award funding is £0.300m less than budget	1-Longer-term planning guidance is awaited 2-Initial advice given by NHSE indicates that there will be a 1-year settlement for 2025/26 with no growth- Medium-term Financial Planning has been provided by NHSE with proposed minimum uplifts of 0.3% and 0.0% for 2026/27 and 27/281. Medium term Financial Planning provided by NHSE with proposed minimum uplifts of 0.3% and 0.0% for 2027/28 and 28/29	Likely	Severe	16	Significant	Medium Term Financial Plan to be developed with the ICB and NHSE	13/05/2026	Iain Omand	Peter Beckwith	Directorate Business Meeting/ Executive Management Team	Board	Unlikely	Severe	∞	High
3	WF57	Persistent and elevated sickness absence rates across Trust staff groups -currently averaging 5.6% (Dec 25) pose a significant risk to workforce capacity, operational delivery, and the ability of the organisations to meet performance expectations under the 2025/26 NHS Oversight Framework as well as reduced staffing levels compromising patient safety, increase waiting times, and hinder service recovery.	Objectives	Almost Certain	Severe	20	Significant	1.Over 700 staff have access HWB MOTs 2. Launch of HWB Plus to support ongoing workplace wellness 3. Internal OH team delivering against management referrals and pre-employment screening 4. People Strategy with focus on Wellbeing and associated metrics 5. Implementation of rapid response model to target and assess teams presenting with 8%+ sickness absence rates	1. People and OD Committee (insight reports). 2. Divisional Business Meetings. 3. EMT 4. Trust Board 5. ODG 6. Accountability Reviews 7. The Trust is currently in segment 2 of the NOF	1. Inpatient areas continue to report high levels of absence	1. 5.55% rolling sickness absence rate (March 2026) above the 5% Trust target. 2. All divisions with the exception of C&LD report absence above the Trust target	Likely	Severe	16	Significant	1- Delivery of the 'Working Towards a Healthier Workforce' plan (30 April 2026) 2- Achieve 5% increase in uptake with the flu vaccine- (31 March 2026) 3. Embed Plus schemes in the organisation (31.03.2027) 4. Continue to deliver HWB MOTs to the workforce (31.03.2027) 5. Recruit to the Psychologist in Occupational Health (30 June 2026)	20/04/2026	Vickie Murray	Karen Phillips	Directorate Business Meeting / Executive Management Team	Trust Board	Unlikely	Severe	∞	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	FI1247	As a result of difficulties within the ICS to meet challenging financial targets for 2026/27, there could be a financial impact for the Trust with loss of funding leading to potential impact to service delivery .	Objectives	Likely	Catastrophic	20	Significant	1. Regular contractual discussions with commissioners and Trust taking all necessary action to ensure receipt of appropriate funding. 2. Budget Reduction Strategy in place up to 2028-29 and small amount of contingency/risk cover provided for in plan.	1. Monthly reporting to EMT 2. Quarterly Reporting to Finance Committee monitoring of performance against plans. 3. Monthly reports and Quarterly Accounts Returns to NHS I with quarterly feedback. 4. ODG and Divisional ODG reports monitoring financial position and performance against plans. 5. Accountability Review monitoring of financial position and discussed with budget holders (regular confirm and challenge).	1. The overarching ICS financial position and the ability for Commissioners to invest 2. Short term nature of Financial Planning from an ICS perspective	Medium term financial planning has been provided by NHSE with uplifts of 0.3% for 2026/27 and 0.0% for 2027/28 and 2028/29	Possible	Catastrophic	15	Significant	1. Ongoing maintenance of relationships with Commissioners (31/03/2027) 2. Continue to bid for national resource as and when it becomes available (31/03/2027)	13/05/2026	Iain Ormand	Peter Beckwith	Directorate business meeting/ Executive Management Team	Board	Rare	Catastrophic	20	Moderate

Agenda Item 22

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Changes to Standing Orders, Scheme of Delegation and Standing Financial Instructions															
Author/s:	Stella Jackson, Head of Corporate Affairs Peter Beckwith, Executive Director of Finance Charlene Reeson, Senior Contracts Manager															
Recommendation:	<table border="1"> <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>				To approve	√	To discuss		To note		To ratify		For assurance			
To approve	√	To discuss														
To note		To ratify														
For assurance																
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	The purpose of this paper is to request that the Board approves the proposed changes to the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions as highlighted in this paper and through track changes in the Standing Orders (attached at Appendix A).															
Key Issues within the report:																
Positive Assurances to Provide: - The Standing Orders, Standing Financial Instructions and Scheme of Delegation have served the Trust well. - The proposed changes ensure the document remains fit for purpose in the future.		Key Actions Commissioned/Work Underway:														
Key Risks/Areas of Focus: The proposed changes are highlighted in the cover paper.		Decisions Made: Recommendations in this paper have been considered by the Executive Management Team and Audit Committee, both of which supported the changes.														
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date												
	Audit Committee	18.5.2026	Remuneration & Nominations Committee													
	Quality Committee		People & Organisational Development Committee													
	Finance Committee		Executive Management Team	7.4.2026												
	Mental Health Legislation Committee		Operational Delivery Group													
	Collaborative Committee		Other (please detail)	Trust Board 27.5.2026												

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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Proposed changes to Standing Orders, Scheme of Delegation and Standing Financial Instructions

1. Introduction:

This document was last updated and approved by Trust Board in May 2025. The document has been further reviewed in 2026 and proposed changes are detailed below:

2. Proposed Changes

a) General changes

Job titles and Committee names have been updated throughout the document to reflect current titles and names.

b) Page 11: Section 2.1: Composition of the Membership of the Trust Board

The number of Executive and Non-Executive Directors on the Board has increased to six to reflect current Board membership. The wording regarding the number of Associate Non-Executive Directors has changed to 'up to 2 Associate Non-Executive Directors' to enable more than one appointment to be made should this be deemed appropriate.

c) Page 35: Scheme of Matters Reserved to the Trust Board and Delegation – Policy Determination

The section regarding the approval of policies has been updated to reflect current arrangements whereby the Executive Management Team (EMT) approves policies and the Board ratifies those policies approved by EMT.

d) Pages 38 (Quality Committee) and 40 (People and Organisational Development Committee)

The role of the Quality and People and Organisational Development committees in ratifying Annual Reports approved by EMT has been added.

e) Page 34: Section C: Part A – Decisions Reserved to the Board

The requirement for the Board to comply with the Government Commercial Spend Controls has been incorporated into the 'Decisions Reserved to the Board' section of the document.

9) Page 61: Financial Limits table

Proposed changes have been made to the financial limits table to take account of inflation and to ensure the administrative burden on the Director of Finance, Chief Executive and Board remains at acceptable levels. The revised financial limits are contained in the table below:

Financial Limit <i>(where this relates to contracts over more than one year, the annual value is delegated as per below)</i>	Delegated to
Up to £9,999	Senior Manager/other staff on authorised signatory list up to their delegated limit
£10,000 to £49,999	Divisional General Manager

£50,000 - £99,999	Director
£100,000 - £499,999	Director of Finance
£500,000 - £999,999	Chief Executive*
Over £1m	Trust Board

h) Page 64: Section D – General

The Trust SFI's must be read alongside (and comply with) Government Spend Control rules whenever those rules apply to a procurement and this requirement has been added.

i) Page 66: Audit Committee Delegation of Detailed Responsibilities

The sentence has been removed as no group or committee was referenced

j) Pages 70/71: Annual Report and Accounts/ Bank Accounts

Reference to Monitor has been replaced with NHSE

k) Page 73: Security of Cash

Reference to coin operated machines has been removed as the Trust has stopped use of these

l) Page 73: Procurement of goods, works and non-health care services

The requirement for the Trust to follow Government commercial spend controls rules in addition to existing procurement rules/regulations has been added. Commercial activity with a whole-life value of £50 million or more may be subject to additional commercial assurance, with the requirement for external assurance and approval dependent on the value, nature and risk of the activity, including whether it is Novel, Contentious or Repercussive (NCR) and whether it exceeds the Departmental Delegated Authority Limits (DALs).

All commercial pipeline activity must be recorded in Atamis with an appropriate forward look to support early commercial engagement and proportionate assurance

m) Page 74: Formal Competitive Tending – General Applicability

A bullet point has been added outlining that, where applicable, required commercial assurance and approvals must be obtained before commencing a tender, in line with Government Commercial Spend Controls.

n) Pages 70/71: Annual Report and Accounts/ Bank Accounts

Reference to Monitor has been replaced with NHSE

o) Page 73: Security of Cash

Reference to coin operated machines has been removed as the Trust has stopped use of these

p) Page 104: Director of Finance will Issue Instructions

Reference to removal of cash to employees has been removed as the Trust doesn't issue cash to employees

Standing Orders,

Scheme of Delegation and Standing Financial Instructions

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May 2026~~5~~

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Date Approved: ~~28 May 2025~~

Review Date: May 202~~7~~~~6~~—



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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);
- ~~65~~ other Non-Executive Directors (appointed by the Council of Governors);
- ~~65~~ 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;~~
- ~~Up to 7~~ two Associate Non-Executive Directors (also non-voting)

The Trust may appoint other Executive, Non-Executive and Associate Non-Executive Directors as deemed necessary and in accordance with the Scheme of Delegation.

2.2 Appointment of Chair and Non-Executive Director Members of the Trust Board

2.2.1 The Chair and Non-Executive Directors shall be appointed and removed by the Council of Governors in accordance with the Constitution. The Chief Executive shall also be appointed and removed in accordance with the Constitution.

2.3 Terms of Office of the Chair

2.3.1 The provisions governing the period of tenure of office of the Chair and the termination of the office of the Chair are contained in the Constitution. The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the Constitution. The terms and conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment and Powers of Deputy Chair

Standing Orders, Scheme of Delegation and Standing Financial Instructions
Approved 28-5-25

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- 2.4.1 The Council of Governors may appoint a Deputy Chair in accordance with the Constitution.
- 2.4.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair.
- 2.4.3 Where the Chair of the Trust has ceased to hold office or has been unable to perform their duties as Chair owing to absence through illness or any other cause, then the term Chair shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair, should a Deputy Chair have been appointed.

2.5 Appointment of Senior Independent Director

- 2.5.1 The Trust Board shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director, using the procedure set out in the Constitution.

2.5.2 Role of Trust Board

The Board will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.6 Joint Directors

- 2.6.1 Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directors, those persons shall become appointed as an Executive Director jointly and shall count for the purpose of Standing Orders as one person.
- 2.6.2 Where a post of Executive Director of the Trust Board is shared jointly by more than one person:
- (a) either or both of those persons may attend or take part in meetings of the Trust Board;
 - (b) if both are present at a meeting they should cast one vote if they agree;
 - (c) in the case of disagreements no vote should be cast;
 - (d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.7 Role of Members

- 2.7.1 The Trust Board will function as a corporate decision-making body, Executive Directors and Non-Executive Directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.7.2 Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.7.3 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.7.4 Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.5 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

2.7.6 Chair

The Chair shall be responsible for the operation of the Trust Board and chair all Trust Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall liaise with the representatives of the Council of Governors over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Trust Board in a timely manner with all the necessary information and advice being made available to the Trust Board to inform the debate and ultimate resolutions.

2.8 Corporate Role of the Trust Board

- 2.8.1 All business shall be conducted in the name of the Trust.
- 2.8.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.
- 2.8.3 The Trust has the functions conferred on it by the Health and Social Care (Community Health and standards) Act 2003 and by its Provider Licence, which include the Constitution.
- 2.8.4 The Trust Board shall define and regularly review the functions it exercises on behalf of the Independent Regulator.

2.9 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation

2.9.1 The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These powers and decisions are set out in the Schedule of Matters Reserved to the Board in Section B of this document and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Trust Board Members

2.10.1 The Chair will ensure that the designation of lead roles or appointments of Board guidance will be made in accordance with that guidance or statutory requirement.

2.11 Relationship between the Trust Board and the Council of Governors

2.11.1 In summary the Trust Board manage the business of the Trust (in accordance with the Constitution) and the Council of Governors conduct a number of tasks amongst them, approving the appointment of Non-Executive Directors and deciding their remuneration, terms and conditions (following recommendations from the Appointments, Terms and Conditions Committee); appointing the external auditors (following recommendations made to the Council of Governors by any task and finish group established to progress the appointment); and to review various periodic reports listed in the Constitution, presented to them by the Trust Board. The Council of Governors will represent the views of their constituencies so that the needs of the local health economy are taken into account when deciding the Trust's strategic direction.

2.11.2 In the event of any issues of conflict between the Trust Board and the Council of Governors, this should be raised with the Lead Governor and Senior Independent Director (SID). If a resolution cannot be found, the issue should be escalated to the Chair whose decision shall normally be final.

3. Meetings of the Trust Board

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Trust Board but shall be required to withdraw upon the Board resolving as follows:

'That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).'

The Chair shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

It was **resolved** that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'in confidence' or minutes and papers headed 'private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.1 Calling Meetings

- 3.1.1 Ordinary meetings of the Trust Board shall be held on a bi-monthly basis at such times and places as the Trust Board may determine. Meetings of the Trust Board will be held in public.
- 3.1.2 The Chair of the Trust may call a meeting of the Trust Board at any time.
- 3.1.3 One third or more of the voting Directors of the Trust Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

- 3.2.1 Before each meeting of the Trust Board a written notice specifying the business proposed to be transacted shall be delivered to every Director (by email or post to the usual place of residence of each Director) so as to be available to members at least five clear days before the meeting. Lack of service of such a notice on any member shall not affect the validity of a meeting. Details of meetings and the public agenda will be published on the Trust's website.
- 3.2.2 In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.
- 3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.
- 3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.
- 3.2.5 Before each meeting of the public Trust Board a notice of the time and place of the meeting shall be displayed on the Trust's website at least three clear days before the meeting. The public agenda and papers will be available on the Trust's website.

3.3 Agenda and Supporting Papers

- 3.3.1 The agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda,

3.4 Petitions

- 3.4.1 Where a petition has been received by the Trust the Chair shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

- 3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Trust Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.
- 3.5.2 The notice shall be delivered at least 14 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

- 3.6.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

3.7 Motions: Procedure at and During a Meeting

3.7.1 i) Who May Propose

A motion may be proposed by the Chair of the meeting or any Director present. It must also be seconded by another Director.

3.7.2 ii) Contents of Motions

The Chair may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the receipt of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Trust Board proceed to next business;
- that the Trust Board adjourn;
- that the question be now put.

3.7.3 iii) Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Trust Board

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 iv) **Rights of Reply to Motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 v) **Withdrawing a Motion**

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 vi) **Motions Once under Debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' Committee to deal with a specific item of business;
- that a Director be not further heard;

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Trust Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chair of Meeting

3.9.1 At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy-Chair (if the Board has appointed one), if present, shall preside.

- 3.9.2 If the Chair and Deputy Chair are absent, such member (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

3.10 Chair's Ruling

- 3.10.1 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

- 3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Board members (including at least one Executive Director and one Non-Executive Director) is present.
- 3.11.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.
- 3.11.3 If the Chair or another Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

- 3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chair of the meeting) shall have a second, and casting vote.
- 3.12.2 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- 3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- 3.12.4 If a Director so requests, their vote shall be recorded by name.
- 3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.
- 3.12.6 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.
- 3.12.7 A manager attending the Trust Board meeting to represent an Executive Officer during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. A manager's status when attending a meeting shall be recorded in the minutes.
- 3.12.8 For the voting rules relating to joint directors see Standing Order 2.6.

3.13 Suspension of Standing Orders

- 3.13.1 Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Trust Board are present (including at least one member who is an Executive Director of the Trust and one member who is a Non-Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board' minutes.
- 3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Trust.
- 3.13.3 No formal business may be transacted while Standing Orders are suspended.
- 3.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and Amendment of Standing Orders

- 3.14.1 These Standing Orders shall not be varied except in the following circumstances:
- upon a notice of motion under Standing Order 3.5;
 - upon a recommendation of the Chair or Chief Executive included on the agenda for the meeting;
 - that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment;
 - providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

- 3.15.1 The names of the Chair and Directors/members present at the meeting shall be recorded.

3.16 Minutes

- 3.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.
- 3.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

3.17 Admission of Public and the Press

3.17.1 Admission and Exclusion on Grounds of Confidentiality of Business to be Transacted

The public and representatives of the press may attend each meeting of the Trust Board, but shall be required to withdraw upon the Trust Board as follows:

It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

The Trust Board meetings shall be held in public, at which members of the public and representatives of the press shall be permitted to attend.

Members of the public are not permitted to ask questions during the meeting as it is a meeting held in public, not a public meeting. However, questions can be submitted to the Chair at the end of a meeting. Responses to the questions may be given at that time or in writing within 5 days of the meeting. Members of the public may be excluded from a meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

3.17.2 General Disturbances

The Chair (or Deputy Chair) or the person presiding over the meeting shall give such directions as they think fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

'That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'.

3.17.3 Business Proposed to be Transacted when the Press and Public have been Excluded from a Meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Trust Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' "private" or minutes headed "strictly confidential, not for wider circulation" outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Trust Board meeting which may take place on such reports or papers.

3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.17.5 Observers at Trust Board Meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. Appointment of Committees and Sub-Committees

4.1 Appointment of Committees

- 4.1.1 Subject to such directions as may be given by NHS England, the statutory entity that regulates NHS foundation trusts, the Trust Board may appoint Committees of the Trust.
- 4.1.2 The Trust Board shall determine the membership and terms of reference of Committees and Sub-Committees and shall if it requires, receive and consider reports of such Committees.

4.2 Joint Committees

- 4.2.1 Joint Committees may be appointed by the Trust Board by joining together with one or more other Trusts, Local Authorities or health service bodies consisting of, wholly or partly of the Chair and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.
- 4.2.2 Any Committee or joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Independent Regulator or the Trust or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

- 4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust. In which case the term "Chair" is to be read as a reference to the Chair or other Committee as the context permits, and the term "member" is to be read as a reference to a member or other Committee also as the context permits. There is no requirement to hold meetings of Committees, established by the Trust in public.

4.4 Terms of Reference

- 4.4.1 Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Trust Board), as the Trust Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees

- 4.5.1 Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-Committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

- 4.6.1 The Trust Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Trust Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Trust

Board as defined by the Independent Regulator. The Trust Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory Functions

- 4.7.1 Where the Trust Board is required to appoint persons to a Committee and/or to undertake statutory functions and where such appointments are to operate independently of the Trust Board such appointment shall be made in accordance with the regulations and directions made with the relevant authority.

4.8 Committees Established by the Trust Board

The Committees, sub-Committees, and joint-Committees established by the Board are:

4.8.1 Audit Committee

In line with the Standing Orders, the NHS Audit Committee Handbook, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Independent Regulator, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis.

The Committee will be comprised of not less than three Non-Executive Directors, unless the Trust Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 Quality Committee

In line with the Standing Orders, a Quality Committee will be established and constituted to provide the Trust Board with a strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues. The terms of reference will be approved by the Trust Board and reviewed on a periodic basis.

The Committee will be comprised of three Non-Executive Directors; the Director of Nursing, ~~Allied Health and Social Care Professionals~~ Quality and Professions; the Medical Director; and the Chief Operating Officer.

4.8.3 Remuneration and Nominations Committee

In line with Standing Orders, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Independent Regulator, a Remuneration and Nomination Committee will be established and constituted.

The Committee will provide assurance and advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, other senior employees on a Very Senior Managers contract and conditions including:

- (i) all aspects of salary (including any performance-related elements/bonuses);

- (ii) provisions for other benefits, including pensions and cars;
- (iii) arrangements for termination of employment and other contractual terms.

The Committee will approve, to the levels outlined in the terms of reference, recruitment and retention premia awarded to any member of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants).

The Committee will be comprised of all Non-Executive Directors (including the Chair).

4.8.4 Mental Health Legislation Committee

The Mental Health Legislation Committee is constituted as a sub-committee of the Trust Board.

The Committee will provide strategic leadership and assurance to the Trust Board pertaining to the Mental Health Act, the Mental Capacity Act and their respective Codes of Practice and other mental health related legislation and will;

- monitor, provide challenge and seek assurance of compliance with external standards relating to Mental Health Legislation.
- approve and review mental health legislation policies and protocols.
- promote and encourage joint working arrangements regarding the implementation of Mental Health Legislation with partner organisations including local authorities, clinical commission groups, acute hospital trusts, police and ambulance services.
- receive report regarding inspecting authorities and to monitor the implementation of action plans in response to any recommendations made

The Committee will be comprised of one Non-Executive Director (who is designated Chair); at least two other Non-Executive Directors (one of which is also a designated Associate Hospital Manager, if not the Chair); the Medical Director; the Chief Operating Officer; the Clinical Director; and the Director of Nursing, Allied Health and Social Care Professionals Quality and Professions.

4.8.5 Finance Committee

The Finance and Investment Committee is constituted as a sub-committee of the Trust Board.

The Committee will provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across all financial areas and any potential investment decisions.

The Committee will;

- Scrutinise, review and endorse all financial plans prior to seeking Board approval.
- Approve the processes and timetable for annual budget setting, and budget management arrangements
- Monitor delivery of Trust's Capital Investment Programme
- Monitor progress and seek assurance on the progress against the Trust Digital Plan
- Scrutinise all business cases for new business and investment and review all tenders presented to the Committee

- Review and assess business cases to support and govern all investments, contracts and projects as set out in the committee's terms of reference.
- Review the robustness of the risk assessments underpinning financial forecasts
- Monitor delivery of the Trust's budget reduction strategy and other financial savings programmes

The committee is comprised of three Non-Executive Directors; the Director of Finance; Chief Operating Officer; and Chief Information Officer.

4.8.6 People and Organisational Development Committee

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

The People and Organisational Development Committee exists to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and organisational development that supports the Trust to deliver its strategic objectives and provide high quality care.'

The Committee will be comprised of three Non-Executive Directors (one of whom will be the Committee Chair); the ~~Associate~~ Director of People and OD; the Chief Operating Officer; the Medical Director; and the Executive Director of Nursing, ~~Allied Health and Social Care Professionals~~Quality and Professions.

4.8.7 Provider Collaborative Committee

The Provider Collaborative Committee is constituted as a sub-committee of the Trust Board.

The Trust is the Lead Provider within the Humber and North Yorkshire Provider Collaborative and will hold the Lead Contract with NHS England. The Trust as Lead Provider will sub-contract with a range of healthcare providers in the delivery of:

- Child and Adolescent Mental Health In-Patient services
- Adult Low and Medium Secure services
- Adult Eating Disorder Services.

The Collaborative Committee has been established by the Trust as the Lead Provider and holds delegated responsibility to provide commissioning leadership and monitoring functions. On behalf of the Provider Collaborative and Lead Provider the Collaborative Committee will review any significant service proposals to ensure developments are in line with the assessed population needs and can be met from within the resources available within the Provider Collaborative. The Collaborative Committee will provide the Trust Board with a strategic overview of and assurance against provider collaborative issues.

The committee will be comprised of two Non-Executive Directors (one of whom will be the Committee Chair); the Associate Non-Executive Director; the Chief Executive; the Director of Finance; the Director of Nursing, ~~Allied Health and Social Care Professionals~~Quality and Professions; the Collaborative Planning Director; and the Clinical and Quality Assurance Director.

4.8.8 Other Committees

The Trust Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5. Arrangements for the Exercise of Trust Functions by Delegation

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to the Constitution and directions as may be given by the Independent Regulator, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, or any of its functions

- a) by a Committee, sub-Committee appointed by virtue of Standing Order 4, or by an officer of the Trust,
- b) or by another body as defined in Standing Order 5.1.2 below,
- c) in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to Committees, sub Committees or Officers, the Trust retains full responsibility.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Trust Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, or sub-Committees, or joint-Committees, which it has formally constituted in accordance with directions issued by the independent regulator. The Constitution and terms of reference of these Committees, or sub-Committees, or joint Committees, and their specific executive powers shall be approved by the Trust Board in respect of its sub-Committees.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a Committee or sub-Committee or joint-Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Trust Board subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Trust Board as indicated above.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Trust Board of the Director of Finance to provide information and advise the Board in accordance with statutory or independent regulator requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board as set out in the "Scheme of Matters Reserved to the Board" in Section C shall have effect as if incorporated in these Standing Orders.

5.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Overlap with Other Trust Policy Statements/Procedures, Regulations and Standing Financial Instructions

6.1 Policy Statements: General Principles

6.1.1 The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Humber Teaching NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy Statements

6.2.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Managing Declarations of Interests
Policy for NHS Staff
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

6.3.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific Guidance

6.4.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Confidentiality: NHS Code of Practice 2003;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. Duties and Obligations of Trust Board Members/Directors and Senior Managers under the Standing Orders

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and Applicability to Trust Board

The Constitution, 2006 Act and the Code of Conduct and Accountability requires Trust Directors to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board Directors should declare such interests. Any Directors appointed subsequently should do so on appointment. It is a condition of employment that those holding director or director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's Provider Licence, the Health & Social Care Act 2012 (Regulated Activities) Regulation, and the Trust's Constitution.

7.1.2 Interests which are Relevant and Material

Interests which should be regarded as "relevant and material" are:

- a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);
- b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
- d) A position of authority in a charity or voluntary organisation in the field of health and social care;
- e) Any connection with a voluntary or other organisation contracting for NHS services;
- f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders and banks
- g) Research funding/grants that may be received by an individual or their department;
- h) Interests in pooled funds that are under separate management

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 and elsewhere) has any pecuniary interest, direct or indirect, the Trust Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Trust Board members have any doubt about the relevance of an interest, this should be discussed with the Chair of the Trust, or with the ~~Trust Secretary~~Head of Corporate Affairs.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in Trust Board Minutes

At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of Declared Interests in Annual Report

Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of Interest which Arise during the Course of a Meeting

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Trust Board. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both Executive and Non-Executive Trust Board members.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local population and to publicise arrangements for viewing it.

7.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

7.3.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 7.1 as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- a) he/she, or a nominee of his/her, is a Director of a company or other body (not being a public body), with which the contract was made, or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration, or
- b) he/she is a partner, associate or employee of any person with whom the contract is made or proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

- a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
- b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
- c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2.

7.3.2 Exclusion in Proceedings of the Trust Board

- (i) Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

- (ii) The Board may exclude the Chair or a Director of the Trust Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.
- (iv) Any remuneration, compensation or allowance payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- (v) This Standing Order applies to a Committee or sub-Committee and to a joint Committee or sub-Committee as it applies to the Trust and applies to a member of any such Committee or sub-Committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff must comply with the Trust's Standards of Business Conduct and Managing Conflicts of Interest Policy for NHS Staff and the national guidance produced by NHS England on Managing Conflicts of Interest.

7.4.2 Interest of Officers in Contracts

- i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or ~~Trust Secretary~~Head of Corporate Affairs as soon as practicable.
- ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.
- iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

- i) Canvassing of Members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.
- ii) A Member shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

- iii) Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

7.4.4 Relatives of Members or Officers

- i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.
- ii) The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself/herself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.
- iii) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust Board whether they are related to any other Director or holder of any office under the Trust.
- iv) Where the relationship to a Director of the Trust is disclosed, the Standing Order headed 'Exclusion of Chair and Members in proceedings on account of pecuniary interest' (SO 7.3) shall apply.

8. Custody of Seal, Sealing of Documents and Signature of Documents

8.1 Custody of Seal

- 8.1.1 The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

- 8.2.1 Where a document is to be sealed, the CEO (or their nominated deputy) and the Director of Finance (or their nominated deputy) shall authorise the use of the seal and the affixing of the seal shall be attested and signed by the CEO (or their nominated deputy) and the Director of Finance (or their nominated deputy).
- 8.2.2 Where a document is required to be executed as a deed (this includes leases, transfers of land, the appointment of trustees and powers of attorney) or where the Trust determines that a contract or other document should be executed as a deed, the document must be executed under seal in accordance with the procedure in 8.2.1 above. All construction contracts and contracts for capital works shall be executed under seal.
- 8.2.3 For the avoidance of doubt, the requirements set out above in relation to the execution of deeds and the affixing of the seal do not affect, and operate in addition to, the delegated authorities set out in the Trust's Scheme of Reservation and Delegation.

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	<i>Regulations and Control</i> 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.

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		11. Confirm the recommendations of the Trust's Committees where the Committees do not have 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. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 16. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 17. Authorisation of any long term loans to be taken out by the Board within the authorisation limits set out in SFI 20.1.6 18. Approve the formation of any joint venture, either contractual or corporate or a subsidiary company. 19. The granting of loans to any subsidiaries will be subject to approval by the Board regardless of value. ~~49. Under decisions reserved to the board.~~ <u>The Board shall ensure compliance with applicable Government Commercial Spend Controls and assurance requirements, including where relevant NHS England, Department of Health and Social Care, Cabinet Office and HM Treasury approvals, and shall retain accountability for high-value and high-risk commercial activity.</u>
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.

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		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. 5. Approve the Trust's Risk Management Strategy policies and procedures for risk management. 6. Approve Outline and Full Business Cases for Capital Investment. 7. Approve budgets. 8. Approve annually the Trust's proposed Organisational Development proposals. 9. Approve the Trust's Organisation Development Strategy and annual plans 10. Approve proposals for acquisition, disposal or change of use of land and/or buildings. 11. Approve Private Finance Initiative (PFI) proposals. 12. Approve the opening of bank accounts. 13. Approve proposals on individual contracts amounting to, or likely to amount to over £750,000 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. <u>Policies will be determined and approved by the Executive Management Team and ratified by the Board in accordance with the Conflicts of Interest, Managing Interests and Standards of Business Conduct for NHS Staff policy</u> ~~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.~~

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REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
	THE BOARD	Audit 1. Receive the annual management letter received from the external auditor and taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Internal Auditor and agree necessary actions taking account of advice from the Audit Committee.
NA	THE BOARD	Annual Reports and Accounts 1. Receive and approval of the Trust's Annual Report and Annual Accounts. 2. Receive and approval of the Annual Report and Accounts for funds held on trust. 3. Receive and approve the Trust's Annual Quality Accounts
NA	THE BOARD	Monitoring 1. Receive such reports as the Board sees fit from Committees in respect of their exercise of powers delegated. 2. Continuously monitor the affairs of the Trust by means of the provision to the Board as the Board may require from Directors, Committees, and officers of the Trust as required. 3. Receive reports from the Director of Finance on financial performance against all internally and externally set targets and standards. 4. Approve and monitor the Board Assurance Framework 5. Approve the Annual Governance Statement based on the Audit Committee's recommendation 6. Approve the Trust's registration with the Care Quality Commission

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PART B: DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will: 1. Advise the Trust Board on internal and external audit services; 2. Monitor compliance with Standing Orders and Standing Financial Instructions; 3. Review schedules of losses and compensations and make recommendations to the Board. 4. Review schedules of debtor/creditor balances 5. Review the annual financial statements prior to submission to the Board. 6. Review the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advise the Board accordingly.
	QUALITY COMMITTEE	The Committee will: 1 Provide a strategic overview of Clinical Governance, Risk and Patient Experience to the Trust Board. 2 Co-ordinate all activities relating to Quality, Patient Safety and Patient Experience on behalf of the Trust Board. 3 Provide an assurance to the Trust Board that risk and governance issues of all types are identified, monitored and controlled to an acceptable level. 4 Provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives 5 Ensure all areas/departments of the Trust produce a risk register that relates local risks to achieving the Trust's strategic objectives. 6 Advise the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action. 7 Ensure that there is an effective mechanism for reporting significant risks and governance issues to the Trust Board in a timely manner. 8 Provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction 9 Oversee the strategic direction of the Recovery College 10 Monitor and advise the work of the Research and Development Committee 11 Quality Committee will ensure that there is an integrated approach to quality and effectiveness, and patient and staff safety throughout the Trust.

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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. 14.15 Ratify quality related annual reports, following approval by the Executive Management Team.
	REMUNERATION AND NOMINATION COMMITTEE	The Committee will: - 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; - 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; - 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; - Approval of any special severance payments in accordance with HM Treasury guidance; - The Committee shall report in writing to the Trust Board the basis for its recommendations.
	MENTAL HEALTH LEGISLATION COMMITTEE	The Committee will: - 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. - 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 commissioning groups, acute hospital trusts, police and ambulance services. - Receive reports regarding inspecting authorities and to monitor the implementation of actions plans in response to any recommendations made.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	FINANCE & ~~INVESTMENT~~ COMMITTEE	The Committee will: 1. Scrutinise, review and endorse 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.
	PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE	The Committee will: 1. Provide oversight and assurance to the Board in relation to robust processes for the effective management of Workforce and Organisational Development; 2. Be assured on the management of the high operational risks on the corporate risk register which relate to workforce and organisational development and ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner. 3. Be assured of the Trust's response to all relevant Directives, national standard, policies, reports, reviews and best practice as issued by the Department of Health, NHS Improvement and other regulatory bodies / external agencies to gain assurance that they are appropriately reviewed and actions are being undertaken and embedded. 4. To be assured that the views of staff are captured, understood and responded to.

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REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<u>5.</u> 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. <u>5-6. Ratify People and Organisational Committee related annual reports, following approval by the Executive Management Team.</u>
	COLLABORATIVE COMMITTEE	The Committee will: 1. Provide commissioning leadership and monitoring functions 2. Provide assurance to the Board on matters of financial performance 3. Undertake contractual monitoring, financial and performance management of the Provider Collaborative to deliver the HCV aims 4. Monitoring performance including quality assurance on outcomes, experience, safety, activity and finance. 5. Contract management, including quality assurance across NHS and independent sector. 6. Appropriate reporting to Humber and North Yorkshire – Specialised Mental Health and Learning Disability - Provider Collaborative Oversight Group and NHSE/I (including nationally required returns)

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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.

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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.

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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;

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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.

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DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHAIR AND DIRECTORS	Declaration of conflict of interests.
THE TRUST BOARD	NHS Boards must comply with legislation and guidance issued by the Independent Regulator and the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.
ASSOCIATE HOSPITAL MANAGERS	Under Section 23(6) of the Mental Health Act 1983 the Trust delegates its power of discharge to individuals authorised by the Board for that purpose.
THE TRUST BOARD	Responsible for ensuring that the requirements of the Mental Health Act are fully met and that there are sufficient Associate Hospital Managers to fulfil the requirements in terms of consideration for discharge.
NON-EXECUTIVE DIRECTOR WITH RESPONSIBILITY FOR MENTAL HEALTH LEGISLATION	Oversees the appointment, review, and termination of Associate Hospital Managers.

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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 GOVERNORS	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 <i>Managing Conflicts of Interest in the NHS - Guidance for staff and organisations</i> " (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	Authorise and attest fixing of the Seal, keep Seal in a safe place and maintain a register of Sealing.
8.4	CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

*A full list of Statutory Roles and Responsibilities of the Council of Governors is appended to this document.

PART F: SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFIs)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.5	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.1	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.2	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.3	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of the Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.

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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.

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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.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
16.6.2	CHIEF EXECUTIVE	Direct Award Justification.
16.6.2	CHIEF EXECUTIVE	Report direct contract award justifications to the Audit Committee.
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.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
16.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
16.17	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
16.17.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
17.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
17.2	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
18.1.1	BOARD	Establish a Remuneration & Nomination Committee
18.1.2	REMUNERATION & NOMINATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the Chief Executive, Executive members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
18.1.3	REMUNERATION & NOMINATION COMMITTEE	Report in writing to the Trust Board its advice and its bases about remuneration and terms of service of Directors and senior employees.
18.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
18.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
18.4.1 and 18.4.2	DIRECTOR OF FINANCE/DIRECTOR OF ~~WORKFORCE PEOPLE~~ & 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.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
18.4.5	DIRECTOR OF FINANCE/DIRECTOR OF ~~WORKFORCE-PEOPLE~~ & 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;

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
19.2.3	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
19.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
19.2.5	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform the Director of Finance if problems are encountered).
19.2.6	CHIEF EXECUTIVE/DIRECTOR OF FINANCE	Authorise who may use and be issued with official orders.
19.2.7	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
19.2.8	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
19.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
20.1.1	DIRECTOR OF FINANCE	The Director of Finance will advise the Board on the Trust's ability to pay dividend on PBC, and any proposed borrowing limits set by its Provider Licence and report, periodically, concerning the PDC debt and all loans and overdrafts.
20.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Director of Finance.)
20.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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
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.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
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).
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.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
23.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking.
23.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
24.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
24.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
24.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Director of Finance.
24.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, the Director of Finance must inform the police if theft or arson is involved. In cases of fraud and corruption the Director of Finance must inform the relevant LCFS and NHS Counter Fraud Authority.
24.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority and External Audit
24.2.3	DIRECTOR OF FINANCE	Notify the Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
24.2.4	BOARD	Approve write off of losses (within limits delegated by H M Treasury's Managing Public Money).
24.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
24.2.7	DIRECTOR OF FINANCE	Maintain a losses and special payments register.
25.1.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
25.1.2	DIRECTOR OF FINANCE	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
25.2.1	RELEVANT OFFICERS	Send details of the outline design of the computer system to the Director of Finance.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
25.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
25.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) Director of Finance and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
25.1.3	DIRECTOR OF NURSING	Shall publish and maintain a Freedom of Information (FOI) Scheme.
26.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
26.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
26.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
27.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
28	CHIEF EXECUTIVE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
29	CHIEF EXECUTIVE	Ensure retention of document procedures in accordance with NHS Records Management: Code of Practice
30.1	CHIEF EXECUTIVE	Ensure a Risk Management programme is in place
30.1	BOARD	Approve and monitor Risk Management programme.
30.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
30.4.1	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
30.4.1	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

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PART G: SCHEME OF BUDGETARY DELEGATION

Quotation, Tendering and Control Procedures – only applicable to goods, works and non-health care services		
Goods, works and non-health care services including Estates and Maintenance <i>(where this relates to contracts over more than one year, the lifetime contract value is delegated as per below)</i>		
Lifetime Value (including extension options) (excluding VAT)	Minimum No	Authorised by
Up to £9,999	At discretion of budget holder/Purchasing officer	Budget holder
£10,000 to £24,999 (Goods, Services & Works)	3 or more quotes or non-competitive quotation only in permissible circumstances	Division General Manager or for works Deputy Director of Estates and Facilities
£25,000 up to Procurement Act threshold (Goods & Services)	3 or more quotes or non-competitive quotation only in permissible circumstances	Director
£25,000 to £249,999 (Works)	3 or more quotes or non-competitive quotation only in permissible circumstances	Director of Finance
£250,000 up to Procurement Act threshold (Works)	Local tendering process	Chief Executive and Board if over £750k (annual value)
For any Goods, Services and Works above Procurement Act thresholds	Formal tendering process in accordance with Procurement Act	Director of Finance/Chief Executive/Board
The above applies to contracts for goods, works and non-health care services unless a framework agreement (SFI 21.1.2) applies in which case the above does not apply.		

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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~~ £10,000 to £49,999	Divisional General Manager
~~£25,000 to £49,999~~ £50,000 - £99,999	Director
~~£50,000 to £249,999~~ £100,000 - £499,999	Director of Finance
~~£250,000 to £750,000~~ £500,000 - £999,999	Chief Executive*
Over ~~£750,000~~ £1m	Trust Board

*during periods of absence of the Chief Executive (planned and unplanned) the authorisation limits will be delegated to the Director of Finance in the first instance, and then to the Deputy Chief Executive (in any instances where both the Chief Executive and Director of Finance are absent at the same time).

Authorisation of Losses and Special Payments		
Delegated Matter	Up to £5,000	£5,000 to £49,999
Losses of cash	Director of Finance ~~and The Head of Financial Controller Trust Secretary~~	Chief Executive and Director of Finance

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Drawing Down of Pre-Arranged Loans		
	1 st Signatory	2 nd Signatory
Any pre-arranged loan	Chief Executive or Director of Finance (or person acting up*)	Deputy Director of Finance or Executive Director

Short term loans		
Short term borrowing up to £499,000	With the authority of two members of an authorised panel, one of which must be the Chief Executive or Director of Finance	The Board must be made aware of all short term borrowings at the next Board meeting.

Expenditure on Charitable and Endowment Funds	
Up to £4,999	Fund Manager, Health Stars Charity/Fundraising Manager
Over £5,000*	Fund Manager, Director of Finance and Executive Management Team
*Any expenditure over £5,000 is subject to procurement rules and budgetary delegation set out above and elsewhere in the SFIs	
Over £25,000	Fund Manager, Director of Finance and Trust Board as Corporate Trustee
Over £100,000	Trust Board as Corporate Trustee

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**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.

10.1.8 These Standing Financial Instructions should be read in conjunction with Government Commercial Spend Controls and assurance guidance, including requirements operated by NHS England and the Department of Health and Social Care under delegated authority from Cabinet Office, and where applicable HM Treasury

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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;

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- (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 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 at NHS Requirement 9 of the Government Functional Standard (GOVS 013: Counter fraud).
- 11.5.3 The LCFS shall report to the Trust's Director of Finance and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Counter Fraud Manual.
- 11.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

- 11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.
- 11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.
- 11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.
- 11.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. Allocations, Planning, Budgets, Budgetary Control and Monitoring

12.1 Preparation and Approval of Plans and Budgets

- 12.1.1 The Chief Executive will compile and submit to the Board an annual budget which takes into account financial targets and forecast limits of available resources. The Strategic Plan will contain:
 - (a) a statement of the significant assumptions on which the plan is based;
 - (b) details of major changes in workload, delivery of services or resources required to achieve the plan.
- 12.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:
 - (a) be in accordance with the aims and objectives set out in the Annual Plan
 - (b) accord with workload and manpower plans;
 - (c) be produced following discussion with appropriate budget holders;
 - (d) be prepared within the limits of available funds;
 - (e) identify potential risks.

- 12.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.
- 12.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.
- 12.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.
- 12.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

12.2 Budgetary Delegation

- 12.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
 - (a) the amount of the budget;
 - (b) the purpose(s) of each budget heading;
 - (c) individual and group responsibilities;
 - (d) authority to exercise virement;
 - (e) achievement of planned levels of service;
 - (f) the provision of regular reports.
- 12.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.
- 12.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 12.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

12.3 Budgetary Control and Reporting

- 12.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:
 - (a) monthly financial reports to the Board in a form approved by the Board containing:
 - (i) income and expenditure to date showing trends and forecast year-end position;
 - (ii) movements in working capital;
 - (iii) movements in cash and capital;
 - (iv) capital project spend and projected outturn against plan;
 - (v) explanations of any material variances from plan;
 - (vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

- (b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- (c) investigation and reporting of variances from financial, workload and manpower budgets;
- (d) monitoring of management action to correct variances; and
- (e) arrangements for the authorisation of budget transfers.

12.3.2 Each Budget Holder is responsible for ensuring that:

- (a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;
- (b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
- (c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

12.3.3 (a) Where an employee has more than one post with Humber Teaching NHS Foundation Trust then for the purposes of approval of expenses on-line the budget holder for the primary post will be the person designated to approve expenses claims for all posts held by the individual staff member.

12.3.4 The Chief Executive is responsible for ensuring the Trust identifies and implements cost improvements and income generation initiatives in accordance with the requirements of the Strategic Plan and a balanced budget.

12.4 Capital Expenditure

12.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

12.5 Monitoring Returns

12.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

13. Annual Accounts and Reports

13.1 The Director of Finance, on behalf of the Trust, will:

- (a) prepare financial returns in accordance with the accounting policies and guidance given by NHSE Monitor, the Trust's accounting policies, and generally accepted accounting practice;
- (b) prepare and submit annual financial reports to NHSE 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 ~~NHSE~~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, and the procedures for keys, ~~and for coin-operated machines;~~
 - (d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

- 15.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.
- 15.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.
- 15.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16. PROCUREMENT OF GOODS, WORKS AND NON-HEALTH CARE SERVICES

This procedure is used for when the Trust is procuring goods, works and non-health care services

16.1 Duty to Comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions (except where SO 3.13 is applied).

16.2 Legislation Governing Public Procurement (Goods and non-health care services)

- (a) The Trust shall comply with The Procurement Regulations 2024 (the "Regulations") 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.

(d) In addition to compliance with Procurement Regulations and NHS guidance, the Trust must adhere to applicable Government Commercial Spend Controls and assurance requirements. Commercial activity with a whole-life value of £50 million or more may be subject to additional commercial assurance, with the requirement for external assurance and approval dependent on the value, nature and risk of the activity, including whether it is Novel, Contentious or Repercussive (NCR) and whether it exceeds the Departmental Delegated Authority Limits (DALs). All commercial pipeline activity must be recorded in Atamis with an appropriate forward look to support early commercial engagement and proportionate assurance.

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16.3 Guidance on Public Procurement and Commissioning

- a. The Trust should have regard to all relevant guidance issued by the NHS England in relation to the conduct of procurement practice and the commissioning of health care services, including but not limited to:
- b. All off payroll engagements of more than six months in duration, for more than a daily rate of £220 should be referred to the Trust Procurement department before commitment to contract is given. This is to ensure contractual provisions are explicit that allow the Trust to seek assurance regarding the income tax, NIC obligations and IR35 status of the engagement – and to terminate the contract if that assurance is not provided. The general provision in relation to tendering 16.6.1 and quotations 16.8.1 also apply in addition to this requirement.

16.4 Decision to Tender and Exceptions to Requirement to Tender

16.4.1 Presumption to Tender

Where:

(a) a contract opportunity that is required to be tendered under The Procurement Regulations 2024 i.e. the contract opportunity is governed by The Procurement Regulations 2024 and the value of the contract opportunity as calculated pursuant to The Procurement Regulations 2024 exceeds the relevant financial threshold for the requirement to run a formal tender process; then the Trust shall ensure that contract opportunities with the Trust are advertised in accordance with SFI 16.6.6 and competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of non-health care services including all forms of management consultancy services;
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- subject to SFI 16.16 for disposals.

16.5 Capital Investment Manual and Other Department of Health Guidance

The Trust shall comply with the requirements of the Department of Health's Capital Investment Manual and Estate code in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply with the Independent Regulator's Management Consultancy spending approval process.

16.6 Formal Competitive Tendering

16.6.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of non-health care services including all forms of management consultancy services;
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

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- Commercial assurance and approvals must be obtained before commencing a tender, in line with Government Commercial Spend Controls.

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16.6.2 Circumstances where Formal Tendering Need Not be Applied and Justifications for Direct Award

Circumstances where formal tendering procedures **need not be applied**:

- 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;
- where the supply is proposed under special arrangements negotiated by NHS England in which event the said special arrangements must be complied with;
- regarding disposals as set out in SFI 24;
- the Trust is entitled to call off from a Framework Agreement and the requirements of SFI 21.1.2 (Use of Framework Agreements) have been followed and have been approved in accordance with the Scheme of Delegation

Direct contract awards are justified in the following circumstances (subject to Director of Finance/Chief Executive approval):

- Prototypes and development
The public contract concerns the production of a prototype, or supply or other novel goods or services, for the purpose of:
 - Testing the suitability of the goods or services,
 - Researching the viability of producing or supplying the goods or services at scale and developing them for that purpose, or
 - Other research, experiment, study or development.
- Single suppliers (applies in three situations)
 - The public contract concerns the creation or acquisition of a unique work of art or artistic performance, or
 - The following conditions are met in relation to the public contract:
 - Due to a particular supplier having intellectual property rights or other exclusive rights, only that supplier can supply the goods, services or works required, and
 - There are no reasonable alternatives to those goods, services or works, or
 - The following conditions are met in relation to the public contract:
 - Due to an absence of competition for technical reasons, only a particular supplier can supply the goods, services or works required, and

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- (b) There are no reasonable alternatives to those goods, services or works.

(g) Additional or repeat goods, services or works

The public contract concerns the supply of goods, services or works by the existing supplier which are intended as an extension to, or partial replacement of, existing goods, services or works in circumstances where:

- i. a change in supplier would result in the contracting authority receiving goods, services or works that are different from, or incompatible with, the existing goods, services or works, and
- ii. the difference or incompatibility would result in disproportionate technical difficulties in operation or maintenance, or

A contract has previously been awarded under a competitive tendering procedure and the tender notice or tender documents set out the authority's intention to carry out a subsequent procurement of similar goods, services or works.

(h) Commodities

The public contract concerns goods purchased on a commodity market.

(i) Advantageous terms on insolvency

The award of the public contract to a particular supplier will ensure terms particularly advantageous to the contracting authority due to the fact that a supplier, whether or not the one to whom the contract is to be awarded, is undergoing insolvency proceedings.

(j) Urgency

Where –

- i. The goods, services or works to be supplied under the public contract are strictly necessary for reasons of extreme and unavoidable urgency, and
- ii. As a result the public contract cannot be awarded on the basis of a competitive tendering procedure.

Urgent is not unavoidable if it is attributable to any act or omission of the authority or could have been foreseen by the authority. The situation must be so urgent that the authority cannot comply with the timescales required for a competitive tender (even the shortened timescales permitted for urgency).

(k) User choice contracts

This refers to situations where an authority is required by law to consider the views of a third party in the choice of supplier (for example, a parent or a carer).

(l) Defence and security

In certain circumstances, some defence and security contracts can be awarded without a competitive tendering procedure.

Where a direct contract award request is submitted to the Contracting and Procurement Team, the requestor should be confident they have evidence to support the request (as outlined in paragraphs (e) to (l) above) and need to complete a Direct Award Justification template. The Direct Award Justification request needs to be authorized by either Director of Finance (direct awards with an annual value upto £249,999) or Chief Executive (direct awards with an annual value of £250,000 or above). All direct award justifications will be reported to the Audit Committee.

16.6.3 Equality of Treatment

The Trust shall ensure that no sector of any market (public, private, third sector/social enterprise is given an unfair advantage in the design or conduct of any tender process.

16.6.4 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.

16.6.5 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

16.6.6 Advertisement of Contract Opportunities

Where a formal tender process is required under SFI 16.4 then:

- (a) where a contract opportunity falls within the Regulations and a process compliant with the Regulations is required, a relevant notice should be utilised; or
- (b) Where a contract opportunity does not fall within the Regulations the Trust shall utilise a form of advertising for such contract opportunity that is sufficient to enable potential providers to access appropriate information about the contract opportunity so as to be in a position to express an interest; and

16.6.7 Choice of Procedure

- (a) Where a contract opportunity falls within The Procurement Regulations 2024 and a process compliant with The Procurement Regulations 2024 is required then the Trust shall utilise an available tender procedure under The Procurement Regulations 2024.

(b) In all other cases the Trust shall utilise a tender procedure proportionate to the value, complexity and risk of the contract opportunity.

16.7 Tendering Procedure

16.7.1 Invitation to Tender

- (a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.
- (b) All invitations to tender shall state that no tender will be accepted unless:
 - (i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;
 - (ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.
 - (iii) or are submitted electronically through the appropriate process using the Trust's e-tendering service, as instructed within the tender documentation;
- (c) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

Every invitation to tender must require each bidder to give a written undertaking not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered.

- (d) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

16.7.2 Receipt and Safe Custody of Tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

16.7.3 Opening Tenders and Register of Tenders

- (a) Tenders are received electronically and the Procurement team will be responsible for the unlocking of the e-tendering portal to allow bids to be opened with an audit trail kept on the accessing of the electronic tender submissions.
- (b) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 16.7.5 below).

16.7.4 Admissibility of Tenders

- (a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.
- (b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

16.7.5 Late Tenders

- (a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.
- (b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.
- (c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

16.7.6 Accountability where In-house Bid

- (a) In all cases where the Trust determine that in-house services (which term includes Trust community services) should be subject to competitive tendering the following groups shall be set up:
 - Specification group, comprising the Chief Executive or nominated officer/s and specialist officer whose function shall be to draw up the specification of the service to be tendered.
 - In-house tender group, comprising a nominee of the Chief Executive and technical support to draw up and submit the in-house tender submission.
 - Evaluation group, comprising normally a specialist officer, a supplies or commissioning officer and a Director of Finance representative whose function is to shortlist expressions of interest received and evaluate

tenders received. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team.

- (b) No officer or employee of the Trust directly engaged or responsible for the provision of the in-house service subject to competitive tendering may be a member of any of the specification or evaluation group established under SFI 16.7.12(a) but the specification group may consult with and take into account information received from such officers or employees in drawing up the Trust's specification subject at all times to observing the duty of non-discrimination at SFI 16.7.6. No member of the in-house tender group may participate in the evaluation of tenders.
- (c) The evaluation group shall make recommendations to the Board.
- (d) The Chief Executive shall nominate an officer to oversee and manage the contract awarded on behalf of the Trust.

16.7.7 Acceptance of Formal Tenders (See overlap with SFI No. 16.7)

- (a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.
- (b) Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders (see SFI 16.7.5 above).
- (c) Where examination of tenders reveals errors which would affect the tender figure, the tenderer may be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.
- (d) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- (i) experience and qualifications of team members;
- (ii) understanding of client's needs;
- (iii) feasibility and credibility of proposed approach;
- (iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

- (e) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

- (i) No tender shall be accepted by the Trust which is obtained contrary to these SFIs except with the authorisation of the Chief Executive or Director of Finance.
- (ii) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be kept confidential and should be retained for 12 months from the date set for the receipt of tenders for inspection.
- (f) The use of these procedures must demonstrate that the award of the contract was:
 - (i) not in excess of the going market rate / price current at the time the contract was awarded;
 - (ii) that best value for money was achieved.
- (g) All tenders should be treated as confidential and should be retained for inspection.
- (h) All tendering activity carried out through e-tendering should be compliant with Trust policies and procedures. Issue of all tender documentation will be done electronically through a secure website with controlled access using secure login, authentication and viewing rules. All tenders will be received into a secure vault so that they cannot be accessed until an agreed opening time.

16.7.8 Tender Reports to the Board

Reports to the Board will be made on an exceptional circumstance basis only.

16.7.9 Monitoring and Audit of Decision to Tender

- (a) The waiving of competitive tendering procedures should not be used with the object of avoiding competition or solely for administrative convenience or subject to SFIs 16.8.2 to award further work to a provider originally appointed through a competitive procedure.
- (b) Where it is decided that competitive tendering need not be applied or should be waived, the fact of the non application or waiver and the reasons for it should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.
- (c) Where the Trust proposes not to conduct a tender process in relation to a contract opportunity for a new health care service or a significantly changed health care service then the Trust shall consider such proposal at a meeting of the Board as recommended by the Trust Procurement Guide

16.7.10 List of Approved Firms for Building and Engineering Construction Works

The Trust does not hold a physical approved contractors list as it uses general open tendering principles the same as for all other tenders created. Where relevant the Trust may use the services of construction industry standards such as Constructionline or YORBuild to pre approve contractors to bid for work.

16.7.11 Checks to be Undertaken When Not Using Approved Lists

Where a contract (and where appropriate a quote) is to be awarded to a contractor who is not

on an approved list there should be appropriate checks to ensure that the Contractor is technically competent, financially secure and where appropriate that they comply with any appropriate equalities and health and safety legislation.

16.7.12 Contracts for Building or Engineering Works

- (a) Subject to SFIs 16.7.9(b) inclusive, every contract for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode.
- (b) When the content of the work is primarily engineering every contract shall embody or be in the terms of:
- the General Conditions of Contract recommended by the Institution of Mechanical Engineers; and/or
 - the Association for Consultancy and Engineering (Form A);
- (c) In the case of civil engineering work every contract shall embody or be in the terms of the General Conditions of Contract recommended by:
- the Institution of Civil Engineers; and/or
 - the Association for Consultancy and Engineering; and/or
 - the Civil Engineering Contractors Association.
- (d) Each of the documents referred to in SFI 16.7.12 (a) to (c) inclusive may be modified and/or amplified to accord with Department of Health guidance and, with appropriate professional advice (including legal advice if necessary), to cover special features of individual projects.

16.8 Quotations: Competitive and Non-Competitive

16.8.1 General Position on Quotations

Quotations for goods and non-health care services are required where formal tendering procedures are not adopted and where the intended expenditure exceeds the threshold set out in the Scheme of Delegation.

16.8.2 Competitive Quotations

- (a) Quotations should be obtained from up to 3 firms/individuals based on Scheme of Delegation prepared by the Trust.
- (b) Quotations should be in writing unless the Chief Executive or their 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 their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

16.8.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

- (a) the supply of proprietary or other goods of a special character and the rendering of non-health care services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
- (b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;
- (c) miscellaneous services, supplies and disposals;
- (d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.

16.8.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

16.9 Evaluation of Tenders and Quotations

16.9.1 Overriding Duty to Achieve Best Value

The Trust shall ensure that it seeks to obtain best value for each contract opportunity.

16.9.2 Choice of Evaluation Methodology

The Trust must for each contract opportunity which is subject to a tender or a competitive quotation choose to adopt evaluation criteria based on either:

- (a) the lowest price; or
- (b) the most economically advantageous tender, based on criteria linked to the subject matter of the contract opportunity including but not limited to some or all of:
 - quality;
 - price;
 - technical merit;
 - aesthetic and functional characteristics;
 - environmental characteristics;
 - running costs;
 - cost effectiveness;
 - after sales service;
 - technical assistance;
 - delivery date;
 - delivery period; and/or
 - period of completion

- (c) Each invitation to tender or invitation to supply a competitive quotation must state the evaluation criteria to be used to evaluate the tender or quotation and the relative weightings of each such criteria.

16.9.3 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract will be decided as specified in Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Board this shall be recorded in their minutes.

16.9.4 Form of Contract: General

Subject to the remainder of SFI 16.9.5 below the Trust shall consider the most applicable form of contract for each contract opportunity (including to the extent appropriate any NHS Standard Contract Conditions available) and should consider obtaining support from a suitably qualified professional advisor (including where appropriate legal advisors).

16.9.5 Statutory Requirements

The Trust must ensure that all contracts that are governed by mandatory statutory requirements (whether contained in Statute, Regulations or directions) comply with such requirements. Such contracts include, but may not be limited to:

- (a) GMS contracts;
- (b) PMS agreements;
- (c) SPMS contracts;
- (d) APMS contracts;
- (e) PCTMS contracts;
- (f) PDS agreements;
- (g) PCTDS contracts;
- (h) GDS contracts;
- (i) GOS contracts (mandatory and/or additional services contract)

16.10 Alternative Finance for Capital Procurement (See also SFI 22.2)

The Trust should normally market-test for different finance options (Including PFI *Private Finance Initiative funding*) when considering a capital procurement. When the Trust Board proposes, or is required, to use finance provided by the private sector the following should apply:

- (a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
- (b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.
- (c) The proposal must be specifically agreed by the Board.
- (d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

16.11 Compliance Requirements for all Contracts

The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

- (a) The Trust's Standing Orders and Standing Financial Instructions;

- (b) any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;
- (c) such of the NHS Standard Contract Conditions as are applicable.
- (d) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.
- (e) 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.
- (e) 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.
- (g) 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 may be by negotiating an irrevocable working capital facility. The value of this facility shall not exceed 30 days worth of normal operating expenditure.

21.1.2 Use of Framework Agreements

The Trust may utilise any available framework agreement to satisfy its requirements for works, services or goods but only if it complies with the requirements of Procurement Legislation in doing so, which include (but are not limited to) ensuring that:

- (a) the framework agreement was procured on its behalf. The Trust should satisfy itself that the original procurement process included the Trust within its scope;
- (b) the framework agreement includes the Trust's requirement within its scope. The Trust should satisfy itself that this is the case;
- (c) where the framework agreement is a multi-operator framework agreement, the process for the selection of providers to be awarded call-off contracts under the framework agreement is followed; and
- (d) the call-off contract entered into with the provider contains the contractual terms set out by the framework agreement.

22. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

22.1 Capital Investment

22.1.1 The Chief Executive:

- (a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- (b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- (c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

22.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

- (a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:
 - (i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
 - (ii) the involvement of appropriate Trust personnel and external agencies;
 - (ii) appropriate project management and control arrangements;
- (b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

22.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Estatecode.

22.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

22.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

22.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

- (a) specific authority to commit expenditure;
- (b) authority to proceed to tender (see also SFI 16.9);
- (c) approval to accept a successful tender (see also SFI 16.9).

The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with Estatecode guidance and the Trust's Standing Orders.

22.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

22.2 Private Finance (See also SFI 16.10)

- 22.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:
- (a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
 - (b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.
 - (c) The proposal must be specifically agreed by the Board.

22.3 Asset Registers

- 22.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.
- 22.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual or later guidance as issued by the Department of Health.
- 22.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:
- (a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
 - (b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
 - (c) lease agreements in respect of assets held under a finance lease and capitalised.
- 22.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 22.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 22.3.6 All assets are initially measured at cost and subsequently at fair value. For specialised buildings this involves a valuation based on modern equivalent assets (see accounting policies)
- 22.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Independent Regulator's Financial Reporting Manual and IFRS.
- 22.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified in the Capital Accounting Manual issued by the Department of Health.

22.4 Security of Assets

- 22.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.
- 22.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:
- (a) recording managerial responsibility for each asset;
 - (b) identification of additions and disposals;
 - (c) identification of all repairs and maintenance expenses;
 - (d) physical security of assets;
 - (e) periodic verification of the existence of, condition of, and title to, assets recorded;
 - (f) identification and reporting of all costs associated with the retention of an asset;
 - (g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
- 22.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.
- 22.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.
- 22.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.
- 22.4.6 Where practical, assets should be marked as Trust property.

23. Stores and Receipt of Goods

23.1 General Position

- 23.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:
- (a) kept to a minimum;
 - (b) subjected to annual stock take;
 - (c) valued at the lower of cost and net realisable value.

23.2 Control of Stores, Stocktaking, Condemnations and Disposal

- 23.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any

Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

- 23.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.
- 23.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
- 23.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.
- 23.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.
- 23.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also SFI 23). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

23.3 Goods Supplied by NHS Supply Chain

- 23.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

24. Disposals and Condemnations, Losses and Special Payments

24.1 Disposals and Condemnations

24.1.1 Procedures

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

- 24.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.
- 24.1.3 All unserviceable articles shall be:
 - (a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;
 - (b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

- 24.1.4 The Condemning Officer shall satisfy himself/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

24.2 Losses and Special Payments

24.2.1 Procedures

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

- 24.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved if this has not already been done. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the LCFS and the NHS Counter Fraud Authority.

The Director of Finance must notify NHS Counter Fraud Authority, the External Auditor and the Independent Regulator of all frauds.

- 24.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

- (a) the Board,
- (b) the External Auditor.

- 24.2.4 Within limits delegated to it by the Managing Public Money guidance the Board shall approve the writing-off of losses.

- 24.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

- 24.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

- 24.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

- 24.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

- 24.2.9 All losses and special payments must be reported to the Audit Committee annually

25. Information Technology

25.1 Responsibilities and Duties of the Director of Finance

- 25.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

- (a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional

disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

- (b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- (c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
- (d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

25.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

25.1.3 The Director of Nursing shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

25.2 Responsibilities and Duties of Other Directors and Officers in Relation to Computer Systems of a General Application

25.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance :

- (a) details of the outline design of the system;
- (b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

25.3 Contracts for Computer Services with Other Health Bodies or Outside Agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

25.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

25.5 Requirements for Computer Systems which have an Impact on Corporate Financial Systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

- (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
- (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- (c) Director of Finance staff have access to such data;
- (d) such computer audit reviews as are considered necessary are being carried out.

26. Patients' Property

26.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as property) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

26.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- a) notices and information booklets;
- b) hospital admission documentation and property records;
- c) the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

26.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

26.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

26.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

26.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

- 26.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

27. Funds Held on Trust

27.1 Corporate Trustee

- a) The Trust Board Acts as the Corporate Trustee for the Trust's charity Healthstars.
- b) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.
- c) The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

27.2 Accountability to Charity Commission and Secretary of State for Health

- (a) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.
- (b) The Schedule of Matters Reserved to the Trust Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust Officers must take account of that guidance before taking action.

27.3 Applicability of Standing Financial Instructions to Funds held on Trust

- a) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. See also SFI No 16.18).
- b) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

28. Acceptance of Gifts by Staff and Link to Standards of Business Conduct (See also SO 6 and SO 7.4.1)

The Director of Finance shall ensure that all officers are made aware of the Trust's Standards of Business and Managing Conflicts of Interest policy for NHS Staff on acceptance of gifts and other benefits in kind by officers. This policy follows the guidance published by NHS England) and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

29. Retention of Records

- 29.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

- 29.2 The records held in archives shall be capable of retrieval by authorised persons.
- 29.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

30. Risk Management and Insurance

30.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

- (a) a process for identifying and quantifying risks and potential liabilities;
- (b) engendering among all levels of staff a positive attitude towards the control of risk;
- (c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- (d) contingency plans to offset the impact of adverse events;
- (e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
- (f) a clear indication of which risks shall be insured;
- (g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current Monitor guidance.

30.2 Insurance: Risk Pooling Schemes Administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

30.3 Insurance Arrangements with Commercial Insurers

- 30.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

- (a) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

- (b) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and
- (c) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

30.4.1 Arrangements to be Followed by the Trust Board in Agreeing Insurance Cover

- (a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.
- (b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
- (c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Statutory Roles and Responsibilities of the Council of Governors

Subject always to provisions of the Constitution, the Governors shall have the following statutory roles and responsibilities:-

- Appoint and, if appropriate, remove the chair (Constitution paragraph 26);
- Appoint and, if appropriate, remove the other non-executive directors (Constitution paragraph 26);
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors (Constitution paragraph 33);
- Approve (or not) the appointment of the chief executive (Constitution paragraph 28);
- Appoint and, if appropriate, remove the NHS foundation trust's auditor (Constitution paragraph 38);
- Receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report at a general meeting of the Council of Governors (Constitution paragraph 44);
- Hold the non-executive directors, individually and collectively, to account for the performance of the Trust Board (Constitution paragraph 16);
- Represent the interests of the members of the Trust as a whole and the interests of the public (Constitution paragraph 12);
- Approve 'significant transactions' (Constitution paragraph 46);
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution (Constitution paragraph 46);
- Decide whether the Trust's non-NHS work would significantly interfere with its principle purpose, which is to provide goods and services for the health service in England or performing its other functions (Constitution paragraph 41);
- Approve amendments to the Trust's constitution (Constitution paragraph 44).

Agenda Item 23

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Report on the Use of the Trust Seal															
Author/s:	Michele Moran Chief Executive															
Recommendation:	<table border="1"> <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>				To approve		To discuss		To note	√	To ratify		For assurance			
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 2025 to 31st March 2026.															
Key Issues within the report:																
Positive Assurances to Provide: A register of the use of the seal is maintained		Key Actions Commissioned/Work Underway: None														
Key Risks/Areas of Focus: None		Decisions Made: None														
Governance:		Date		Date												
	Audit Committee		Remuneration & Nominations Committee													
	Quality Committee		People & Organisational Development Committee													
	Finance Committee		Executive Management Team													
	Mental Health Legislation Committee		Operational Delivery Group													
	Collaborative Committee		Other (please detail) Annual report													

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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 2025 to 31st March 2026.

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 2025 – 31st March 2026, the Trust Seal has been used 6 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
03/25	10/04/25	Contractual Settlement Agreement.
04/25	29/05/25	Lease Agreement relating to 174 Prospect Road, Scarborough, YO12 7LB (<i>Trust as Lessee</i>).
05/25	18/06/25	Lease Agreement relating to East Riding Community Hospital (<i>Trust as Lessor</i>).
06/25	05/08/25	Lease Agreement relating to Miranda House car park (<i>Trust as Lessee</i>).
07/25	26/08/25	Lease relating to the Land to the south of Beverley Community Hospital, Swinemoor Lane, Beverley, HU17 0FA (<i>Trust as Lessor</i>).
01/26	24/03/26	Licence to assign (<i>to the Trust</i>) the First and Second Floor, Block 3, Willerby Hill Business Park, Beverley Road, Hull.

4 Recommendation

The Board is asked to note the use of the Trust Seal

Agenda Item 24

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Compliance with the Provider License – Annual Review														
Author/s:	Pete Beckwith Stella Jackson Director of Finance Head of Corporate Affairs														
Recommendation:	<table border="1"> <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>			To approve		To discuss	√	To note		To ratify		For assurance	√		
To approve		To discuss	√												
To note		To ratify													
For assurance	√														
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	This report provides evidence of how the Trust continues to meet the terms of its Provider Licence, elements of the NHS Act and its Constitution. Trust Board is asked to: - Consider whether the information in Appendix A provides evidence that the Trust is meeting its licence conditions. - Note updates to the evidence are highlighted in red text, track changes or struck through, where it is proposed to remove out of date evidence, in appendices A and B. - Note that the Executive Management Team has reviewed the evidence. - Note the report will be shared with Governors for information at the July Council of Governors meeting.														
Key Issues within the report: This report provides evidence of how the Trust continues to meet the terms of its Licence, elements of the NHS Act and its Constitution.															
Positive Assurances to Provide: High level of assurance provided in June 2022 by Audit Yorkshire regarding the annual declarations process.		Key Actions Commissioned/Work Underway: The evidence which outlines how the Trust continues to meet the terms of the Provider Licence is reviewed on an annual basis and was last approved by the Board in May 2025.													
Matters of Concern or Key Risks: None		Decisions Made: N/A													

Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	28.4.26
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Compliance with the Provider Licence Annual Review

1 Introduction

Up until the financial year 2023/24, NHS Providers were required to publish a declaration of compliance against the NHS provider licence. This requirement was removed from the Provider Licence which came into force on 1 April 2023.

The new licence does not require licence holders to publish a declaration of compliance but they are expected to self-assess their compliance against the conditions.

NHS England will not be monitoring compliance with the Licence and Integrated Care Boards will decide if and how they want to monitor compliance.

However, NHS England will use the licencing framework to take action against an NHS provider should a breach occur.

The Code of Governance for Provider Trusts provides that when holding to account, the governors should 'ensure the board of directors acts so that the trust does not breach the conditions of its licence'. The report will be shared with governors at the July Council of Governors meeting in order to appraise them of how the Trust is meeting its licence conditions.

2 Declarations

In previous years the Trust has made the following declarations:

Declaration	Details
G6 (3)	Providers must certify that their Board has taken all necessary precautions to comply with the licence, NHS Act and NHS Constitution.
FT4 (8)	Providers must certify compliance with required governance standards and objectives
CoS7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services.

Evidence to support the above declarations is attached at Appendix A and B and updates to the evidence are highlighted in yellow for ease of reference.

Appendix A
Licence Conditions:

Condition	Explanation	Comments
Trust Working in Systems (WS)		
WS1. Cooperation	Requirement for NHS providers to carry out their legal duties to co-operate with NHS bodies and with local authorities, having regard to any guidance produced regarding cooperation.	The Trust CEO is a member of the ICB Board The Trust has active participation across the ICB in various groups The Trust is well represented on Health and Wellbeing Boards Good representation at local level across service areas National work
WS2. The Triple Aim	Obligated, when making decisions, to comply with the Triple Aim duty and any guidance published by NHS England regarding this.	- The Trust consider all aspects of the Triple aim when making decisions (Improving Patient Experience, Improving Value for Money, Improving Population Health). - The Trust will comply with any guidance issued by NHS England
WS3. Digital Transformation	Requirement to comply with required levels of digital maturity as set out in guidance published by NHS England	The Trusts Data Quality Maturity Index (DQMI) score at 91% (Dec 2025) - 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.~~ The Trust achieved an overall digital maturity score of 3.03 out of 5 for 2025. The Trust has performed well, scoring the 3rd out 53 for Mental health and 10th out of 100 for Community services.
General licence conditions (G)		
G1. Provision of information	Obligation to provide NHS England with any information it requires for its licensing functions.	- The Trust complies with any NHS England requests for information. ~~and complies with the reporting requirements as set out in the Single Oversight Framework.~~ - The Trust has robust data collection and validation processes. - Accurate, complete and timely information is produced and submitted to third parties to meet specific requirements. - The Trust makes monthly submissions to NHS England

Condition	Explanation	Comments
G2. Publication of information	Obligation to publish such information as NHS England may require regarding the health care services it provides for the purposes of the NHS.	• The Trust Board of Directors continues to meet in public with digital access available to view meetings. • Agendas, minutes and papers are published on the Trust's website. • Public Board meetings include updates on operational performance, quality and finance. • The Trust's website contains a variety of information and referral point information should the public require further information. • The Trust Publishes Quality Accounts and an Annual Report. • The Trust responds to Freedom of Information requests • The Board Assurance Framework and Trust Wide Risk Register are reported to the Board quarterly. • The Council of Governors receives regular communication about the work of the Trust. • The Trust complies with its obligations under Duty of Candour.
G3. Fit and proper persons as Governors and Directors	Prevents licensees from allowing unfit persons to become or continue as governors or directors.	• Governors and Members of the Board of Directors are required to make an annual declaration to ensure that they continue to meet the Fit and Proper Persons Test. • The Trust complies with NHS England Fit and Proper Person Test framework requirements.
G4. NHS England guidance	Requires licensees to have regard to NHS England guidance.	• The Trust responds to guidance issued by NHS England. • Submissions and information provided to NHS England are approved through relevant and appropriate authorisation processes. • The Trust has regard to NHS England guidance with reports to Board and Council of Governors providing assurance.
G5. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	• The Trust's Internal Auditors (Audit Yorkshire) considered the Board Assurance Framework and Risk Management as part of the 2025/26 audit work programme; the outcome provided 'Significant' 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. • 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 • The 2024/25 Annual Head of Internal Audit Opinion is expected to provide 'Significant' Assurance

Condition	Explanation	Comments
G6. Registration with the Care Quality Commission (CQC)	Requires providers to be registered with the CQC and to notify NHS England if their registration is cancelled.	• The Trust is registered with the Care Quality Commission (CQC). • The Trust's last full CQC inspection was in 2019 and assessed the Trust as 'Good'
G7. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	• Details of Services the Trust provides are published on the Trust's website • Patients referred to the Trust are not selected on any eligibility grounds. • Eligibility is defined through commissioner contracts and patient choice • Treatment decisions are made on clinical grounds and treatment options (risks and benefit) are discussed with the patient through the consent to treatment process.
G8. Application of section 6 (Continuity of Services)	Sets out the conditions under which a service will be designated as a CRS	• CRS are defined in the Trusts contracts with the Integrated Care Board
Costing conditions (P)		
C1. Obtaining, recording and maintaining sufficient information about expended costs	Obligation of licensees to record information, particularly about costs consistent with the guidance in NHS England's Approved Costing Guidance.	• The Trust has well established systems for coding, collection, retention and analysis of activity and cost information. • The 2024/25 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 has signed off the process in relation to National Cost Collection (September 2025).
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 - Adult Secure inpatient care (Low/Medium Secure) - Children's and Adolescent Mental Health Inpatient Services - 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.
Continuity of service (CoS)		

Condition	Explanation	Comments
CoS1. Continuing provision of Commissioner Requested Services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	• The Current Contracts with commissioners require agreement with commissioners on the ways CRS services are provided.
CoS2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS England's consent before disposing of these assets if NHS England has concerns about the licensee continuing as a going concern.	• The Trust maintains a full capital asset register. • Any disposals are reported to and approved by the Trust Board
CoS3. Standards of corporate governance, financial management and quality governance	Licensees are required to adopt and apply systems and standards of corporate governance, quality governance and financial management, which would be regarded as appropriate for a provider of NHS services, enable the Trust to continue as a going concern and provide reasonable safeguards against the licensee being unable to deliver services due to quality stress.	• The Trust has Standing Orders, Standing Financial Instructions and a Scheme of Delegation in place, and these are reviewed on an annual basis. • The Board of Directors/Executive Management Team receive regular performance reports aligned to the Trust Strategic Goals. • The Trust has a Board Assurance Framework and Risk Register which are reviewed at Board meetings and each Committee meeting • The Trust's Internal Auditors review risk management processes as part of the strategic audit plan. • The Trust has a current CQC rating of 'Good' for Well Led • The Trust received a green rating in relation to its provider capability rating • The Trust was placed in the Highest Segment (Segment 1) as part of the Q3 National Oversight Framework ratings.
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 £20m • 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 • The Trust has submitted a compliant (breakeven) financial plan for 2026/27
Foundation Trust conditions (FT)		
NHS1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHS England.	• The Trust has provided NHS England with a copy of its NHS Foundation Trust Constitution • The Trust has provided NHS England with a copy of its Board approved Annual Report and Accounts.
NHS2.NHS Foundation Trust governance arrangements	Obliges the Licensee to apply principles, systems and standards of good corporate governance.	• The Trust reports, via its Annual Report, on its compliance against the NHS Foundation Trust Code of Governance. • Succession planning on the Board is considered on an annual basis. • The Board has an Annual workplan which ensures decisions are made in a timely way • Evidence regarding the Trust's compliance with its Licence conditions is considered on an annual basis. * Evidence against this submission is detailed in appendix B.

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 are updated and refreshed as applicable on an annual basis. Constitution is reviewed and, if appropriate, updated on an annual basis
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Trust Wide Risk Register Board Assurance Framework Board Performance Reports Finance Report
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Committee Structures well established Committee Effectiveness reviews are reported to Trust Board Annually Clear Accountability through EMT and Executive Directors Portfolios. Level 3 performance reports and 'ward to board' reporting. Well Led Review has taken place and all recommendations have been implemented.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the	<i>External Audit Opinion on VFM (ISA260)</i> <i>Going Concern review to Trust Board in May</i> <i>Annual Governance Statement</i> All Statutory requirements met The Trust exceeded its Financial Targets in 2025/26 Breakeven plan submitted for 2026/27 Regular Performance report to Trust Board and EMT Quality Reports to Quality Committee which meet the insightful board standards Monthly returns to NHS Improvement via ICB

	Statement	Sources of Evidence and Assurance
	Care Quality Commission, the NHS Commissioning Board and statutory 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 <i>Annual Report and Accounts</i> <i>Annual Quality Report</i>
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, Quality and Professions Update ○ Operations Update ○ Medical Update ○ HR Update Refreshed Trust Strategic Objectives Patient and Staff Stories reported to Board Programme of Exec Visits (Virtual and Physical) Friends and Family Test Quality Standards Group Work plan Midday Mail/Midweek Global EMT New Headlines Board Talk Meet with Michele

	Statement	Sources of Evidence and Assurance
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Trust Board undertake Fit and Proper Persons Test Board Secretary maintains declarations of interest register Staffing Figures reported to the Board regularly. Trust Workforce Strategy Workforce included in Service Plans The Trust has an established People and Organisational Development Committee

Agenda Item 25

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Constitution Review 2026															
Author/s:	Name: Stella Jackson Title: Head of Corporate Affairs															
Recommendation:	<table border="1"> <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>				To approve		To discuss		To note	✓	To ratify		For assurance			
To approve		To discuss														
To note	✓	To ratify														
For assurance																
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	In 2023, the Council of Governors and Board approved a number of changes to the Trust's Constitution following a review by Hill Dickinson to ensure it remained fit for purpose following the commencement of the Health and Care Act 2022. In 2025 minor amendments to the section of the Constitution regarding the affixing of the Trust Seal were approved (to make it consistent with Standing Orders and the Scheme of Delegation). Trust Board is asked to note: - No further changes are currently proposed for 2026. - The Council of Governors did not highlight any changes when they considered a paper regarding the Constitution on 16 April 2026.															
Key Issues within the report:																
Positive Assurances to Provide: - The changes approved in 2023 ensure the Constitution remains fit for purpose by addressing requirements brought about by the Health and Care Act 2022. - The further amendments in 2025 ensure the Constitution remains consistent with the Standing Orders and Scheme of Delegation. - A copy of the Constitution was circulated to Governors and Board members in March 2026 with an invitation that they contact the Head of Corporate Affairs should they believe any changes were required. No recommendations to change were made.		Key Actions Commissioned/Work Underway: n/a														
Matters of Concern or Key Risks: None.		Decisions Made: n/a														
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date		Date												
	Audit Committee		Remuneration & Nominations Committee													
	Quality Committee		People & Organisational Development Committee													
	Finance Committee		Executive Management Team													

	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail) Council of Governors Trust Board	16.4.26 27.5.26

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Proposed Changes to the Constitution May 2026

1. Introduction

In 2023, the Council of Governors and Board approved a number of changes to the Trust's Constitution following a review by Hill Dickinson to ensure it continued to meet the requirements of the Model Constitution and that it reflected the provisions of the Health and Care Act 2022. In 2025, changes to the section regarding the affixing of the Trust Seal were approved to ensure this was consistent with the Standing Orders and Scheme of Delegation.

A copy of the Constitution was circulated to Governors and Board members in March 2026 with an invitation that they contact the Head of Corporate Affairs should they believe any changes were required. No recommendations to change were made.

The revisions in 2023 and 2025 ensure the Constitution remains fit for purpose and no further changes are currently proposed for 2026.

2. The Approval Process

The Constitution provides that any changes to the Constitution must be approved by the Council of Governors and Board of Directors.

3. Recommendation

Trust Board is asked to note:

- That no further changes are proposed.
- The Council of Governors did not highlight any changes when they considered a paper regarding the Constitution on 16 April 2026.

Constitution

Humber Teaching NHS Foundation Trust Constitution

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1. Interpretation and Definitions

Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health & Social Care Act 2012 and Health and Care Act 2022.

Unless expressly provided otherwise, a reference to legislation or legislative provision shall be to that legislation as it is in force, amended or re-enacted from time to time.

The 2006 Act is the National Health Service Act 2006.

The 2012 Act is the Health and Social Care Act 2012.

The 2022 Act is the Health and Care Act 2022.

Accounting Officer is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

Annual Members' Meeting is defined in paragraph 11 of the Constitution.

Appointed Governors are those Governors appointed by the appointing organisation listed in Annex 4.

Constitution means this Constitution and all annexes to it.

Director means a member of the Board of Directors.

Elected Governors are those Governors elected by the public and staff constituencies.

Member means a member of the Trust.

NHS England (NHSE) is the statutory entity as provided by section 1H of the 2006 Act that regulates NHS Foundation Trusts.

Senior Independent Director means the person appointed by the Board of Directors, in consultation with the Council of Governors, to provide a sounding board for the Chair, to serve as an intermediary for the other Directors when necessary and to be available to Governors if they have concerns that contact through normal channels has failed to resolve.

Service User and Carer Constituency means (collectively) the members of the service user and carer constituency which is referred to as the 'patients' constituency' in the 2006 Act.

Service User and Carer Governor means a Governor elected by the members of the Service User and Carer Constituency.

Trust Secretary means the Secretary of the Trust or any person appointed to perform the duties of the Secretary of the Trust

Voluntary Organisation is a body, other than a public or local authority, the activities of which are carried on not for profit.

2. Name

The name of the Foundation Trust is Humber Teaching NHS Foundation Trust (the Trust).

3. Principal Purpose

- 3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

The Trust undertakes both provision and commissioning functions, as the Lead Provider for the Humber Coast and Vale Provider Collaboration in the delivery of Child and Adolescent Mental Health In-Patient, Adult Low and Medium Secure and Adult Eating Disorder Services.

- 3.2 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.

- 3.3 The Trust may provide goods and services for any purposes related to

- 3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
- 3.3.2 the promotion and protection of public health.

- 3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order to better carry on its principal purpose.

- 3.5 The Trust's vision is 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 valued partner.

4. Powers

- 4.1 The powers of the Trust are set out in the 2006 Act.

- 4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

The Board has a delegated responsibility from NHSE for the commissioning, contractual and quality and safety oversight of the entirety of the contracts awarded to the Trust as the Lead Provider of the Humber Coast and Vale Provider Collaboration in the delivery of Child and Adolescent Mental Health In-Patient, Adult Low and Medium Secure and Adult Eating Disorder Services.

- 4.3 The Board of Directors may authorise any three or more persons each of whom is neither:

- 4.3.1 an executive Director of the Trust; nor
- 4.3.2 an employee of the Trust;

To exercise the powers conferred on the Trust by Section 25 of the Mental Health Act (MHA)

4.4 The Trust may enter into arrangements for the carrying out, on such terms as the Trust considers appropriate, of any of its functions jointly with any other person.

4.5 The Trust may arrange for any of the functions exercisable by the Trust to be exercised by or jointly with any one or more of the following:

- 4.5.1 A relevant body;
- 4.5.2 A local authority within the meaning of section 2B of the 2006 Act;
- 4.5.3 A combined authority.

4.6 The Trust may also enter into arrangements to carry out the functions of another relevant body, whether jointly or otherwise.

4.7 Where a function is exercisable by the Trust jointly with one or more of the other organisations mentioned at paragraph 4.6, those organisations and the Trust may:

- 4.7.1 Arrange for the function to be exercised by a joint committee of theirs;
- 4.7.2 Arrange for the Trust, one or more of those other organisations, or a joint committee of them, to establish and maintain a pooled fund

in accordance with section 65Z6 of the 2006 Act.

4.8 The Trust must exercise its functions effectively, efficiency and economically.

4.9 In making a decision about the exercise of its functions, the Trust must have regard to all likely effects of the decision in relation to:

- 4.9.1 The health and well-being of (including inequalities between) the people of England;
- 4.9.2 The quality of services provided to (including inequalities between benefits obtained by) individuals by or in pursuance of arrangements made by relevant bodies for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;
- 4.9.3 Efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

4.10 In the exercise of its functions, the Trust must have regard to its duties under section 63B of the 2006 Act (complying with targets under section 1 of the Climate Change Act 2008 and section 5 of the Environment Act 2021, and to adapt any current or predicted impacts of climate change in the most recent report under section 56 of the Climate Change Act 2008).

4.11 For the purposes of this section, “relevant body” means NHSE, an integrated care board, an NHS trust, a NHS foundation trust (including the Trust) or such other body as may be prescribed under section 65Z5(2). “Relevant bodies” means two or more of these organisations as the context requires.

4.12 The arrangements under this paragraph 4 shall be in accordance with:

- 4.12.1 any applicable requirements imposed by the 2006 Act or regulations made under that Act;
- 4.12.2 any applicable statutory guidance that has been issued and
- 4.12.3 otherwise on such terms as the Trust sees fit.

5 Membership and Constituencies

The Trust shall have members, each of whom shall be a member of one of the following constituencies:

- 5.1 a Public Constituency
- 5.2 a Staff Constituency
- 5.3 a Service User and Carer Constituency

6 Application for Membership

An individual who is eligible to become a member of the Trust may do so on application to the Trust.

7 Public Constituency

- 7.1 An individual who lives in an area specified in Annex 1 as an area for a Public Constituency may become or continue as a member of the Trust.
- 7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.
- 7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8 Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a staff member of the Trust provided:

- 8.1.1 He/she is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- 8.1.2 He/she has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The minimum number of members in the Staff Constituency is specified in Annex 2.

Automatic Membership by Default –Staff

8.5 An individual who is:

- 8.5.1 eligible to become a member of the Staff Constituency;
and
- 8.5.2 invited by the Trust to become a member of the Staff Constituency

shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he/she informs the Trust that they do not wish to do so.

9. Service User and Carer Constituency

9.1 An individual who has, within the period specified below, attended any of the Trust's services as either a patient or as the carer of a patient may become a member of the Trust.

9.2 The period referred to above shall be the period of 3 years immediately preceding the date of an application by the patient or carer to become a member of the Trust.

9.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Service User and Carer Constituency.

9.4 An individual providing care in pursuance of a contract (including a contract of employment) with a voluntary organisation, or as a volunteer for a voluntary organisation, does not come within the category of those who qualify for membership of the Service User and Carer Constituency.

9.5 The minimum number of members in the Service User and Carer Constituency is specified in Annex 3.

10. Restriction on Membership

10.1 An individual who is a member of a constituency, or of any class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 14 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 9 – Further Provisions.

11. Annual Members' Meeting

The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

12 Council of Governors – Composition

- 12.1 The Trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.
- 12.2 The composition of the Council of Governors is specified in Annex 4.
- 12.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within that constituency, by their class within the constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 4.

13. Council of Governors – Election of Governors

- 13.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.
- 13.2 The Model Election Rules as published from time to time by NHS Providers form part of this Constitution. The Model Election Rules are attached at Annex 5.
- 13.3 A subsequent variation of the Model Election Rules by NHS Providers shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 44 of the Constitution.
- 13.4 An election, if contested, shall be by secret ballot.
- 13.5 Governors must be at least 16 years of age at the closing date for nominations for their election or appointment.

14. Council of Governors - Tenure

- 14.1 An elected Governor may hold office for a period of up to 3 years.
- 14.2 An elected Governor shall cease to hold office if he/she ceases to be a member of the constituency or class by which he/she was elected.
- 14.3 An elected Governor shall be eligible for re-election at the end of their term. However, no Governor may stand for re-election having served 3 terms or a maximum of 9 years.
 - 14.3.1 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply:
 - 14.3.2 where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for a three year term;

14.3.3 where the vacancy arises amongst the Elected Governors, the next highest polling candidate for that seat at the most recent election (who is willing to take office) will be invited to fill the seat for the remainder of the current term.

14.4 Appointed Governors may hold office for a period of up to 3 years.

14.4.1 Appointed Governors shall cease to hold office if the appointing organisation withdraws its sponsorship of him/her.

14.4.2 An Appointed Governor shall be eligible for re-appointment at the end of his/her term, but, subject to paragraph 14.4.3 below, shall serve no more than 3 consecutive terms of office or a maximum of 9 years.

14.4.3 Where an appointing organisation considers that an individual who would not otherwise be eligible for appointment as an Appointed Governor because of the restriction in paragraph 14.4.2 above remains the most appropriate person to represent the organisation, it may seek the approval of the Chair and the Chief Executive to appointing the individual to serve a further term or terms of office.

14.5 Any Governor shall cease to hold office if he/she is disqualified for any of the reasons set out in this Constitution.

15. Council of Governors – Disqualification and Removal

15.1 The following may not become or continue as a member of the Council of Governors:

15.1.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person who has made a composition or arrangement (including a debt relief order under the Insolvency Act) or granted a Trust deed for, his/her creditors and has not been discharged in respect of it;

15.1.3 A person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;

15.2 Governors must be at least 16 years of age at the closing date for nominations for their election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors and provision for the removal of Governors in certain circumstances are set out in Annex 6.

16. Council of Governors – General Duties

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public at large.

16.2 The Trust must take steps to ensure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – Meetings of Governors

17.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 26 below) or, in his/her absence the Deputy Chair (appointed in accordance with the provision of paragraph 27 below) or, in their absence, another non-executive director (as the Directors present shall choose), shall preside at meetings of the Council of Governors.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting, or part of a meeting, for special reasons.

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

18. Council of Governors – Standing Orders

The standing orders for the practice and procedure of the Council of Governors is attached at Annex 7.

19 Council of Governors – Referral to the Panel

19.1 In this paragraph, the "Panel" means a panel of persons appointed by NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS foundation trusts to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:-

19.1.1 to act in accordance with its Constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - Conflicts of Interest of Governors

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other

matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he/she becomes aware of it. The Standing Orders for the Council of Governors (Annex 7) shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – Travel Expenses

The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22. Council of Governors – Further Provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

23. Board of Directors – Composition

23.1 The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 a Non-Executive Chair

23.2.2 up to 6 other Non-Executive Directors;

23.2.3 up to 6 Executive Directors

23.3 One of the Executive Directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the Executive Directors shall be the Finance Director.

The Executive Director of Finance shall also be the executive lead for the Trust's commissioning responsibilities through Provider Collaboratives and other contractual mechanisms.

23.6 One of the Executive Directors is to be a Registered Medical Practitioner

23.7 One of the Executive Directors is to be a Registered Nurse

23.8 The operation of 23.2 above shall be such that, at all times, at least half of the Board of Directors, excluding the Chair, shall be Non-Executive Directors

23.9 The Board of Directors 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.

24. Board of Directors – General Duty

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors – Qualification for Appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if –

- 25.1 he/she is a member of the Public Constituency, or
- 25.2 he/she is a member of the Service User and Carer Constituency
- 25.3 he/she is not disqualified by virtue of paragraph 29 below
- 25.4 he/she is not disqualified by virtue of the further provisions as set out in Annex 9

26. Board of Directors – Appointment and Removal of Chair and other Non-Executive Directors

- 26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other Non-Executive Directors.
- 26.2 Removal of the Chair or another Non-Executive Director shall require the approval of three quarters of the members of the Council of Governors.

27. Board of Directors – Appointment of Deputy Chair

The Council of Governors at a general meeting of the Council of Governors may appoint one of the Non-Executive Directors as a Deputy Chair.

28. Board of Directors - Appointment and Removal of the Chief Executive and other Executive Directors

- 28.1 Non-Executive Directors shall appoint or remove the Chief Executive.
- 28.2 The appointment of the Chief Executive shall require the approval of the Council of Governors as per the Council's Standing Orders, Annex 7.
- 28.3 The Chief Executive is to be appointed in accordance with paragraph 28.2 above.
- 28.4 A Committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

29. Board of Directors – Disqualification

The following may not become or continue as a member of the Board of Directors:

- 29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

- 29.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);
- 29.3 a person who has made a composition or arrangement (including a debt relief order under the Insolvency Act) or granted a Trust deed for, his/her creditors and has not been discharged in respect of it;
- 29.4 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him/her;
- 29.5 he/she is a medical practitioner that has been removed from the professional register by the General Medical Council;
- 29.6 he/she has conducted his or herself in a way that has caused, or is likely to cause, material prejudice, to the best interests of the Trust or the proper conduct of the Board of Directors or otherwise in a manner inconsistent with continued membership of the Board of Directors.

30. Board of Directors – Meetings

- 30.1 Meetings of the Board of Directors shall be held in public and open to members of the public. Members of the public may be excluded from a meeting for special reasons and having regard to the confidential or commercially sensitive nature of the business to be transacted, publicity of which would be prejudicial to the public interest (known as a 'Part II' meeting).
- 30.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors. Board meetings held in public (known as 'Part I' meetings) will be published on the Trust's website.

31. Board of Directors – Standing Orders

The Standing Orders for the practice and procedure of the Board of Directors are attached at Annex 8.

32. Board of Directors - Conflicts of Interest of Directors

- 32.1 The duties that a Director of the Trust has by virtue of being a Director include in particular -
 - 32.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.
 - 32.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.
- 32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if –

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

31.2.2 The matter has been authorised in accordance with the Constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than –

32.4.1 The Trust, or

32.4.2 A person acting on its behalf.

32.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest –

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the Directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a Committee of the Directors appointed for the purpose under the Constitution.

33. Board of Directors – Remuneration and Terms of Office

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

33.2 The Trust shall establish a Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

34. Registers

The Trust shall have:

- 34.1 a register of members showing, in respect of each member, the constituency to which he/she belongs and, where there are classes within it, the class to which he/she belongs;
- 34.2 a register of members of the Council of Governors;
- 34.3 a register of interests of Governors;
- 34.4 a register of Directors; and
- 34.5 a register of interests of the Directors.

35 Admission to and Removal from the Registers

- 35.1 The Trust Secretary shall add to the confidential register of members the name of any member who is accepted under the provisions of this Constitution
- 35.2 The Trust Secretary shall remove from the register the name of any member who ceases to be entitled to be a member under the provisions of this Constitution

36. Registers – Inspection and Copies

- 36.1 The Trust shall make the registers specified in paragraph 35 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.
- 36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if the member so requests.
- 36.3 So far as the registers are required to be made available:
 - 36.3.1 they are to be available for inspection free of charge at all reasonable times; and
 - 36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.
- 36.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. Documents Available for Public Inspection

- 37.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
 - 37.1.1 a copy of the current Constitution,
 - 37.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and
 - 37.1.3 a copy of the latest annual report.

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

37.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

37.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHSE's decision), 65KB (Secretary of State's response to NHSE's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

37.2.8 a copy of any final report published under section 65I (administrator's final report).

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

37.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

37.4 If the person requesting a copy or extract is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Trust shall have an auditor.

38.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

38.3 The Auditor is to carry out his duties in accordance with Schedule 10 to the 2006

Act and in accordance with any directions given by NHSE, the statutory entity that remains the regulator of NHS foundation trusts.

39. Audit Committee

The Trust shall establish a Committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

- 40.1 The Trust must keep proper accounts and proper records in relation to the accounts.
- 40.2 NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.
- 40.3 The accounts are to be audited by the Trust's auditor.
- 40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHSE) may with the approval of the Secretary of State direct.
- 40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

41. Annual Report and Forward Plans and Non NHS Work

- 41.1 The Trust shall prepare an Annual Report and send it to NHSE .
- 41.2 The Trust shall give information as to its forward planning in respect of each financial year to NHSE (NHSE).
- 41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.
- 41.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.
- 41.5 Each forward plan must include information about –
 - 41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
 - 41.5.2 the income it expects to receive from doing so.
- 41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.5.1 the Council of Governors must
 - 41.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and
 - 41.6.2 notify the Directors of the Trust of its determination.
- 41.7 The Trust, if it proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England, may implement the

proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

42. Presentation of the Annual Accounts and Reports to the Governors and Members

- 42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
 - 42.1.1 the annual accounts
 - 42.1.2 any report of the auditor on them
 - 42.1.3 the annual report.
- 42.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.
- 42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

43. Instruments

- 43.1 The Trust shall have a seal.
- 43.2 The seal shall not be affixed except under the authority of the Chief Executive (or their nominated deputy) and the Director of Finance (or their nominated deputy).

44. Amendment of the Constitution

- 44.1 The Trust may make amendments to its Constitution only if:
 - 44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and
 - 44.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.
- 44.2 Amendments made under paragraph 44 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.
- 44.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust).
 - 44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and
 - 44.3.1 The Trust must give the members an opportunity to vote on whether they approve the amendment.
- 44.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.5 Amendments by the Trust of its Constitution are to be notified to NHSE . For the avoidance of doubt, NHSE's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45 Mergers etc. and Significant Transactions

45.1 The Trust may only apply for a merger, acquisition, separation or dissolution (in accordance with the provisions of the 2006 Act) with the approval of more than half of the members of the Council of Governors.

45.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

45.3 A “significant transaction” means a transaction that equates to:

The income attributable to the assets or the contract associated with the transaction is greater than 25% of the current Trust income (i.e for £200m turnover, this would equate to new income above £50m); or

The gross assets subject to the transaction are greater than 25% of the total gross assets of the Trust (i.e for £90m of gross assets, this would equate to new assets valued above £22.5m); or

The gross capital of the company or business being acquired/divested is greater than 25% of the total capital for the Trust (i.e: for £70m total capital, capital for the transaction would exceed £17.5m). Total Capital for a foundation trust relates to taxpayers' and others equity in the statement of financial position within the annual accounts.

ANNEX 1 – THE PUBLIC CONSTITUENCY

Name of Areas within the Constituency	Area	Minimum Number of Members	Number of Governors
East Riding of Yorkshire	The electoral wards of East Riding of Yorkshire	100	6
Hull	The electoral wards of Hull	100	4
Rest of England	The electoral wards of the rest of England (excluding those electoral wards covered by the other areas of the Public Constituency)	15	1
Whitby, Ryedale and Scarborough	The electoral wards of Whitby, Ryedale and Scarborough and surrounding areas	15	1

ANNEX 2 – THE STAFF CONSTITUENCY

Name of Constituency	Class of Staff Membership	Minimum number of members	No of Governors
Staff	Clinical	200	2
	Non Clinical		2
	Either Clinical or Non Clinical		1
	Total		5

ANNEX 3 – THE SERVICE USER AND CARER CONSTITUENCY

Name of Constituency	Description of individuals eligible to become members	Minimum number of Members	No of Elected Governors
Service User and Carer	An individual who has attended any of the Trust's services as a patient or a carer in the 3 years preceding the date of their application to become a member of the trust.	15	2

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

ELECTED GOVERNORS:

Public Constituency	NUMBER OF GOVERNORS
HULL	4
EAST RIDING OF YORKSHIRE	6
REST OF ENGLAND	1
WHITBY, RYEDALE AND SCARBOROUGH	1
Service User and Carer Constituency	2
Staff Constituency	5
Total Elected	19

APPOINTED GOVERNORS:

SPONSOR	NUMBER OF GOVERNORS
UNIVERSITY	1
HUMBERSIDE POLICE	1
VOLUNTARY PARTNER	1
HULL LOCAL AUTHORITY	1
EAST RIDING OF YORKSHIRE LOCAL AUTHORITY	1
FIRE & RESCUE	1
Total Appointed	6

ANNEX 5 - THE MODEL ELECTION RULES

MODEL ELECTION RULES 2014

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1. Interpretation

1.1 In these rules, unless the context otherwise requires:

“*2006 Act*” means the National Health Service Act 2006;

“*corporation*” means the public benefit corporation subject to this constitution;

“*council of governors*” means the council of governors of the corporation;

“*declaration of identity*” has the meaning set out in rule 21.1;

“*election*” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

“*e-voting*” means voting using either the internet, telephone or text message;

“*e-voting information*” has the meaning set out in rule 24.2;

“*ID declaration form*” has the meaning set out in Rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“*internet voting system*” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“*lead governor*” means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

“*list of eligible voters*” means the list referred to in rule 22.1, containing the information in rule 22.2;

“*method of polling*” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“*numerical voting code*” has the meaning set out in rule 64.2(b)

“*polling website*” has the meaning set out in rule 26.1;

“*postal voting information*” has the meaning set out in rule 24.1;

“*telephone short code*” means a short telephone number used for the purposes of submitting a vote by text message;

“*telephone voting facility*” has the meaning set out in rule 26.2;

“*telephone voting record*” has the meaning set out in rule 26.5 (d);

“*text message voting facility*” has the meaning set out in rule 26.3;

“*text voting record*” has the meaning set out in rule 26.6 (d);

“*the telephone voting system*” means such telephone voting facility as may be

provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

“the text message voting system” means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

“voter ID number” means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

“voting information” means postal voting information and/or e-voting information

- 1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

- (a) a Saturday or Sunday;
- (b) Christmas day, Good Friday, or a bank holiday, or
- (c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
- 8.1 The returning officer is to publish a notice of the election stating:
- (a) the constituency, or class within a constituency, for which the election is being held,
 - (b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
 - (c) the details of any nomination committee that has been established by the corporation,
 - (d) the address and times at which nomination forms may be obtained;
 - (e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
 - (f) the date and time by which any notice of withdrawal must be received by the returning officer
 - (g) the contact details of the returning officer
 - (h) the date and time of the close of the poll in the event of a contest.
9. Nomination of candidates
- 9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.
- 9.2 The returning officer:
- (a) is to supply any member of the corporation with a nomination form, and
 - (b) is to prepare a nomination form for signature at the request of any member of the corporation,
- but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.
10. Candidate's particulars
- 10.1 The nomination form must state the candidate's:
- (a) full name,
 - (b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
 - (c) constituency, or class within a constituency, of which the candidate is a member.
11. Declaration of interests

- 11.1 The nomination form must state:
- (a) any financial interest that the candidate has in the corporation, and
 - (b) whether the candidate is a member of a political party, and if so, which party,
- and if the candidate has no such interests, the paper must include a statement to that effect.
12. Declaration of eligibility
- 12.1 The nomination form must include a declaration made by the candidate:
- (a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
 - (b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.
13. Signature of candidate
- 13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
- (a) they wish to stand as a candidate,
 - (b) their declaration of interests as required under rule 11, is true and correct, and
 - (c) their declaration of eligibility, as required under rule 12, is true and correct.
- 13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.
14. Decisions as to the validity of nomination
- 14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
- (a) decides that the candidate is not eligible to stand,
 - (b) decides that the nomination form is invalid,
 - (c) receives satisfactory proof that the candidate has died, or
 - (d) receives a written request by the candidate of their withdrawal from candidacy.
- 14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:
- (a) that the paper is not received on or before the final time and date for return

of nomination forms, as specified in the notice of the election,

- (b) that the paper does not contain the candidate's particulars, as required by rule 10;
- (c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
- (d) that the paper does not include a declaration of eligibility as required by rule 12, or
- (e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

- (a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
- (b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

- 16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.
17. Withdrawal of candidates
- 17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.
18. Method of election
- 18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.
- 18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.
- 18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:
- (a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
 - (b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot
- 19.1 The votes at the poll must be given by secret ballot.
- 19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.
- 19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.
- 19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.
- 19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:
- (a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
 - (i) configured in accordance with these rules; and
 - (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;
 - (b) if telephone voting is to be a method of polling, the telephone voting system to be used for the purpose of the election is:
 - (i) configured in accordance with these rules; and
 - (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;
 - (c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
 - (i) configured in accordance with these rules; and
 - (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.
20. The ballot paper
- 20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.
- 20.2 Every ballot paper must specify:

- (a) the name of the corporation,
- (b) the constituency, or class within a constituency, for which the election is being held,
- (c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
- (f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
- (g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

- (a) that the voter is the person:
 - (i) to whom the ballot paper was addressed, and/or
 - (ii) to whom the voter ID number contained within the e-voting information was allocated,
 - (b) that he or she has not marked or returned any other voting information in the election, and
 - (c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,
- ("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is

not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

- (l) the address and final dates for applications for replacement voting information, and
- (m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

- (a) a ballot paper and ballot paper envelope,
 - (b) the ID declaration form (if required),
 - (c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
 - (d) a covering envelope;
- ("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

- (a) instructions on how to vote and how to make a declaration of identity (if required),
- (b) the voter's voter ID number,
- (c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

- (a) only be sent postal voting information; or
- (b) only be sent e-voting information; or
- (c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

- 24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.
25. Ballot paper envelope and covering envelope
- 25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.
- 25.2 The covering envelope is to have:
- (a) the address for return of the ballot paper printed on it, and
 - (b) pre-paid postage for return to that address.
- 25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
- (a) the completed ID declaration form if required, and
 - (b) the ballot paper envelope, with the ballot paper sealed inside it.
26. E-voting systems
- 26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").
- 26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").
- 26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").
- 26.4 The returning officer shall ensure that the polling website and internet voting system provided will:
- (a) require a voter to:
 - (i) enter his or her voter ID number; and
 - (ii) where the election is for a public or patient constituency, make a declaration of identity;in order to be able to cast his or her vote;
 - (b) specify:
 - (i) the name of the corporation,
 - (ii) the constituency, or class within a constituency, for which the election is being held,
 - (iii) the number of members of the council of governors to be elected

- from that constituency, or class within that constituency,
- (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (v) instructions on how to vote and how to make a declaration of identity,
- (vi) the date and time of the close of the poll, and
- (vii) the contact details of the returning officer;
- (c) prevent a voter from voting for more candidates than he or she is entitled to at the election;
- (d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
 - (i) the voter's voter ID number;
 - (ii) the voter's declaration of identity (where required);
 - (iii) the candidate or candidates for whom the voter has voted; and
 - (iv) the date and time of the voter's vote,
- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and
- (f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

- (a) require a voter to
 - (i) enter his or her voter ID number in order to be able to cast his or her vote; and
 - (ii) where the election is for a public or patient constituency, make a declaration of identity;
- (b) specify:
 - (i) the name of the corporation,
 - (ii) the constituency, or class within a constituency, for which the election is being held,
 - (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
 - (iv) instructions on how to vote and how to make a declaration of identity,
 - (v) the date and time of the close of the poll, and
 - (vi) the contact details of the returning officer;
- (c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

- (d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
 - (i) the voter's voter ID number;
 - (ii) the voter's declaration of identity (where required);
 - (iii) the candidate or candidates for whom the voter has voted; and
 - (iv) the date and time of the voter's vote
- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
- (f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

- (a) require a voter to:
 - (i) provide his or her voter ID number; and
 - (ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;
- (b) prevent a voter from voting for more candidates than he or she is entitled to at the election;
- (d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
 - (i) the voter's voter ID number;
 - (ii) the voter's declaration of identity (where required);
 - (ii) the candidate or candidates for whom the voter has voted; and
 - (iii) the date and time of the voter's vote
- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
- (f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

- 28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.
29. Spoilt ballot papers and spoilt text message votes
- 29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a “spoilt ballot paper”), that voter may apply to the returning officer for a replacement ballot paper.
- 29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.
- 29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:
- (a) is satisfied as to the voter’s identity; and
 - (b) has ensured that the completed ID declaration form, if required, has not been returned.
- 29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list (“the list of spoilt ballot papers”):
- (a) the name of the voter, and
 - (b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
 - (c) the details of the unique identifier of the replacement ballot paper.
- 29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a “spoilt text message vote”), that voter may apply to the returning officer for a replacement voter ID number.
- 29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.
- 29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter’s identity.
- 29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list (“the list of spoilt text message votes”):
- (a) the name of the voter, and
 - (b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
 - (c) the details of the replacement voter ID number issued to the voter.
30. Lost voting information
- 30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for

- replacement voting information.
- 30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:
- (a) is satisfied as to the voter's identity,
 - (b) has no reason to doubt that the voter did not receive the original voting information,
 - (c) has ensured that no declaration of identity, if required, has been returned.
- 30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):
- (a) the name of the voter
 - (b) the details of the unique identifier of the replacement ballot paper, if applicable, and
 - (c) the voter ID number of the voter.
31. Issue of replacement voting information
- 31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.
- 31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):
- (a) the name of the voter,
 - (b) the unique identifier of any replacement ballot paper issued under this rule;
 - (c) the voter ID number of the voter.
32. ID declaration form for replacement ballot papers (public and patient constituencies)
- 32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet
- 33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.
- 33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

- 33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.
- 33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.
- 33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.
34. Voting procedure for remote voting by telephone
- 34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.
- 34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.
- 34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.
- 34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.
- 34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.
35. Voting procedure for remote voting by text message
- 35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.
- 35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.
- 35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents
- 36.1 Where the returning officer receives:
- (a) a covering envelope, or
 - (b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,
- before the close of the poll, that officer is to open it as soon as is practicable; and

rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

- (a) the candidate for whom a voter has voted, or
- (b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

- (a) put the ID declaration form if required in a separate packet, and
- (b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

- (a) mark the ballot paper “disqualified”,
- (b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
- (c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and
- (d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

- (a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
- (b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified

documents; and

- (c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)¹

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

- (a) mark the ID declaration form “disqualified”,
- (b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
- (c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

- (a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
- (b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

- (a) mark the ballot paper “disqualified”,
- (b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
- (c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
- (d) place the document or documents in a separate packet; and
- (e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

- (a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
- (b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
- (c) place the internet voting record, telephone voting record or text voting

¹ It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

record (as applicable) in a separate packet, and

- (d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

- (a) the disqualified documents, together with the list of disqualified documents inside it,
- (b) the ID declaration forms, if required,
- (c) the list of spoilt ballot papers and the list of spoilt text message votes,
- (d) the list of lost ballot documents,
- (e) the list of eligible voters, and
- (f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

“ballot document” means a ballot paper, internet voting record, telephone voting record or text voting record.

“continuing candidate” means any candidate not deemed to be elected, and not excluded,

“count” means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

“deemed to be elected” means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

“mark” means a figure, an identifiable written word, or a mark such as “X”,

“non-transferable vote” means a ballot document:

- (a) on which no second or subsequent preference is recorded for a continuing candidate,

or

- (b) which is excluded by the returning officer under rule STV49,

“preference” as used in the following contexts has the meaning assigned below:

- (a) *“first preference”* means the figure “1” or any mark or word which clearly indicates a first (or only) preference,
- (b) *“next available preference”* means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and
- (c) in this context, a *“second preference”* is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“quota” means the number calculated in accordance with rule STV46,

“surplus” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

“stage of the count” means:

- (a) the determination of the first preference vote of each candidate,
- (b) the transfer of a surplus of a candidate deemed to be elected, or
- (c) the exclusion of one or more candidates at any given time,

“transferable vote” means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

“transferred vote” means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

“transfer value” means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

- (a) the board of directors and the council of governors of the corporation have approved:
 - (i) the use of such software for the purpose of counting votes in the relevant election, and
 - (ii) a policy governing the use of such software, and
- (b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

- (a) count and record the number of:
 - (iii) ballot papers that have been returned; and
 - (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
- (b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

- (a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
- (b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which votes are given for more candidates than the voter is entitled to vote,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

- (a) elsewhere than in the proper place,
- (b) otherwise than by means of a clear mark,
- (c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

- (a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
- (b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

- (a) does not bear proper features that have been incorporated into the ballot paper,
- (b) voting for more candidates than the voter is entitled to,
- (c) writing or mark by which voter could be identified, and
- (d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

- (a) on which votes are given for more candidates than the voter is entitled to vote,
- (b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
- (c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

- (a) otherwise than by means of a clear mark,
- (b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

- (a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
- (b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

- (a) voting for more candidates than the voter is entitled to,
- (b) writing or mark by which voter could be identified, and
- (c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

- STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.
- STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).
- STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.
- STV47. Transfer of votes
- STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:
- (a) according to next available preference given on those ballot documents for any continuing candidate, or
 - (b) where no such preference is given, as the sub-parcel of non-transferable votes.
- STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.
- STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.
- STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:
- (a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
 - (b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).
- STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:
- (a) according to the next available preference given on those ballot documents for any continuing candidate, or
 - (b) where no such preference is given, as the sub-parcel of non-transferable votes.

- STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.
- STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:
- (a) a transfer value calculated as set out in rule STV47.4(b), or
 - (b) at the value at which that vote was received by the candidate from whom it is now being transferred,
- whichever is the less.
- STV47.8 Each transfer of a surplus constitutes a stage in the count.
- STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.
- STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:
- (a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
 - (b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.
- STV47.11 This rule does not apply at an election where there is only one vacancy.
- STV48. Supplementary provisions on transfer
- STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:
- (a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
 - (b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.
- STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:
- (a) record the total value of the votes transferred to each candidate,
 - (b) add that value to the previous total of votes recorded for each candidate and record the new total,

- (c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
 - (d) compare:
 - (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
 - (ii) the recorded total of valid first preference votes.
- STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.
- STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.
- STV49. Exclusion of candidates
- STV49.1 If:
 - (a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
 - (b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).
- STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:
 - (a) ballot documents on which a next available preference is given, and
 - (b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).
- STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.
- STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.
- STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which

had been transferred to any candidate excluded under rule STV49.1 into sub-parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

- (a) record:
 - (i) the total value of votes, or
 - (ii) the total transfer value of votes transferred to each candidate,
- (b) add that total to the previous total of votes recorded for each candidate and record the new total,
- (c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
- (d) compare:
 - (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
 - (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

- (a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal

number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

- (b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

- (a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
- (b) give notice of the name of each candidate who he or she has declared elected:
 - (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
 - (ii) in any other case, to the Chair of the corporation; and
- (c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

- (a) the total number of votes given for each candidate (whether elected or not), and
- (b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
- (c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

- (a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
- (b) give notice of the name of each candidate who he or she has declared elected –
 - (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or
 - (ii) in any other case, to the Chair of the corporation, and
- (c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

- (a) the number of first preference votes for each candidate whether elected or not,
- (b) any transfer of votes,
- (c) the total number of votes for each candidate at each stage of the count at which such transfer took place,
- (d) the order in which the successful candidates were elected, and
- (e) the number of rejected ballot papers under each of the headings in rule STV44.1,
- (f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

- (a) declare the candidate or candidates remaining validly nominated to be elected,
- (b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and
- (c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

- (a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
- (b) the ballot papers and text voting records endorsed with “rejected in part”,
- (c) the rejected ballot papers and text voting records, and
- (d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

- (a) the disqualified documents, with the list of disqualified documents inside it,
- (b) the list of spoilt ballot papers and the list of spoilt text message votes,
- (c) the list of lost ballot documents, and
- (d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

- (a) its contents,
- (b) the date of the publication of notice of the election,
- (c) the name of the corporation to which the election relates, and
- (d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

- (a) any voting documents are received by the returning officer after the close

of the poll, or

- (b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
- (c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

- (a) the inspection of, or the opening of any sealed packet containing –
 - (i) any rejected ballot papers, including ballot papers rejected in part,
 - (ii) any rejected text voting records, including text voting records rejected in part,
 - (iii) any disqualified documents, or the list of disqualified documents,
 - (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
 - (v) the list of eligible voters, or
- (b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

- (a) persons,
- (b) time,
- (c) place and mode of inspection,
- (d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

- (a) in giving its consent, and
- (b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

- (i) that his or her vote was given, and
- (ii) that NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS foundation trusts) has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

- (a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
- (b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

- (a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
- (b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

- (a) its contents,
- (b) the date of the publication of notice of the election,
- (c) the name of the corporation to which the election relates, and
- (d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to

the Chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

- (a) publish a notice stating that the candidate has died, and
- (b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
 - (i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
 - (ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

- (a) personal expenses,
- (b) travelling expenses, and expenses incurred while living away from home, and
- (c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

- (a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
- (b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

- (a) compile and distribute such information about the candidates, and
- (b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

- (a) objective, balanced and fair,
- (b) equivalent in size and content for all candidates,
- (c) compiled and distributed in consultation with all of the candidates standing for election, and
- (d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

- (a) a statement submitted by the candidate of no more than 250 words,
- (b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility (“numerical voting code”), and
- (c) a photograph of the candidate.

65. Meaning of “for the purposes of an election”

65.1 In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects; and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election
- 66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).
- 66.2 An application may only be made once the outcome of the election has been declared by the returning officer.
- 66.3 An application may only be made to Monitor by:
- (a) a person who voted at the election or who claimed to have had the right to vote, or
 - (b) a candidate, or a person claiming to have had a right to be elected at the election.
- 66.4 The application must:
- (a) describe the alleged breach of the rules or electoral irregularity, and
 - (b) be in such a form as the independent panel may require.
- 66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.
- 66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.
- 66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.
- 66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.
- 66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

- (a) the returning officer,
- (b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

- (i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
- (ii) the unique identifier on any ballot paper,
- (iii) the voter ID number allocated to any voter,
- (iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

- (a) a member of the corporation,
- (b) an employee of the corporation,
- (c) a director of the corporation, or
- (d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

- (a) the delivery of the documents in rule 24, or
- (b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

Eligibility to be a Member of the Council of Governors

1. Council of Governors – Further Provisions on disqualification and removal:

Further to the provisions set out in paragraph 15.1 the following may not become or continue as a Governor of the Council of Governors if they are:

- 1.1 a person who has been dismissed in the previous 5 years from any NHS body (except for redundancy or sickness);
- 1.2 a person whose tenure of office as a Chair, Non- Executive Director or Governor of an NHS body has previously been terminated on the grounds that his appointment is not in the interests of the NHS for non-attendance at meetings or for non-disclosure of a pecuniary interest;
- 1.3 a person who has previously been or is currently subject to a sex offender order or sexual harm prevention order and/or required to register under the Sex Offences Act 2003 or committed a sexual offence prior to the requirement to register under current legislation;
- 1.4 a person who is a vexatious complainant of the Trust;
- 1.5 a person who has had his name removed from any list prepared under the 2006 Act in accordance with section 91, 106, 123 and 272 of that Act or has otherwise been suspended or disqualified from any healthcare profession, and has not subsequently had his name included in such a list or had their suspension lifted or qualification re-instated;
- 1.6 a person who is currently a member of an independent scrutiny body whose role includes or will include independent scrutiny of Humber Teaching NHS Foundation Trust;
- 1.7 a person who is a spouse, partner, parent or child of a Director or the Chair of the Trust;
- 1.8 a person who is under 16 years of age;
- 1.9 a person who on the basis of disclosures obtained through an application to the Disclosure and Barring Scheme is not considered suitable by the Trust;
- 1.10 a person who has physically or verbally abused any NHS staff member and has been taken to Court, found guilty and convicted;
- 1.11 he/she is incapable of managing and administering his property and affairs because of mental disorder, illness or injury and will be suspended from their duties to undertake treatment. Duties will not resume until all the issues are resolved;
- 1.12 making false declaration for any purpose of this Constitution or the 2006 Act; and
- 1.13 he or she has conducted his or herself in a manner that has caused, or is likely to cause, material prejudice to the best interests of the Trust or the proper conduct of the Council of Governors or otherwise in a manner inconsistent with continued membership of the Council of Governors.

- 11.14 If the conduct or behaviour of a Governor is called into question, discussion with the Governor will take place and relevant support will be provided for the Governor to resume normal duties but under close supervision of the Chair. However, if the behaviour and conduct does not improve and is unacceptable a decision may be made in conjunction with the Lead Governor and Senior Independent Director to suspend the Governor from duties and ultimately could lead to a recommendation to the full Council of Governors to withdraw the Governor from the Council under paragraph 11.13 of this Annex.

This action will only be taken if previous attempts to resolve the situation informally have failed;

- 11.15 Removal under paragraph 11.13 of this Annex shall be on the recommendation of the Trust Chair and should require the approval of at least two-thirds of the voting Governors present, the Governor concerned not being eligible to participate in such a vote and being absent from the room whilst it takes place. If a Governor's tenure of office is terminated, then he/she should be ineligible to stand for re-election as a Governor for a period of three years. A decision for termination should be effective notwithstanding any reference to dispute resolution.

2 Termination of Tenure

In addition to 14.2 and 15.1 and 15.3 the following apply;

- 2.1 A Governor may resign from that office at any time during the term of office by giving notice in writing to the Trust Secretary;
- 2.2 If a Governor fails to attend 3 consecutive meetings of the Council of Governors his/her tenure of office is to be terminated immediately unless the other Governors or Chair are satisfied that;
- the absence was due to reasonable cause; and
 - he/she will be able to start attending meetings of the Trust again within such a period as they consider reasonable.
- 2.3 The Council of Governors may terminate the tenure of a Governor by a three quarter majority of those voting if it is satisfied that he/she;
- fails to adhere to the Trust's 'Governors Code of Conduct'; and/or
 - persists in acting in a manner prejudicial to the best interests of the Trust.
- 2.4 An appointed Governor will cease to hold office if the appointing authority terminate their sponsorship of the individual.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

Standing Orders for Council of Governors Meetings

1. Calling Meetings

- 1.1 The Council of Governors is to meet at least four times in each financial year.
- 1.2 One of these meetings will be an Annual Members' Meeting (AMM) which will be held prior to 31 October each year.
- 1.3 Ordinary meetings of the Council of Governors may be called at any time by the Chair.
- 1.4 One third or more of the Council of Governors may requisition a meeting in writing to the Chair specifying the business to be carried out. If the Chair refuses to organise a meeting, or within 14 days of the requisition being presented fails to organise a meeting, the Governors signing the requisition may forthwith call a meeting.

2. Notice of Meetings and Business to be Transacted

- 2.1 The Trust Secretary shall give at least 30 days' notice of the date and place of every meeting of the Council of Governors to each Governor. This notice should also specify the business proposed to be transacted.
- 2.2 General meetings may be called by the Chair if the subject matter does not allow for 30 days notice to be given.
- 2.3 In the case of a meeting called by Governors in default of the Chair calling the meeting the notice should be signed by those Governors.

3. Agenda and Supporting Papers

- 3.1 The Agenda will be sent out to Governors not less than 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 clear days before the meeting.
- 3.2 Before each meeting of the Council of Governors, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least 3 days before the meeting.

4. Setting the Agenda

- 4.1. A Governor or Director desiring a matter to be included on the agenda will make his/her request in writing to the Chair at least 20 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 may be included at the discretion of the Chair.

5 Moving, Amending, Withdrawing and Rescinding Motions

- 5.1 A Governor desiring to move or amend a motion should send a written notice thereof at least 14 working days before the meeting to the Chair, who will include it in the agenda (where permissible under the appropriate regulations). This includes motions on the possible termination of tenure of Governors as described in Annex 6. This does not prevent a motion being moved during a meeting without notice on any business mentioned on the agenda.
- 5.2 A motion or amendment once moved and seconded can be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.
- 5.3 Notice of a motion to amend or rescind any resolution which has been passed within the preceding 6 calendar months shall bear the signature of the Governor who gives it and also the signature of 10 other Governors. When such a motion has been disposed of by the Council of Governors it cannot be proposed again to the same effect within the next 6 calendar months unless the Chair considers it appropriate.
- 5.4 The proposer of a motion shall have the right of reply at the close of any discussion on the motion or any proposed amendment.
- 5.5 When a motion is under discussion it shall be open to a governor to move
- An amendment to the motion
 - The adjournment of the discussion or the meeting
 - That the meeting proceed to the next business(*)
 - The appointment of an ad hoc committee to deal with the specific item of business
 - That the motion now be put(*)
 - That the public now be excluded
- (*) denotes these motions may only be put by a Governor who has not previously taken part in the debate.
- 5.6 No amendment to a motion will be admitted if the Chair is of the opinion it negates the substance of the motion.

6 Declarations

- 6.1 An elected Governor cannot vote at a meeting of the Council of Governors, unless immediately prior to the commencement of each meeting, he has made a declaration in the form specified by the Trust Secretary, of the particulars of their qualification to vote as a member of the Foundation Trust, and that they are not prevented from being a member of the Council of Governors by the conditions set out in paragraph 15 in this Constitution.

An elected Governor shall be deemed to have confirmed the declaration upon attending subsequent meetings of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of the elected Governors.

- 6.2 Each Governor is required to declare their interests in accordance with paragraph 20 of this Constitution and the Trust policy. In the event of a material interest which has been previously declared being pertinent to a discussion or decision of a meeting of the Council of Governors the Governor in question should
- Withdraw from the meeting and play no part in the relevant discussion or decision
 - Not vote on the issue
- 6.3 Any Governor who fails to disclose any interest required to be disclosed in accordance with paragraph 20 of this Constitution or the Trust policy will have his/her tenure automatically terminated if required to do so by two thirds of the Governors in accordance with paragraph 2.3 of Annex 6 of this Constitution.

7 Voting

- 7.1 Every question at the meeting shall be determined by a majority of the votes of the Governors present except those issues referred to in the Constitution where other than a simple majority is required.
- 7.2 In the case of an equality of votes the Chair of the meeting will have the casting vote.
- 7.3 All questions put to the vote shall be determined by a show of hands. A paper ballot may also be used if a majority of Governors present request it.

8 Minutes

- 8.1 Minutes of the meeting will be drawn up and submitted for approval at the next meeting where they will be signed by the Chair of that meeting. These will be circulated according to the Governors' wishes.
- 8.2 The names of the Chair of the meeting and the names of those present shall be recorded in the minutes.
- 8.3 Minutes of the meeting shall be available to the public except for minutes relating to business conducted when members of the public are excluded under the terms of paragraph 18.

9 Quorum

- 9.1 No business shall be transacted at a meeting unless at least one third of those Governors holding one of the Council of Governors' currently occupied governor seats are present
- 9.2 If such a quorum is not present the meeting can stand adjourned to such time and place as the Trust Secretary may determine.
- 9.3 The Council of Governors can make decisions despite any vacancy in its membership or any defect in the appointment or election of any Governor.

10 Miscellaneous

- 10.1 The Council of Governors may invite the Chief Executive, or any other member of the Board of Directors, or a representative of the financial auditor or other advisors to attend a meeting of the Council of Governors.

- 10.2 Council of Governor meetings will be held online to facilitate attendance unless the Chair deems otherwise or where the Chair is requested in writing by at least one-third of those Governors holding Council of Governors currently occupied Governor seats to hold a face-to-face meeting
- 10.3 The Council of Governors may not delegate any of its powers to a committee or sub-committee, but it may appoint Committees to assist the Council of Governors in carrying out its functions. The Council of Governors may appoint Governors and invite Directors and other persons, to serve on such committees. The Council of Governors may, through the Trust Secretary, request that external assessors assist them or any Committee they appoint in carrying out its duties.
- 10.4 If a meeting is called by Governors in default of the Chair calling a meeting, and the Chair or nominated deputy do not attend, a Governor can, with the agreement of the other Governors present, take on the role of Chair.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

Meetings of the Board

1. Calling Meetings

- 1.1 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may determine.
- 1.2 The Chair of the Trust may call a meeting of the Board of Directors at any time.
- 1.3 One third or more members of the Board of Directors may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within 7 days of a requisition being presented, the Directors signing the requisition may forthwith call a meeting.

2 Notice of Meetings and the Business to be Transacted

- 2.1 Before each meeting of the Board of Directors a written notice specifying the business proposed to be transacted shall be delivered to every Director, or sent by post to the usual place of residence of each Director, so as to be available at least 5 clear days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Lack of service of the notice on any Director shall not affect the validity of a meeting. Details of meetings and the public agenda will be published on the Trust's website.
- 2.2 In the case of a meeting called by Directors in default of the Chair calling the meeting, the notice shall be signed by those Directors.
- 2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 7.
- 2.4 A Director 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 Agenda and Supporting Papers

The agenda will be sent to Board members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency, with the agreement of the Chair. . An agenda shall be presumed to have been served two days after posting.

4. Petitions

Where a petition has been received, the Chair shall include the petition as an item for the agenda of the next meeting.

5 Chair of Meeting

- 5.1 At any meeting of the Board of Directors, the Chair, if there is one present, shall preside. If the Chair is absent from the meeting, the Deputy Chair if present, shall preside.
- 5.2 If the Chair and Deputy Chair are absent, another Non-Executive Director as the Directors present shall choose shall preside.

6 Notice of Motion

- 6.1 Subject to the provision of Standing Orders 8 'Motions: Procedure at and during a meeting' and 9 'Motions to rescind a resolution', a member of the Board of Directors 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.
- 6.2 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.

7 Emergency Motions

- 7.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 8 'Motions: Procedure at and during a meeting', a member of the Board of Directors 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 Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision on whether to include the item shall be final.

8 Motions: Procedure at and During a Meeting

8.1 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.

8.2 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 Board of Directors;
- the accuracy of minutes;
- that the Board of Directors proceed to next business;
- that the Board of Directors adjourn;
- that the question be now put.

8.3 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 Board of Directors.

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.

8.4 Rights of Reply to Motions

- Amendments

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.

- Substantive/original motion

The Director who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

8.5 Withdrawing a Motion

A motion, or an amendment to a motion, may be withdrawn.

8.6 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 Board of Directors 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.

9 Motion to Rescind a Resolution

- 9.1 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 3 other Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to any appropriate Committee or the Chief Executive for recommendation.
- 9.2 When any such motion has been dealt with by the Board of Directors 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.

10 Chair's Ruling

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.

11 Voting

- 11.1 Save as provided in Standing Orders 13 - Suspension of Standing Orders and 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.
- 11.1.1 Where more than one person is appointed jointly to a post in the Trust this shall count as one vote.
- 11.2 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.
- 11.3 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 Director present voted or did not vote (except when conducted by paper ballot).
- 11.4 If a Director so requests, their vote shall be recorded by name.
- 11.5 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.
- 11.6 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 all rights including the voting rights of the Executive Director.
- 11.7 A manager attending the Board of Directors meeting to represent an Executive Director 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.

12 Minutes

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.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

13 Suspension of Standing Orders

- 13.1 Except where this would contravene any statutory provision or the rules relating to the Quorum (Standing Order 16), 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 Board of Directors are present (including at least one member who is an Executive Director 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 Board of Directors' minutes.
- 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.
- 13.3 No formal business may be transacted while Standing Orders are suspended.
- 13.4 The Audit Committee shall review every decision to suspend Standing Orders.

14 Variation and Amendment of Standing Orders

These Standing Orders can only be amended in accordance with paragraph 3 of Annex 9.

15 Record of Attendance

The names of the Chair and Directors/managers present at the meeting shall be recorded.

16 Quorum

- 16.1 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.
- 16.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.
- 16.3 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 17) 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.

17 Declarations

- 17.1 Each Director is required to declare their interests in accordance with paragraph 32 of this Constitution and Trust policy. In the event of a material interest which has been previously declared being pertinent to a discussion or a decision of a meeting of the Board of Directors the director in question should
- Withdraw from the meeting and play no part in the relevant discussion or decision, and:
 - Not vote on the issue.
- 17.2 A report on any Non-Executive Director who fails to disclose any interest to be disclosed in accordance with paragraph 32 of this Constitution or the Trust policy will be considered by the Council of Governors in accordance with the process to remove a Non-Executive Director.
- 17.3 A report on any Executive Director who fails to disclose any interest to be disclosed in accordance with paragraph 32 of this Constitution or the Trust policy will be considered by a Committee consisting of the Chair, the Chief Executive and the Non-Executive Directors in accordance with the process to remove an Executive Director.

18 Admission of Public and the Press

The Board of Directors 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.

ANNEX 9 – FURTHER PROVISIONS

1 Restrictions on Membership

- 1.1 An individual may not become or continue as a member of the Trust unless he/ she is aged 14 years or over when an application for membership is made and he/ she:
 - 1.1.1 lives in an area specified in Annex 1 as an area for a Public Constituency; or
 - 1.1.2 is eligible for membership of the Staff Constituency in accordance with paragraph 8.1 or paragraph 8.2 of the Constitution.
- 1.2 In addition:-
 - 1.2.1 no member should act in a manner which could associate the Trust with any personal opinions expressed by the member;
 - 1.2.2 other than staff members, no member may designate the Trust as his/her personal or professional postal address.

2. Dispute Resolution

- 2.1 Any dispute or complaint arising from the procedures set out in the Constitution as they relate to the functioning of the Board of Directors, the Council of Governors or any aspect of the membership or election arrangements will be referred in the first instance for resolution by the Trust Secretary, in consultation with the Chair, Chief Executive or the Council of Governors as appropriate.
- 2.2 If the dispute is between the Council of Governors and the Board of Directors the Chair or Deputy Chair (if the dispute involves the Chair) will endeavour to resolve the issue through discussion with the Governors and Directors to the satisfaction of both parties.
- 2.3 Failing resolution, under 2.2 the Board or the Council, as appropriate, will at its next formal meeting, approve the precise wording of a disputes statement setting out clearly the issues in dispute.
- 2.4 The Chair will ensure that the disputes statement is an agenda item and paper at the next formal meeting of the Council of Governors or Board as appropriate. That meeting will agree a response to the disputes statement.
- 2.5 The Chair (or Deputy Chair) will immediately as soon as practicable communicate the outcome to the other party and deliver the written response.
- 2.6 If the matter remains unresolved and following further discussions and/or use of the above process there appears to the Chair to be no prospect of resolution then he will advise the Council of Governors and the Board accordingly.
- 2.7 Where the dispute remains unresolved or only partially resolved the view of the Board of Directors will prevail.
- 2.8 Nothing in the above procedure will prevent the Council of Governors if it wishes, from informing NHSE , the statutory entity that remains the regulator of NHS foundation trusts that, in the Council's opinion, the Board of Directors has not responded constructively to concerns of the Council that the Trust is not meeting the conditions of its Licence.

4 Further Provisions on Disqualification of Non-Executive Directors

Further to the requirements set out in paragraph 25 the Board of Directors will determine, and identify in the annual report, each Non-Executive Director it considers to be independent. Anyone identified as not being independent will not be permitted to become or continue as a Non-Executive Director and consideration of independence or otherwise will include the following factors:

- If he/she has been an employee of the Trust within the last 5 years;
- If he/she has, or has had within the last 3 years, a material business relationship with the Trust either directly, or as a partner, shareholder, Director, or senior employee of a body that has such a relationship with the Trust;
- If he/she has received or receives additional remuneration from the Trust apart from a Director's fee, participates in the Trust's performance related pay scheme, or is a member of the Trust's pension scheme;
- If he/she has close family ties with any of the Trust's Directors or senior employees;
- If he/she holds cross Directorships or has significant links with other Directors through involvement in other companies or bodies;
- If he/she has served on the Trust's Board of Directors for more than 9 years from the date of their first appointment.

The Board must state its reasons if it determines that a Director is independent despite the existence of relationships or circumstances such as those listed above.

5 Indemnity

Members of the Board of Directors and Council of Governors and members of those committees which have delegated powers to make decisions or taken actions on behalf of the Board, as in the case of Mental Health Act Hospital Managers' Panel, who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Board of Directors' or Council of Governors functions, save where they have acted recklessly. Any costs arising where members have acted honestly and in good faith will be met by the Trust.

The Trust may make such arrangements, as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, or Directors, or Governors and members of those committees which have delegate powers to make decisions or taken actions on behalf of the Board, as in the case of Mental Health Act Hospital Managers' Panel to meet all or any liabilities, which are properly the liabilities of the Trust under the paragraph above.

Agenda Item 26

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Finance Committee Assurance Report - Chair’s Log															
Author/s:	Keith Nurcombe, Chair (Non-Executive Director)															
Recommendation:	<table><tr><td>To approve</td><td></td><td>To receive & discuss</td><td></td></tr><tr><td>For information/To note</td><td></td><td>To ratify</td><td></td></tr><tr><td>Assurance</td><td>√</td><td></td><td></td></tr></table>				To approve		To receive & discuss		For information/To note		To ratify		Assurance	√		
To approve		To receive & discuss														
For information/To note		To ratify														
Assurance	√															
Purpose of Paper:	The aim of this paper is to provide assurance to the Trust board on the financial and digital performance of the Trust.															
Key Issues within the report:																
Matters of Concern or Key Risks to Escalate: - Month 10 and potential financial year end is very challenging for the wider ICB system and will potentially create challenges for year end close and 2026/2027. - Potential risk to trust from greater financial support ask to support system and further potential savings that could be required for the trust as current year progresses.		Key Actions Commissioned/Work Underway: - Request for agency plan for 2026/2027 and 2027/2028 to be presented to committee in July given increasing requirement to lower spend. Request especially for detail around consultant and medic plan which has highest spend levels. - Request for additional trajectory information to be added to front sheet where we have it for Model Hospital so we can see improvement or worsening conditions. - Presentation on Interweave following progress and NHS England ask around integration at July F&D Committee Meeting.														
Positive Assurance to Provide: - Trust ledger closed for 2025/2026 and the trust has delivered an on performance plan with small surplus to plan of £8k. Excellent result for the trust given wider system position. - Cash position remains very strong with cash position remining consistent over the last 5 years. - Recognition for the excellent performance of achieving Segment 1 overall performance for the trust.		Decisions Made: To address section 3 of the committee meetings to reflect larger digital discussion and to move out some other elements around estates and partnerships to other executive areas.														

Governance: <i>Please indicate which committee or group</i>		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail) Report produced for the Trust Board	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Committee Assurance Report – Key Issues

Overall the committee has received strong assurance in key areas for the board:

Section 1 on grip and control and financial performance of the trust the committee is very assured.
Section 2 on productivity and efficiency the trust is mainly assured with some further areas and work around workforce and sickness and absence.

Section 3 on digital, BAF and other matters the committee is very assured.

Section 1

Agency spend progress has continues to deliver significant savings and agency spend is well below spend three years ago reducing by over 50% but further requirements in the next two years require another 30% to be removed from agency spend, this will be a continued focus area and challenge for the trust.

Significant BRS challenges for the wider system with a number of trusts declaring that they will under achieve savings targets. The trust has delivered its BRS over the last three years and continues to focus on delivery now in 2026/2027. The committee was very clear on the excellent progress that has been made by the trust along with the continued need to focus for the current year.

Section 2

Good progress on measuring and demonstrating efficiency and productivity across the organisation:

Model hospital report demonstrating continued strong performance for the organisation with read areas demonstrating concern around sickness and absence rates which the committee has asked from more information on at the next meeting. Provides good assurance.

NOF data revealing again some areas of good performance (Segment 1) as well as continued areas for focus. Provides good assurance.

Section 3

Corporate Benchmarking report on digital – very good results – 7/50 for digital maturity and 17/90 overall for digital benchmarking across relevant trusts. Both these results are very strong but with an overall rating of 2.9/5 there are still some areas of improvement etc. Plan in place to take the trust to 4 out of 5.

BAF – asking EMT to review BAFs 3 and 4 around current score as the committee feels that on agency and wider financial risk while the risks remain there they have fallen a little form their respective scores of 12 and 16.

Received updates from Partnerships and strategy and also around estates plan for the next year.

Agenda Item 27

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	People & Organisational Development Committee Assurance Report from meeting held on 06 May 2026															
Author/s:	Carrie Wollerton – Non-Executive Director															
Recommendation:	<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>				To approve		To discuss		To note	✓	To ratify		For assurance	✓		
To approve		To discuss														
To note	✓	To ratify														
For assurance	✓															
Purpose of Paper:	This paper provides an executive summary of the key discussions and outcomes from the People and Organisational Development Committee meeting held on 06 May 2026. The Committee operates as a formal sub-committee of the Trust Board and is responsible for providing assurance on matters relating to workforce, organisational development, and equality, diversity and inclusion (EDI). The report highlights key points for the Board's attention and consideration.															
Key Issues within the report:																
Positive Assurances to Provide: - The Committee received strong assurance that the Trust continues to maintain stable workforce performance, including low vacancy and turnover rates, high appraisal completion, and sustained compliance with statutory and mandatory training requirements. - The Trust continues to demonstrate a strong and inclusive culture, with the 2025 National Staff Survey confirming performance above national and benchmark averages across all People Promise themes, and high levels of staff engagement, advocacy and pride. - Health and wellbeing provision remains well established, with good engagement across services and targeted interventions in place for areas		Key Actions Commissioned/Work Underway (to include comments/discussion at Committee/Executive Management Team (EMT)): - A Trust-wide staff listening exercise has been undertaken, with findings currently being analysed to inform targeted workforce and organisational development actions. - Continued targeted support to divisions with higher sickness absence, including structured insight meetings and intervention programmes. - Implementation of a phased readiness plan for the Employment Rights Act 2025, including policy updates, management training and system changes.														

experiencing higher sickness absence, supported by robust governance and insight processes. • The Trust is maintaining effective financial and workforce control, delivering a year-end surplus and reducing bank and agency usage, demonstrating improved productivity and workforce planning. • Continued assurance was provided that the Trust is meeting professional education and registration requirements, supported by strong learning environments, preceptorship, and workforce pipeline development. • The Trust continues to perform strongly within national frameworks, including Model Hospital metrics and the National Oversight Framework (Segment 1), demonstrating high-quality, efficient and sustainable service delivery. • Workforce risks are appropriately identified and managed through the Risk Register and Board Assurance Framework, with no additional risks requiring escalation	• Ongoing delivery of the Medical Workforce Plan, improving recruitment pipelines, reducing agency dependency, and strengthening workforce sustainability. • Progression of the Transforming People Services programme, with Humber positioned as an early adopter and preparatory work underway for implementation. • Delivery of a comprehensive Annual Training Plan for 2026/27, strengthening workforce capability, compliance and inspection readiness. • Implementation of an action plan following the Job Evaluation audit to address identified development areas.
Key Risks/Areas of Focus: • Areas identified from the Staff Survey require focused improvement, including declining appraisal quality, reduced feelings of being valued, increasing musculoskeletal issues and burnout, and reduced confidence to speak up. • Sickness absence remains a pressure in some areas, requiring continued targeted intervention and monitoring to ensure sustained improvement. • Whilst consultant vacancies are reducing overall, there remain ongoing challenges in recruiting to hard-to-fill specialties, which may impact service resilience. • Job Evaluation processes, while compliant overall, require strengthening in panel representativeness and assurance capacity to meet future national requirements.	Decisions Made: • Approval of the People and Organisational Development Committee effectiveness review for 2025/26. • Approval of the revised Terms of Reference for 2026/27. • Endorsement of the Medical Workforce Plan and workforce strategy approach, including continued focus on recruitment, retention and workforce sustainability. • Support for ongoing delivery of key strategic programmes, including Transforming People Services, Employment Rights Act readiness, and workforce and training plans.

There is an ongoing requirement to ensure visible delivery of actions arising from staff feedback to maintain confidence, engagement and trust.					
Governance:		Date			Date
	Audit Committee		Remuneration & Nominations Committee		
	Quality Committee		People & Organisational Development Committee		
	Finance Committee		Executive Management Team		
	Mental Health Legislation Committee		Operational Delivery Group		
	Collaborative Committee		Other (please detail) Trust Board	27/05/26	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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 06 May 2026

Health & Wellbeing Insight Report:

The Committee received a comprehensive update on health and wellbeing and noted: staff engagement with wellbeing services remains steady, with strong uptake of physical health MOTs, including significant engagement from staff who had not previously accessed the service. Targeted divisional support continues for areas with sickness absence above 8%, with interventions offered across all tiers. The impact of these interventions is routinely reviewed through structured divisional Insights meetings, providing ongoing assurance of effectiveness and governance.

Equality, Diversity and Inclusion Insight Report:

Equality, Diversity and Inclusion remains a core organisational priority, underpinned by clear governance, strong leadership and robust data analysis. The 2025 NHS Staff Survey demonstrates a well-embedded culture of inclusion, with staff reporting high levels of respect and psychological safety.

The Trust continues to strengthen staff safety and support through proactive communication and targeted initiatives in response to external events. Staff Networks are being further empowered through a structured leadership induction programme, enhancing engagement and escalation within EDI governance.

Progress against external frameworks, including WRES, WDES and Patient and Carer Race Equality Framework, alongside evidence submitted to the CQC, provides assurance that inequalities are being systematically identified and addressed. The formal adoption of the IHRA definition of antisemitism further reinforces the Trust's commitment to tackling discrimination and promoting an inclusive and respectful workplace.

Professional Education Insight Report – Nurse/AHP/Registered Professionals:

The Committee was given assurance that the Trust is meeting national professional education and registration requirements across nursing, AHP and social work workforces. A safe and supportive learning environment is in place, supported by strong governance arrangements, high engagement in continuing professional development, and an established multi-professional preceptorship offer. The Trust continues to demonstrate commitment to patient safety, workforce capability and future sustainability through high-quality placements, strong links with higher education institutions, and innovative approaches to professional development and workforce pipelines.

People Insight Report:

The committee noted that the Trust continues to make strong progress against its workforce and people strategy. statutory and mandatory training compliance remains high and above target, leadership and talent programmes are delivering positive outcomes, and apprenticeship provision is well-utilised. Workforce indicators remain stable, with low vacancy and turnover rates, high appraisal completion, and early signs of improvement in in-month sickness absence.

Finance and Workforce Controls Assurance Report:

The committee noted assurance that the Trust remains in a strong financial and workforce position. A year-end surplus exceeding the agreed plan has been delivered, alongside improved performance and productivity. Workforce controls

remain effective, with vacancy rates below target and significant reductions in bank and agency usage and spend, demonstrating strengthened workforce planning and financial control.

Risk Register and Board Assurance Framework (BAF):

It was noted that workforce-related risks are appropriately identified, managed and monitored through the People and Organisational Development risk register and the BAF. An overall assurance rating has been applied against the relevant strategic goal, reflecting the level of assurance available to the Executive Lead at the time of review. No additional workforce risks require escalation beyond those already captured, and the People and Organisational Development section of the BAF continues to be reviewed and refined for 2026/27.

2025 Staff Survey Results:

The Trust continues to perform strongly in the National Staff Survey, exceeding national and benchmark averages across all People Promise themes. Staff report high levels of engagement, advocacy and pride in their work, with particularly strong scores in compassionate culture, inclusion and teamworking. The improved response rate provides confidence in the robustness of the findings, and clear organisational and divisional actions are in place to respond to identified priorities.

It was also noted that there are areas of focus include declining appraisal quality, reduced feelings of being valued, rising musculoskeletal issues and burnout, and a small reduction in confidence to speak up. An in-depth listening exercise with staff across the Trust has taken place and the result are currently being collated.

Medical Workforce Plan:

The Committee welcomed the update that Medical Workforce Plan continues to deliver positive impact, with strengthened recruitment pipelines, improved trainee fill rates and significantly reduced reliance on agency staffing. Consultant vacancies have reduced substantially, supported by robust financial oversight, skill-mix optimisation and strengthened medical leadership arrangements, providing confidence in workforce sustainability and continuity of safe, high-quality services.

It was also noted that while consultant vacancies are reducing work continues around recruiting to the hard to fill specialties.

Insightful Board Domains:

The committee noted that the Trust has effective governance arrangements in place against the Insightful Board framework. The Board and senior leaders are actively engaged with the guidance, responsibilities for the domains are embedded within committee structures, and identified gaps are supported by agreed action plans. Ongoing triangulation across committees, alongside targeted improvements in workforce, quality and people insight measures, provides continuing assurance of board effectiveness and oversight.

Training Plan:

The committee welcomed that the Trust has a comprehensive and deliverable Annual Training Plan in place for 2026/27. Statutory and mandatory training arrangements support regulatory compliance and patient safety, while accessible learning pathways, improved ESR recording, and embedded coaching and mentoring strengthen workforce capability, development and inspection readiness.

Employment Rights Bill:

The committee noted the Trust has a clear and robust approach in place to prepare for the Employment Rights Act 2025. A phased implementation plan, supported by strong governance, structured readiness activity, policy and system updates, and targeted management training, is underway. Early engagement with staff-side and clear arrangements for compliance, assurance and ongoing oversight provide confidence in organisational readiness as the new legislation is implemented.

Model Hospital – Workforce Metrics:

The Trust is performing strongly against key Model Hospital productivity and efficiency measures. Implied productivity growth is positive and above peer and national averages, temporary staffing costs remain within green thresholds, estates and facilities costs compare favourably, and employee engagement scores remain upper quartile. Operational and workforce productivity indicators demonstrate stable and efficient service delivery alongside maintained quality and safety.

National Oversight Framework Q3:

The Trust continues to perform strongly within the National Oversight Framework. Quarter 3 results place the Trust in Segment 1, with a high national ranking, demonstrating strong performance across access, quality, workforce and productivity domains. Key indicators show zero long waits, strong urgent response performance, reduced long lengths of stay, positive staff engagement and stable financial oversight, providing confidence in overall organisational performance and governance.

Transforming People Services:

The committee noted the National Transforming People Services update and were briefed on the readiness activity taking place at a local level, with assurance around the proactive work to align to the model. National approval and funding are in place, governance arrangements have been established, and Humber is positioned as an early adopter with a clear Shared Services roadmap. Preparatory work is underway, providing confidence in organisational readiness as the programme moves from planning into implementation.

Job Evaluation Audit Submission:

The committee noted the Trust has completed the nationally mandated Job Evaluation Practices Audit in line with national and partnership requirements. Core Job Evaluation governance and partnership arrangements are in place and functioning effectively, with no systemic failures identified. An agreed action plan is underway to address identified Amber areas, providing confidence in continued compliance and readiness for forthcoming national Job Evaluation developments.

It was also noted that there was an area of focus required to strengthening job evaluation panel representativeness, enhancing routine monitoring and assurance, and ensuring sufficient capacity and readiness for future national JE requirements.

People & Organisational Development Committee Effectiveness Review 2025/26:

The committee agreed and approved to committees' effectiveness review for 2025/26.

Annual Review of People & Organisational Development Committee Terms of Reference:

The committee agreed and approved to committees revised Terms of Reference for 2026.

Agenda Item 28

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026			
Title of Report:	Quality Committee Board Assurance Report – May 2026			
Author/s:	Dr Phillip Earnshaw, Non-Executive Director and Chair of Quality Committee			
Recommendation:	To approve		To discuss	
	To note		To ratify	
	For assurance	√		
Purpose of Paper:	The Quality Committee is one of the sub committees of the Trust Board. The paper provides a summary of discussions held at the Quality Committee on 8th April 2026 with a summary of key issues for the Board to note.			
Key Issues within the report:				
Positive Assurances to Provide: The Committee received positive assurances through the following reports. - Effectiveness Review and Terms of Reference Review - Quality Insight Briefing Report - Quality Committee Risk Register Summary, and BAF - Multi-Professional Strategy – enabling strategy - Clinical Outcomes Report - Waiting List Trajectory and Performance Update Q3 - Patient Safety Incident Response Framework (PSIRF) Plan update - Briefing on enhanced therapeutic observations of care (ETOC) - Annual Ligature Report - National Confidential Enquiry on Suicide update - Suicide Prevention Plan update - Staffer staffing report		Key Actions Commissioned/Work Underway: - To schedule the review of each of the BAF strategic goals as discussion items following the update of the template. - To add the additional updates to actions around the mock inspections and update on the Townend Court published CQC report to the BAF as part of the ongoing review. - The reporting schedule has been updated to allow the Safer Staffing report to be presented to Quality Committee prior to Trust Board at future meetings		
Key Risks/Areas of Focus: Nil raised at this meeting		Decisions Made: The Committee approved the refreshed Patient Safety Incident Response Framework (PSIRF) Plan.		
Governance: Please indicate which committee or group this paper has previously been presented to:		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		People & Organisational Development Committee	
	Finance Committee		Executive Management Team	

	Mental Health Legislation Committee		Operational Delivery Group	
	Collaborative Committee		Other (please detail)	

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Committee Assurance Report – Key Issues

The key areas of note arising from this meeting held on 8th April 2026 are as follows:

The minutes of the meeting held on the 4th December 2025 were agreed as a true record and the action log approved noting the one closed item. The Quality Committee Assurance for December was noted as being presented to Board in January 2026. The Committee work plan for 2026/27 was reviewed and discussed, with an action to cross reference the workplan against the updated Terms of Reference to ensure all areas were included.

Quality Committee Effectiveness and Terms of Reference (ToR) Review - The Effectiveness Review paper was reviewed and approved noting the update to the ToR and the additional items to be added to the work plan ensuring all regulatory and strategic requirements were captured. It was agreed that once the final amendments were added to the ToR a 'clean copy would be sent to committee members for that final oversight before presenting to Board in May for approval.

Board Assurance Framework (BAR) Review - The committee discussed the ongoing updates to the BAF, with the changes to reflect the audit recommendations including a focus on a more collaborative approach among executive leads for underlying objectives. The revised template should be ready for planned review of the strategic goal at the next meeting. It was noted the CQC Inspection report for Townend Court had now been published and would be reflected within the BAF and the review should allow the mock inspection action to be closed as this is now underway. It was also noted the agenda has been updated so the meeting would reflect on items to be included within the BAF at the end of each meeting.

Quality and Safety Insight Briefing - The Quality Insight Report outlined key national updates, including the Patient Safety Incident Response Framework(PSIRF) maturity matrix and HSSIB recommendations on temporary staff in patient safety investigations. Incident reporting remains stable, with self-harm remaining most common, and improvements in areas such as falls and pressure ulcer prevention, with a planned deep dive of violence and aggression incidents on PICU. Safeguarding training compliance exceeded Trust threshold, and a review of complaints processes is underway. Ongoing learning and improvement work includes inspection findings, audit outcomes, and quality priorities, with actions to address VTE assessment challenges and strengthen engagement in quality initiatives. Organisational development at Whitby is focused on culture, staffing, and governance, while the internal PSIRF audit provided strong assurance, with all actions nearing completion

Quality Committee Risk Register Summary - The summary was presented reporting on the comprehensive review of the Quality Committee risk register, which led to an increase in recorded quality and safety risks from 3 to 29, reflecting improved identification and oversight. Risks are now monitored across multiple organisational levels with clear processes for escalation, closure, and a defined threshold for executive review. Discussions highlighted the need to strengthen narrative detail for high-scoring risks, particularly around areas such as neurodiversity waiting times, to better capture system challenges and mitigation actions.

Multi-professional Strategy - The draft multi-professional strategy, is an enabling strategy and aligns with the Trust and Workforce strategies and has been developed through extensive co-production with staff, patients, and service users. It encompasses all health professions and is underpinned by four key promises, with clear accountability through assigned leads. Committee discussions focused on the importance of role clarity, effective interprofessional working, and strong leadership to support productive, patient-centred care. Plans were agreed to circulate the final draft for virtual feedback ahead of Board approval, alongside additional sessions to support NEDs with non-clinical understanding. Emphasis was also placed on aligning outcome metrics with delivery, improving workforce efficiency, and using triangulated data to monitor impact.

Clinical Outcomes Report - PJ presented an update on the implementation of Patient Reported and Clinician Reported Outcome Measures (PROMS and CROMS), outlining a structured project framework with clear governance, risk management, and regular reporting to support delivery. Divisions have identified suitable measures, with a pragmatic, locally driven approach required due to limited national guidance, and a focus on embedding meaningful use in clinical practice. The work emphasises

triangulating clinician and patient perspectives to ensure outcomes are relevant and effective, supported by ongoing feedback. Regional alignment is being explored to encourage consistency, while maintaining local progress to avoid delays.

Waiting List Trajectory and Performance Update Q3 – The quarterly Waiting List and Performance update was presented to the committee, highlighting ongoing pressures on children's neurodiversity services, particularly ADHD and ASD pathways, alongside progress in reducing over 52-week waits, with a focus on prioritising those waiting longest. The Trust has improved operational performance and introduced new board metrics to better track trends, while continuing to support patients through 'waiting well' initiatives such as regular contact and accessible self-help resources. Work is also underway with system partners to improve diagnostic pathways and explore a lead provider model, although some challenges remain around data quality and access targets due to external reporting constraints.

Patient Safety Incident Response Framework (PSIRF) Plan – The refreshed Patient Safety Incident Response Framework (PSIRF) plan was presented, which reflects further development following consultation with staff and patient safety partners and aligns with national requirements. The update emphasises a continued cultural shift in safety governance away from blame towards a more systemic, restorative approach, aiming to strengthen psychological safety and encourage staff engagement in learning from incidents. The Committee reviewed and approved the plan.

Briefing on enhanced therapeutic observations of care (ETOC) – The briefing outlined efforts to align local policy with national guidance and incorporate learning from a recent patient safety incident through peer review, policy updates, and staff training. The discussion highlighted the complexity of applying national expectations within mental health settings and emphasised the importance of a clear, consistent approach. It was also recognised that staff must understand the distinction between physical and therapeutic observations to ensure appropriate use and minimise the risk of harm.

Annual Ligature report – The report highlighted continued progress in reducing fixed ligature anchor points across the Trust and addressing previous delays in the rollout of door alarms. A new Environmental Risk in Clinical Areas (ERICA) group has been established to oversee and coordinate environmental risk management, with ongoing monitoring and mitigation plans in place for any residual risks that cannot be fully eliminated, such as certain bathroom door structures where alarms are not feasible.

National Confidential Enquiry on Suicide update – The report gave an update on national and local suicide data, highlighting key risk factors including higher prevalence in rural and coastal areas, among older men, migrants, and individuals experiencing social adversity. The discussion emphasised critical risk periods such as care transitions and post-discharge, alongside the importance of personalised risk assessment.

Suicide Prevention Plan Update – The draft Suicide Prevention Plan was presented, which aligns with the National Suicide Prevention Strategy (2023–2028) and the Trust's strategic priorities, outlining a two-year approach focused on crisis care, post-discharge support, priority groups, social determinants, and responsible media reporting. The plan will be supported by a dynamic delivery framework with clear milestones and accountability, regular updates to committees, and strong multi-agency collaboration. Governance will be provided through the Suicide Prevention Group with reporting to QPAS and the Quality Committee, and success will be measured through engagement, timely access to support, and the delivery of compassionate, person-centred care rather than fixed reduction targets.

Safer Staffing Report – The Committee noted the Safer Staffing Report, which confirmed that current staffing establishments remain appropriate, with only minor adjustments to deployment being considered to better meet peak demand, and no need to change care hours per patient day. Future reports will be brought to the Quality Committee for review prior to Board submission, ensuring appropriate oversight and scrutiny.

The meeting was reviewed with agreement on good discussion. CW observed for her first meeting the complex and diverse organisation and felt the meeting was patient focused and sensitive to patients in all areas. The synergies between the various committees were recognised.

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026															
Title of Report:	Assurance Report to Board from Audit Committee															
Author/s:	Kath Smart, Non-Executive Director															
Recommendation:	<table border="1"> <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>				To approve		To discuss		To note		To ratify		For assurance	√		
To approve		To discuss														
To note		To ratify														
For assurance	√															
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	Report to the Board of the outcomes of the Audit Committee.															
Key Issues within the report:																
Positive Assurances to Provide: - The Trusts strategic risks on the BAF are up to date and work is ongoing to address audit recommendations for the 26/27 BAF - The deep dive into Community & Primary Care Division Risk Register demonstrated risks being managed within the Division, including GP Practice transfer, Service transfer and workforce challenges (sickness/ vacancies) - The internal audit programme continues to deliver to plan with 2 audits left for this year to be delivered - Positive Assurance audit outcomes for the following audits: BAF/Risk Management; Succession Planning; Lone Working; Clinical Stock Management & Efficiency; Medical Examiner - There is a good compliance with implementing actions arising from audit tested by Audit Yorkshire. Overdue actions (12) are being monitored by management. - The Draft HOIA Opinion is “significant assurance” which will be finalised in June - The counterfraud programme was delivered for 25/26 - Procurement activity, including justifications for direct awards, is controlled & monitored		Key Actions Commissioned/Work Underway: - Feedback on the Annual Governance Statement by the end of May. - Accounts work with the Finance Team and Mazars is underway. Final ISA 260 report due back to June Committee														

Declarations of Interest Annual Report – Good compliance with decision makers, with a few outstanding which are being actively managed			
Key Risks/Areas of Focus: - No new risks were identified - Risks within the BAF/ Risk register & Division Risk register discussed		Decisions Made: - Endorse the external audit workplan for the year end process 25/26; - Approved the Counterfraud plan for 26/27 - Endorsed direct award justifications - Approved the refreshed Standing Orders, Scheme of Delegation and Standing Financial Instructions - Approved the Risk Management Annual Report - Approved the Terms of Reference for Audit Committee	
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date	
	Audit Committee		Remuneration & Nominations Committee
	Quality Committee		People & Organisational Development Committee
	Finance Committee		Executive Management Team
	Mental Health Legislation Committee		Operational Delivery Group
	Collaborative Committee		Other (please detail) Trust Board
			May 2026

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Inequalities	√			
Collaboration (system working)	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Assurance Report to Board from Audit Committee's 18th May meeting

The Committee was quorate, and considered the following:

Minutes/Actions: reviewed and approved

Board Assurance Framework: A review of the BAF confirmed Committee noted the management review and discussed key areas (GP Practice transfer/ No Right to Reside/ Sickness Absence) & whether they would impact on the scores. It was noted further improvements are being made to the BAF to implement recommendations from Audit Yorkshire's recent audit report (Significant Assurance). It was confirmed that Board Risk Appetite would be refreshed in July 2026.

Corporate Risk Register: The four risks scoring over 15+ were reviewed and noted as known significant risks with identified mitigating actions

Community & Primary Care Divisional Risk Register: A deep dive into this register presented by the divisional gave insight into how the division are managing workforce challenges (vacancies/ sickness) and service challenges. Some follow up work was requested on older risks and amalgamation of certain risks.

External Audit: Forvis Mazars presented their Annual Audit Plan for 25/26 covering audit scope, approach and timeline. Their presentation covered significant risks; materiality levels; fee and independence. It was confirmed that Mazars have undertaken no non-audit work. A separate meeting will be arranged with Audit Committee members to meet with Mazars once the ISA 260 report is available.

Internal Audit: The plan continues to be delivered and since the last Committee, five more reports have been issued, all with significant assurance - BAF/ Risk Management; Clinical Stock Management & Efficiency; Succession Planning; Medical Examiner & Lone Working. All five reports were viewed positively by the Committee and represent good outcome for Humber.

Internal Audit confirmed that the Trust is implementing recommendations as agreed (34/34 submitted for review).

Implementation of internal audit recommendations: We noted the position with 6 recommendations now overdue, and asked for progress updates on the PSIRF recommendations. A new SOP approved by ODG aims to clarify the process for closing audit recommendations.

Counter Fraud: We received a positive update on current counter fraud activity, training, a Local Proactive Exercise and approved the Counterfraud plan for 26/27. The annual fraud submission (CFFSR) was delegated to the DoF and Audit Chair to sign off before the end of May

Procurement Activity: Committee considered the latest direct award justifications showing 4 new direct awards; and the status of existing awards

Losses & Special Payments: Annual update on the amounts & reasons for losses/special payments were noted

Declarations / Conflict of Interests – Committee received an update in relation to declarations made by decision makers in the Trust, and received assurance on work in progress to chase up those decision makers yet to make a return.

Accounting Judgements - No major changes to disclose in this years accounts.

Draft Annual Accounts – The financial position and accounts were noted, with the Audit Chair having a session with the Finance Team on the accounts scheduled. The external audit work has commenced and will be presented to Junes Audit Committee.

Annual Governance Statement – The refreshed AGS was noted as having been reviewed via EMT. Comments from internal / external audit colleagues and Committee to be provided by 31 May. The final version will be scrutinised through the June Audit Committee.

Draft Head of Internal Audit opinion 25/26 – The draft opinion currently stands at “significant assurance”, which is unlikely to be affected by the last 2 Audit Reports. This is a positive outcome for Humber.

Standing Orders, Scheme of Delegation and Standing Financial Instructions – Some minor changes and refresh of these key documents were highlighted to the Committee and endorsed. Recommended to Board for approval.

Audit Committee Effectiveness & Terms of Reference – the Audit Committee effectiveness outcome was positive, having met its TOR and workplan for the year. Changes to align the TOR and Workplan were agreed by Committee, and recommended to Board.

Risk Management Strategy Annual Report & plan – This was a review 25/26 and highlighted progress against 3 main pillars of the Risk Management Strategy, alongside an improvement plan.

Review of Meeting: The meeting overran slightly, although agenda items will be allocated timing for next time. Comments were positive about discussion, quality of papers, and papers highlighting changes to lengthy documents were welcomed.

Title & Date of Meeting:	Trust Board Public Meeting – 27 May 2026														
Title of Report:	Mental Health Legislation Committee Assurance Report following a meeting on 7 May 2026														
Author/s:	Stephanie Poole Non-Executive Director and Chair of Mental Health Legislation Committee														
Recommendation:	<table border="1"> <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>			To approve		To discuss		To note		To ratify		For assurance	√		
To approve		To discuss													
To note		To ratify													
For assurance	√														
Purpose of Paper: <i>Please make any decisions required of Board clear in this section:</i>	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 7 May 2026.														
Key Issues within the report:															
Positive Assurances to Provide: - Activity report for Q4 to end March 2026. - Reducing Restrictive Interventions (RRI) and Use of Force Act Q4 Report. - Insight Report, including Mental Health Act (MHA) 2025 updates; Personalised Care Framework (PCF); CQC MHA visits; advocacy update. - CQC Monitoring the Mental Health Act in 2024/25 report - Associate Hospital Managers (AHM) annual report. - Mental Health Insightful Board domains. - Mental Health Inequalities and MHA report. - Mental Capacity Act (MCA) assurance report. - Risk assessment prior to patient leave (ad hoc report) - S132 rights and appeals against detention under the MHA (ad hoc report) - Annual committee effectiveness review, ToR review and workplan for 2026/27.		Key Actions Commissioned/Work Underway: - Mental Health Act (MHA) 2025 implementation is monitored by this committee, an internal Trust project has been initiated and will progress at pace once a code of practice is available in early 2027. - Continued focus on RRI training compliance. - Continued work on missed seclusion reviews. - Continued exploration of the introduction of trust-level MHA benchmarking and comparative data nationally and regionally. - Work to implement the Personalised Care Framework (PCF). - Measures aligned to the issues identified in the CQC Report Monitoring Mental Health Act in 2024/25, including inequalities.													

Review of Board Assurance Framework (BAF)/risk as it relates the MHLC.			
Key Risks/Areas of Focus: No new risk areas identified.		Decisions Made: Some minor changes to the committee Terms of Reference.	
Governance: <i>Please indicate which committee or group this paper has previously been presented to:</i>		Date	
	Audit Committee		Remuneration & Nominations Committee
	Quality Committee		People & Organisational Development Committee
	Finance Committee		Executive Management Team
	Mental Health Legislation Committee	7/5/26	Operational Delivery Group
	Collaborative Committee		Other (please detail)

Monitoring and assurance framework summary:

Links to Strategic Goals <i>(please indicate which strategic goal/s this paper relates to)</i>				
√ 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	√			To be advised of any future implications as and when required by the author
Quality Impact	√			
Risk	√			
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

Action list update

DoLS - In Q1, the Committee heard that occasionally, there are a very small number of patients where urgent Deprivation of Liberty Safeguards (DoLS) authorisation would expire prior to the standard DoLS being authorised by the Local Authority. An agreement is in place with Hull Council so that patients are prioritised and as at Q4 a similar agreement is now also in place with East Riding Council. These incidences are being closely scrutinised and the associated risk included on the Trust risk register.

Activity Report Q4 March 2026

The number of patients admitted was as expected and within control limits (80 in March 26, compared to 90 in March 25). Comparisons of detention by section, regrades, s136, tribunals and hearings are within control limits and do not show any significant trends. It was noted that there has been an increase in the use of Community Treatment orders (CTOs) to 42 and these have gradually been increasing from 21 a year ago. AWOL incidents were reviewed in detail with issues at one of the units being closely monitored by the Clinical Director. It was noted that no under 18s were admitted on a section to an adult ward.

MHA Benchmarking - in the absence of suitable national performance data, the Medical Director continues to explore options for capturing comparative benchmarking data between trusts and is seeking to influence the production of meaningful at both regional and national levels.

Reducing Restrictive Interventions Q4

The committee noted 2 good practice stories related to a young person admitted to Inspire and the Specialist Phlebotomy Clinic for Adults with Learning Disabilities.

De-escalation Management Intervention (DMI) training compliance has consistently remained above the 85% compliance rate and is currently at 91.79%. There has been an increase in compliance with CTR/disengagement training to 83.23%. However concerted efforts are being made to schedule training and it is expected that the compliance target will be reached in Q1.

There is some indicative benchmarking data available, which shows the Trust very much at the lower end of restrictive intervention use nationally.

Assurance is now in place for data quality and reporting from SystmOne regarding seclusion data, while work continues on restraint reporting. The use of seclusion has continued to reduce during Q4. The use of restraint has continued to reduce in Q4 and there have been no incidences of prone restraint. All incidences of use of restrictive interventions continue to be subject to clinical review via the daily safety huddle and weekly by the Clinical Risk Management Group (CRMG). Co-production and service user by experience involvement within the Culture of Care programme has continued to strengthen and the new lived experience lead is now in post within the mental health division. There is an improving picture around missed nursing and medic seclusion reviews, which are showing improved compliance since Q1.

Insight Report

Mental Health Act 2025 – A project has been initiated within the trust with allocated resources from the Project Management team to ensure effective planning and monitoring. A 'kick off' event was arranged between all the divisions at end April 2026 and preliminary work is planned around capacity and demand. A new Sharepoint site will be continually updated with every change moving forward. Some minor amendments have come into force in Q4 but no further dates are yet available for the implementation of the other changes. A Code of Practice is expected in early 2027, which will signal the start of a programme training and implementation of changes over a 10 year period. The Committee will seek

assurance through its Insight Reports until a substantive project plan is in place with an indicative implementation timetable, at which point a standing agenda item will be introduced. Consideration of the risks and resource requirements will need to be included once they are identified.

CQC MHA visits – 2 reports were received in Q4 regarding inspections at Maister Lodge and Swale. The findings and actions were noted. Outstanding themes and action from previous visits are progressed by the units and are proactively followed up by the MHL team.

Independent Mental health Advocacy – the committee received an update regarding the service provided by Cloverleaf and the monitoring arrangements via the MHL team and steering group. 30 clients were supported in Q3.

The Personalised Care Framework (PCF) – this is a modernised approach to the Care Programme Approach for adults and older adults with severe mental health problems. A trust policy is in draft and a multi agency implementation group is in place, but government sign off is awaited for the new framework.

Associate Hospital Managers (AHMs) Annual Report

It was noted that we have 13 AHMs in total with some diversity in gender, age and ethnicity. There are quarterly forum meetings and training / case law updates. Reviews, appraisals and appointments have been completed and arranged in line with Board dates. The committee monitors via activity and Insight reports at each meeting. There is continued consideration of innovative ways to increase numbers of requests for AHM and a patient experience survey is offered after every hearing. Ongoing discussions regarding AMH honorary contracts and payments were noted. There is always focus on recruitment of new AHMs. At present 3 NEDs are AHM trained and attend occasional hearings.

CQC Monitoring the Mental Health Act in 2024/25 report

The committee considered the CQC's annual national findings and the Trust perspective on these. The key findings were in the following areas:

1. Demand, flow and bed capacity
2. Workforce pressures
3. Environment and infrastructure
4. Quality and safety of care (and reducing restrictive interventions)
5. Inequalities

Positive assurances were noted with regard to re-admission rates; statutory roles and patient rights; restrictive interventions; trauma informed practice and personalised care planning; strategic alignment on safety, dignity and equity. Work underway includes measures to strengthen community capacity (eg. Hull CMHT), safer wards model; capital programme and plans; delivery of mandatory autism/LD training. Key risks noted were high acuity and constrained community provision, which places pressure on inpatient services particularly in older adult and PICU pathways; the need for sustained focus on inpatient environments; workforce pressures and potential increased reliance on temporary staffing.

Mental Health Inequalities and MHA

The committee received an annual overview of health inequalities in the use of MHA drawing on local ethnicity, gender, age and deprivation data from Hull and East Riding. There has been some national concern regarding disproportionate detention of people from ethnic minority communities and that the CQC 2024/5 report (above) highlighted persistent inequalities in access, experience and outcomes for certain population groups.

There is no evidence within the Trust of disproportionate use of MHA detentions or Community Treatment Orders. It was noted that the numbers of patients within the Trust from ethnic minority groups are very small. Patterns associated with deprivation are expected and understood, reflecting wider structural determinants of mental health need. This remains an area of focus.

Mental Capacity Act (MCA) assurance

Positive assurance was received regarding level 1 MCA training compliance at 92% (85% target) and level 2 (clinicians) is at 80% (85% target). It was noted that quarterly data regarding deprivation of Liberty applications (DoLs) is now included in the Activity Report. An update was received in relation to national development including Liberty Protection Safeguards (LPS) consultation. A progress update was noted regarding last year's administrative audit.

Risk assessment prior to patient leave (ad hoc report)

Following previous discussion at committee regarding the number of absent without leave (AWOL) incidents, assurance was sought that proper risk assessment procedures were always followed prior to inpatients being allowed out on (section 17) leave. Regular compliance audits are completed and actions monitored. Data for the full year 2025 was analysed and generally showed very good compliance rates at 93.41%. However 3 units are slightly below expectations and will be closely monitored.

S132 rights and appeals against detention under the MHA (ad hoc report)

A sample of patients were examined in detail to explore whether the level of appeals to panels and tribunals was reasonable. This work supported positive assurance regarding patients being given their rights. This is an area that is regularly audited on a sample basis.

Annual committee effectiveness review, ToR review and workplan for 2026/27

The review was completed and areas of positive feedback were noted

- The committee provides strong, constructive challenge in a supportive environment.
- Participants engage very positively and fully in the meetings.
- There has been a welcome, increased focus on assurance re public protection (MAPPA) and MCA issues.
- The quality of RRI reports is excellent and the introduction of case studies is very positive.
- The thorough re-design and improvements in performance reports have been a great benefit.
- Ensures robust oversight of Mental Health Act responsibilities.
- Committee has matured further over the last 12 months, good debate takes place and a range of contributions is encouraged.

For future, there would be focus around implementation of the MHA 2025; an annual development session for members to consider emerging issues; further work on benchmarking. Some related minor changes to the ToR were agreed to remove policies and procedure build in benchmarking comparison; advocacy and oversight of changes to legislation.

Next meeting 6 August 2026

Board Strategic Development Meeting Agenda

Wednesday 1 July 2026, 10.00am – 4.00pm
Multi Use Room, Trust Headquarters, Willerby

		Lead	Action	Report format	Timings
	Arrive from 9.30am for tea and coffee				
1.	Apologies, Welcome and Purpose of the Day	CF	Note	-	10.00
2.	Notes of Meeting held on 29 April 2026 (including action log)	CF	Notes	✓	10.05
3.	Business Items: - Annual Report and Accounts, including Annual Governance Statement - Quality Accounts - Social Values Report	PB/SJ SS KF	Ratify Ratify Approve		10.10
4.	Follow up from the actions from the April Strategic Board Development Meeting	PB/JD	Discuss		10.30
5.	Break				11.30
6.	Board Assurance Framework Benchmarking Report from Audit Yorkshire	Chris Reeves	Discuss	Presentation	11.35
7.	Risk Appetite Review	SS/OS	Agree		12.05
	Lunch with Clinical Apprentices				12.35
8.	Future Statutory Role of Governors	CF/MM	Discuss	✓	13.35
9.	Digital Governance Report	PB	Approve	✓	14.20
10.	Well-Led Bitesize Briefings: - Patient Safety - Workforce, Equality, Diversity and Inclusion, and Sexual Safety (to	SS/KP	Discuss	Presentations	14.50

	include health and wellbeing and Staff Survey)				
11.	Any Other Topical Issues	CF/MM	Discuss	Verbal	16.05
12.	Date, Time and Venue of Next Meeting Wednesday 26 August 2026, Multi-Use Room, Trust Headquarters.				

Members of the Board, Governors and Committees who receive copies of the agenda and meeting papers for Private meetings are required to observe the strictest confidence regarding any information contained within them and are required not to disclose any confidential information. Failure to comply with this requirement may be considered a breach of the Codes of Conduct for Trust Board members, Governors and Committee members.