NHS
Humber Teaching
NHS Foundation Trust

Trust Board Meeting 18 May 2022
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 18 May 2022, via Microsoft Teams

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence	CF	To note	verbal
2.	Declarations of Interest	CF	To receive & note	√
3.	Minutes of the Meeting held on 27 April 2022	CF	To receive & approve	√
4.	Action Log and Matters Arising	CF	To receive & discuss	√
5.	Patient Story – Humber Youth Action Group – Making a Difference	JB	To receive & note	√
6.	Chair's Report	CF	To note	verbal
7.	Chief Executives Report	MM	To receive & note	√
8.	Publications and Highlights Report	MM	To receive & note	√
	Performance & Finance			
9.	Performance Report	PBec	To receive & note	√
10.	Finance Report	PBec	To receive & note	√
	Assurance Committee Reports			
11.	Quality Committee Assurance Report & 2 February 2022 Minutes	MS	To receive & note	√
12.	Mental Health Legislation Committee Assurance Report	MS	To receive & note	√
13.	Audit Committee Assurance Report	SMcKE	To receive & note	√
14.	Collaborative Committee Report	MM	To receive & note	√
15.	Annual Committee Effectiveness Reviews & Terms of Reference	MH	To receive & approve	√
16.	Council of Governors 13 January 2022 Minutes	CF	To receive & note	√
	Strategy			
17.	Risk Management Annual Report and Risk Management Strategy Update - Oliver Sims, Corporate Risk and Compliance Manager attending	HG	To receive & note	√
	Corporate			
18.	External Review of Governance Action Plan Update	MH	To receive & note	√
19.	Annual Declarations 2021/22 Report	PBec	To receive & approve	√

Caring, Learning
& Growing Together

20.	Humber and North Yorkshire Health and Care Partnership – Mental Health, Learning Disabilities and Autism Collaborative Programme Update Alison Flack attending	MM	To receive & note	√
21.	Health Stars Annual Review*	SMcG	To receive & note	√
22.	Health Stars Key Performance Indicators (KPI) 2022/23*	SMcG	To receive & approve	√
23.	Standing Orders, Scheme of Delegation and Standing Financial Instructions Annual Review.	MH	To receive & approve	√
24.	Items for Escalation	All	To note	verbal
25.	**Any Other Business**			
26.	**Exclusion of Members of the Public from the Part II Meeting**			
27.	**Date, Time and Venue of Next Meeting** Wednesday 22 June 2022, 12.30pm by Microsoft Teams – **please note change of time for the meeting**			

* Presented to Board as Corporate Trustee

Humber Teaching NHS Foundation Trust

Agenda Item 2

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Declarations of Interest
Author/s:	Caroline Flint Chair
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The report provides the Board with a list of current Executive Directors and Non-Executive Directors interests.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No issues to note	**Key Actions Commissioned/Work Underway:** • N/A
Positive Assurances to Provide: • Updated declarations	**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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Monthly Board report	✓

Monitoring and assurance framework summary:

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

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

Directors' Declaration of Interests

Name	Declaration of Interest
Executive / Directors	
Ms Michele Moran Chief Executive (Voting Member)	• Appointed as a Trustee for the RSPCA Leeds and Wakefield branch • Chair of Yorkshire & Humber Clinical Research Network • SRO Mental Health/Learning Disabilities Collaborative Programme. • HCV CEO lead for Provider Collaboratives
Mr Peter Beckwith, Director of Finance (Voting Member)	• Sister is a Social Worker for East Riding of Yorkshire Council • Son is a Student at Hull York Medical School
Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	No interests declared
Dr John Byrne, Medical Director (Voting Member)	• Executive lead for Research and Development in the Trust. No personal involvement in research funding or grants. Funding comes into the Trust and is governed through the Trust's Standing Instructions • Senior Responsible Officer for the Local Health Care Record Exemplar (LHCRE), which is governed through Humber Teaching NHS FT standing orders and procedures
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	No interests declared
Mr Steve McGowan, Director of Workforce and Organisational Development (Non-Voting member)	No interests declared
Non Executive Directors	
Rt Hon Caroline Flint – Chair (Voting Member)	• Husband is a member of Doncaster MBC Councillor and Cabinet member • Brother-in-law works at Sandwell and West Midlands NHS Trust as the Senior Consultant for Ophthalmology at the Birmingham and Midland Eye Centre in City Hospital. He is also Professor of Ophthalmology at Aston University and Hon Consultant at Birmingham Children's Hospital. • Chair of the Committee on Fuel Poverty which is an advisory non-departmental public body sponsored by the Department for Business, Energy and Industrial Strategy
Mr Mike Smith, Non-Executive Director (Voting Member)	• Director MJS Business Consultancy Ltd • Director Magna Trust • Director, Magna Enterprises Ltd • Sole Owner MJS Business Consultancy Ltd • Associate Hospital Manager RDaSH • Associate Hospital Manager John Munroe Group, Leek • Non-Executive Director for The Rotherham NHS Foundation Trust • Chair of Charitable Funds Committee at The Rotherham NHS Foundation Trust • Trustee - The Rotherham Minster Development Trust
Mr Francis Patton, Non-Executive Director (Voting Member)	• Non-Executive Chair, The Cask Marque Trust • Treasurer, All Party Parliamentary Beer Group • Industry Advisor The BII (British Institute of Innkeeping) • Managing Director, Patton Consultancy • Non Executive Director of SIBA and Chair of SIBA

	Commercial, The Society of Independent Brewers • Appointed to Baxi Partnership Limited as a Trustee • Appointed as a Trustee to the Spirit Pension Trust
Mr Dean Royles, Non-Executive Director (Voting Member)	• Director Dean Royles Ltd • Owner Dean Royles Ltd • Advisory Board of Sheffield Business School • Strategic Advisor Skills for Health • Associate for KPMG
Mr Hanif Malik, Associate Non-Executive Director (Non-Voting Member)	• Non-Executive Director, Karbon Homes
Mr Stuart Mckinnon-Evans, Non-Executive Director (Voting Member)	• Chief Finance Officer of the University of Bradford

Humber Teaching NHS Foundation Trust

Item 3

Trust Board Meeting
Minutes of the Public Trust Board Meeting held on Wednesday 27 April 2022 via Microsoft Teams

Present:	Rt Hon Caroline Flint, Chair Mrs Michele Moran, Chief Executive Mr Hanif Malik OBE, Associate Non-Executive Director Mr Stuart McKinnon-Evans, Non-Executive Director Mr Francis Patton, Non-Executive Director Mr Dean Royles, Non-Executive Director Mr Mike Smith, Non-Executive Director Mr Peter Beckwith, Director of Finance Dr John Byrne, Medical Director Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals Mr Steve McGowan, Director of Workforce and Organisational Development Mrs Lynn Parkinson, Chief Operating Officer
In Attendance:	Mrs Michelle Hughes, Head of Corporate Affairs Mrs Jenny Jones, Trust Secretary (minutes) Ms Sadie Milner, Quality Standards Practice Development Nurse (for item 66/22) Mr Charlie Bosher, Senior Business Consultant, Quality Health (for item 67/22) Mrs Alison Flack, Freedom to Speak Up Guardian (for item 81/22)
Apologies:	None

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

64/22 **Declarations of Interest**
The declarations were noted. Any further changes to declarations should be notified to the Trust Secretary. The Chair requested that if any items on the agenda presented anyone with a potential conflict of interest, they declare their interest and remove themselves from the meeting for that item.

The Chief Executive and the Director of Finance have a standing declaration of interest in items relation to the Collaborative Committee.

65/22 **Minutes of the Meeting held 30 March 2022**
The minutes of the meeting held on 30 March were agreed as a correct record.

66/22 **Matters Arising and Actions Log**
The action log and work plan were noted.

67/22 **Staff Story- Patient Safety Journey**
Ms Milner attended to share her journey with the Board. Sadie's story reflected her 25 year

journey working in the NHS and the roles she has undertaken during that time. Sadie explained that she came to work in the Trust in 2017 as the patient safety lead, prior to that she worked at the Acute trust. She explained how her role in the organisation has changed over the last five years including overseeing clinical policy and approving clinical procedures, protocols and guidance, medical devices and alerts.

Sadie is proud of what she has achieved so far which included being an early adopter of the NEWS 2, work around zero events which are determined by the Trust using evidence from serious incidents investigations and clinical audits. These include reduction pressure ulcers and falls provisions. Sadie also provides support in a buddying role for Serious incident investigators and undertakes peer reviews. One of her most memorable times is working with mental health colleagues at Mill View leading the rapid response Covid team and developing Covid pathways and caring for patients at an early part of the pandemic.

The corporate safety huddle is another area Sadie is proud of which ~~is~~ reviews all patient safety incidents reported in the previous 24 hours ensuring all relevant processes have been undertaken. There have been some challenges over the last two years particularly around the change to remote working. However, she recognised that this has allowed her more interaction with teams across our wide geographical area and more collaborative working when previously it may not have been as possible.

Mr Smith appreciated the detail Sadie provided and asked if there was anything that she was particularly concerned about. Sadie responded that there were no particular issues as she had assurance that systems and processes were in place and that she had support from the Director of Nursing, Allied Health and Social Care Professionals and Medical Director should it be required.

Mr McKinnon-Evans asked if the change to remote working and not seeing people physically was an issue now and in the future. Sadie admitted that she struggled at first as she is a people person and liked the contact aspect. The Trust has provided all the resources necessary for remote working and there are opportunities to meet her team in person. There are benefits from remote working including productivity, no commute and saving on fuel costs. The peer reviews give an opportunity for face-to-face contact depending on location or online which some patients prefer. In terms of any new safety issues due to the new way of working, Sadie explained that the closed culture raised a potential patient safety concern when we went into lockdown and being unable to get out to clinical areas as it is important that visits were done in person to ensure there were no issues around closed culture.

The Chair and Chief Executive thanked Sadie for sharing her journey and for the work she has done during her time with the organisation. The Chief Executive reported that the safety huddle and the Clinical Risk Manager Group were highlighted as part of the Well led review and was testament to her work.

Resolved: The story was noted

68/22 **2021 NHS National Staff Survey Results**

Mr Bosher, Senior Business Development Consultant with Quality Health who undertook the survey on behalf of the organisation gave a presentation on the results of the survey.

The Trust achieved a response rate of 44% and the results gives a good understanding of what staff are saying about the organisation. The presentation covered the areas of the survey where the Trust had scored well and the areas where further work would help to improve future scores. It highlighted the specific areas where scores had reduced and how they benchmarked against the national average.

Other areas of note included:

- A slight increase was noted in staff engagement and staff morale.

- Staff recommending the organisation as a place to work had reduced slightly in line with the national trend.
- Staff agreed that the care of patients/service users is the top priority which was at a high level.
- Staff experiencing discrimination at work from a manager or other colleague is low and above the national average.
- Staff feeling valued was another area that was above the national average and has improved hugely over the last few years.
- Staff also felt satisfied with their level of pay

It was pointed out that the pandemic has had an effect on all scores across the country. Staff engagement has also been affected by the unique nature of care provision and the Trust should celebrate it's positive scores

Recommendations for areas to improve on were highlighted in the presentation and included:

- Drilling down into data on lower scores in Advocacy specifically staff who would not recommend the organisation as a a place to work
- Investigate the low scores on morale
- Priorities the issue of stress at work with particular focus on staff who report coming into work when not well enough
- Review the content of appraisals
- Consider training for immediate managers to help empower them to better support their staff
- Ensure staff are recognised and rewarded tor good performance

The Chair commented that the survey results had been shared at a recent Board Time Out and at the Council of Governors meeting. Mr Royles felt the results linked in with the Well Led review work with improvements seen despite the challenges of the last two years. The recommendations are helpful to work on and will be an area of focus for the Workforce and Organisational Development Committee. The data is being drilled down into and the Committee will look at these areas however it was noted that where there are less than 10 respondents this is not possible.

It was noted that all the results have been broken down into Divisions and teams and managers are sharing the results. It was emphasised that all data is anonymised as it is a legal obligation and individuals cannot be identified from their responses.

Mr Malik asked if there were organisations that scored higher in areas that the Trust could link into to see what they are doing differently. Mr Bosher explained that information is more anecdotal than statistical. He suggested communicating with the high performers in the areas the Trust is interested in and further details can be provided for this. The Chief Executive felt this would be helpful for the information to on the action plan report as any information that can be shared would be welcomed.

The Chair noted that the survey was a snapshot in time of how people are feeling and asked if there are any other suggested methods that could be used to take more account of staff's views over time. Mr Bosher suggested that the quarterly pulse surveys are helpful in providing some of this information. It was confirmed that these are used by the organisation already.

Mr Bosher was thanked for attending and for his presentation.

69/22 **External Review of Governance Report, Recommendations and Action Plan**

The findings and action plan to address the recommendations arising from the external review of governance were presented by the Chief Executive.

The review is part of the statutory and mandatory obligations of the Foundation Trust licence

and is undertake every five years. Grant Thornton undertook the work reviewing the well led and governance around eight Key Lines of Enquiry (KLOE's). Board members have been briefed on the outcome at a Time Out as part of the process. It was also presented at a Council of Governors meeting and their comments have been taken into account. In terms of ratings the Trust achieved five greens and three amber greens. Five medium recommendations were made and 18 low recommendations.

The action plan presented as part of the report provided an update on actions taken with the recommendations. The Chief Executive provided updates for all of the work that is underway for the recommendations and explained the areas where work is being undertaken. The work is expected to be completed in the coming weeks due to the progress being made. No recommendations were made for KLOE's 7 or 8.

Mr Malik asked if the timescales were realistic given the pressures there are and some of the recommendations may require more in-depth work. The Chief Executive felt that the work is doable within the timescales identified especially as work is already underway. Mrs Hughes agreed that the progress already made with the recommendations the timescales are achievable. There is also the opportunity for a facilitator to come back six months after the review to check how the action plan has been delivered. The Board will monitor the action plan via regular updates. Reference has been made by Mr Patton to the visit programmes which are taking place in June and the embedding of these. The Chief Executive suggested that in light of the comments made, the timescale be moved to June for the second part of the 3rd recommendation.

Mr Royles thanked all who had been involved in the work through staff discussions and showed the difference that has been made in the organisation since the last review. Mr McKinnon-Evans agreed with the comments made. He asked about the overarching risk statement referred to and wondered how much value will be gained from the definition of an overarching risk.

The Chair commented that visits have been discussed by both Non-Executive Directors and Governors. She felt it may be helpful outside of the meeting to clarify the shape of visits, who they include and sharing the infection control guidance in place. This would help when planning visits to determine if more than one unit can be visited in one day and whether it is just inpatient units or other areas such as primary care. The Chief Executive suggested that the Board pack that was produced on visits before Covid be updated with the relevant information

The Chair reported that Governors were very pleased to receive the report at their recent Council of Governors meeting and the opportunity to make comments before the Trust Board. Thanks were extended to Grant Thornton for their work on the well led review.

Resolved: The Board accepted the report and the recommendations and approved the action plan to address the recommendations. Monthly updates will be provided to Board until delivery of the action plan is complete.
The timescales for the visit recommendation to be amended to June **Action MH**
Information on visits for Board members to be updated **Action MM/CF**

70/22 **Chair's Report**

The Chair provided a verbal update on activity she has been involved with since the last meeting that included: -

- The Non-Executive Director recruitment process was completed last week. There was a candidate who was offered the post subject to approval by the Council of Governors. Further details will be released in the future.

- The Council of Governors meeting was held on 14 April and included discussions on the Well Led review and Staff Survey. The highlight was hearing from a member of the Hull Youth Action Group about their work experience and involvement with the Trust.

- The Chair has observed and attended the Finance and Investment Committee meeting as part of her annual duties

- A Governor Development working groups has been established to look at support for Governors and engagement with NEDs with the first meeting held recently. Areas discussed included IT support, scheduling and purpose of meetings/forums and visits

- A Governor Development session tool place recently using a blended approach of in person and Microsoft teams. A presentation was also given on Risk by the Corporate Compliance and Risk Manager.

Resolved: The verbal report was noted

71/22 **Chief Executive's Report**

The report provided updates from each of the Directors along with a summary of activities undertaken by the Chief Executive. Of particular note were: -

- Three policies were submitted for ratification – Job Planning, Bullying and Harassment and Attendance Management
- The Use of Force Act has come into being and approval was sought for the Chief Operating officer to be the identified responsible person. This is an important Act for all organisations, but especially for the Trust.
- The Chief Executive's challenge is taking place on 23 June and will be a virtual cycle ride. The distance is approximately 93 – 100 miles.
- A charity golf day has been arranged for 9 September with all funds raised going to Health Stars
- Band 5 nurses are our hardest to recruitment to post and in line with the national picture we have agreed to offer a payment of £3,000 to all new employees and a retention payment to our current Band 5 nurses of £1,000. We value all staff and have offered regular thank you payments to staff and will continue to do so.
- An Easter gift has been given to staff and will be included in April's pay
- ICB Updates on appointments was included in the report. The ICB has held its first meeting in shadow form.
- Health Stars the Big Fat Quiz was held at the end of March. Thank you to all who took part

The Head of Corporate Affairs reported that the Marketing and Communications Strategy is being refreshed and will include a five-year plan. Transformation across the Trust progresses with the branding, intranet and internet being developed. Eight entries were made into the Parliamentary Awards and HSJ awards entries are in progress. Given the staff story it was posed whether an entry could be developed around patient safety in the Trust.
Due to forthcoming elections, a period of Purdah is in place which the Trust is abiding by.

Mrs Parkinson reported that there are still high pressures across operations with the NHS level at OPEL 4. Infection rates are still high across the patch and there are five Covid positive patients across the Trust. Covid absence remains static and non-related Covid absence is high. Operational pressures have increased and were at OPEL 3 but this has not reduced to OPEL 2 despite the pressures that continue to impact on the organisation. Staff health and wellbeing remains a key area of focus and an important area for the Board to monitor going forward.

The Board's attention was drawn to the Ockenden Report review of maternity services. The Trust does not provide services that are in the scope but will be undertaking a gap analysis on the 79 recommendations made in the report to see if there is any learning.

Mr Patton thanked the Executive Team for a comprehensive report. He asked for more detail on the virtual wards mentioned in the updates. Mrs Parkinson explained that these are not new, but with acute hospital pressures new investment has been provided. The virtual wards can

follow clinical pathways and will be focussing on frailty. The virtual wards do exist for other pathways including respiratory. They work within intensive support under the MDT and have small caseloads to provide intensive support and avoid hospital admission. The organisation is in a position to implement the plan with a focus on Scarborough.

Mr Malik referred to the changing guidance in relation to Covid and asked if there will be any changes in the Trust. Guidance is changing rapidly and in terms of the organisation advice is aimed to be clear and as simple as possible. A risk-based approach is being taken and areas can reduce to 1 metre for social distancing within the risk framework. Staff are asked to continue wearing masks in clinical and non-clinical areas and this has been communicated to staff. Mrs Gledhill added that guidance is being followed for patients in relation to lateral flow tests and positive results. Full risk assessments continue to be undertaken using clinical skills and common sense to keep everyone safe.

Mr Smith commented about the Use of Force Act noting that the Mental Health Legislation Committee looks at the legal requirements and the Quality Committee reviews the quality implications. The Chief Executive agreed that the Mental Health Legislation Committee was the primary committee, and the Quality Committee would undertake reviews of any quality implications. This is an area the CQC will be interested in and why a responsible person has been identified. From a Board perspective, the Mental Health Legislation Committee will prepare a report for the Board on any implications for the organisation.

Of the three policies presented for ratification, Mr Royles asked about the changes made. He was informed that all three policies had been rewrites working with staff side representatives to gain agreement for each policy and making sure that nothing was omitted and that the policies are current. EMT has approved the policies and the changes made. Mr Royles suggested it would be useful for Non-Executive Directors to be made aware of what changes have been made to policies. The three policies were ratified by the Board.

Dr Byrne referred to the CQC report for Princes Medical Centre. He reported that work is ongoing to resolve the issues and to take on board the learning. Updates will come to EMT and through other governance routes.

Resolved: The report and updates were noted.
The Board approved Mrs Parkinson as the responsible person for the Use of Force Act
A report on the Use of Force Act to be prepared by the Mental Health Legislation Committee for a future meeting **Action LP/JB**
The Job Planning, Bullying and Harassment and Attendance Management Policies were ratified

72/22 **Publications and Highlights Report**

The report provided an update on recent publications and policy with updates provided by the Lead Executives.

The Ockenden report was again drawn to the Board's attention to review.

Resolved: The report was noted.

73/22 **Performance Report**

Mr Beckwith presented the report relating to the current levels of performance as at the end of March 2022. Commentary for indicators that fell outside of normal variation was included in the report. Information on waiting times was reported separately in the report to provide more detail.

Following a review of the performance report by Executive Management Team, a number of minor changes have been made to the content of the report, these can be summarised as

- Finance indicators have been removed from the report, as these are already included in the separate finance report which appears later on this agenda
- Grey Shading (To indicate the start of the covid pandemic) has been removed from

the report
- Sickness absence includes information excluding covid related absences
- New chart included to report consultant vacancies
- Staff Turnover figure updated (including retrospective information) to exclude any TUPE related

Other areas of note were:

- Safer staffing – performance in February identified sickness issues.
- Care hours Per Patient Day remained strong
- Turnover increased due to retirements. Some people have returned after retirement
- Update on ambulance waiting times included in the report. Awaiting NHSE information for daily reports.
- Incident information was omitted from the report and has been circulated outside the meeting. Work is being undertaken on the use of an SPC chart for the next report.

Mr Patton noted from the safer staffing dashboard that Pine View had a high use of bank and agency, and sickness levels were high. Ullswater sickness levels were also reporting high, and Maister Lodge and Whitby were low on mandatory training.

Mrs Gledhill explained that sickness affected these indicators and in February this was the tine of the renewed Covid present and units particularly in secure services were using more bank and agency cover and also affected training as staff were not able to attend. The figures are coming down for April and clinical supervision is better in the current figures. Mrs Parkinson added that at that time there were significant Covid outbreaks at Pine View with all patients affected apart from one. Staffing was also affected and coupled with the challenges, sickness absence, vacancies and turn over it did affect some of the performance indicators.

Dr Byrne reminded the Board that Covid is still here, and he advised caution in removing the grey shading to ensure that in future years it was clear why there had been specific results.

In response to a query from Mr McKinnon-Evans about whether all consultant vacancies were covered by temporary agency staff. Mr McGowan confirmed this was correct. It was suggested that future reports could include this in the narrative. Mr Beckwith will include this in future narrative.

Resolved: The report and verbal updates were noted
Narrative to include that consultant vacancies are covered by temporary agency staff **Action PBec**

74/22 **Finance Report**

Mr Beckwith presented the highlights from the finance paper as at the end of March 2022. Highlights included: -

- The Trust recorded an overall balanced operational finance position, this is consistent with the Trust planning target. Some technical items came in at year end including impairments and evaluation of the estate accumulating in a £5 million deficit for the year.
- Within the reported position at Month 12 is Covid expenditure of £4.865m and income top up of £2.658m.
- Cash balance at year end was £29.533m. A reduction was seen from last month due to repayment of the loans which have been discussed previously at the Finance and Investment Committee
- The Year-to-Date Agency expenditure was £8.406m, this is £1.695m more than the previous year's position.

Better payment practice is reported at 91% and it was important to note that for the treatment of the Yorkshire and Humber Care Record which was intended to be brought in as grant income to

fund capital, we have been unable to do this. There are no issues for 21/22 and working on a solution for 22/23 capital programme.

The annual accounts are being prepared for auditing and a draft submitted to ET and to Audit Committee members.

The financial control total was achieved, and the Trust ends the year in a relatively strong position.

Mr Royles referred to the Cumulative Agency spend graph noting there had been a higher spend in March. Mr Beckwith explained that this was due to catching up on invoices to clear any backlog.

Resolved: The report was noted.

75/22 **Finance & Investment Committee Assurance Report**

A summary of discussions held at the 20 April meeting was provided. Mr Patton reported that as part of the insight report a HMFA briefing was discussed which has been circulated to the Board for information. The Committee recognised the work of the Finance team and complimented them and the Executive team on their work in achieving the financial position.

The organisation is one of a few trusts who continue to deliver on the Budget reduction Strategy (BRS). It was recommended that going forward having a case study come to the Board as a story to show the benefits of the BRS and not just as a cost cutting measure. The Committee received the capital programme for 22/23 and recommended it to the Board when it is presented. It was noted that the annual effectiveness review will come as part of the overall item at the May Board and not this meeting as the paper suggested.

Resolved: The report was noted.

76/22 **Workforce & Organisational Development Committee Assurance Report**

The report provided an executive summary of discussions held at the meeting on 13 April 2022. The minutes of the meeting held on 12 January were provided for information.

Mr Royles explained that the Committee receive reports from three sub committees. As the Health and Wellbeing champion he attends the Health and Wellbeing meeting which is a vibrant and enthusiastic meeting. Mr Royles will also be attending the Equality Diversity Inclusion group and the Medical Education meeting.

The insight report was discussed and the apprenticeships policy with the first approach being for all new vacancies to be via apprenticeships. The Committee does look at vacancy rates and already there are a number of vacancies of net growth with 52 Registered Nurses recruited. The 0-19 service was recognised as a challenge due to the change in base level and inheritance of posts as a result of the contract.

Resolved: The report and minutes were noted.

77/22 **Collaborative Committee Report**

The paper provided an executive summary of discussions held at the meeting on 28 March 2022.

There continues to be significant pressure on CAMHS beds with 8 young people delayed discharge from hospital to limited local authority care and community care packages. An update was provided on the Schoen Clinic position. All Safe and Wellbeing Reviews are all complete and have been submitted to HCV ICS Panel.

Resolved: The report was noted.

7822 **Emergency Preparedness, Resilience and Response (EPRR) Annual Report**
The annual report provided assurance that the Trust has met the EPRR duties and obligations as set out in the Health and Social Care Act (2012) as a responder during the period 1 April 2021 to 31 March 2022. The report provided an overview of EPRR activities including its response to the Covid-19 pandemic and set out EPRR priorities for 2022/23

A summary for self-assessment against the core standards and the work undertaken to take this forward were included and a plan is in place for next year. It is important to test the arrangements and business continuity plans which is done internally within the organisation. Training is provided to staff and senior managers. Mr Smith is the lead for the Board and has seen the report. He confirmed that he has been involved in the process. At the last Board meeting a report on NED roles was received which stated that the EPRR role is a Board responsibility, and that overall Committee assurance is with the Audit Committee.

The Board was informed that the planning exercise will take place in June due to organisational pressures.

Resolved: The report was noted.

79/22 **Recovery Strategic Framework – Progress Update**
The paper provided a summary update of progress across the priority areas set out in the Recovery Strategic Framework 2021-2026. Mrs Parkinson explained that a full evaluation of year one will begin in May 2022 against the year one priority areas set out in the framework which will outline successes and the key challenges for year two. The report demonstrated that despite the pressures across services that progress is being made particularly for the mental health service and how the recovery approach principles could be applied to other service areas.

At the last meeting the Board heard from some Peer Support Workers and their roles. Good progress is being made with this work and the co-production of the strategic framework with service users and other stakeholders.

The Chief Executive was pleased to see this, and that work has continued during challenging times. The recovery phase of Covid is important and continues to be raised at Board meetings. Mr McGowan referred to the Recovery College aspect asking if this is accessible to staff and if so if this was being publicised. It was confirmed that this is available and has been communicated through team meetings. It is also available to ICS staff. The Recovery College has adapted quickly to changes during the pandemic as it was only face to face pre Covid but has been developed with support from the IT team into a virtual platform. A blended approach is being offered and there is increased accessibility online. The Chair commented that this also links in with the development of the Patient and Carer Experience work of Every Member Counts. Mrs Parkinson agreed that it works hand in glove with this.

Resolved: The report was noted.

80/22 **Report on the Use of the Trust Seal**
In line with the Trust Standing Orders (8.3.1) a report of all sealings is made to the Trust Board on an annual basis**.**

Over the period 1 April 2021 – 31 March 2022, the Trust Seal was used four times with details included in the report.

Resolved: The report was noted

81/22 **Freedom to Speak Up (FTSU) Annual Report 2021/22**
The Freedom to Speak Up Annual Report 2021/22 was presented to the Trust Board. The report included an update on the work of the National Guardian's Office, the regional network

and the work within Humber NHS Foundation Teaching Trust.

The Speak Up vision and Strategy is being refreshed and reviewed. Following consultation with Staff Governors a small working group is being established to take this work forward and to align it with the Trust's strategy.

A vacancy exists for a Deputy Guardian role, and this continues to be advertised. Regular quarterly meetings take place with the Chair, Chief Executive and Non-Executive Director.

The NGO have recently released a new training module for Executives and Board members. All new staff joining the Trust receive Level 1 as part of their induction and plans are being developed to implement Level 2 for managers.

During 21/22 there have been 27 speak up concerns received by the Guardian. This is a slight increase on reporting for 20/21. During this period no staff member has reported feeling a detriment to themselves by raising their concerns through this route. Concerns raised in relation to patient safety come through the Speak Up route and any related to team working are sign posted to the Workforce & OD team. Two independent investigations were requested one of which is still outstanding. A follow up system has ben introduced three months after the concern has been dealt with to ensure that everything is as it should be. All patient safety concerns are also reported on to Datix. The next report will also break down the data by ethnic group and gender.

An action from the Well Led review is to review the resources for the team and some additional resource has been identified and adverts for FTSU ambassadors will be publicised. It is hoped that there will be one from each of the Divisions.

Dr Byrne asked if there is data available showing the number of concerns raised over the last four years and any context as to the areas that raised them. Mrs Flack explained that numbers have decreased over the four years. It was important to note that if there was more than one person raising the same concern it is classed as the number of people not just one team. The agenda and culture supporting FTSU is evolving, and the role of the Guardian has developed over the last few years and there is now an FTSU strategy and vision in place. Dr Byrne felt it would be helpful to see these statistics in the report from a benchmarking point of view and to put some context against historical data. This will be reviewed for future reports.

The Chief Executive explained that Mrs Flack and the team do a lot of work with clinicians around FTSU and going forward will consider how this is communicated further.

Mr McGowan referred to the staff survey and the indicator that staff felt secure in reporting unsafe clinical practice with 50 – 80% of the concerns should be attributed to this. It was of credit to Mrs Gledhill and Dr Byrne for promoting this area. In relation to 27 FTSU concerns raised, Mr McGowan asked if there was a breakdown of how many had been sign posted to the Workforce team. Mrs Flack can provide detail outside the meeting but explained that moving forward it has been agreed to record separately the number of staff raising concerns that are signposted to the Workforce team and those that are FTSU. Mr McGowan felt it was important to recognise the difference between the two and appropriate Trust processes are followed.

Resolved: The report was noted
The next report will break down the data by ethnic group and gender **Action AF**

82/22 **Items for Escalation**
No items were raised.

83/22 **Any Other Business**
No other business was raised.

84/22 **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.

85/22 **Date and Time of Next Meeting**

Wednesday 18 May 2022, 9.30am via Microsoft Teams

Signed …… Date …….

Chair

Humber Teaching NHS Foundation Trust

Agenda Item 4

Action Log:
Actions Arising from Public Trust Board Meetings

Summary of actions from April 2022 Board meeting and update report on earlier actions due for delivery in May 2022 *Rows greyed out indicate action closed and update provided here*						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
27.4.22	69/22(a)	External Review of Governance Report, Recommendations and Action Plan	The timescales for the visit recommendation to be amended to June	Head of Corporate Affairs	April 2022	28/4/22 update made to report (and included in May Board papers)
27.4.22	69/22(b)	External Review of Governance Report, Recommendations and Action Plan	Information on visits for Board members to be updated	Chief Executive/Chair	June 2022	Updating in progress
27.4.22	71/22	Chief Executive's Report	A report on the Use of Force Act to be prepared by the Mental Health Legislation Committee for a future meeting	Chief Operating Officer/Medical Director	September 2022	Report to go to the next Mental Health Legislation Committee meeting and then to Board
27.4.22	73/22	Performance Report	Narrative to include that consultant vacancies are covered by temporary agency staff	Director of Finance	May 2022	Updated Narrative included in the performance report Front Sheet
27.4.22	81/22	Freedom to Speak Up (FTSU) Annual Report 2021/22	The next report will break down the data by ethnic group and gender	FTSU Guardian	October 2022	Item not yet due

Date of Board	Minute No	Agenda Item	Action	Lead	Timescale	Update Report
27.10.21	206/21	Finance and Investment Committee Assurance Report	Pharmacy services proposed to be a future staff story	Director of Workforce & Organisational Development	April 2022	This story has been moved to June in agreement with the Chief Executive
26.1.22	04/22	2021 Community Mental Health Survey	Quality Committee to look at medicines management work	Chief Operating Officer	May 2022	Update will be taken to the next quality committee by Paul Johnson Clinical and Weeliat Chong, Chief Pharmacist.
26.1.22	18/22	Health Inequalities and the Humber Approach	Discussion on Health Inequalities to take place at a future Board Time Out	Medical Director	July 2022	The divisions will be undertaking a review of their own work and how it links to CORE20PLUS5 as part of a mapping program associated with their Quality Improvement plans for 22/23 which will be presented at Quality Committee. When this is completed a Health Inequalities session will be arranged for a future Board Time Out.
23.2.22	32/22(a)	Performance Report	Consideration as to whether indicators on the safer staffing dashboard for Granville Court can be provided	Director of Nursing, Allied Health and Social Care Professionals	March 2022	BI have commenced a manual process to capture CHPPD. The information will start to pull through into the safer staffing dashboard in April's data which is submitted to the Board in June.
30.3.22	51/22	Finance Report	Discussion on the cash balance and how it can be used for patient care to be held at September Board Time Out	Director of Finance	Sept 2022	Item not yet due

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

NHS
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NHS Foundation Trust

Board Public Workplan 2022/2023 – *(no August or December meeting) (v2g)*

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

Board Dates:- / Reports:	Strategic Headings	LEAD	27 Apr 2022	18 May 2022	22 June 2022	27 Jul 2022	28 Sep 2022	26 Oct 2022	30 Nov 2022	25 Jan 2023	22 Feb 2023	29 Mar 2023
Standing Items - monthly												
Minutes of the Last Meeting	Corporate	CF	x	x	x	x	x	x	x	x	x	x
Actions Log	Corporate	CF	x	x	x	x	x	x	x	x	x	x
Chair's Report	Corporate	CF	x	x	x	x	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	x	x	x	x
Publications and Highlights Report	Corporate	MM	x	x	x	x	x	x	x	x	x	x
Monthly Items												
Performance Report	Perf & Del	PBec	x	x	x	x	x	x	x	x	x	x
Finance Report	Perf & Del	PBec	x	x	x	x	x	x	x	x	x	x
Humber Coast and Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative – Collaborative Committee Report	Committees	SMcKE	**x**	**x**	**x**	**x**		x	x	x	x	x
Quarterly Items												
Finance & Investment Committee Assurance Report	Committees	FP	x			x	x	x		x		
Charitable Funds Committee Assurance Report	Committees	SMcKE			x		x			x		x
Workforce & Organisational Development Committee	Committees	DR	x			x		x		x		
Quality Committee Assurance Report	Committees	MS		x			x		x		x	
Mental Health Legislation Committee Assurance Report	Committees	MS		x			x		x		x	
Audit Committee Assurance Report	Committees	SMcKE		x			x		x		x	
Board Assurance Framework	Corporate	MM			X		x		x			x
Risk Register	Corporate	HG			X		x		x			x
HCV Update	Corporate	MM		x			x		x		X	
6 Monthly items												
Trust Strategy Refresh/Update	Strategy	MM			X update							x
Freedom to Speak Up Report	Quality & ClinGov	MM	X A/R					**x**				
MAPPA Strategic Management Board Report inc in CE report	Strategy	LP					x					x
Safer Staffing 6 Monthly Report	Quality & ClinGov	HG				x				x		
Research & Development Report	Quality & ClinGov	JB				x				x		

NHS
Humber Teaching
NHS Foundation Trust

Board Dates:- / Reports:	Strategic Headings	LEAD	27 Apr 2022	18 May 2022	22 June 2022	27 Jul 2022	28 Sep 2022	26 Oct 2022	30 Nov 2022	25 Jan 2023	22 Feb 2023	29 Mar 2023
Annual Agenda Items												
Review of Strategic Suicide Prevention Strategy	Strategy	JB	x									
Recovery Strategy Update	Strategy	LP	x				X					
Mental Health Managers Annual Progress Report **inc in Assurance Report**	Quality&ClinGov	LP		x								
Patient & Carer Experience Strategy not due until 2023	Quality &ClinGov	JB			x							
Presentation of Annual Community Survey – Quality Health	Quality &ClinGov	JB								x		
Guardian of Safeworking Annual Report	Quality &ClinGov	JB					x					
Patient & Carer Experience (incl Complaints and PALs) Annual Report	Quality &ClinGov	JB					x					
Quality Accounts	Reg.Comp	HG			x							
Risk Management Strategy Update	Strategy	HG	x									
Infection Control Strategy	Strategy	HG					X					
Infection Prevention Control Annual Report	Quality &ClinGov	HG					x					
Safeguarding Annual Report	Quality &ClinGov	HG					X					
Annual EPRR Assurance Report	Quality &ClinGov	LP	x									
EPRR Core Standards	Corporate	LP					X					
Patient Led Assessment of the Care Environment (PLACE) Update –	Quality &ClinGov	LP					x					
Health Stars Strategy Annual Review	Strategy	SMcG		x								
Health Stars Operations Plan Update (moved to May from April)	Perf & Delivery	SMcG		x								
Annual Operating Plan	Strategy	MM									xdraft	x
Report on the use of the Trust Seal	Corporate	MM	x									
Review of Standing Order Scheme of Delegation and Standing Financial Instructions	Corporate	MH					x					
Annual Non Clinical Safety Report	Corporate	PBec			X							
Annual Declarations Report	Corporate	PBec		x								
Charitable Funds Annual Accounts	Corporate	PBec						x				
Equality Delivery Scheme Self Assessment moved to June from May	Corporate	SMcG			x							
Gender Pay Gap	Corporate	SMcG				x						
WDES Report — reports into Workforce & Organisational Development Committee , but separate report to the Board	Reg. Compl	SMcG				x						
WRES Report reports into Workforce Committee with report to Board	Corporate	SMcG				x						
Equality Diversity and Inclusion Annual Report	Corporate	SMcG				x						
Board Terms of Reference Review	Corporate	CF		x								
Committee Chair Report	Corporate	CF										x
Annual Committee Effectiveness Reviews & Terms of Reference (one	Corporate	MH		x								

Board Dates:- Reports:	Strategic Headings	LEAD	27 Apr 2022	18 May 2022	22 June 2022	27 Jul 2022	28 Sep 2022	26 Oct 2022	30 Nov 2022	25 Jan 2023	22 Feb 2023	29 Mar 2023
paper)												
Reaffirmation of Slavery and Human Trafficking Policy Statement in Chief Executive report	Corporate	MM									X	
Review of Disciplinary Policy and Procedure	Corporate	SMcG	x									x
Fit and Proper Person Compliance	Corporate	CF			x							
Workplan for 2021/22: To agree	Corporate	CF/ MM		x								
Deleted /Removed Items												
Digital Plan Annual Update – reports into Finance and Investment Committee		PBec		x	x	x						
Estates Strategy Review –reports into Finance and Investment Committee		PBec				x				x		
Estates Annual Update - reports into Finance and Investment Committee		PBec				x						
Procurement Strategy Annual Review – reports into Finance and Investment Committee		MM				x				x		
Workforce & OD Strategy including an Annual Refresh – reports into Workforce & Organisational Development Committee		SMcG		x					x			
Guardian of Safeworking Quarterly Report – reports into Workforce & Organisational Development Committee		JB	x			x		x		x		
Sustainable Development Management Plan Update –reports into Finance and Investment Committee		PBec										
Equality Diversity and Inclusion Public Sector Duties- reports into Workforce & Organisational Development Committee		SMcG										
Safeguarding Annual Report (internal) – reports into Quality Committee		HG					x					
Internal Audit Annual Report – reports into Audit Committee		PBec										
Review Risk Appetite moved to July as per previous year and moved to part II July		HG				x						

Humber Teaching NHS Foundation Trust

Agenda Item 5

Title & Date of Meeting:	Trust Board Public Meeting– 18 May 2022
Title of Report:	Humber Youth Action Group – Making a Difference
Author/s:	Bethia Dennis – Engagement Lead, Children's Services
Recommendation:	To approve: ; To receive & note: ✓ ; For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	• To inform Board Members about the newly formed Humber Youth Action Group how it is contributing to improving health services for young people.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:	**Key Actions Commissioned/Work Underway:**
• To highlight the importance of including young people in the development and improvement of health services.	• .N/A
Positive Assurances to Provide: 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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Patient Story	✓

Monitoring and assurance framework summary:

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

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

Agenda Item 7

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Chief Executive's Report
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	To approve ✓ | To receive & note ✓ For information | To ratify ✓
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To provide the Board with an update on local, regional and national issues. Policies for ratification – Use of Force Act & Disciplinary Policy

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • Nil	**Key Actions Commissioned/Work Underway:** • N/A
Positive Assurances to Provide: • Use of Force Act • Looking Back on a Year of Success	**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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Monthly report to Board	✓

Monitoring and assurance framework summary:

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

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

Chief Executive's Report

1 Items for Approval

1.1 Trust Policies

The policies in the table below are presented for ratification. 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 Board to ratify the following policies.

As agreed at the April Board, an additional column has been added to provide Board with information on the key changes made to each policy presented for ratification.

Policy Name	Date Approved	Lead Director	Key Changes to the Policy *(extracted from the document control sheet appended to the policy)*
Use of Force Policy	9/5/22	Chief Operating Officer	This policy has replaced the Management of Violence and Aggression Policy in response to the requirements of the Mental Health Units Use of Force Act 2018.
Disciplinary Policy	9/5/22	Director of Workforce & OD	Full re-write of the policy. Full copy available on request

The Document Control Policy sets out the requirements that must be met for approval, ratification and dissemination of all Humber Teaching NHS Foundation Trust policies. Document Control Policy C-003.pdf (humber.nhs.uk)

Section 8 of the policy describes the consultation phase with some key steps to note including members of appropriate sub committees and forums having the opportunity to contribute to the document in order to ensure the relevant expertise is used before it is presented formally for approval to EMT. EMT require the lead director to make it clear on the appended document control sheet that appropriate consultation and engagement has taken place including with appropriate sub committees.

Whilst some committees are routinely involved in the consultation and agreement phase, including taking a draft to a committee, not all appropriate expert committee members including non-executive chairs have the opportunity to comment before it is presented for approval.

In response to Board discussions, it is recommended that all members of appropriate committees be included in the consultation phase and given the opportunity to comment when developing policies. Going forward, lead executives for policies should ensure that committee members are provided with the opportunity via email to comment on a draft or if time permits taking a developed draft for discussion to a committee. Individuals and groups that have been consulted, as usual, should be reflected on the document control sheet appended to the policy.

1.2 Use of Force Act

In response to this key piece of legislation, a new policy has been developed that has been presented to Board for ratification. The policy has been through extensive consultation including

Quality Committee and MHL Committee and is attached in full at Appendix 1 for Board's information.

2 Around the Trust

2.1 Blended Working

In keeping with our blended working patterns, we have asked staff to work one day a week face to face, unless they have have permanent home based contracts. This is to ensure contact for staff supervision and support.

2.2 Highlights of our Year

As the COVID-19 pandemic became a part of our working lives there continued to be challenges throughout the year. The response from you, our Humbelievable team, was again outstanding. You can see from the number of highlights that follow what a year of success and celebration it has been despite the ongoing difficulties.

Whether this is going that extra mile in the care that you provide, improving the working lives of your colleagues or delivering exceptional service, you never stop trying to make things better.

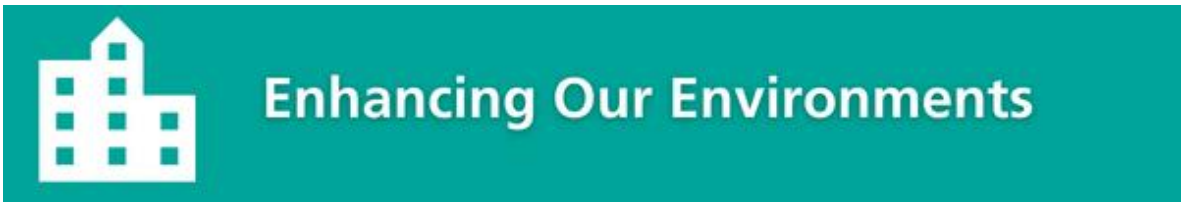
Michele Moran, Chief Executive said: "It's been a 'Humbelievable' effort from all involved and you should be extremely proud of all that you have achieved. I want to say a huge thank you to our Staff, Governors, Volunteers, Board Members and Students for all that you do. I hope that you enjoy looking back over the last year and finding out more about some of your Humbelievable achievements."

Our Highlights

- Since the pandemic began, we have regularly paid tribute to your dedication and support and provided celebrations and rewards to all our staff colleagues

as part of our thank you and value programme. A summary of our health and wellbeing support programme throughout the pandemic can be found here.

- We launched our first ever virtual 'Staff Thank You & Celebration Week' in September to thank our #Humbelievable team for everything they've done throughout the pandemic, to support our patients, their families, carers and each other. Read more here.



- Local artist "Skeg" worked with teams at our Avondale Assessment Unit and Psychiatric Intensive Care Unit to create a series of feature wall murals, to soften the appearance of harsh borders. This has made the space brighter, more welcoming and has been well received by both staff and patients who have commented on the improved atmosphere and the positive impact of the artwork on their wellbeing. Read more here.

- The £13.1m renovation of Whitby Community Hospital has continued to progress over the last 12 months. The hospital, which is owned by NHS Property Services with the Trust as lead tenant, re-opened the Tower Block part of the building to patients in October 2021. Read more here.

- More staff than ever completed the annual staff survey last year. Over 1,304 staff (44.1%) took part which will directly influence our actions and the improvements we make to our staff experience and wellbeing, as well as steering the direction of the NHS People Plan. We were pleased to make a significant improvement against 18 of the questions answered and 11 without any change compared to 2020.

- In October, we welcomed our first cohort of internationally recruited Nurses to receive training locally within Hornsea Cottage Hospital. The vacant ground floor space at the hospital has been transformed into a dedicated and fit for purpose NMC Objective Structured Clinical Examination (OSCE) training

facility. Read more here.

- Our award winning YOURhealth Health Trainer service launched a new initiative to support the wellbeing of staff and volunteers of the Trust. The service both supports and enables staff to lead healthy lives and look after their mental and physical wellbeing, both at home and in the workplace. Read more here.

- In October, our Workforce team were awarded with a HPMA Excellence in People Award for HR Analytics. Judges recognised the hard work of the team in producing the Workforce Scorecard and Insights Report; a vital tool helping us analyse trends across our workforce, to ensure we can plan our resources in advance and minimise any impact on patient care. Read more here.

- In Spring 2021, we launched GP Connect, a platform designed to enhance the information clinical and care staff can access about people in their care using connectivity generated by Yorkshire & Humber Care Record. Read more here.

- We were delighted to be shortlisted for four HSJ Patient Safety Awards including Sensory Processing, Pharmacy, Learning Disabilities and Addictions services. Read more here.

- We marked World Patient Safety Day in September across our internal communications and on social media. Our campaign received over 1,700 engagements, spreading understanding of patient safety and increasing public engagement in the safety of health care.

- To support patients who use English as their second language, we created an online Friends and Family Test (FFT) form that can be translated into any language using the Reach Deck tool on our Trust's website.

- The Panel Volunteer Initiative launched in March 2022. This online database

holds contact information for all patients, carers and service users who have opted in, to be contacted by the Trust for interviews. Find out more here.

- The Humber Youth Action Group (HYAG) was launched in 2021 with the aim of bringing those aged 11-25 together, with the goal of helping our organisation improve its services for children and young people. More about the HYAG here.

- We partnered with Wyke Sixth Form College to provide the new T Level qualification in Health, which will allow students to access work experience in healthcare settings as part of their further education course. Read more here.

- In September, we received £1.74million in funding from the Department for Business, Energy, and Industrial Strategy (BEIS) as part of Phase 2 of the Public Sector Decarbonisation Scheme (PSDS). The grant will specifically go towards improvements at the Humber Centre and East Riding Community Hospital and the completion date is expected to be Spring/ Summer 2022. Read more here.

- In November, we were selected as one of only seven Trusts across the UK to participate in the NHSX Digital Aspirant Plus (DA+) programme. We were one of just three in the mental health and community services sector specifically. The goal of the DA+ programme is to encourage innovation in Electronic Patient Record (EPR) systems across acute, mental health and community sectors. Read more here.

- We held our fifth Research Conference, “Developing a City of Research V” on 17 and 18 November 2021. We had a blended approach for our 5th annual conference, with a live audience in attendance alongside those watching online. Read more here.

- As part of our digital development plan, we re-launched our Intranet platform in August 2021. Feedback from staff has been positive with useability and clarity

of layout much improved. In addition, we have relaunched all eight of our GP surgery websites so they now follow a consistent design and are instantly recognisable as belonging to our Trust.

- In September 2021, we hosted our second virtual Annual Members Meeting (AMM). This was an opportunity to share with the public everything we achieved as a Trust in the previous 12 months.

- Throughout the pandemic we provided internal and external communications support in the roll out of Covid-19 related communication. We developed a dedicated campaign to specifically encourage 12–15-year-olds to “grab a jab”. Citing useful information and peer testimonials, we created engaging graphics and video content designed to reach younger audiences and their guardians. The 12-15 vaccination clinics were well attended.

- As part of our recruitment drive, we launched the “New Year, New Job” #Humbelievable campaign in late December 2021.The overall aim of the campaign was to capture the attention of those looking for new job opportunities in the New Year. We have received a combination of positive anecdotal and stats-based feedback indicating that the campaign was a success. Read more here.

- A survey by the Royal Pharmaceutical Society (RPS) and Pharmacy Support highlighted the mental health and wellbeing difficulties experienced every day by those working in Community Pharmacy. To help tackle these issues our Your Health team, in partnership with NHS England, Humber Local Pharmaceutical Committee and North Yorkshire Local Pharmaceutical Committee, introduced a dedicated service that has benefited both staff and their families who live or work in Pharmacy in our area. Read more here.

- Our Health Trainers’ ‘Working with Fishermen’ service launched in Scarborough in 2021, allowing the team to work with local fishermen and their dependants. This was following a successful two-year pilot on the Holderness Coast, from Bridlington to Withernsea. Read more here.

- The new Mental Health Advice and Support Line was launched in July 2021, available 24 hours a day, 7 days a week and free to access for anyone over the

age of 18, who lives in Hull and the East Riding of Yorkshire. Read more here.

- The Minor Injury Unit (MIU) at Whitby Community Hospital was transformed into an Urgent Treatment Centre (UTC) in August 2021. The UTC treats patients with minor injuries and illnesses and also has x-ray facilities. This change of service has ensured that local patients have improved access to urgent care, regardless of where they live. Read more here.

- The Humber, Coast and Vale (HCV) Specialised Mental Health, Learning Disability and Autism Provider Collaborative officially launched in October 2021. Our Trust is the Lead Provider for commissioning services. Read more here.

- Jo Kent (Suicide Prevention Programme Lead at our Trust and Humber, Coast and Vale Health and Care Partnership, ICS) received a High Sheriff Award for work in Suicide Prevention. Read more here.

- The Trust was placed in the Top 5 of Mental Health and Community Trusts for the theme of Equality, Diversity and Inclusion (EDI). This placement was decided based on our National Staff Survey results and is a significant achievement for us, as the Trust has risen from 19th position and to just 0.1 points away from the top spot in our category. Read more here.

- We won two Health and Care Awards in June 2021. One of which was the 'Health Improvement Award', which our YOURhealth team won for their Smoking in Pregnancy project. The second award was for 'Volunteer of the Year', which was won by Soraya Hutchinson. Read more here.

- We were delighted to win a HSJ Patient Safety Award for the 'Improving Care for Children and Young People Initiative of the Year' category for our work with the Humber Sensory Processing Hub's website. We were also nominated for three additional awards: 'Maternity and Midwifery Initiative of the Year', 'Learning Disabilities Initiative of the Year' and 'Improving Safety in Medicines Management.' Read more here.

- Lee Rickles, Chief Information Officer at our Trust and Programme Director at Yorkshire & Humber Care Record recently became a Fellow of BCS, The

Chartered Institute for IT, in recognition of his leadership within digital health. Read more here.

- Our CAMHS Inspire Inpatient Service won two awards at the Design in Mental Health Awards (2021). Inspire was named 'Project of the Year: New Build 2021' and 'Clinical Team 2021'. Read more here.

- Our Practice Education team were shortlisted for the Student Nursing Times Award in the 'Student Placement of the Year: Community' category. The project submitted was the Virtual Placement programme, and this shortlist comes in as fantastic recognition of the hard work our Practice Education team have done over the past years.

- Our Market Weighton Practice won the Clinical Improvements: Chronic Conditions category at the national General Practice Awards. They won for their work around improving care for patients with a diagnosis of Chronic Heart Failure; a condition that is often poorly understood and sub optimally managed in general practice. Read more here.

Once again, thank you for your continued dedication to make a difference to the lives our patients and their families and carers. You are all truly Humbelievable and should be proud off everything that you have achieved against the backdrop of a global pandemic.

2.3 Whitby Hospital

Whitby Hospital has been shortlisted for a RICS Award in the category:

Refurbishment/Revitalisation Project.

2.4 Veterans Aware

Following our annual review, I am pleased to inform the Board that the Trust's Veterans Aware status has been signed off by the national team – great work and many thanks

2.5 Research Team

Various members of our Research team (the whole team for 1 award) have been shortlisted in various categories in the new Clinical Research Network (CRN) Annual Awards being held on 17 May in Leeds.

- Early Career Researcher of the Year - Dr Hannah Armitt, Research Clinical Psychologist (also just appointed as CRN Specialty Lead for CAMHS half day/week)
- Best contribution in non-NHS setting – Clive Nicholson, Research Nurse
- Best Patient Experience – Emma Anderson, Senior Research Assistant, and Lisa Airey, Research Assistant
- Best Public Engagement Contribution – Trust Research Team

Good Luck

2.6 Recommendation Arising for the External Review of Governance – Quadrant Report

One of the agreed recommendations following the recent review was that consideration should be given to the use of a quadrant style report to present key issues emerging from Committees to the Board meeting.

The Trust's template front sheet for Board and Committee papers has been updated to reflect this and should be used when presenting all committee assurance reports to Board – the new quadrant box should include any key bullet points followed with the usual report of key issues narrative and committee minutes. The revised front sheet does not replace the committee assurance report and should have the usual report appended to the revised front cover.

The updated template is to be used for all Board and Committee reports and has been added to our Brand Centre for staff to use.

2.7 Queens Speech 2022

The Queen's Speech, the central part of the State Opening of Parliament, outlined 38 Bills which covered a range of topics:

- Digital and media
- Levelling up and infrastructure
- Security and justice
- Brexit and the constitution
- Education and schools
- Climate, environment and energy
- Finance and regulation
- Housing

As usual, we will monitor progress and any potential impact for us as an organisation. The most notable at this stage for us is the Draft Mental Health Bill to overhaul the mental health system in England and Wales. The Act is being reformed so people are only detained when "strictly necessary", and people can no longer be detained solely because of learning disabilities. A 'nominated person' will replace a patient's 'nearest relative', with patients having access to statutory care and treatment plans plus supervised community discharge.

The Board will be kept updated on key policy and publications in order respond to relevant legislation. Full detail on the Queen's Speech can be found here: Queen's Speech 2022 - GOV.UK (www.gov.uk)

3 Around the System

3.1 East Riding – Director Appointment

I was part of the panels to appoint East Riding new Director. East Riding Council have appointed to the Director of Adult Services - Beverley Compton, Beverly is currently in the role in North East Lincolnshire.

3.2 University of Hull

The University has secured funding of £86m to invest in its campus facilities and help in the delivery of Strategy 2030 in the move towards the University's long-term vision to be a carbon neutral campus by 2027.

The funding, supplied in partnership with three UK and US institutional investors, and with Lloyds Bank as the arranger, will be used to develop green infrastructure on the University's campus, building on the institution's long-term vision and accelerating its upward trajectory in providing the highest quality education and research facilities. One of the University's key priorities is providing its students with the skills and understanding essential for a career in green industries and tackling the climate emergency.

The funding will be directed towards upgrading facilities in areas that are central to the University's long-term vision, creating world-class laboratories and teaching spaces. This will include new carbon efficient and carbon neutral buildings, as well as additional renewable energy and digital infrastructure.

4 National News

4.1 Royal Assent of the Health and Care Bill

Royal Assent of the Health and Care Bill took place during the month, this is an important step on the journey towards establishing Integrated Care Systems on a statutory footing, which will take place on 1 July 2022.

By bringing together the local organisations responsible for delivering health and care services in a pragmatic and practical way, we will deliver better care for our populations and consider a person's complete needs – with greater decision-making rooted at a local level.

The ICS will hold a public board meeting 1st July 2022, setting out the establishment order.

5 Covid-19 and Winter Plan Summary Update

Covid-19 Update – May 2022

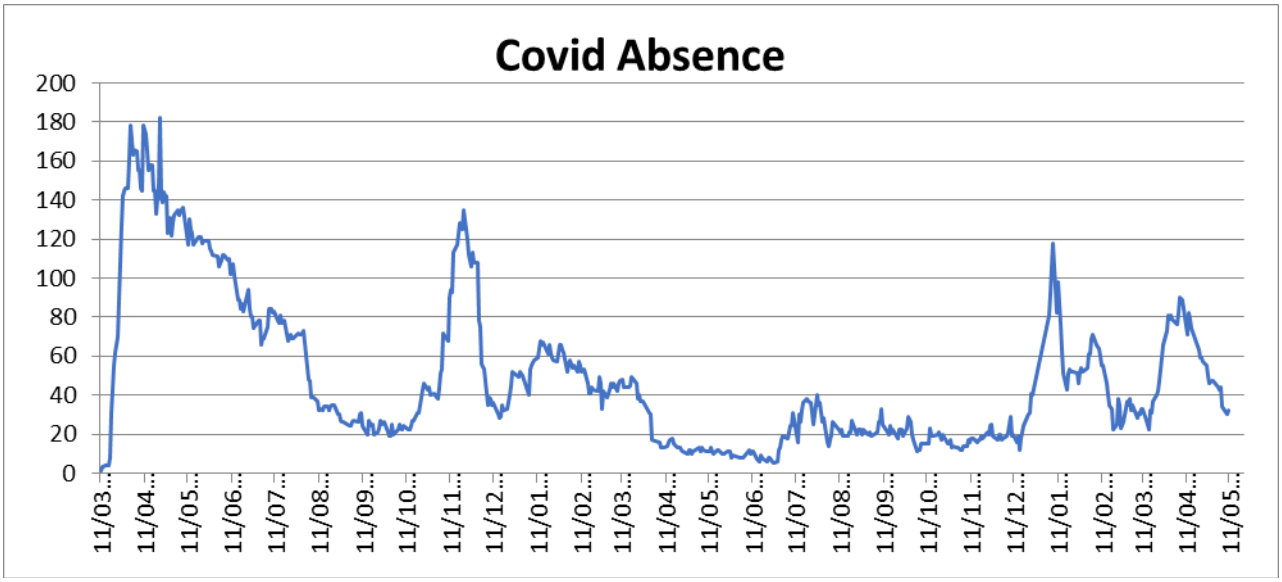
This update provides an overview of the ongoing arrangements and continuing work in place in the Trust and with partner organisations to manage the ongoing Covid-19 emergency. NHS England and Improvement raised the national incident alert level from 3 to level 4 on 13th December in recognition of the impact of the Omicron variant on the NHS of both supporting the increase in the vaccination programme and preparing for a potentially significant increase in Covid-19 cases.
As of the 6th May 2022, the confirmed cases of Covid-19 for Yorkshire and the Humber are:

Covid case rate per 100,000. Period: 25th April – 1st May	
Area	**(25th April – 1st May)**
East Riding of Yorkshire	146.0
Hull	137.0
North East Lincolnshire	141.8
North Lincolnshire	138.4
Yorkshire and Humber	115.3
England	117.0

As of 6th May, the 7-day rate per 100,000 population for Scarborough is 70.0, for Ryedale is 85.0 and Hambleton is 122.0. The overall 7- day rate for North Yorkshire is 104.0

As of 6th May 2022, there have been 1,832 hospital deaths due to COVID-19 across the Humber area. This includes 1,182 deaths registered by HUTH, 620 deaths registered by NLAG, 27 deaths registered by CHCP (East Riding Community Hospital) and 3 deaths registered by HTFT. York Teaching Hospitals NHS Trust recorded 930 deaths over the same period.

The Trust has recorded a peak of 13 cases of a Covid-19 positive inpatient since the last report, this has reduced to three cases currently.



Staff sickness absence related to Covid has decreased in the last month to between 89 and 30 cases daily in April and early May. When combined with non-covid related sickness the overall absence position is currently at 6.56%.

The Trust's emergency planning command arrangements were stood down on 31st January 2022. A gold command rota has been instigated over the recent bank holiday weekends due to ongoing high system pressures rather than an increase in Trust pressures. Twice weekly Sitrep reporting remains in place to monitor the ongoing impact of the pandemic on our services. The command arrangements will remain under close monitoring and will be stood up again as necessary. System emergency planning arrangements have remained in place. The Covid- 19 task group chaired by the Deputy Chief Operating Officer continues to meet to ensure that any changed requirement in relation to Covid are responded to and addressed.

Operational service pressures remained high in some areas in April and early May due to the ongoing position related to staff absence. The highest pressures were seen in our mental health inpatient beds due to having the highest rate of covid related absence along with a high level of demand. Community services in Scarborough, Ryedale and Whitby due to ongoing high demand from the acute hospitals for discharges to be supported along with ongoing high demand for primary care. The Trusts overall operational pressures reduced in the last month with escalation levels (OPEL) being 2 (moderate pressure) predominantly.

Child and Adolescent Mental Health (CAMHS) services are continuing to experience high demand for both community and inpatient services in line with the nationally anticipated surge due to the direct impact of the pandemic on children, young people and their families. Demand has continued to plateau during April and early May at a higher level than typical for this time of year, with presenting needs continuing to be of high levels of acuity and complexity. Break down of placements for young people in residential care continues to lead to urgent and crisis admissions to mental health and acute hospital beds. High demand for young people experiencing complex eating disorders has led to pressure on CAMHS beds locally and nationally leading to admissions to acute hospital beds. System and ICS work is ongoing to enhance provision to support out of hospital care for children and young people including those with eating disorders. Focus continues on reducing waiting times in these services, particularly in relation to autism and attention deficit hyperactivity disorder diagnosis.

Nationally requirements are in place to eradicate the use of out of area mental health beds and our services are implementing plans to achieve this. It remains a challenge however as infection prevention and control guidance requires patients to be isolated. Our out of area bed use is reducing. Our overall bed occupancy has remained high in April and early May with the pressures especially high for mental health, learning disability beds and our community beds at Malton and Whitby Hospitals, it has been between 79.3 – 86.8%.

System pressures have remained very high in North Yorkshire and York and in the Humber areas in April and early May for both health and social care, system command arrangements remain in place. Acute hospital partners in all parts of our area have reported pressures at OPEL 4 for periods of time during the last month. Local authorities have also seen their pressures remain very high due to staff availability and the national requirement that all patients who do not meet the criteria to reside in an acute hospital should be discharged. Ambulance services have continued to experience pressures and delays in handover times at acute hospitals resulting in decreased call response times. The combined impact of these pressures has seen system pressures reach overall OPEL 3. System work has focussed on reducing the number of patients in the acute hospitals who do not meet the criteria to reside to accommodate a rise in the number of patients requiring admission who are covid positive, to reduce ambulance handover times and to recover elective activity.

Ongoing work has been taking place by our recruitment team to increase the number of staff available to us on our bank, recruitment campaigns focussed on specific clinical areas e.g. CAMHS have had some success. Staff availability remains an area of operational priority as we respond to the ongoing impact of the pandemic. To further address this the recruitment team has been tasked to prioritise clinical posts.

Testing and Isolation Arrangements

New national guidance "Living with COVID-19 – National Staff and Patient Testing Update" was received on 31st March 2022. Further updated guidance was received from NHS England/Improvement on 14th April "Next steps on IPC: Publication of revised UK Infection Prevention and Control (IPC) Guidance and an IPC Manual for England". This revised guidance has been implemented across the Trust supported by local risk assessments as appropriate.

Covid-19 Vaccine

Our hospital vaccination hub remains stood down.

An Autumn vaccination programme has been announced as despite the known uncertainties, in the year ahead, winter will remain the season when the threat from Covid-19 is greatest both for individuals and for health communities. It is JCVI's interim view that:

- an autumn 2022 programme of vaccinations will be indicated for persons who are at higher risk of severe COVID-19; such as those of older age and in clinical risk groups
- precise details of an autumn programme cannot be laid down at this time
- this advice should be considered as interim and for the purposes of operational planning

We continue to encourage and support any of our staff who are not vaccinated to have the vaccine.

Personal Protective Equipment (PPE) and Infection Prevention and Control (IPC)

Our established robust systems to ensure that staff have access to the appropriate Personal Protective Equipment (PPE) remain in place. Stock continues to be received via a PUSH delivery system from the NHS Supply chain and SITREPS are used to determine the content and frequency of deliveries. Currently, the supplies of PPE remain at good levels.

Staff Health and Wellbeing

We continue to recognise that for all of our staff, this is a unique and challenging time. Since the start of our response to this pandemic help and resources have been shared and built on through the Trusts Health and Wellbeing Hub on our intranet and through developments led by our Staff Health, Well Being and Engagement Group. Feedback from our staff continues to be positive and they value the support that has been provided.

Our staff have now experienced and worked through the pandemic for 25 months and in some areas service demand and operational pressures remain high, they are continuing to tell us that

they are feeling fatigued. Staff continue to have access to a range of options for wellbeing support and the Trust continues enhance its offer of wellbeing resources via the “ShinyMind” app. The Humber Coast and Vale Resilience Hub to support frontline staff remains operational and providing an increased offer of psychological and emotional wellbeing support for our staff.

Our communications team have continued their efforts to maintain a focus on staff health and wellbeing. Monthly “Ask the Exec” sessions continue, and these are positively received.

Focus has been maintained on those groups of staff that are more vulnerable to Covid-19, such as those with underlying health conditions, older staff, pregnant women, people from Black, Asian and Minority Ethnic (BAME) backgrounds and men. The guidance requires managers to liaise frequently with staff in any of the increased risk groups in order to support them and to consider if adaptations are needed to their roles. Uptake of the use of the risk assessment continues to be monitored closely to ensure that it has been offered to all vulnerable staff. This is a dynamic process and reviews of completed assessments are required to ensure that mitigation being taken to reduce risks and work role adaptations are effective.

Support remains in place for our staff who are experiencing long covid and this has been developed further.

Covid-19 Clinical Advisory Group

The Covid-19 clinical advisory group continues to meet to consider and address any clinical implications of the impact of the pandemic on our services. In April and early May, the group has continued to focus on:

- Ensuring that our covid related changes and interventions do not increase restrictive practices.
- Ensuring that all areas with patients who are unwell with coronavirus are receiving the correct support.
- Maintaining focus on developing further use of digital clinical interventions.

Operational Planning - Recovery and Restore

The **operational planning guidance for 2022/2023** was published on 24th December. It set out that the NHS’s financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. It asks systems to focus on the following priorities for 2022/23:

- Invest in workforce
- Respond to COVID-19 ever more effectively
- Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.
- Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity
- Improve timely access to primary care
- Improve mental health services and services for people with a learning disability and/or autistic people
- Continue to develop our approach to population health management, prevent ill health and address health inequalities
- Exploit the potential of digital technologies to transform the delivery of care and patient outcomes
- Make the most effective use of our resources – moving back to and beyond pre pandemic levels of productivity when the context allows this.
- Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system

and places.

The Trust continues to effectively manage the impact of Covid-19 within its ongoing arrangements. The current continuing phase of delivery and planning is crucial to ensure that we can sustain our services supported with adequate capacity to manage the ongoing and anticipated increase in demand. The ICS Mental Health, Learning Disability and Autism collaborative continues to maintain focus on delivering the ambitions within the long term plan and particularly those areas with increased clinical challenges including CAMHS and Learning Disabilities.

Trusts have been asked to prepare for a public inquiry into the government's handling of the pandemic commencing in the spring of 2022 and the government have now announced the chair of the enquiry.

Staff health, wellbeing and engagement continues to be paramount to our successful ability to achieve our plans and continued focus will remain on this. The efforts our staff make to keep our patients, their colleagues and themselves safe remains exceedingly impressive and we continue to demonstrate our appreciation for that.

6 Director's Updates

6.1 Chief Operating Officer Update

6.1.1 Redesigning Adult Inpatient Mental Health Services

The Project Board is now meeting with its new wider membership in place who will oversee the development of the Pre-Consultation Business case (PCBC). This work will also articulate and link the Trust case with the Humber Acute Service Review (HASR) to demonstrate the full benefits in the context of the ICS. Whilst a decision on the New Hospitals Programme funding is awaited, the Executive Management Team have discussed potential opportunities for alternative capital funding.

6.1.2 Acute Community Service Update

The Acute community services (ACS) began in December 2020 to expand the offer of alternative to hospital admission provision for older people. It complemented the existing Crisis Intervention Team for Older People (CITOP). It is designed for patients over the age of 65 who present with acute and complex mental health needs with symptoms of high levels of anxiety, suicidal ideation and depression who would otherwise require admission to a hospital bed.

It aims primarily to reduce inpatient admissions by providing an effective and safe alternative to inpatient care, with a focus on risk management, containment, and interventions which improve the coping and self-management skills of this patient group. A secondary aim is to reduce the length of inpatient admission by facilitating safe and timely discharges from the ward.

The service model focuses on three key aspects which are:

- Safety and crisis management,
- Containment
- Control and regulation (coping skills).

The latest quarterly report demonstrates the service has been utilised by 95 patients. 72% of referrals were planned to prevent admission; admissions were prevented in 93% of these cases (only 6 admissions occurring in 15 months for patients referred to the service). The remaining 28% of referrals were to facilitate safe and timely discharge from inpatient care, of this cohort no readmissions to hospital were required.

Outcome measures have indicated improvements in anxiety, depression, suicidality, and quality of life. Service user feedback has also been very positive. These outcomes were achieved from an average of just 10.9 days of attendance at the service.

Case Study

Patient A was referred to the service in February 2022. They were on the CMHT waiting list at the time due to increased mental distress following a recent life-changing surgery.
Patient A was struggling with low mood, anxiety, and family relationships. They were finding it difficult to adjust to the changes that had taken place since surgery and were reluctant to leave the house. They expressed that they wished they had died and were experiencing suicidal thoughts.

It was considered that Patient A's situation required timely access to intensive support in order to prevent further deteriorating.

Patient A attended ACS for 10 days across a period of 6 weeks.

Self-report outcome measures demonstrated clinically significant improvements in:

- *Quality of life (from impaired to non-impaired)*
- *Anxiety (from clinically significant to non-significant)*
- *Mood (from mild depression to no depression)*

At the end of the interventions, Patient A reported that mood was "the best it's ever been". They were able to view their recent surgery as "life-saving" as opposed to just "life-altering". Patient A had been getting out of the house and engaging in positive activities. They reported improved communication with family, and no further suicidal ideation.

Both the team and Patient A did not feel that CMHT input was now required, and they instead accepted a referral for a time-limited period of additional primary care support, via the Mental Wellbeing Coaches.

Feedback and comments from Service Users

"The staff are so kind, helpful and understanding"

"I enjoyed myself and my mood got better"

"I feel so much better now compared to when I first sought help"

"Very satisfied with the staff and the care they gave"

"When I came here I was very low on confidence and self-esteem. I was self-harming and had suicidal thoughts and no understanding of my problems…the service saved my life"

"Everyone has been so patient with me and supported me"

6.1.3 Primary Care

As part of our plans to ensure that all of the Trusts primary care practices are delivering optimal clinical models that are sustainable, discussions have taken place between ourselves in relation to Peeler House Practice with The Ridings Medical Group, Hessle Grange Medical Practice and East Riding of Yorkshire CCG. Peeler House is a small practice that delivers primary care to 2,983 patients from a small building with two clinic rooms that cannot realistically be expanded. It is part of the Harthill Primary Care Network. The location of Peeler House does not provide opportunity for a merger to take place with any of the other Trust delivered practices. Having explored the options available, the decision has been taken between the CCG, the practices and the Trust to support a merger between them. Peeler House merger with The Ridings Medical Group will take place on 15th June 2022. This will be shortly followed by Hessle Grange merging with The Ridings Medical Group on 1st July 2022. Consultation and engagement has taken place with the staff and patients impacted by this change. This means that patients currently registered at Hessle Grange will continue to be seen at The Grange Hessle Primary Care Centre. However, the plan does mean that the practice will no longer be operating from Peeler House Surgery and it will be moving into The Grange Hessle Primary Care Centre. This plan will ensure that all practices involved will benefit from the strength and stability of being part of a larger, single practice group which will be known as The Ridings Medical Group.

Merging brings a number of important benefits for our patients, which include:

- the potential for specialist medical staff to provide a wider range of clinical services in the community.
- the opportunity to share clinical leadership work across a larger organisation and improve health outcomes for the population
- the ability to better manage the workforce challenges and reduce reliance on locum and agency staff.

The Trust will continue to work closely with the CCG to ensure that the practice is transferred safely and that staff and patients who are transferring are fully engaged and informed.

6.2 Director of Nursing, Allied Health and Social Care Professionals

6.2.1 Draft Quality Accounts

The Draft Quality Accounts have been presented to the Executive Management Team in April and the Quality Committee in May. The accounts are currently out for consultation and feedback from stakeholders. Feedback has been received to date from Humber Coast and Vale Provider Collaborative, North Yorkshire CCG, and Healthwatch North Yorkshire which are all very positive about the accounts.

Progress against the four quality priorities for 2021-22 in relation to involving services users in recruitment of staff, embedding NICE Guidance, clinical skills competency roll out and teams having access to real time patient safety data is presented in the accounts with good progress noted and the work becoming embedded in practice going forward.

Four new quality priorities for 2022-23 are identified in the accounts as follows:

Priority One: In line with national directives, move away from a root cause analysis approach to investigating serious incidents which can inadvertently lead to individual/team blame and therefore a poor patient safety culture, to one of reviewing the systems within which staff work which facilitates inquisitive examination of a wider range of patient safety incidents “in the spirit of reflection and learning” rather than as part of a “framework of accountability”.

Our first quality priority for 2022-23 aligns with the national priority for patient safety. The priority will be led by the Trust’s two patient safety specialists.
Priority Two: To work towards ensuring that services are delivered and co-ordinated to ensure that people approaching the end of their life are identified in a timely manner and supported to make informed choices about their care.

Our second priority for 2022-23 has been identified following audit information received in relation to adherence to national end of life standards. Whilst good care was found there are areas where we need to improve compliance with the national standards. Consultation on the work required has been undertaken with our clinical staff and in our Trusts Family Bereavement working group which consists of patients, carers and service users. This priority aligns to national workstreams and to our Patient Safety Strategy and will strengthen the Trust compliance with CQC’s related end of life key line of enquiry requirements. The priority will be led by our newly appointed End of Life Professional Lead supported by the Trusts End of Life group.

Priority Three: To increase service user involvement in our patient safety priorities and associated work incorporating a strengthened approach to involving patients, families and carers strengthening our approaches to ‘Think Family’.

Our third priority for 2022-23 has been identified following review of incidents and survey findings and aims to strengthen service user involvement/family and carer involvement in the shaping and delivery of our patient safety priorities. We have undertaken consultation with our patient and carer experience groups, staff and with our governors’ regarding this priority all of whom are supportive of this direction of travel. This priority also meets the requirements of both the national and trust

patient safety strategy priorities. This priority will be led by the Head of Patient and Carer Experience and Engagement working with our Patient Safety Specialists.

Priority Four: To ensure all our staff feel supported and confident in saying that caring for patients is our main priority as an organisation

Our fourth priority has been identified following receipt of our 2021 staff survey results which showed that 73.8% of staff felt care of patients/service users was the organisations top priority. This is below the NHS average of 78.5%. This priority will be led by the Deputy Director of Nursing, Allied Health & Social Care Professionals supported by the Executive Management Team. The Quality Account is due to be presented to the June Board meeting seeking approval.

6.2.2 Professional Nurse Advocate (PNA) Update April 2022

There has been a lot of preparation work going on within the Trust to promote the role of the PNA, establish processes for accessing restorative supervision, collecting data and encouraging staff to apply to undertake the programme and become a PNA.

To date we have 6 qualified PNA's a further 4 started their training in April with a further 3 due to start the programme in May. Expressions of interest are still being taken and we are awaiting an update about the availability of further courses.

We are linked in with the regional and national work around the role of the PNA by regular attendance at the regional meetings. As of April, we will be required to submit data on the activity of the PNA's via the Provider workforce return (PWR).

During supervision week in May there are plans to promote the role of the PNA and the benefits of restorative supervision. The Trusts internal PNA peer group has now been established and all those in training have been invited to attend.

There is a regional PNA conference in June of this year and the Trust has been allocated 4 places, there is also work taking place on establishing a regional community of practice.

6.2.3 Resuscitation Officer Annual Update

The following annual update was presented to the Quality Committee at its meeting in May. Achieving the Trust 85% compliance with all levels and types of Resuscitation courses has remained a challenge in 2021/22 due to multiple factors including reduced room capacity, increased staff absences and capacity to release clinical staff for training due to clinical demand. However, a recovery plan has been developed which will support teams to improve compliance rates. This includes additional resources, equipment and room availability. An extra basic life support trainer will increase the number of available training places and provide additional resilience. Courses will continue to be delivered at both the learning centre and were practical, at other sites across the trust. The end of year compliance figures are Adult Immediate Life Support (ILS) 71%, Basic Life Support (BLS) 71% and Paediatric Immediate Life Support (PILS) 58%. Whilst improving compliance rates will remain a key focus in the coming months, HTFT are in a favourable position when benchmarked against other organisations across the Yorkshire region, with many organisations experiencing similar challenges due to the additional pressure of the pandemic. For example a nearby Trusts pre-pandemic compliance rate was 81% and is currently 60%.

Post incident reviews are carried out on all cardiorespiratory arrest. During 2021/22 there were 4 such incidents. In all staff acted promptly, efficiently and all guidelines were followed resulting in patient's having a return of spontaneous circulation prior to emergency transfer to the acute hospital.

Following the publication of the revised Resuscitation Guidelines in 2021 the Trust's resuscitation course has been updated to reflect changes in best practice such as the inclusion of a scenario to highlight the recommended drugs to be administered in anaphylaxis and the updated sequence for paediatric basic life support. These changes have also been reflected in the revision of relevant

trust policies and procedures, Medical Emergencies and Resuscitation Policy and Procedure and the Deteriorating Patient Policy and Protocol. Significant changes to treatment algorithms have led to update to the Anaphylaxis Guidelines. All clinical areas have been provided with laminated 2021 Resuscitation and Anaphylaxis algorithms and any outdated ones removed and destroyed. It should be acknowledged that the changes in guidance are minor and in view of our current low compliance rates there remains no risk to patient's dues to staff not being aware of the new guidance.

2021 also saw the release of Version 3 of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) which has been widely adopted across the Trust. Version 3 is even more patient-centred than previous versions and contains more prompts for explicit clinical reasoning for people who do not have capacity to make or express choices in relation their preferences for emergency treatment. It addresses areas where misunderstandings have been reported and includes more personable and clearer language.

The Resuscitation Officer continues to ensure our provision of resuscitation equipment meets the needs of the trust and our patients, is fit for purpose, and properly maintained. The Resuscitation Officer has also provided support for the vaccination programme as required.

6.3 Medical Director Updates

6.3.1 Clinical Pharmacists

The Specialist Clinical Pharmacists, who are also Non-Medical Prescribers, are fully embedded on the wards, in the community setting and in general practice. They have led and continue to lead on the safe prescribing of medication and ensure that patients are not put at risk from their medication. Several pharmacists run specialist clinics, for example, diabetes and cardiometabolic clinics. This has helped release the pressures within services especially with the shortage of doctors. We are looking to expand these specialist pharmacist clinics into the mental health teams.

6.3.2 Pharmacy Technicians

With the introduction to ward-based technicians, the provision of pharmacy services across the Trust has been transformed. The role is continually expanding; most technicians now complete at least one administration round per shift. Not only does this further free up nursing time but we have also seen a decrease in the number of missed doses, most significantly in categories "patients refuse with capacity" and "missed due to medicines being unavailable".

We have now received Health Education England (HEE) funding to start a rolling programme to train Pharmacy Technicians within our Trust and for the ICS.

6.3.3 Medicines Safety Officers

The interim Medicines Safety Officers have implemented a suite of programmes to improve learning from medicine-related incidents. These include proactive reporting of near-misses by ward-based pharmacy technicians; visiting in-patient wards and community teams to identify and systematically address medicines safety issues; publishing "Learning the Lessons" newsletters

6.4 Director of Workforce & Organisational Development Update

6.4.1 Staff Side Chair

Sarah Mellors (UNITE) has taken up the Trust Staff Side Chair with effect from 2nd May.

6.4.2 Job Evaluation

A new software based system is now in place for the Agenda for Change Job Evaluation process. This allows all evaluations to be stored electronically, allowing quicker retrieval and comparisons to be made.

6.4.3 Appraisal Window

The appraisal window is open in the Trust. Running from April to the end of June all staff are expected to have an appraisal during this time. Training sessions for managers and drop in sessions for staff have been run during March and April to help staff get the most out of their appraisal.

6.4.4 Looking After Our People Retention- ESR Masterclass on 24th May 2022

The HR team will be attending a masterclass run by the North West and North East NHS Business Services Authority (BSA) Electronic Service Record (ESR) partnered with the NHSE&I Retention team offering a retention masterclass to understand how ESR can help with retention. This takes place on 24th May.

6.4.5 Workforce Disability Equality Standard (WDES)

The 2021 NHS wide report was published on 10th May. Key findings are

- Workforce representation shows an increase of 0.3% to 3.7% of the workforce
- Disabled staff are nearly twice as likely to enter the formal capability process compared to non-disabled colleagues
- Disabled board member numbers increased by more than 20 to 3.7%.
- 76.6% of disabled staff report they have the adjustments necessary to perform their duties effectively, an increase of 2.8% from 2020.

The Board considered the Trust 2021 WDES in July 2021. The 2022 will come before the Board in July later this year.

6.5 Director of Finance Update

6.5.1 Cyber Security Updates

There are two types of CareCert notifications,

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

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

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

The Trust are using new software to track that status of its digital estate, consequently new data is included in this section of the report.

In terms of CareCerts

- CareCERT notices issued during 2022: 82 (Inc. 17 in April)
- High Priority CareCERT notices Issued during 2022: 3 (Inc 2 issued in March)

April Data

- CareCERT Notices with patch(s) NOT approved for deployment: 0
- CareCERT notices with patch(s) applied to all devices: 12
- CareCERT notices with devices still to check in to patch: 5

Workstations update:

- Total workstations detected 3,318 (2,960 are laptops)
- Workstations non seen in last 60 days (50)
- Workstations non seen in last 90 days (2)

There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during April 2022.

6.5.2 Office 365

We continue to provide focused drop in sessions to staff to support the use of the new office 365 systems. We have now implemented MS Forms and replaced survey monkey.
Policies have been updated to reflect the office 365 and that is can be used remotely and on other IT equipment. We are planning the implementation of Sharepoint and onedrive, we will start with a small number of pilot departments to test the information governance.

6.5.3 Digital Aspirant plus Innovator Updates

Work is now starting on the outline business case which is planned to be approved by August 2022. We have scheduled electronic patient record supplier market engagement for June 2022 and it will be carried out by a joint operational/corporate team.
As part of the innovator developments we are looking at digital solutions to support carers.

6.5.4 SIRO Training

The SIRO and deputy SIRO have completed their National Cyber Security Centre (NCSC) Certified SIRO Training. The office of the SIRO has delivered the 20/21 remediation plan and is currently developing the 21/22 remediation plan.

6.5.5 Yorkshire & Humber Care Record

We now have access to more information from Hull University Teaching Hospital NHS Trust and York and Scarborough Teaching Hospitals NHS Foundation Trust. We are now also providing a significant level of information into the Yorkshire & Humber Care Record.

The Yorkshire & Humber Care Record branding will be relaunched in June 2022. This will include the launch of the interweave branding for the products which provide the Yorkshire & Humber Care Record, Leicester Leicestershire and Rutland Care Record and in the near future the Nottingham and Nottinghamshire Care Record.

6.5.6 Blend and Thrive

Following the decision to lease a second building on the Willerby Hill Business Park, negotiations are underway with the landlord with a view to securing the lease as soon as possible.
The fit out of building A is expected to be completed to facilitate occupation by the end of July.
Sessions for managers and staff will be held in May and June to formally support the move to an agile working environment. A building Coordinator has been appointed who will oversee the provision of accommodation across the Willerby Hill site and monitor its use.

6.5.7 Future Focussed Finance

The finance team have submitted their reaccreditation application for the Future Focused Finance (FFF) level 1 award. The application has been accepted by the FFF team and the Financial leadership Council are expected to formally confirm reaccreditation at the end of May.
The team have held the award since 2019 and are progressing towards level 2 accreditation.

6.5.8 Strategy Refresh

The refresh of the Trust Strategy is progressing well. Between February and April 2022, we held a second round of consultation and engagement events where we shared a draft of the new strategy with participants.

The events were attended by a wide range of people from inside and outside the Trust, including partner organisation across health, care and local government as well and voluntary and community sector organisations.
The conversations at these events covered a rich and broad range of issues, and have informed the style and content of final draft of the strategy. The draft text is currently being reviewed with execs and will be presented to the July Trust Board for sign off.
We would like to take this opportunity to thank everyone who was involved in this process for their invaluable contribution to developing our shared Trust Strategy.

6.5.9 Band 5 Retention Payments
The Payroll Team implemented the Trust's retention payment to Band 5 Nurses in April in recognition of their length of service with the trust with this group being in receipt of up to £1k for those staff that have been at the Trust for 12 months.

6.5.10 Budget Upload
Following the ICS Plan and Trust Board approval, budgets have been uploaded to the ledger for Month 1 and reflects the ICS agreed position of a £1.011m deficit. Divisions and Corporate Teams will be able to access their month 1 positions via the ledger from close of play on Tuesday 10 May.

6.5.11 Humber Centre Works Update
Contracts for the early enabling works at the Humber Centre (Gym and Shop) are on site and programmed for completion in June 2022.

Works package to reconfigure the reception areas is programmed for tender issue in May.
Tender package in development to reconfigure the entrance and reception to provide a dedicated staff entrance and independent access to the first floor, which will be issued to tender at the end of May 2022.

A review of options for the main ward refurbishment has been commissioned and will be presented to EMT and Finance and Investment Committee for consideration.

6.5.12 National Standards for Healthcare Cleanliness
National Standards for Healthcare Cleanliness came into force this month, with implementation being rolled out by the Hotel Services Team. Cleaning Charters for each Trust Site have been developed and will be displayed, alongside key risk rated tasks.

6.5.13 Other Capital Works Update
Refurbishment works completed at West End to facilitate accommodation for the Hull Core CAMHS team, with further plans being developed to accommodate Children's Services.
Staff Welling works are on site at Townend Court, the Grange and Princes Medical to provide enhanced staff welfare provisions. 38 welfare areas have been completed to date.

Secure Bike shelters have been delayed and will be installed from week commencing 23 May 2022, which will include lighting and a provision for EV cycle charging.

6.5.14 Ventilation Works Update
Air scrubbers and CO2 monitors rolled out across all inpatient nurse offices. This is to assist in the provision of safe working environments, by informing staff of ventilation levels, supported by purified air.

Proposal for targeted mechanical ventilation enhancements to be considered at the Ventilation Group in June. A capital investment application will then be considered at the Estate Strategy and Capital Group in July.

7 Communications Update

Key Projects

External Communications

Service Support
We continue to support a range of services to reach external audiences with key messages and campaigns, including:

GP Practice merges – Hessle/Bridlington

Humber, Coast and Vale Keyworker Service
We have worked closely with service team and the Humber and North Yorkshire Health and Care Partnership to set up a new section on the Trust website and intranet which houses all the information about the new Humber, Coast and Vale Keyworker Service.

Recruitment Campaign
Our Trust recruitment campaign, 'Humbelievable' continues to be very active across our platforms. Over the period over 2000 users visited the recruitment website having found the site by searching on Google for jobs or being referred by our adverts on social media.

Plans and funding for another year of the campaign will support us to refresh the site and develop bespoke advertising campaigns with a focus on hard to recruit to roles.

- **Trust Website Update**

	Target	**Performance over period**
Bounce Rate	50%	66%
Social Referrals	12% (a 10% increase in 2019 position)	3%

- **Social media**

	Target	**Performance over period**
Engagement Rate	4%	4.4%
Reach	+50,000 p/m	57425
Link Clicks	1500 p/m	560

Public Relations and the Media

- **Media Coverage**

Due to a high number of quality proactive PR campaigns, media interest remains high. This demonstrates improved engagement with the wider Trust team who now understand to come to us to share their news and celebrations.

We have worked closely with teams to develop stories that attract positive media attention and promote timely Trust and national key messages such as around Whitby Hospital news.

Please note, these figures are lower than the normal average due to the shorter reporting time for this month's Board and also due to the Trust currently observing Purdah.

Positive new stories published		**Negative new stories**	
Local media	4	Local media	1
Humber website	4		
TOTAL	**8**		**1**

- **Awareness Days**

In April, we have covered a wide range of different events, including Stress Awareness Month and World Immunization Week .

World Immunization Week (24 – 30 April 2022)

This year's theme from the World Health Organisation (WHO) was 'long life for all'.

To celebrate this year's awareness event, we worked with our Pharmacy and PACE teams to showcase the fantastic work achieved by our teams in association with Covid-19 vaccinations. The core element of this was a visual infographic, demonstrating the number of vaccines given, hours worked, volunteers who helped, and so on. It also included positive feedback from our hub.

Internal Communications

Annual Members' Meeting

Planning is underway for this year's Annual Members' Meeting. The event will be held at the MKM Stadium in Hull on Thursday, 6 October 2022 in front of a small audience of 50 people and live streamed on our YouTube channel.

Poppulo – Internal Emails

Between 13 April and 2 May 2022, we issued 13 internal communications to staff. This month our Open Rates increased by 2.6% our click through rates saw a 0.35% decrease.

According to Campaign Monitor's 2022 Email Marketing Benchmarks Report the average email open rate was 21.5 across all industries in 2021 worldwide. The report breaks down the open rate and click through rate per industry and in the health care sector it is 23.7% and 3.0% respectively. Our table below shows that we are performing well against the average engagement rates for our industry.

	Trust average engagement rates this month	**Average Rates for Health Care Sector***
Open Rate	62.25%	23.7%
Click Through Rates	6.5%	3.0%

*According to Campaign Monitor's 2022 Email Marketing Benchmarks Report

Intranet

Our intranet platform has been visited 107,214 times between 13 April and 2 May 2022.

	Target	**Performance over period**
Bounce Rate	40%	57.44%
Visits	+20% on 2021 average	-20.23%

Second to our home page which had 77,257 visits, our Document Library was the second most visited page with 7,502 page views within this period.

8 Health Stars Update

Events

Health Stars CEO Challenge will take place on the 23rd June. Michele Moran will take on a 91-mile virtual cycle ride in just one day! The virtual route will start from Trust Headquarters and cover all Inpatient settings across the Trust finishing at Whitby Hospital. The event will take place at Trust Headquarters in Conference rooms A&B and staff, patients and sponsors will be invited to come

down and cycle alongside Michele for parts of the route. This is an extremely difficult challenge and will push Michele to the limits.

For further information and to get involved please contact Kristina Poxon: Kristina.poxon@nhs.net
A range of virtual ways to support the challenge have also been created:

Text **CEOCHALLENGE** to **70085** to donate £5

https://health_stars.donr.com/ceochallenge

Places are still available for this year's Health Stars 2022 Golf Day. The event will take place at Ganstead Golf Club and teams of 4 will play a shotgun format starting at 11.20am. Teams cost £140, and this will include breakfast rolls and coffee on arrival, green fees followed by pie and chips in the clubhouse. Up to 16 teams can participate in this year's event, you can express your interest by contacting Fundraising Manager Kristina Poxon: Kristina.poxon@nhs.net

For further information on fundraising for our Trust Charity, Health Stars you can contact the Charity team hello@healthstars.org.uk

Whitby Hospital Appeal
Health Stars continue to fundraise for £43,715.82 to meet the fundraising appeal target for Whitby Hospital.

The team have submitted 2 grant applications this month and the details are listed below:

- **Application Submitted Whitby Freemasons -£5,451.62**
- **Application Submitted Liz and Terry Bramall Foundation- up-to £32,000**

Health Stars Fundraising Manager will be attending the community led Art engagement events held on the 5th May, promoting ways to support the Whitby Hospital Appeal.

The fundraising bricks campaign is still live. Personalised bricks can be purchased at £20 each and these will be installed within the new dementia friendly garden, encasing the retaining wall to create a bespoke focal point within the grounds leaving a legacy for all to see.
You can sponsor a brick here: https://healthstars.org.uk/community-services/fundraising-bricks/
Health Stars continue to engage with the local community, discussing and planning future fundraising opportunities. The next Fundraising T&F group chaired by Head of Smile Health will take place on the 6th June at 3pm.

Wishes

Health Stars have been working closely with a range of staff teams, and the Charity Executive lead this period, to help bring wishes to life through accessing Charitable funds.

An insight in to some of our recent wishes granted can be seen below:

- Wellbeing Bags for Patients of Whitby Hospital
- Mindfulness Resources to support Patients at STaRS
- Garden Games for Patients at Avondale

A range of other wishes are currently being processed by the charity and we look forward to hearing more about the difference these have across our Trust.
You can submit your wish requests here: https://healthstars.org.uk/submit-your-wish/

Michele Moran
Chief Executive
May 2022

Humber Teaching
NHS Foundation Trust

Use of Force Policy (OP-004)

Version Number:	1.0
Author (name & job title)	Patti Boden – Clinical Lead (Secure Services) Michelle Nolan – Mental Health Act Clinical Manager Jess Slingsby, Modern Matron Joanne Bone, Modern Matron Paul Warwick, Modern Matron
Executive Lead (name & job title):	Lynn Parkinson, Deputy Chief Executive and Chief Operating Officer
Name of approving body:	Executive Management Team (EMT)
Date full policy approved:	*To be updated on approval*
Date Ratified at Trust Board:	*To be updated on ratification*
Next Full Review date:	March 2023

Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	
Date EMT as approving body notified for information:	

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

A proportion of people who need the support of mental health and learning disabilities services require on occasions to be cared for under conditions that are viewed as restrictive interventions. Even when restrictive interventions are used as an appropriate response to maintain safety, it is accepted that the potential negative outcomes, including physical and psychosocial trauma, can lead to fragmented therapeutic relationships and inequalities of care and support.

Humber Teaching NHS Foundation Trust is committed to reducing the use of restrictive interventions. Where restrictive interventions are used to prevent harm to the patient or others, services will ensure that they are used:

- Safely and effectively;
- As a last resort;
- With the least possible force; and
- For the shortest possible duration.

These commitments are met by staff training, working collaboratively with patients and their families, ensuring good leadership of services, maintaining appropriate environments, availability of meaningful therapies and activities, individualised care (which includes crisis and risk management plans), support and engagement, and the involvement and empowerment of patients.

This overarching policy outlines the statutory responsibilities of all staff in relation to the management of violence and aggression of patients under our care and the subsequent possibility of use of force. There are a number of associated policies that relate specifically to the restrictive intervention and the patient safeguards required when implementing the use of such restrictions. Details can be found in section 11.

The policy should be read in conjunction with Chapter 26 of the MHA 1983 Code of Practice (2015) on safe and therapeutic responses to disturbed behaviour, and also the Mental Health Units (Use of Force) Act 2018 and the accompanying statutory guidance.

The guiding principles related to the Mental Health Act are:

Least restrictive option and maximising independence Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery.

Empowerment and involvement Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and equity Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care

services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

2. SCOPE

This policy applies to all staff working within the organisation or trust who will be involved in the use of force who work within mental health and learning disability inpatient units. This includes NHS employees, and temporary or bank or agency staff.

3. POLICY STATEMENT

All staff have a statutory obligation to follow the standards and processes set out within the Mental Health Act (1983) Code of Practice 2015 and the Mental Health Units (Use of Force) Act 2018. The procedures outlined in this Policy are in line with the requirements of the Code and the statutory guidance to the Mental Health Units (Use of Force) Act 2018. There must be no exceptions.

Humber Teaching NHS Foundation Trust recognise the potentially traumatising impact the use of force can have on people. The Trust is committed to minimising the use of force through the promotion of positive cultures, relationships and approaches which understand the trauma history and triggers of individuals which will prevent escalation and any need to use force.

Humber Teaching NHS Foundation Trust are committed to preventing closed cultures and to promote and support the commitment to reduce and limit the use of restrictive interventions across all healthcare settings. The aim is to promote an open culture which delivers care to enhance the quality of life and lived experience of those in receipt of Trust services.

By a closed culture we mean **a poor culture that can lead to harm, which can include human rights breaches such as abuse.** Any service that delivers care can have a closed culture, and features of a closed culture include:

- staff and/or management no longer seeing people using the service as people
- very few people being able to speak up for themselves. This could be because of a lack of communication skills, a lack of support to speak up, or fear of abuse.

This may mean that people who use the service are more likely to be at risk of harm. This harm can be deliberate or unintentional. It can include abuse, human rights breaches or clinical harm.

People using services that have closed cultures, are more likely to be exposed to risks of abuse, avoidable harm and breaches of their rights under the Human Rights Act 1998 and the Equality Act 2010.

This policy aims to:

- ensure the physical and emotional safety and wellbeing of the patient
- ensure the voices of people who use services are sought, listened to and acted on
- ensure that the patient receives the care and support rendered necessary should any restrictive interventions be unavoidable
- ensure that any necessary use force takes place where possible in a designated suitable environment that takes account of the patient's dignity and physical wellbeing
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of force and any follow-up action

Input into the consultation of the Use of Force Policy was sought from various service user groups in order to reflect their needs and experiences, specifically:

- Learning Disabilities and Autism groups
- Humber Youth Action Group
- Secure Services, Patients and Carers
- Mental Health Service User Reference Group and Crisis Involvement and Action Group

The Policy is also to be circulated to the BAME network and Local Healthwatch (as a statutory body for patients and the public).

4. DUTIES AND RESPONSIBILITIES

4.1. Chief Executive

The chief executive has overall responsibility to ensure that policies and processes are in place for the treatment of the patients subject to seclusion.

4.2. Deputy Chief Executive and Chief Operating Officer

As the named Responsible Person for the Mental Health Units (Use of Force) Act 2018 the Deputy Chief Executive and Chief Operating Officer is accountable for ensuring the requirements in the act are carried out.

The responsible person:

- must publish a policy regarding the use of force by all staff of any profession who work in each individual unit
- must publish information for patients about their rights in relation to the use of force by staff who work in each individual unit
- must ensure staff receive appropriate training in the use of force
- must keep records of any use of force on a patient by staff who work in each individual unit,
- should attend appropriate training in the use of force to ensure they understand the strategies and techniques their staff are being trained in
- may delegate some of their functions under the act to other suitably qualified members of staff within the organisation, including the deputy responsible person

(Whether the responsible person delegates any of the act's functions or not, they retain overall accountability for these functions being carried out).

4.3. Director of Nursing, Allied Health & Social Care Allied Health and Social Care Professionals / Caldicott Guardian

The Director of Nursing has responsibility to ensure that this policy is understood and adhered to by nursing staff and that all the processes are in place to ensure the policy is fully implemented.

4.4. Medical Director

The Medical Director is responsible for ensuring that this policy is understood and carried out by medical staff involved in the implementation of this intervention.

4.5. General Managers and Divisional Clinical Leads

General Managers and Divisional Clinical Leads have responsibility for ensuring that all clinical and professional staff within the care group are familiar with the requirements of the policy and are able to implement them.

4.6. Modern Matrons

The modern matrons have the responsibility to ensure that all staff working within inpatient areas comply with the policy and ensure it is implemented effectively and safely.

4.7. Responsible Clinician

The responsible clinician has specific responsibilities for the commencement, review and termination of seclusion and long-term segregation, and has ultimate responsibility for the care and treatment of the patient.

4.8. Charge Nurses/Registered Staff/Other Clinical Staff

Charge nurses/registered staff/other clinical staff must be aware of and comply with their responsibilities to work within the safeguards and requirements of this policy; and to be aware of and follow associated policies where restrictive interventions are clinically appropriate to support the management of violent and aggressive incidents.

5. PROCEDURES

5.1. Individualised Assessments

Individuals supported by the Trust should be assessed for risk of behavioural distress and disturbance. Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person's behaviour, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.

While previous history is an important factor in assessing current risk, staff should not assume that a previous history of behavioural disturbance means that a person will necessarily behave in the same way in the future.

Care should be taken to ensure that negative and stigmatising judgements about certain diagnoses, behaviours or personal characteristics do not obscure a rigorous assessment of the degree of risk which may be presented, or the potential benefits of appropriate treatment to people who are assessed as liable to present with behavioural distress or disturbance. Providers should consider the accuracy of assessments of risks as part of routine audit arrangements and put training in place to learn lessons. Cultural awareness is particularly important in understanding behaviour and responding appropriately; assessments should be carried out in a way that takes account of the individual's communication abilities and any cultural issues.

Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural distress or disturbance occur. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behaviours that challenge services. Assessments should seek to understand the underlying function of the behaviour in its broader context and not presume behavioural distress to be a manifestation of a mental disorder.

Assessments should be carried out where possible in collaboration with patients and their families, carers and advocates about why an individual might be behaving in a particular way, including any historical accounts of behaviour and possible reasons for that behaviour. This is particularly important because they can provide useful strategies, interventions and insights regarding individual responses to distressed states that have been tried in the past.

The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance quality of life outcomes for the individual and others who care for and support them.

When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviour serves or the outcomes they achieve for the individual. These assessments should inform the patient's care

programme approach (CPA) care plan and/or positive behaviour support plans (or equivalent).

Factors which may contribute to behavioural disturbance and which should be considered within assessments include:

- poorly treated symptoms of mental disorder
- unmet social, emotional or health needs
- excessive stimulation, noise and general disruption
- excessive heating, overcrowding and restricted access to external space
- boredom, lack of constructive things to do, insufficient environmental stimulation
- lack of clear communication by staff with patients
- the excessive or unreasonable application of demands and rules
- lack of positive social interaction
- restricted or unpredictable access to preferred items and activities
- patients feeling that others (whether staff, friends and/or families) are not concerned with their subjective anxieties and concerns
- exposure to situations that mirror past traumatic experiences
- a sense of personal disempowerment
- emotional distress
- frustrations associated with being in a restricted environment
- antagonism, aggression or provocation on the part of others
- inconsistent care
- difficulties with communication
- the influence of alcohol or drugs intoxication and/or withdrawal
- a state of confusion, and physical illness.
- not having a sense of Sexual Safety

This is not an exhaustive list.

Where it can reasonably be predicted on the basis of risk assessment, that the use of force / restrictive interventions may be a necessary and a proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Plans should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient.

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalents). Patients eligible for support from an independent mental health advocate (IMHA) should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan (or equivalent). The preparation of positive behaviour support plans (or equivalents) also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. For example, on occasion, family members may wish to be notified if the patient is becoming anxious and to contribute to efforts to de-escalate the situation by speaking to the individual on the phone. People must consent to the involvement of families or advocates if they have capacity to give or refuse such consent.

It is important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account.

5.2. Individual Positive Behaviour Support Plans/Care Plans

Positive Behavioural Support Plans and Individualised Care Plans are developed following assessment. They consist of a description of the functions of the behaviours that might be seen at times of distress, the proactive strategies that may reduce the risk of the individual becoming distressed, and the de-escalation and the reactive strategies that have been agreed will be used if needed. They should also include arrangements for review and de-briefs with the patient. Individual Positive Behaviour Support plans are developed in partnership with the person wherever possible. Staff must follow individualised plans at all times.

5.3. Intervention Strategies

5.3.1. Primary Preventative Strategies

Positive Behaviour Support demands that in addition to responding to distressed behaviour when it occurs (reactive **strategies**), we must also develop and introduce approaches that reduce the chances of the person becoming distressed and promote change over time.

Primary preventative strategies include ensuring there is a supportive and therapeutic culture in the care environment for all patients, whilst also ensuring that the individual's assessed needs are catered for in a proactive way.

Unless an individual is subject to specific justifiable restrictions (e.g. for security reasons), the care environment should typically include the following:

A: The care environment:

- providing predictable access to preferred items and activities
- avoiding excessive levels of environmental stimulation
- organising environments to provide for different needs, for example, quiet rooms, recreation rooms, single-sex areas and access to open spaces and fresh air giving each patient a defined personal space and a safe place to keep their possessions
- ensuring an appropriate number and mix of staff to meet the needs of the patient population
- ensuring that reasonable adjustments can be made to the care environment to support people whose needs are not routinely catered for, for example, sensory impairments, and
- ensuring care is individualised, and not based on service-based routines or adherence to 'blanket rules'

B: Engaging with individuals and their families:

- ensuring that individuals are able to meet visitors safely in private and convivial environments, as well as to maintain private communication by telephone, post and electronic media, respecting the wishes of patients and their visitors
- engaging individuals, supporting them to make choices about their care and treatment and keeping them fully informed, and communicating in a manner that ensures the individual can understand what is happening and why
- involving individuals in the identification of their own trigger factors and early warning signs of behavioural disturbance and in how staff should respond to them
- engaging individuals in all aspects of care and support planning
- ensuring that meetings to discuss an individual's care occur in a format, location and at a time of day that promotes engagement of patients, families, carers and advocates

- with the individual's consent (if they have the capacity to give or refuse such consent), involving their nearest relative, family, carers, advocates and others who know them and their preferences in all aspects of care and treatment planning, and
- promptly informing patients, families, carers and advocates of any significant developments in relation to the individual's care and treatment, wherever practicable and subject to the patient's wishes and confidentiality issues

C: Care and support:

- opportunity for individuals to be involved in decisions about an activity and therapy programme that is relevant to their identified needs, including evening and weekend activities
- delivering individualised patient-centred care which takes account of each person's unique circumstances, their background, priorities, aspirations and preferences
- supporting individuals to develop or learn new skills and abilities by which to better meet their own needs
- developing a therapeutic relationship between each patient and care workers, including a named key worker or nurse identified as the patient's primary contact at the service
- providing training for staff in the management of behavioural disturbance, including alternatives to restrictive interventions, desirable staff attitudes and values, and training in the implementation of models of care including positive behavioural support plans
- having the right number of staff with the right knowledge, skills and experience in the right place at the right time, and the recognition of the impact this can have on reducing the use of force and for safe and effective care: (escalated where necessary via safer staffing process)
- ensuring that individuals' complaints procedures are accessible and available and that concerns are dealt with quickly and fairly
- ensuring that physical and mental health needs are holistically assessed and that the person is supported to access the appropriate treatments, and
- developing alternative coping strategies in response to known predictors of behavioural disturbance

Primary strategies also include personalised interventions that are known to help keep the patient emotionally well and reduce the risk of them becoming distressed. These strategies will be identified from the assessment as described in 5.1 and may include specific actions that help the individual feel safe, have a greater sense of control, ensure they have regular time with family, opportunities for specific relaxation strategies, regular 'check-in' times with staff, etc, dependent on their identified needs.

5.3.2. Secondary Preventative Strategies

Secondary strategies are the strategies to be employed where a warning sign has been identified that the patient may be becoming distressed.

De-escalation is a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance or a behaviour of concern.

De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. When employing de-escalation strategies one staff member should take the primary role in communicating with the patient. This staff member should assess the situation for safety, seek clarification with the patient and negotiate to resolve the situation in a non-confrontational manner. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion,

negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

Staff should liaise with individuals and those who know them well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the individual's positive behaviour support plan (or equivalent). In some instances it may be feasible for families to contribute to de-escalation approaches, e.g., by speaking to their relative on the telephone.

Staff should ensure that they do not exacerbate behavioural disturbance, e.g. by dismissing genuine concerns or failing to act as agreed in response to requests, or through the individual experiencing unreasonable or repeated delays in having their needs met. Where such failures are unavoidable, every effort should be made to explain the circumstances of the failure to the individual and to involve them in any plans to redress the failure.

De-escalation training is included in the Trust-approved DMI and PATs and conflict resolution training to prevent escalation of behavioural disturbances. This training is compliant with Restraint Reduction Network National Training Standards, which is BILD accredited.

5.3.3. Engagement and Observation

There may be times when enhanced levels of engagement are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm.

The Trust has a specific Supportive Engagement Policy for use within mental health and learning disability inpatient settings. Staff must ensure they are fully aware of the policy and receive local training on implementation and recording.

Enhanced engagement can be used as a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their distress constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc.)

Occasionally restrictions on activity may be needed to ensure an individual's safety. Such interventions should always be individualised, and subject to discussion and review by the whole MDT. Any restrictions should be reasonable and proportionate to the risks associated with the behaviour being addressed and consistent with the guiding principles of the Mental Health Act and Mental Capacity Act. Access to leave, food and drink, fresh air, shelter, warmth, a comfortable environment, exercise, confidentiality or reasonable privacy should never be restricted or used as a 'reward' or 'privilege'.

5.3.4. Tertiary Interventions: Restrictive Interventions

Tertiary interventions are those that take place at the time of a patient becoming distressed, violent or aggressive, in order to manage the immediate risk. These interventions may include restrictive interventions.

Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others

Restrictive interventions should not be used to punish or for the intention of inflicting pain, suffering or humiliation or establishing dominance. Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option

The most common reasons for needing to consider the use of restrictive interventions are:

- current and ongoing physical assault by the patient
- dangerous, threatening or destructive behaviour
- self-harm or risk of physical injury by accident
- attempts to escape or abscond (where the patient is detained under the Act or deprived of their liberty under the MCA)

The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- the patient's wishes and feelings, if known (e.g. by an advance statement)
- what is necessary to meet the needs of the individual based on a current assessment and their history
- degree of frailty
- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- obligations to others affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff

Where an individual has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Any restrictive intervention will be carried out in a calm and reassuring manner.

Where patients have an identified history of trauma it will be particularly useful to obtain their recorded wishes about restrictive interventions. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected where possible.

The following tertiary restrictive interventions are approved for utilisation in line with the Code of Practice 2015 and in line with guidance laid out in this policy:

- Physical restraint
- Seclusion and long-term segregation
- Rapid tranquilisation
- Mechanical restraint (Forensic Services only)

Each restrictive intervention has policy guidance, documentation and training that must be adhered to at all times by staff. It is the responsibility of staff to ensure that they are fully familiar and trained in the application, monitoring and post care of patients subject to utilisation of restrictive interventions.

The Mental Health Act 1983: Code of Practice sets out the following in relation to physical restraint where restrictive intervention is required:

- patients should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered there should be no pressure to the neck region, rib cage and/or abdomen
- unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor

Positive and Proactive Care 2014: reducing the need for restrictive interventions also states:

- if exceptionally a person is restrained unintentionally in a prone or face down position, staff should either release their holds or reposition into a safer alternative as soon as possible
- staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation

5.4. Reporting of Incidents Involving Violence and Aggression

All incidents of challenging behaviour, violence and aggression, physical or non-physical, and near misses to incidents will be reported using the Trust reporting system Datix via the internet.

Physical assaults on NHS staff are now defined as:

> *"The intentional application of force to the person of another without lawful justification, resulting in physical injury or personal discomfort".*

Non-physical assaults on NHS staff are now defined as:

> *"The use of inappropriate words or behaviour causing distress and/or constituting harassment".*

Employees will be supported in the incident reporting procedure and advised to complete requests as soon after the incident or near miss as possible. They will be offered timely support based upon their individual need or preference. Support methods can include:

- Practical help with transport or accessing medical help
- Signposting to specific victim support or individual counselling
- Access to Occupational Health Services
- Critical incident analysis/guided reflection
- Counselling or psychological therapies
- Assistance in making requests and incident reports
- Information and assistance in relation to criminal justice procedures
- Training opportunities – refresher or additional as required
- Access to staff representation and buddy systems, where appropriate
- Professional and line management supervision which must be documented
- Capability policy
- Staff wellbeing

All employees are advised to contact the local police force, using the emergency 999 or 101 number, if they are involved in challenging behaviour, a violent or aggressive situation that cannot be de-escalated or managed by the range of clinical procedures and interventions available or have been injured. This is particularly important if a violent incident is provoked or initiated by those who are not in receipt of clinical services and are not known to employees.

Each incident must be considered on a case by case basis in light of all the available facts i.e. capacity/clinical condition. If the police are involved and attend an incident, every effort should be made to ascertain if the police intend to take action against the assailant, along with obtaining the details of the police officers involved so that these can be passed onto the ALSMS to assist in their role in monitoring the progress and/or providing assistance. Where the police decline to investigate

the incident, the aLSMS will consider investigating further to see whether or not a private prosecution or other action, such as a Criminal Behaviour Order (CBO) or civil injunction is necessary. Irrespective of whether a sanction is pursued or not, management should consider whether "warning letters" about future conduct should be sent (advice and a range of templates – warnings, responsibilities agreements, withholding treatments, Acceptable Behaviour Orders are available from the aLSMS – Vickie Shaw 01482 477861 vickie.shaw@nhs.net and/or Paul Dent 01482 477859 pdent@nhs.net) along with adding an alert on to the service users (if known) medical records to warn other employees of the potential risks.

5.4.1. Post Incident Review

As part of learning from all incidents of violence and aggression, a post incident Review should be undertaken.

The post incident review with a patient involved in the violence should be undertaken by an appropriate member of staff, as soon as it is deemed clinical appropriate and should be recorded in their electronic records.

Patient's families, carers, and independent advocates should be involved in post incident reviews following the use of force, and how the impact (physical or emotional) will be reflected in the patients' follow up care. Patient's families, carers, and independent advocates can raise concerns about the use of force separately if required.

A post incident review with any patient should who witnessed the violence and aggression should be undertaken by an appropriate member of staff, as soon as it is deemed clinical appropriate and should be recorded in their electronic records.

A post incident review with staff involved in the violence and aggression should be undertaken by an appropriate member of the team, this could be straight after the event or maybe at another appropriate time and should be part of staff reflection and learning from events. There should also be recognition of the emotional impact the use of force has on staff and how they will be supported.

5.4.2. Use of Force Information to be recorded

The Mental Health Units (Use of Force) Act 2018 requires that the record of the use of force used on a patient by a member of staff must include the following:

a. the reason for the use of force
b. the place, date and duration of the use of force
c. the type, or types of force used on the patient
d. whether the type or types of force used on the patient formed part of the patient's care plan / Positive Behavioural Support Plans (or equivalent)
e. name of the patient on whom force was used
f. a description of how force was used
g. the patient's consistent identifier
h. the name and job title of any member of staff who used force on the patient
i. the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
j. the patient's mental disorder (if known)
k. the relevant characteristics of the patient (if known) - proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.
l. whether the patient has a learning disability or autistic spectrum disorder
m. a description of the outcome of the use of force - the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were

called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

n. whether the patient died or suffered any serious injury as a result of the use of force (the injuries the patient suffered should be recorded)
o. any efforts made to avoid the need for use of force on the patient - this should include details of what led to the use of force and provide a record of the de-escalation techniques which were employed.
p. whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan / Positive Behavioural Support Plans (or equivalent) - this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

For (k) in the above list the patient's relevant characteristics are:

a. the patient's age
b. whether the patient has a disability, and if so, the nature of that disability
c. the status regarding marriage or civil partnership
d. whether the patient is pregnant
e. the patient's race
f. the patient's religion or belief
g. the patient's sex
h. the patient's sexual orientation
i. gender reassignment – whether the patient identifies with a different gender to their sex registered at birth.

A record of the use of force must be reported via the adverse incident on Lorenzo in order for the data be reported to the NHS Digital Mental Health Services Data Set.

5.4.3. Negligible use of force

The duty to keep a record of the use of force does not apply if the use of force is negligible. The inclusion of this distinction within the act is to ensure that the recording of the use of force remains proportionate within the aims of the act, which are to:

- introduce transparency and accountability about the use of force, and
- require mental health units to take steps to reduce their use of force

Negligible does not mean irrelevant to a person's experience of care or treatment. It is expected that negligible use of force will only apply in a very small set of circumstances. Whenever a member of staff makes a patient do something against their will, the use of force must **always** be recorded. If a member of staffs' contact with a patient goes beyond the minimum necessary in order to carry out therapeutic or caring activities, then it is not a negligible use of force and must be recorded.

The use of force can only be considered negligible where it involves light or gentle and proportionate pressure.

Any negligible use of force for the purpose of this section must also meet all of the following criteria:

- it is the minimum necessary to carry out therapeutic or caring activities (for example, personal care or for reassurance)
- it forms part of the patient's care plan
- valid consent to the act in connection with care and treatment (which may include the use of force) as part of the delivery of care and treatment has been obtained from the patient and where appropriate a member of their family or carer has been consulted, particularly a person with parental responsibility if the child is not Gillick competent. Where the patient lacks capacity to consent to the relevant act a Best Interest decision would need to be made and s5 and s6 Mental Capacity Act 2005 should be complied with to the extent applicable

- and only if they are outside of the circumstances in which the use of force can never be considered negligible as set out below

Any use of force that meets the above criteria must be included in the patient's care plan and be recorded proportionately. This could mean a weekly summary and will not be of the same level of detail required for non-negligible force which must be reported via the adverse incident on Lorenzo in order for the data be reported to the NHS Digital Mental Health Services Data Set.

The use of force can never be considered as negligible in any of the following circumstances:

1. any use of rapid tranquillisation
2. any form of mechanical restraint
3. the patient verbally or physically resists the contact of a member of staff. For example, telling a member of staff to get off them, to stop touching them or to take their hands off them. It would also include a patient struggling to regain control over their body. It will be important to consider the communication needs of patients with autism or a learning disability and the employment of a more complete behavioural and communication assessment may be needed to establish whether behaviour is used to communicate discomfort
4. where the use of force involves the use of a wall, floor, (or other flat surface) and the use of force is disproportionate. In practice, it will be unlikely that such a surface would be used where a patient is not resisting
5. a patient complains about the use of force either during or following the use of force. For example, telling a member of staff they are hurting them
6. someone else complains about the use of force. This does not have to be a formal complaint and can include another patient telling a member of staff they are hurting a patient
7. the use of force causes an injury to the patient or a member of staff. In this context, this would include any type of injury or other physical reaction including scratches, marks to the skin and bruising
8. the use of force involves more members of staff than is specified in the patient's care plan
9. during or after the use of force a patient is upset or distressed
10. the use of force has been used to remove an item of clothing or a personal possession

In accordance with the Mental Health Units (Use of Force) Act 2018 statutory guidance, one example of a negligible use of force is: the use of a flat (not gripping) guiding hand by one member of staff to provide the minimum necessary redirection or support to prevent potential harm to a person. Using this example, it is important to note that the contact is so light or gentle that the person can at any time over-ride or reject the direction of the guiding hand and exercise their autonomy. It is essential that the guiding hand does not cause distress to the person.

If the same routine negligible force (which is the minimum necessary to carry out therapeutic or caring activities) is used on the same patient on a regular basis then it must be subject to a restraint reduction plan which includes the justification and the proportionality of the measures taken. The minimum information that should be included in the restraint reduction plan is:

- why it is necessary to use this type of force and what other less restrictive options have been considered or already tried
- what the use of force consists of (a clear operational description)
- how frequently the force is likely to be used and in what circumstances
- what is the outcome for the patient if the activity that uses negligible force isn't carried out
- whether the patient consented to the negligible use of force
- how much discomfort it causes the patient
- any special health consideration, for example sensory issues, frailty, or limited communication which makes the patient more vulnerable to the use of any force
- any measures that are being implemented to reduce the need for force to be used
- how the patient subject to the use of force (and where appropriate their families or carers) are involved in actively finding a solution to the need for the use of force

- how often the reduction plan will be reviewed and by who
- what training is needed by staff to implement the negligible use of force safely and competently

5.5. Managing Children and Young People Under 18

Management of violence and aggression in children and young people will follow this policy with staff taking into account:

- The child or young person's level of physical, intellectual, emotional and psychological maturity
- That all safety plans should be co-produced with young people and their parents/carers (where appropriate)
- The Mental Capacity Act 2005 applies to young people aged 16 and over. For young people under 16 staff should assess for competency as described in the Trust's Consent Policy.
- CAMHS staff should be familiar with the Children Act 1989 and 2004, the Mental Health Act 1983, the Human Rights Act 1998 and the United Nations Convention on the Rights of the Child.

In the case of children and young people under the age of 18, the use of restrictive interventions may require modification to take account of their developmental status.

A standard operating procedure has been developed by the Trust to support identified wards who would accept emergency admissions of young people under the age 18; in addition policies for specific restrictive interventions also include guidance related to young people. The CAMHS service will support any young person admitted to an adult inpatient ward and contribute to the development of the treatment and care plan.

Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.

Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

Should seclusion ever be required for children / young people, their rights will be protected as they would be for any person in line with the Trust Use of Seclusion and Segregation Policy, which also specifies requirements for the physical environment. Similarly to adults, all restrictions will be proportionate to the risk needing to be managed and should be applied individually and not as a blanket application so like staff on other wards the risk will be regularly reviewed and the child / young person supported accordingly. A child / young person supported in seclusion may have access to items that support their recovery such as sensory objects. As with adults this will be risk assessed and offered at a point when it is safe to do so. Where possible, they will be provided with stimulating activities, in addition to support and meaningful contact with staff. Staff will be responsible for notifying parents or others with parental responsibility.

5.6. Use of force specific to women and girls

It is essential that staff are properly trained to provide safe, trauma-informed, person-centred care, where women and girls are treated with dignity and respect and their views and feelings are understood and their specific needs are met.

Staff must show respect for patients' past and present wishes and feelings, have an understanding of the patient's past experiences of trauma and abuse and how this should be reflected in their care plan. Staff working with girls and young women in particular should understand that girls' and

young women's mental health, experiences of trauma, discrimination and inequality are interlinked and that a trauma-informed approach to working with girls and young women should be sensitive to both age and sex recognising the high levels of trauma amongst patients in mental health units, particularly among women and girls.

Staff must consider how the sex of the person applying the use of force could trigger trauma memories for certain patients, particularly women and girls who are disproportionately likely to have experienced violence and abuse from male perpetrators.

5.7. Use of force specific to patients with autism or a learning disability

Management of violence of aggression in people with a learning disability and / or autism will follow this policy with staff taking into account:

- The person's diagnosis and / or any comorbid physical / mental health problems
- The person's level of social or adaptive functioning and ability to understand new or complex information
- Potential for diagnostic overshadowing - This occurs when the symptoms of physical ill health are incorrectly either attributed to a mental health/behavioural problem or considered inherent to the person's learning disability or autism diagnosis
- The person's past experiences of use of force in any environment
- The person's communication skills and the staff ability to communicate in ways that they understand and is meaningful to them
- The person's sensory needs and as documented in sensory assessments if available / completed
- Making reasonable adjustments in the immediate environment to meet individual sensory needs where possible to do so
- All positive behavioural support plans should be co-produced with individuals where possible and with their family / carers (where appropriate and with consent) and will have specific regard to include person's views and wishes detailing when and how to use physical restraint
- All plans and information about use of force will be provided in easy read documents

All Mental Health and Learning Disability staff should be familiar with the Mental Health Act 1983, Mental Capacity Act 2005, the Human Rights Act 1998 and Equality Act 2010.

All patient leaflets and information regarding the use of force, and personal plans will be provided in easy read documents.

5.8. Use of force specific to people from black and minority ethnic backgrounds and people who share protected characteristics under the Equality Act 2010

It is important to be aware of the differences in approach required to ensure services are culturally appropriate, and respectful and responsive to the cultural differences, beliefs and practices of the patient population being served. This should include understanding of cultural identity and heritage, and the discrimination faced by many people from black and minority ethnic backgrounds, in particular by black men.

Where an organisation or trust is providing different types of services across several units the policy should clearly set out the different needs or considerations that may be relevant for particular patient groups, for example, children and young people, adults, women and girls, patients with autism or a learning disability, people from black and minority ethnic backgrounds and people who share protected characteristics under the Equality Act 2010.

5.9. Police support and Section 136 assessments

The police may be required to support the Trust in the management of violence and aggression on inpatient wards and within the 136 suite. The police are trained in different violence and aggression management techniques and training. All staff should be trained in DMI when working on an inpatient ward and should follow the Trust-approved techniques. Staff should be aware of their

responsibilities and that the police are in Trust wards. Trust staff should always ensure that patient safety is paramount and should address any concerns with the police who are on the ward.

If the risk is high or if the patient is in possession of a weapon, the staff member must consider the potential consequences of taking action and if there is a need to request police presence to assist with use of force; as outlined in the 'The College of Policing 'Memorandum of Understanding' – The Police Use of Restraint in Mental Health and Learning Disability Setting MH and LD services' should be prepared for known eventualities and only call the police if it is a very dangerous situation and there is a risk of serious harm to others.

Each situation where the police are called for emergency assistance should be properly assessed on its merits. There will be no assumption that police cannot be involved because the patient is either detained under the Mental Health Act (MHA) or in hospital. The police role is the prevention of crime and protection of persons and property from criminal acts.

The Trust's role and responsibilities when restraint is used by the police

- Throughout the incident health staff will remain responsible for the service user's health and safety. This will require active monitoring of the service user's vital signs.
- Health staff **must** alert police officers regarding any concerns as to the service user's welfare during any period of restraint.
- Allocate a lead member of staff to co-ordinate the incident and instruct and inform attending police.
- Trust staff should record details of all incidents, including details/rationale of the restraint and complete a Datix.

5.10. Advanced Decisions

Patients should be involved in all decisions about their care and treatment, and offered the opportunity to jointly develop care and risk management plans. If a patient is unable or unwilling to participate, they should be offered the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carer.

Staff should check whether patients have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example during admission to an inpatient psychiatric unit).

Staff should ensure that patients understand that during any restrictive intervention their human rights will be respected and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Staff should identify and reduce any barriers to a patient exercising their rights and, if this is not possible, record the reasons in their notes.

It is essential that carers are involved in decision-making whenever possible, if the patient agrees, and that appropriate carers are involved in decision-making for all service users who lack mental capacity, in accordance with the Mental Capacity Act 2005.

It is also important to recognise that there may be circumstances where it could be harmful to the patient to involve their family or carers for example, for survivors of domestic abuse or violence. The patient's wishes and preferences must be taken into account.

Definitions

> **Advance decision**: a written statement made by a person aged 18 or over that is legally binding, if valid and applicable to the circumstances arising, and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance statement: a written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Patients detained under the Mental Health Act (MHA) 1983

Encouraging patients to set out their wishes in advance is often a helpful therapeutic tool, encouraging collaboration and trust between patients and professionals. It is a way in which effective use can be made of patients' expertise in the management of crises in their own conditions.

Whenever expressing a preference for their future treatment and care, patients should be encouraged to identify as precisely as possible the circumstances they have in mind. If they are saying that there are certain things that they do not want to happen, e.g. being given a particular type of treatment, or being restrained in a particular way, they should be encouraged to give their views on what should be done instead.

Patients should be made aware that expressing their preference for a particular form of treatment or care in advance like this does not legally compel professionals to meet that preference. However, professionals should make all practicable efforts to comply with these preferences and explain to patients why their preferences have not been followed.

Where patients express views to any of the professionals involved in their care about how they should be treated or ways they would not wish to be treated in future, the professional should record those views in the patient's notes. If the views are provided in a written form, they should be kept with the patient's notes.

Whether the patient or the professional records the patient's views, steps should be taken, unless the patient objects, to ensure that the information:

- is drawn to the attention of other professionals who ought to know about it, and
- it is included in care plans and other documentation which will help ensure that the patient's views are remembered and considered in situations where they are relevant in future

The Trust has updated guidance for staff supporting mental health service users to prepare an advance statement/decision available on the intranet or seek advice from the MH Legislation Department.

5.11. Respecting Human Rights

The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds, women, girls and disabled people.

Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

Action that is not medically necessary may well breach a patient's rights under article 3, which prohibits inhuman or degrading treatment.

Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

Unless a patient is detained under the Act or is subject to a deprivation of liberty authorisation or Court of Protection order under the MCA, providers and their staff must be careful to ensure that the use of restrictive interventions does not impose restrictions which amount to a deprivation of liberty.

5.12. Identification of inappropriate or disproportionate use of force

Healthcare staff, managers and independent advocates have a professional responsibility to be alert to the disproportionate use of force, to know what they must do if they witness or suspect the abusive use of force, and to take action. Staff must ensure they understand their safeguarding responsibilities and are familiar with the trust's safeguarding policies and procedures. If staff witness or suspect the inappropriate or disproportionate use of force, they should immediately raise their concerns with the staff involved in the first instance and then escalate if necessary.

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

This Policy, procedures and guidelines ensure that all people are in receipt of services that are safe, effective and led by the needs of the person. The standards within the policy will be applied equally to all patients irrespective of the protected characteristics of the Equality Act 2010. Where individuals are being detained or receiving treatment under the terms of the Act no community group will be treated less favourably.

The impact assessment has identified that the trends in the use of the Mental Health Act will be monitored by the Mental Health Act Legislation Committee against National Equality and Diversity data to identify any impacts on the target groups.

Where patients' legal status is affected we have a clear duty to inform them of their rights regardless of their main language or communication difficulties. DVDs are available in 28 languages (other than English) with the rights of detained patients.

When patients are detained with any impairment to understanding, clinical staff must identify this need as soon as possible and access appropriate interpreter support (e.g. Language specialist, BSL interpreter, Independent Mental Health Advocate). All staff will ensure that patients are repeatedly advised of their rights using these methods of interpretation.

Religious beliefs will be respected and the Trust Chaplain will support access to relevant faith leaders and information. All clinical settings (wherever possible) should accommodate individual prayer/meditation space with appropriate access facilities.

7. IMPLEMENTATION/TRAINING

This policy will be disseminated by the method described in the Document Control Policy.

The Policy will also be available on the staff intranet and the use of force web page. The final version will be communicated to the groups initially involved in the co-production of the policy.

The policy will be reviewed annually by the authors and those involved in the Trust's reducing restrictive interventions group, and this will include the involvement of patients, their families, and carers in providing ongoing feedback for the life of the policy to inform any changes.

All staff must receive appropriate and relevant induction and training appropriate to their place of work and use of restrictive interventions and minimising the need for the use of force.

Additional training will be identified by the ward manager but will likely include DMI as a mandatory requirement on inpatient mental health and learning disability wards. Training will include focus on de-escalation and preventing escalation of potentially violent situations.

8. MONITORING AND AUDIT

The monitoring of the agreed suite of metrics will be through the Reducing Restrictive Interventions Group where any associated actions are proposed and forwarded to Executive Management Team Meeting for oversight and monitoring.

Compliance against the requirements of this policy will be monitored by the modern matrons via monthly audit. Additionally there are individual audit requirements for each episode of seclusion, long term segregation, CAFO (Care Away From Others) and rapid tranquilisation.

Data will be collated via the adverse incident form around the use of force on people who share protected characteristics under the Equality Act 2010 in order to enable the Trust to monitor any disproportionate practice against such groups.

This information is reported to the Mental Health Legislation Committee within its six monthly reporting cycle (RRI report), and where required associated actions should be agreed as part of the quarterly committee meeting. Any identified actions will be used to inform the development and review of this policy.
Local management information (such as learning from post incident review data, deaths (specifically Coroner's Preventing Future Deaths reports) or serious injuries, complaints data and records of force used in the previous year) should be used to update the policy on use of force. For example, post incident review data should include information on ways in which to prevent or reduce the use of force in the future for a patient, such as those who share a protected characteristic under the Equality Act.

9. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Department of Health (2014) Positive and proactive care: reducing the need for restrictive interventions London DH.
DoH (2015) The Code of Practice, Mental Health Act 1983 London, TSO.
NICE (2015) Violence and aggression: short-term management in mental health, health and community settings, London, NICE.

Glossary

MHA	Mental Health Act
MCA	Mental Capacity Act
DMI	De-escalation Management Intervention
PATS	Personal and Team Safety
BILD	British Institute of Learning Disabilities
MDT	Multi-Disciplinary Team
ALSMS	Accredited Local Security Management Specialist
RRI	Reducing Restrictive Interventions
QPaS,	Quality and Patient Safety Group
CAMHS	Child and Adolescent Mental Health

Gillick competent	Refers to the ability of the child (under the age of 16) to give consent following assessment of whether they have enough understanding to make up their own mind about the benefits and risks of a certain issue.

10. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Seclusion and Long-Term Segregation Policy
Mental Health Act Policy
Supportive Engagement and Observation Policy
Mental Capacity Policy
Being Open and Duty of Candour Policy and Procedure
Rapid Tranquilisation Policy
Physical Intervention Policy
Guidance for Staff Supporting Mental Health Service Users to Prepare an Advance Statement/Decision

Appendix 1: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Mental Health Units Use of Force Policy ()		
Document Purpose	This overarching policy outlines the statutory responsibilities of all staff in relation to the management of violence and aggression of patients under our care and the subsequent possibility of use of force. There are a number of associated policies that relate specifically to the restrictive intervention and the patient safeguards required when implementing the use of such restrictions. Details can be found in section 11.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	Circulated 09.03.22	Mental Health Division inpatient senior staff	
	10 March 2022	QPaS	
	Circulated 15.03.22	Clinical Advisory Group	
	Circulated 16.03.22	CAMHS, and Learning Disability Matrons for inpatients	
	Circulated 18.03.22	Learning Disabilities and Autism groups	
	Circulated 18.03.22	Humber Youth Action Group	
	Circulated 18.03.22	Secure Services, Patients and Carers	
	Circulated 18.03.22	Mental Health Service User Reference Group and Crisis Involvement and Action Group	
	20 April 2022	MHL Steering Group	
	20 April 2022	BAME network	
	20 April 2022	Local Healthwatch (Hull and ER)	
Approving Committee:	EMT	Date of Approval:	
Ratified at:		Date of Ratification:	
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	All staff must receive appropriate and relevant induction and training appropriate to their place of work and use of restrictive interventions. Additional training will be identified by the ward manager but will likely include DMI as a mandatory requirement on inpatient mental health and learning disability wards. Training will include focus on de-escalation and preventing escalation of potentially violent situations.		
Monitoring and Compliance:	Compliance against the requirements of this policy will be monitored by the modern matrons via monthly audit. Additionally there are individual audit requirements for each episode of seclusion, long term segregation, CAFO (Care Away From Others) and rapid tranquilisation. This information is reported to the Mental Health Legislation Committee within its quarterly reporting cycle, and where required associated actions should be agreed as part of the quarterly committee meeting.		

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)

Version number/name of procedural document this supersedes	*Type of change, e.g. review/ legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
P199 Management of Viloence and Aggressive Behaviours Policy (Reference updated to N-049 2017)			
1.00	*New policy*	*March 2014*	*New policy. Merged and replaced P059 Violence & Aggression policy and P164 Challenging Behaviour Policy.*
2.00	*Legislation*	*January 2017*	*Updated policy in line with Code of Practice 2015.*
2.01	*Review*	*March 2017*	*Amendments relating to other policies page 10*

2.02	*CAMHS review*	*July 2019*	*Policy Reference updated to N-049 (transfer to HealthAssure system)* *Addition of text in section 5.5 Managing Children and Young People Under 18*
2.03	*Review*	*November 2019*	*Minor amendments to section 5.2 and 5.3*
OP-004 – replacing N-049 due to legislation			
1.00	*New Policy*	*March-22*	*This policy has replaced the Management of Violence and Aggression Policy in response to the requirements of the Mental Health Units Use of Force Ac 2018.*

Appendix 2: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: ***Use of Force Policy (OP-004)***
2. EIA Reviewer (name, job title, base and contact details): ***Michelle Nolan, Mental Health Act Clinical Manager***
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? ***Policy***

Main Aims of the Document, Process or Service
This overarching policy outlines the statutory responsibilities of all staff in relation to the management of violence and aggression of patients under our care. There are a number of associated policies that relate specifically to the restrictive intervention and the patient safeguards required when implementing the use of such restrictions. Details can be found in section 14.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	Staff should always ensure that any use of force is used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including disabled people. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.
Gender	Men/Male Women/Female	Low	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including women and girls.
Pregnancy/ Maternity		Low	Staff should always ensure that any use of force is used only after having due regard to the individual's maternity status and having taken full account of their physical, emotional and psychological wellbeing.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Race	Minority Ethnic Gypsies and Travellers	Low	The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including people from black and minority ethnic backgrounds. It is acknowledged that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Lesbian Gay men Bisexual	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Transgender and/or Transsexual	Choice of dress/ behaviour Adopt opposite gender role Feel they are gender opposite to their birth gender	Low	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any gender identity related preferences, needs or requirements. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people.

Summary

The standards and principles described within the policy prompt the clinician to have regard to individual holistic needs of the patient in relation to use of force.

It is felt that this policy and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs.

The policy takes significant consideration of the protection of all service users and their carers under the Equalities Act 2010 and the Human Rights Act. Significant attention has been paid to ensure that no groups are discriminated against either directly or indirectly.

Healthcare staff, managers and independent advocates have a professional responsibility to be alert to the disproportionate use of force, to know what they must do if they witness or suspect the abusive use of force, and to take action. Staff must ensure they understand their safeguarding responsibilities and are

familiar with the trust's safeguarding policies and procedures. If staff witness or suspect the inappropriate or disproportionate use of force, they should immediately raise their concerns with the staff involved in the first instance and then escalate if necessary.	
EIA Reviewer: ***Michelle Nolan***	
Date completed: ***March 2022***	Signature: ***M Nolan***

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Agenda Item 8

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Publications and Policy Highlights
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	To approve ( ) To receive & note (/) For information ( ) To ratify ( )
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To inform and update the Trust Board on recent publications and policy since the April Board: I. Health and Care Bill granted Royal Assent II. National infection prevention and control guidance

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No issues identified.	**Key Actions Commissioned/Work Underway:** •
Positive Assurances to Provide: • 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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	6/5/22
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

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

Caring, Learning
& Growing Together

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

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

Publications and Policy Highlights

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

1. **Health and Care Bill granted Royal Assent in milestone for healthcare recovery and reform** Department of Health and Social Care 28 April 2022

The Health and Care Bill has today received Royal Assent by Her Majesty The Queen, enacting the most significant health legislation in a decade into law.
The Health and Care Bill received Royal Assent, on marking a milestone in the recovery and reform of how health and care services work together enacting the most significant health legislation in a decade into law.

- It will ensure the NHS can rebuild from the pandemic and tackle the coronavirus (COVID-19) backlog, harness the best ways of working and ensure people are benefitting from more joined-up care
- Long-term plans for recovery and reform are backed by £36 billion over the next three years through the Health and Care Levy

The act introduces measures to tackle the COVID-19 backlogs and rebuild health and social care services from the pandemic, backed by £36 billion over the next 3 years through the Health and Care Levy. It will also contain measures to tackle health disparities and create safer, more joined-up services that will put the health and care system on a more sustainable footing.
The Health and Care Act builds on the proposals for legislative change set out by NHS England in its Long Term Plan, while also incorporating valuable lessons learnt from the pandemic to benefit both staff and patients.

It marks an important step in the government's ambitious health and care agenda, setting up systems and structures to reform how health and adult social care work together, tackle long waiting lists built up during the pandemic, and address some of the long-term challenges faced by the country including a growing and ageing population, chronic conditions and inequalities in health outcomes.

The health and social care integration white paper published in February will build on the act to ensure people receive the right care for them in the right place at the right time. It follows the People at the Heart of Care white paper which set out a 10 year vision for social care funded through the Health and Care Levy, and the COVID-19 Backlog Recovery Plan outlining NHS targets to tackle waiting lists. Dedicated plans to tackle health disparities are set to be published in due course.

Lead: Chief Executive

The Board is regularly updated on the developing work of the ICS. The Chief Executive is a member of the ICB Board and leads the provider collaborative work across the patch. Webinars have been undertaken for all staff previously and will be scheduled as the system becomes a statutory body.

2. **National infection prevention and control guidance** NHS England 14 April 2022

This is an evidence-based practice manual for use by all those involved in care provision in England. It should be adopted as mandatory guidance in NHS settings or settings where NHS services are delivered, and the principles should be applied in all care settings.

The manual will ensure a consistent UK-wide approach to infection prevention and control, although some operational and organisational details may differ across the nations. https://www.england.nhs.uk/wp-content/uploads/2019/03/C1630_Next-steps-on-IPC-Publication-of-revised-UK-Infection-Prevention-and-Control-IPC-Guidance-and-an-IPC-Man.pdf

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

The Infection Prevention and Control Team have worked through the manual with Matrons to ensure its application across all Trust services. It appears it can be adopted across Trust services in its entirety. Th manual will be presented to the Healthcare Infection Control Group in May for approval prior to commencing implementation.

Humber Teaching NHS Foundation Trust

Agenda Item 9

Title & Date of Meeting:	Trust Board Public Meeting - 18th May 2022
Title of Report:	Performance Report April 2022
Author/s:	Name: Peter Beckwith/Richard Voakes Title: Director of Finance/Business Intelligence Lead
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	This purpose of this report is to inform the Trust Board on the current levels of performance as at the end of April 2022 and to bring the updated performance report for 2022-23 reporting. The key issues are highlighted below with full detail in the paper. The report is presented using statistical process charts (SPC) for a select number of indicators with upper and lower control limits presented in graphical format

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:	**Key Actions Commissioned/Work Underway:**
Safer Staffing Dashboard • fill rates on four wards – see detail below. • Clinical supervision • Bed occupancy at Mill View Court • Sickness levels continue to impact on clinical supervision levels. Over 52 week waiting times remain a challenge and a high operational priority.	Safer Staffing Dashboard. • Targeting training for ILS and BLS for non compliant units • Inspire's staffing establishment is being reviewed to reflect the PICU beds Memory Diagnosis - An element of the recovery plan for this service included increasing the medical capacity. Early Intervention in Psychosis - Changes have been made to the clinical pathway including triage and assessment, to optimise the available capacity and reduce waiting times IAPT 6 weeks- Two new providers have started a phased mobilisation from 1 April and will be working to full capacity against the contracted target by the end of May. The recovery plan is therefore on track to achieve the 6 week wait position by July 2022
Positive Assurances to Provide: • All units have made a compliance return in respect of clinical supervision	**Decisions Made:** • n/a – report to note.

• Some improvement against ILS and BLS noted.	

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

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

Monitoring and assurance framework summary:

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

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

Performance Report - Key Issues:

Safer Staffing Dashboard - Four wards have below target levels of fill rates for registered nurses on days which is an improvement from five wards in February. In all instances this is due to having only one RN on duty instead of two. The registered fill rates on nights are all above the threshold with the exception of Pine view which is showing fill rates of 50% due to frequently only having one registered nurse on nights. All CHPPD levels remain above the threshold.

The low fill rates on STARS are because there is often one OT on shift during the day that needs to be reflected in the demand template. This will be addressed in the next safer staffing

review. CHPPD remain excellent.

The registered fill rates on days for Mill View Lodge (MVL) is 52% a slight improvement from February.. The B6s and nursing associates are not currently counted in the planned hours but this will be addressed in their next safer staffing review and their CHPPD are above target. Overall the fill rates on Townend Court (TEC) have improved to 64% from 54% last month. The RN fill rates remain below target due to having one registered nurse on duty at times, however they maintain good CHPPD levels. Clinical supervision compliance is a concern. Staff sickness has impacted upon this. It has been raised with the matron and via the divisional accountability reviews.

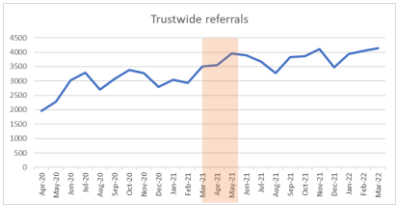
The high bed occupancy on Mill View Court (MVC) reflects the fact that five beds were stood down to enable the Covid pod to be opened. These beds have now been brought back into general use but this will not be reflected in the OBD until April.

Sickness levels continue to impact on clinical supervision levels

Over 52 week waiting times remain a challenge and a high operational priority. Focussed work continues to take place with all areas on validation of waiting lists to identify data quality issues. Main areas contributing to the over 52 week waiting time position are:

- Children's ADHD and ASD
- Adult ASD
- Memory Services

Overall demand for service remains high in some areas and the chart below demonstrates the position with overall rates of referrals. Work continues in all areas with high waiting times to implement their recovery plans. Progress continues to be made on reducing the waiting times for paediatric ASD.



Safer Staffing Dashboard – The Resuscitation Officer has been informed of the ILS and BLS rates on the units which are currently not compliant, and they are targeting training in these units**.**

Inspire's staffing establishment is being reviewed to reflect the PICU beds and once this has been confirmed target for fill rates will be introduced into the dashboard**.**

Memory Diagnosis - An element of the recovery plan for this service included increasing the medical capacity. This resource should have been in placed this month but unfortunately the resource was not available at short notice. Alternative resource is being identified. This will have a very positive impact on long waiting times when it can be put in place. The service continues to explore opportunities to improve access to diagnostic imaging which is also impacting on the time from assessment to diagnosis.

Early Intervention in Psychosis - This service has seen a significant increase in referrals which has impacted on waiting times whilst staff absences and vacancies have impacted on available capacity. The service is now nearly fully recruited with some new postholders

commencing shortly, others in late July/August and September. Changes have been made to the clinical pathway including triage and assessment, to optimise the available capacity and reduce waiting times

IAPT 6 weeks- Two new providers have started a phased mobilisation from 1 April and will be working to full capacity against the contracted target by the end of May. The recovery plan is therefore on track to achieve the 6 week wait position by July 2022

Positive Assurances to Provide:

Clinical Supervision - we have achieved excellent compliance this month of 90.5% against an uplifted trust compliance target of 85% (previously 80%).

Safer Staffing Dashboard - All units have made a compliance return in respect of clinical supervision this month which is an improvement on last month where 3 units did not report compliance.

Some improvement against ILS and BLS noted.

It should be noted that all consultant vacancies are being covered by agency consultants.

The Trust Board are asked to note the Performance Report for April 2022, and comment accordingly.

Financial Year
2022-23

NHS
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TRUST PERFORMANCE REPORT

This document provides a high level summary of the performance measures stemming from the Integrated Quality and Performance Tracker.

The purpose of this report is to present to the Board a thematic review of the performance for a select number of indicators for the last 24 months including Statistical Process Control charts (SPC) with upper and lower control limits.

Chief Executive: Michele Moran

Prepared by: Business Intelligence Team

Reporting Month:
Apr-22

Humber Teaching NHS Foundation Trust
Trust Performance Report

For the period ending:	Apr 2022

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 new format and the use of Statistical Process Control (SPC) in the following charts. SPC charts contain upper and lower control limits which are based on 2 standard deviation points above and below the 2 yearly average.
What are SPCs?	Statistical process control (SPC) 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: 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. SPC should be used to help to get a baseline and evaluate how we are currently operating. SPC will 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 control limits. The average and control limits 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.

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

Dashboard	Safer Staffing	A dashboard to provide overview on a number of clinical indicators for the Trust's inpatient units across all services
Dashboard	Mortality	Learning from Mortality Reviews
Goal 1	Mandatory Training	A percentage compliance for all mandatory and statutory courses
Goal 1	Vacancies	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.
Goal 1	Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks
Goal 1	FFT - Patient Recommendation	Results where patients would recommend the Trust 's services to their family and friends
Goal 2	FFT - Patient Involvement	Results where patients felt they were involved in their care
Goal 2	72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from hospital
Goal 2	CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months

Humber Teaching NHS Foundation Trust
Trust Performance Report

NHS Humber Teaching NHS Foundation Trust

For the period ending:	Apr 2022

Goal 2	RTT - Completed Pathways	Based on patients who have commenced treatment during the reporting period and seen within 18 weeks of their referral
Goal 2	RTT - Incomplete Pathways	Based on patients who are waiting for assessment and/or treatment and are waiting less than 18 weeks since referral.
Goal 2	RTT - 52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - Adult ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Adult and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - Paediatric ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Children and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks
Goal 2	RTT - Early Interventions	Percentage of patients who were seen within two weeks of referral
Goal 2	RTT - IAPT 6 Weeks and 18 weeks	Percentage of patients who were seen within 6 weeks and 18 weeks of referral
Goal 3	Recovery Rates - IAPT (East Riding)	Recovery Rates for patients who were at caseness at start of therapeutic intervention
Goal 3	Out of Area Placements	Number of days that Trust patients were placed in out of area wards
Goal 4	Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care
Goal 4	Staff Sickness	Percentage of staff sickness across the Trust (not including bank staff). Including and Excluding Covid Sickness
Goal 4	Staff Turnover	Percentage of leavers against staff in post (excluding employee transfers wef April 2021
Goal 6	Complaints	The number of Complaints Responded to and Upheld
Goal 6	Compliments	Chart showing the number of Compliments received by the Trust by month

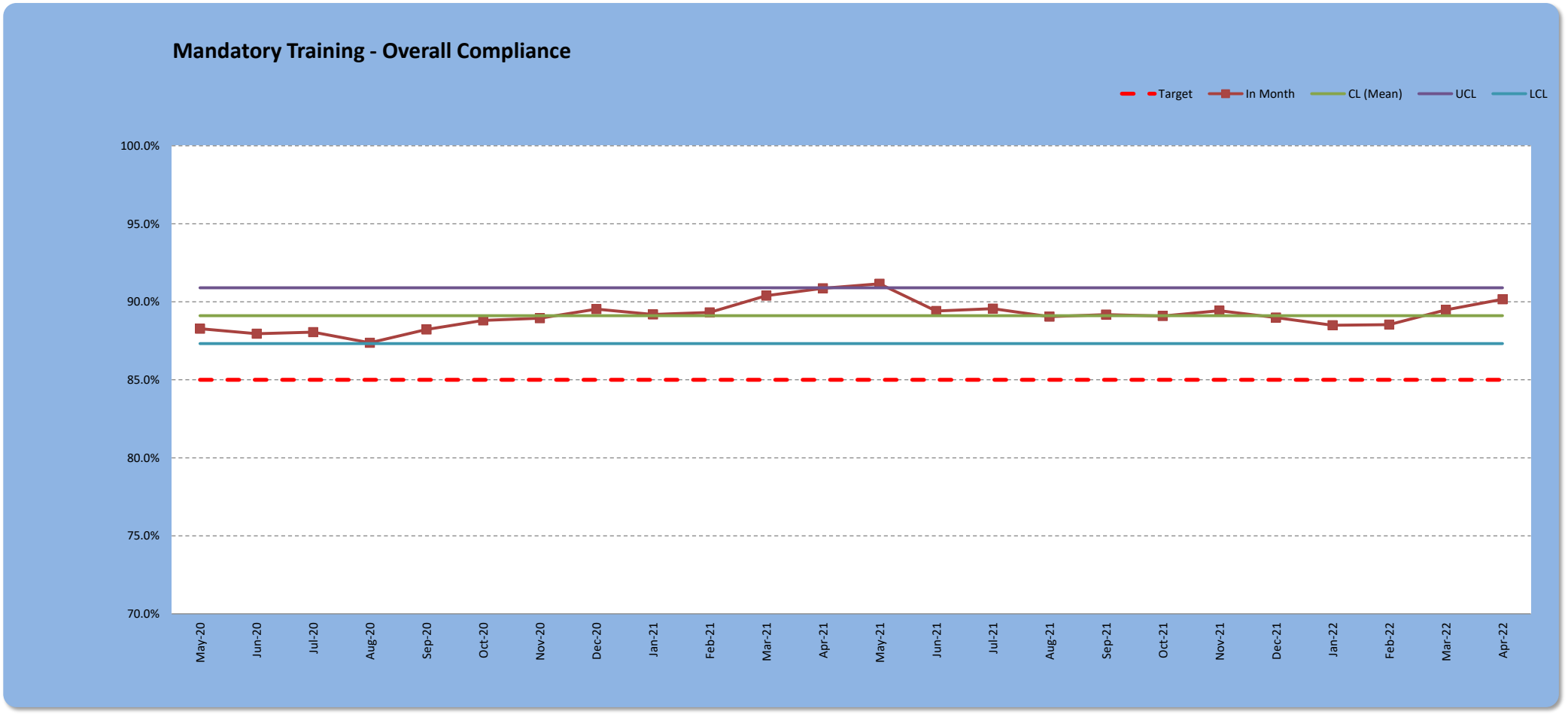
PI RETURN FORM 2022-23

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
85%	80%	90.2%

Indicator Title	Description/Rationale	Executive Lead	KPI Type
Mandatory Training	A percentage compliance based on an overall target of 85% for all mandatory and statutory courses	Steve McGowan	WL 5



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

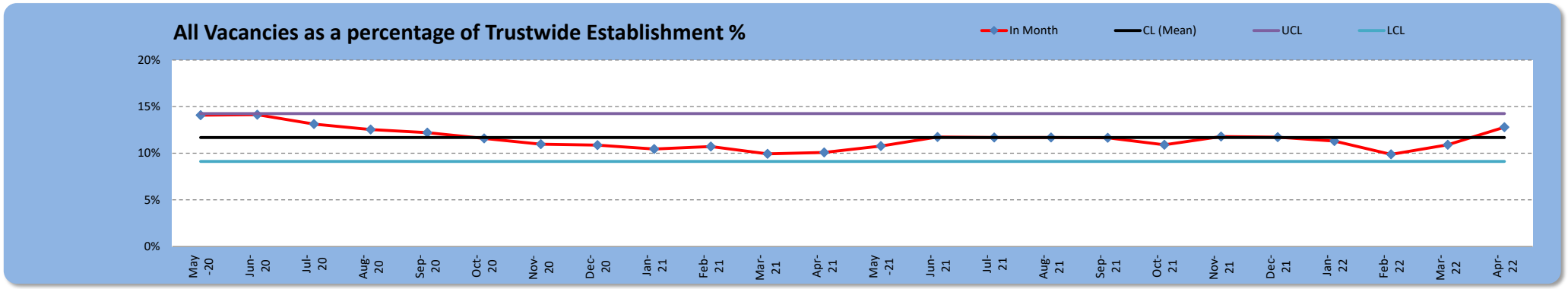
PI RETURN FORM 2022-23

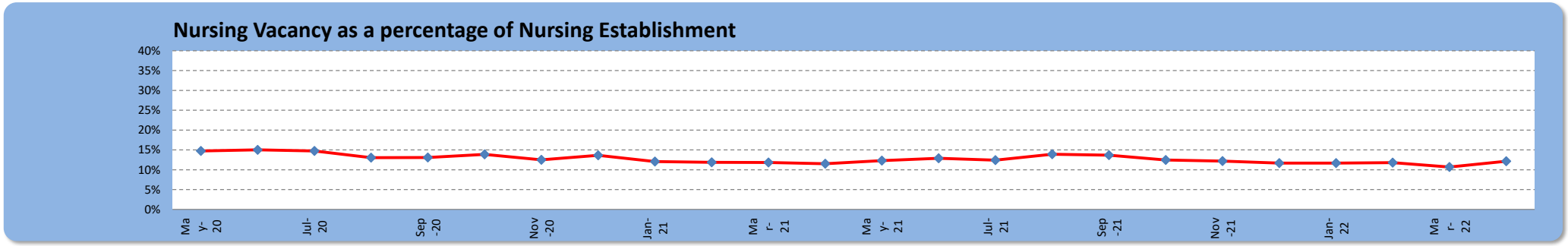
Goal 1 : Innovating Quality and Patient Safety

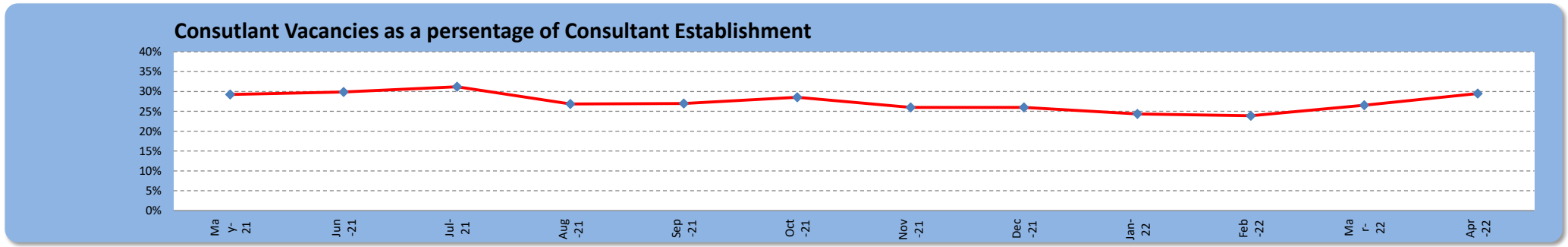
Target:	Amber:	Current month stands at:
85%	80%	12.8%

For the period ending: **Apr 2022**

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







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

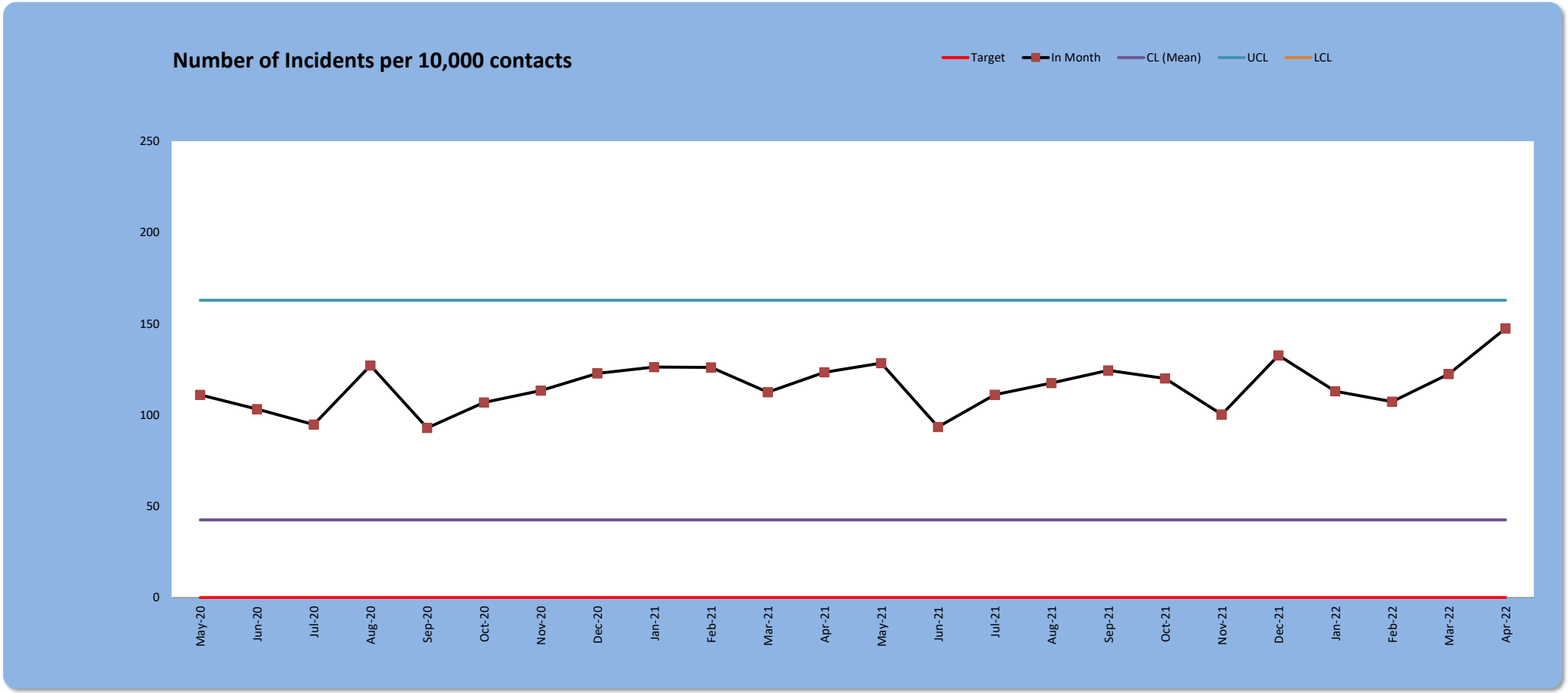
PI RETURN FORM 2022-23

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
0	0	147

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



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

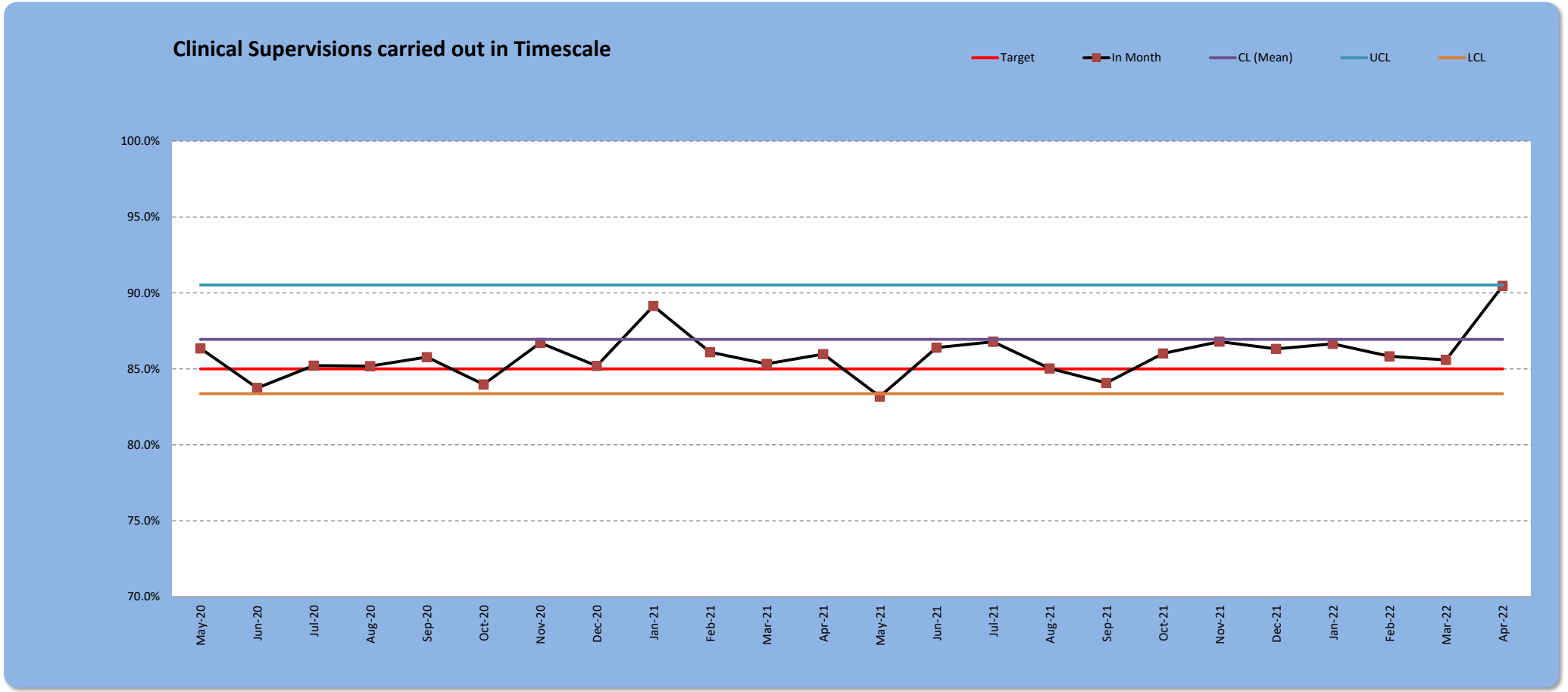
PI RETURN FORM 2022-23

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
85%	80%	90.5%

Indicator Title	Description/Rationale		KPI Type
Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks	Executive Lead Hilary Gledhill	WL 9a



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

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

Staffing and Quality Indicators

Contract Period: 2021-22

Reporting Month: Mar-22

NHS Humber Teaching NHS Foundation Trust

Shown one month in arrears

Units						Bank/Agency Hours				Average Safer Staffing Fill Rates				High Level Indicators												
										Day		Night		QUALITY INDICATORS (Year to Date)											Indicator Totals	
Speciality	Ward	Speciality	WTE	OBDs (inc leave)	CHPPD Hours (Nurse)	Bank % Filled	Improvement	Agency % Filled	Improvement	Registered	Un Registered	Registered	Un Registered	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Aggression	Complaints (Upheld/ partly upheld)	Failed S17 Leave	Clinical Supervision	Mandatory Training (ALL)	Mandatory Training (ILS)	Mandatory Training (BLS)	Sickness Levels (clinical)	WTE Vacancies (RNs only)	Feb-22	Mar-22
Adult MH	Avondale	Adult MH Assessment	29.8	69%	12.8	26.9%	↓	11.7%	↓	88%	73%	96%	96%	2	24	8	0	84.6%	87.9%	54.5%	82.4%	2.3%	2.0	2	2
	New Bridges	Adult MH Treatment (M)	40.1	95%	8.54	16.1%	↓	15.2%	↓	83%	94%	98%	122%	0	40	0	0	76.9%	91.5%	93.8%	96.2%	4.0%	-0.2	2	1
	Westlands	Adult MH Treatment (F)	35.8	92%	8.90	15.6%	↓	17.4%	↑	90%	84%	100%	117%	2	119	8	0	87.5%	91.2%	86.7%	52.4%	9.2%	2.0	4	3
	Mill View Court	Adult MH Treatment	27.9	121%	8.94	16.3%	↑	18.2%	↓	79%	79%	90%	103%	0	16	2	0	100.0%	88.9%	62.5%	86.7%	2.4%	5.8	4	2
	STARS	Adult MH Rehabilitation	39.6	99%	23.20	21.4%	↓	0.2%	↑	56%	68%	100%	98%	1	15	0	0	89.7%	85.0%	92.9%	69.2%	6.4%	-1.5	3	4
	PICU	Adult MH Acute Intensive	30.9	70%	24.28	28.0%	↑	35.5%	↓	109%	111%	97%	155%	2	84	0	0	100.0%	82.5%	69.2%	76.5%	15.6%	2.0	1	1
OP MH	Maister Lodge	Older People Dementia Treatment	31.4	73%	18.64	22.7%	↓	9.9%	↑	110%	89%	106%	109%	0	48	0	0	100.0%	80.0%	72.7%	39.1%	5.4%	2.0	3	2
	Mill View Lodge	Older People Treatment	22.5	94%	16.61	18.3%	↓	32.4%	↓	52%	133%	103%	158%	8	27	0	0	79.2%	84.9%	75.0%	53.8%	3.9%	1.8	3	3
	Maister Court	Older People Treatment	17.4	81%	22.91	21.8%	↑	24.7%	↓	126%	111%	100%	100%	0	3	0	0	92.9%	86.9%	83.3%	72.7%	0.0%	1.1	2	0
Forensic Services	Pine View	Forensic Low Secure	30.6	91%	9.38	32.8%	↑	0.0%	→	80%	116%	50%	116%	8	16	1	40	72.4%	87.9%	100.0%	72.7%	6.2%	1.8	3	3
	Derwent	Forensic Medium Secure	26.7	70%	13.47	17.3%	↓	0.0%	→	90%	74%	97%	85%	0	10	2	0	100.0%	94.7%	100.0%	70.6%	14.0%	0.2	2	2
	Ouse	Forensic Medium Secure	24.9	100%	5.96	15.2%	↓	0.0%	→	51%	94%	97%	91%	2	5	2	16	100.0%	94.9%	75.0%	78.9%	17.8%	2.6	3	3
	Swale	Personality Disorder Medium Secure	26.8	93%	8.69	36.9%	↓	0.0%	→	92%	97%	95%	93%	1	20	10	29	64.0%	92.2%	70.0%	77.8%	12.0%	3.0	2	3
	Ullswater	Learning Disability Medium Secure	37.4	50%	16.71	16.7%	↑	0.0%	→	89%	103%	100%	95%	0	33	6	4	41.7%	85.9%	70.0%	52.4%	17.8%	0.8	3	3
Child & LD	Townend Court	Learning Disability	38.6	86%	35.87	22.9%	↑	16.2%	↓	64%	95%	102%	134%	10	95	1	0	31.0%	87.6%	61.5%	87.5%	12.3%	4.1	4	4
	Inspire	CAMHS	60.0	78%		18.36	15.0%	↑	8.4%	↓	43%	85%	71%	100%	8	75	2	0	85.7%	82.2%	66.7%	59.5%	8.8%	0.0	3	2
	Granville Court	Learning Disability Nursing Treatment	51.7		n/a		n/a	33.6%	↓	6.6%	↑	129%	76%	103%	96%	1	4	0	0	82.2%	87.9%	83.3%	94.3%	3.8%	-1.0	0	0
CH	Whitby Hospital	Physical Health Community Hospital	41.2	81%		9.89	2.8%	↑	2.8%	↑	93%	88%	108%	106%	4	0	1	0	94.6%	85.0%	77.8%	38.1%	6.1%	3.8	3	2
	Malton Hospital	Physical Health Community Hospital	28.4	84%		7.86	Not on eRoster	→	Not on eRoster	→	87%	80%	100%	100%	2	2	1	0	100.0%	82.0%	75.0%	64.7%	7.3%	-1.0	3	2

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

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

	Staffing and Quality Indicators
Contract Period:	2021-22
Reporting Month:	Mar-22

Humber Teaching NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : March

Four wards have below target levels of fill rates for registered nurses on days which is an improvement from five wards in February. In all instances this is due to having only one RN on duty instead of two. The registered fill rates on nights are all above the threshold with the exception of Pine view which is showing fill rates of 50% due to frequently only having one registered nurse on nights. All CHPPD levels remain above the threshold.

The low fill rates on STARS are because there is often one OT on shift during the day that needs to be reflected in the demand template. This will be addressed in the next safer staffing review. CHPPD remain excellent.

The registered fill rates on days for Mill View Lodge (MVL) is 52% a slight improvement from February.. The B6s and Nursing associates are not currently counted in the planned hours but this will be addressed in their next safer staffing review and their CHPPD are above target.

Overall the fill rates on Townend Court (TEC) have improved to 64% from 54% last month. The RN fill rates remain below target due to having one registered nurse on duty at times, however they maintain good CHPPD levels. Clinical supervision compliance is a concern.Staff sickness has impacted upon this. It has been raised with the matron and via the divisional accountbaity reviews.

The high bed occupancy on Mill View Court (MVC) reflects the fact that five beds were stood down to enable the Covid pod to be opened. These beds have now been brought back into general use but this will not be reflected in the OBD until April.

All units have made a compliance return in respect of clinical supervision this month which is an improvement on last month where 3 units did not report compliance. Sickness levels continue to impact upon compliance.

Inspire's staffing establishment is being reviewed to reflect the PICU beds and once this has been confirmed target for fill rates will be introduced into the dashboard.

Some improvement against ILS and BLS noted. The Resuscitation Officer has been informed of the ILS and BLS rates on the units which are currently not compliant and they are targeting training in these units.

The CHPPD RAG ratings are based on the National Average Benchmark of 8.9. More than 8.9 = Green, 8.0 to 8.9 = Amber, Less than 8.0 = Red
Community Hospitals are NOT RAG rated currently.
Inspire is not fully open therefore the fill rates and CHPPD is not RAG rated until such time the facility is fully opertional.

OBD RAG ratings for Safer Staffing (exc Specialist) are: Less than 87% = Green, 87% to 92% = Amber, More than 92% = Red
OBD RAG ratings for Safer Staffing for Specialist are: Less than 50% = Red and More than 50% = Green

Registered Nurse Vacancy Rates (Rolling 12 months)

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
8.40%	8.80%	10.10%	8.92%	8.70%	11.20%	8.70%	10.90%	10.30%	10.50%	8.80%	7.20%

Slips/Trips and Falls (Rolling 3 months)

Rolling 3 months	Jan-22	Feb-22	Mar-22
Maister Lodge	3	6	4
Millview Lodge	5	5	6
Malton IPU	4	3	7
Whitby IPU	0	0	1

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

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

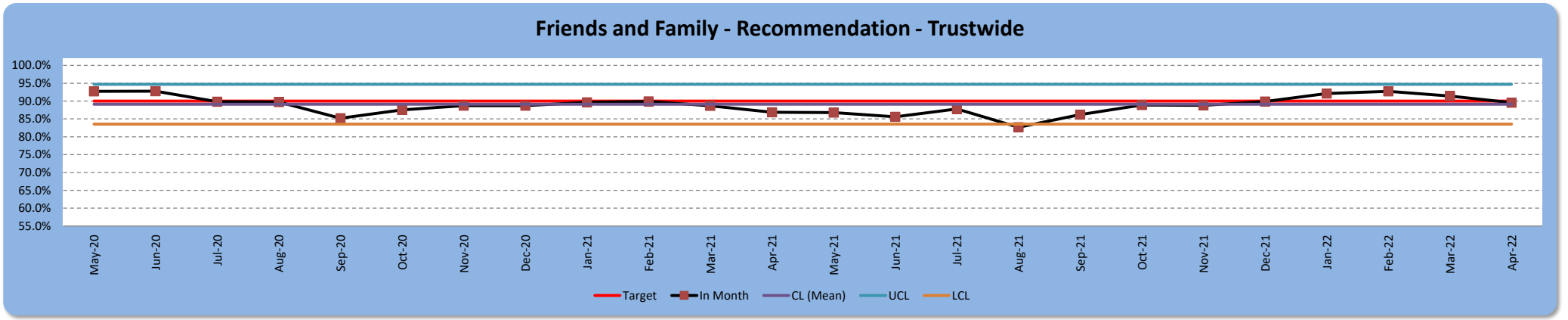
PI RETURN FORM 2022-23

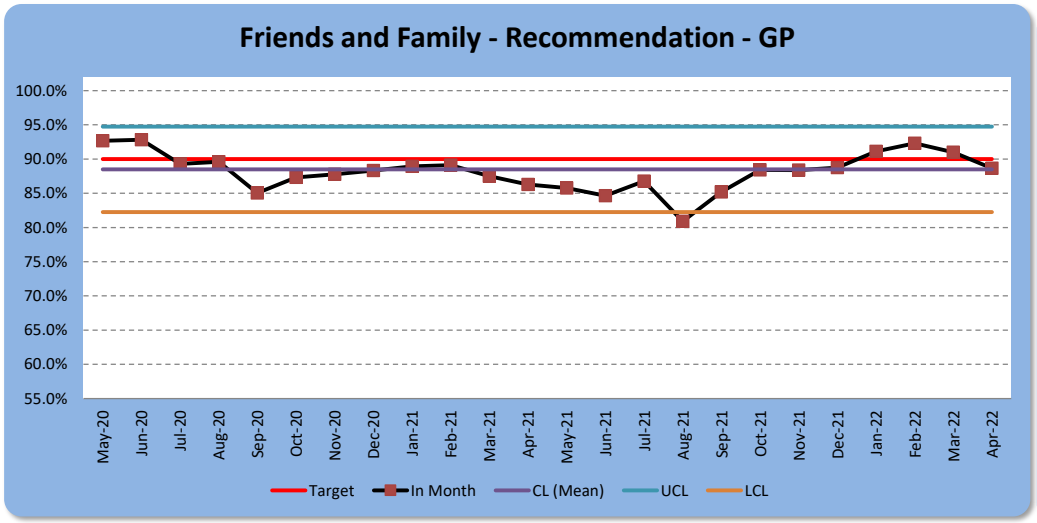
Goal 1 : Innovating Quality and Patient Safety

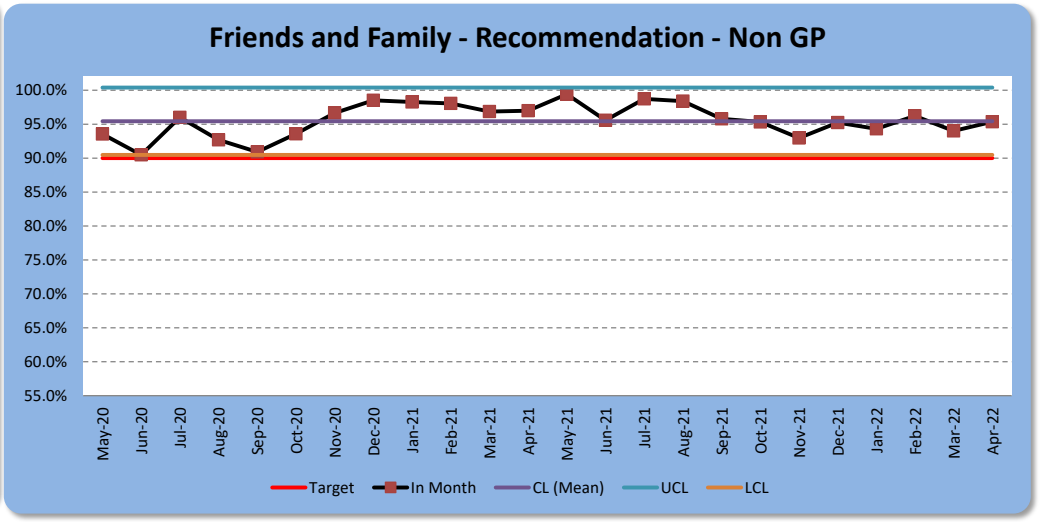
Target:	Amber:	Current month stands at:
90%	80%	89.5%

For the period ending: **Apr 2022**

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







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

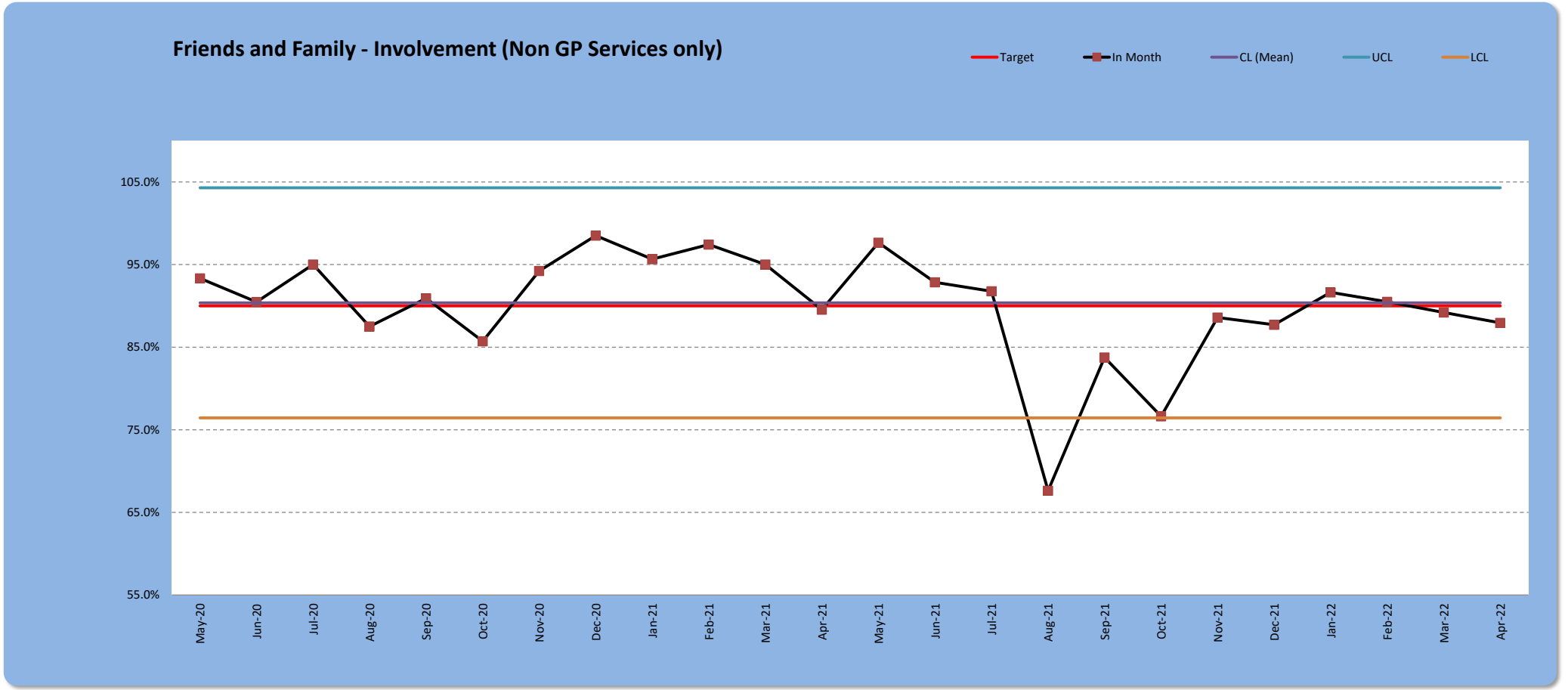
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
90%	80%	88.0%

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



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

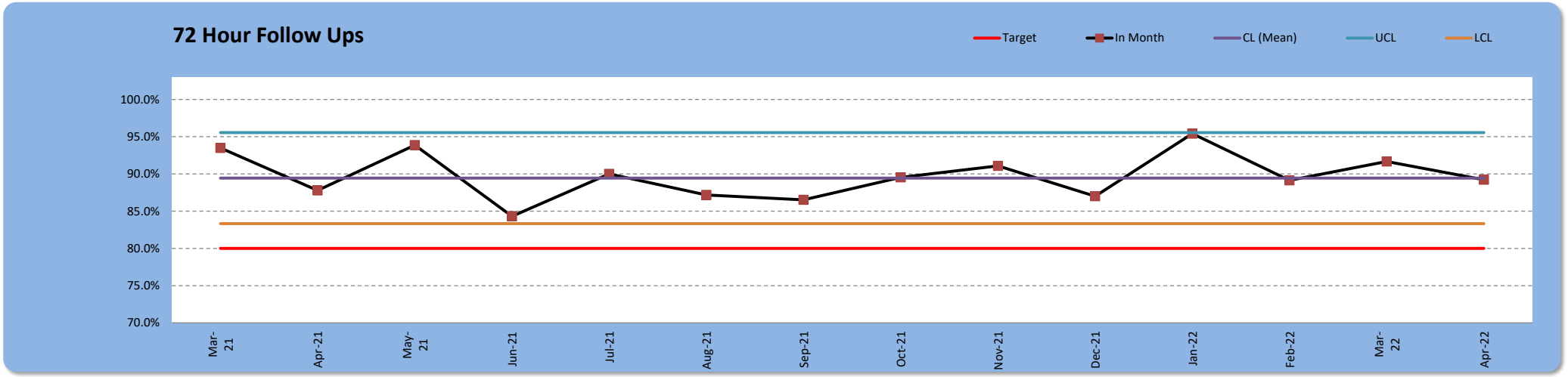
PI RETURN FORM 2022-23

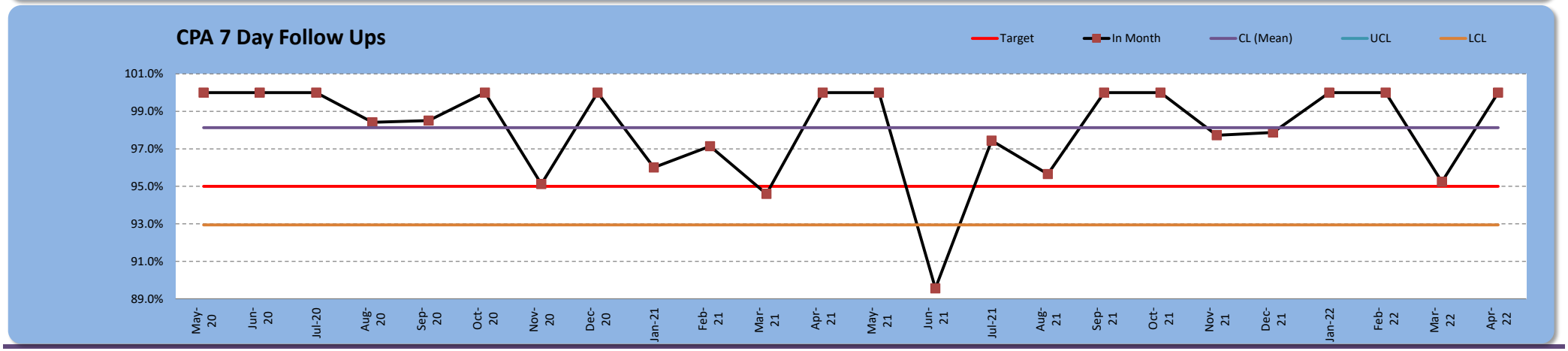
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month for 72 hour stands at:
80%	60%	89.2%

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
72 Hour Follow Ups	This indicator measures the percentage of patients who were in the CQUIN scope and had a follow up within 72 hours of discharge	Executive Lead Lynn Parkinson	OP 12





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

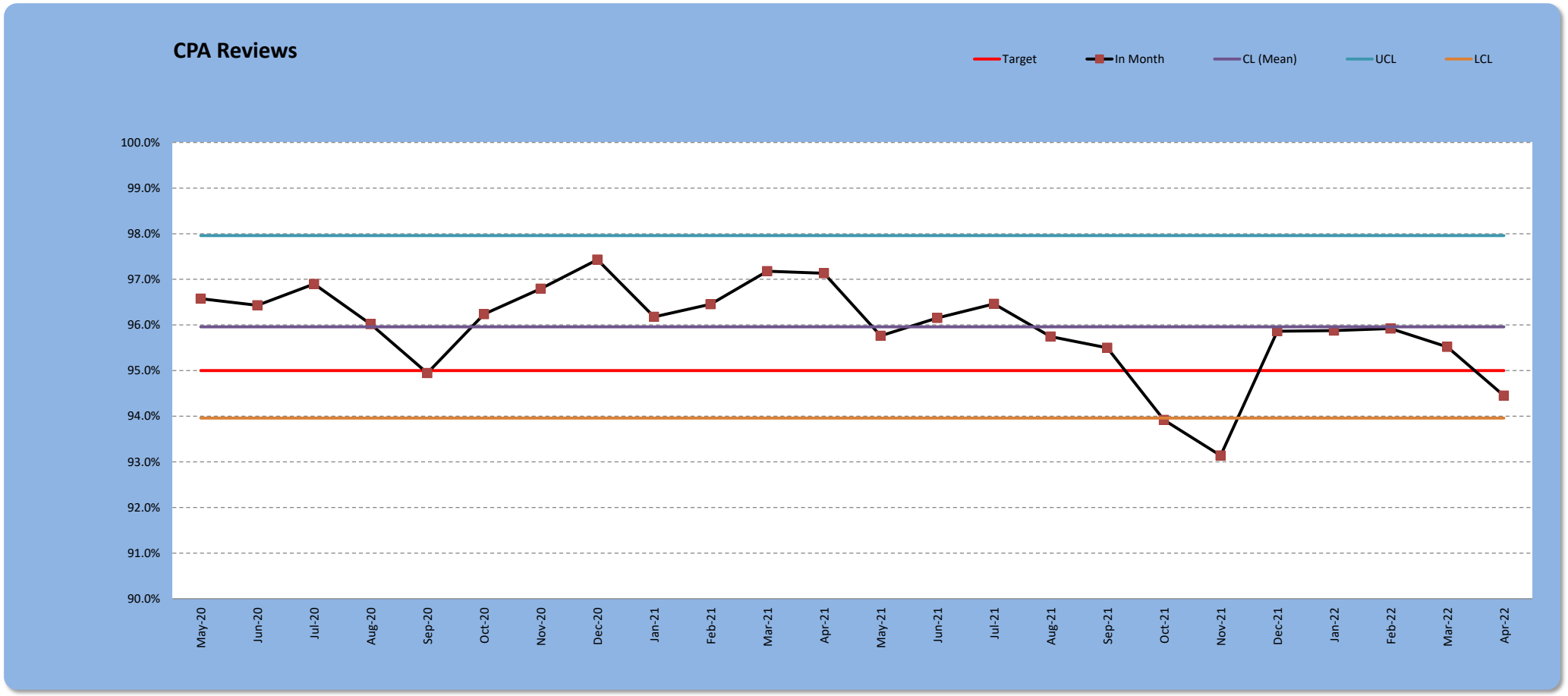
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
95%	85%	94.5%

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
Care Programme Reviews	This indicator measures the percentage of patients who are on CPA and have had a review in the last 12 months	Executive Lead Lynn Parkinson	OP 7



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

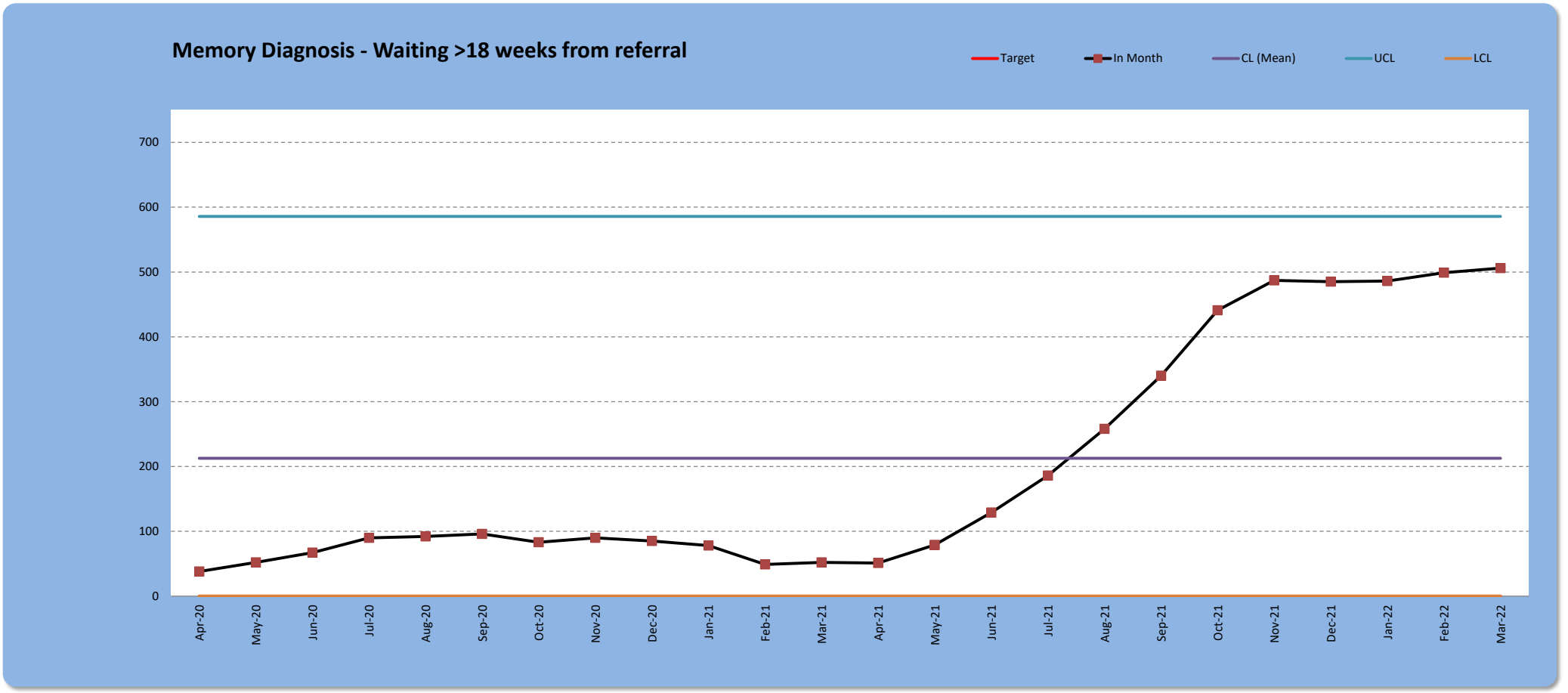
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
n/a	n/a	506

For the period ending: **Apr 2022**

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



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

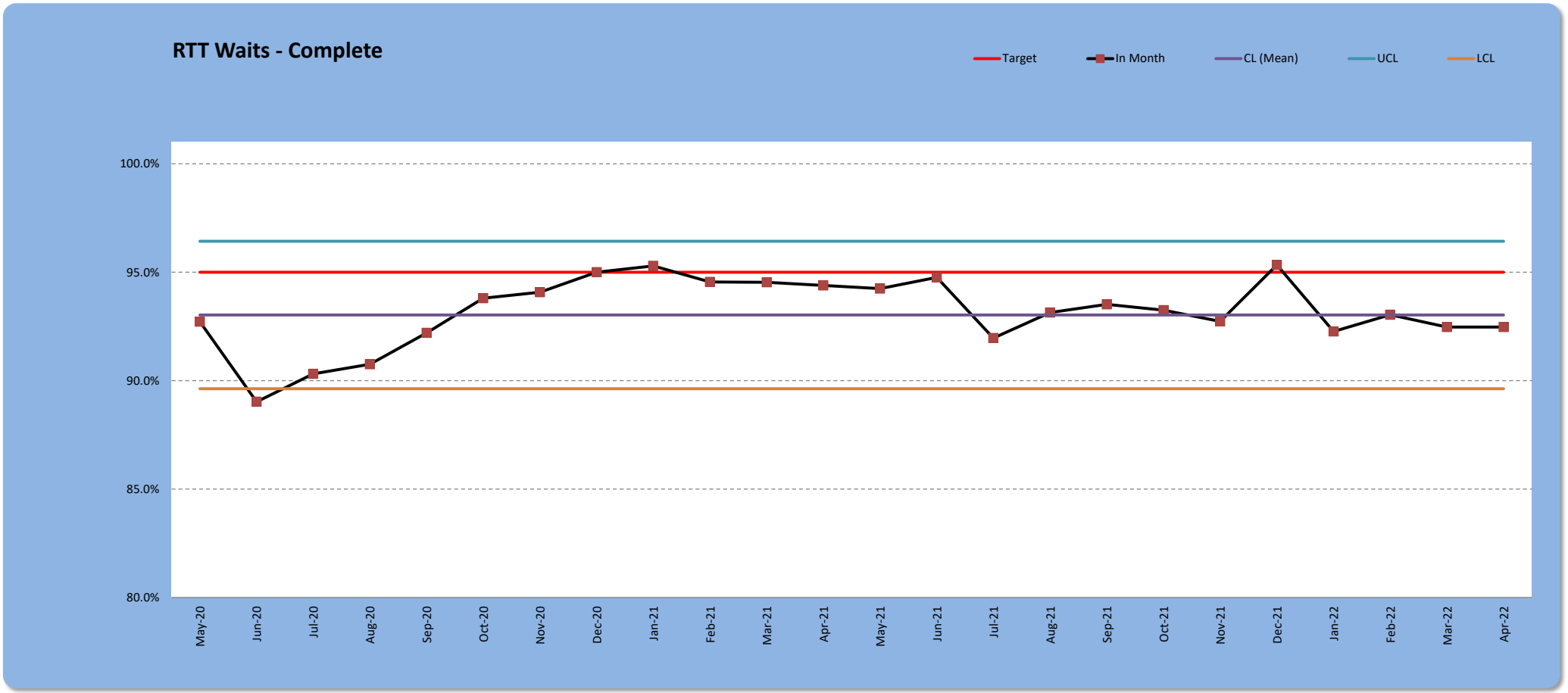
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
95%	85%	92.5%

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



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

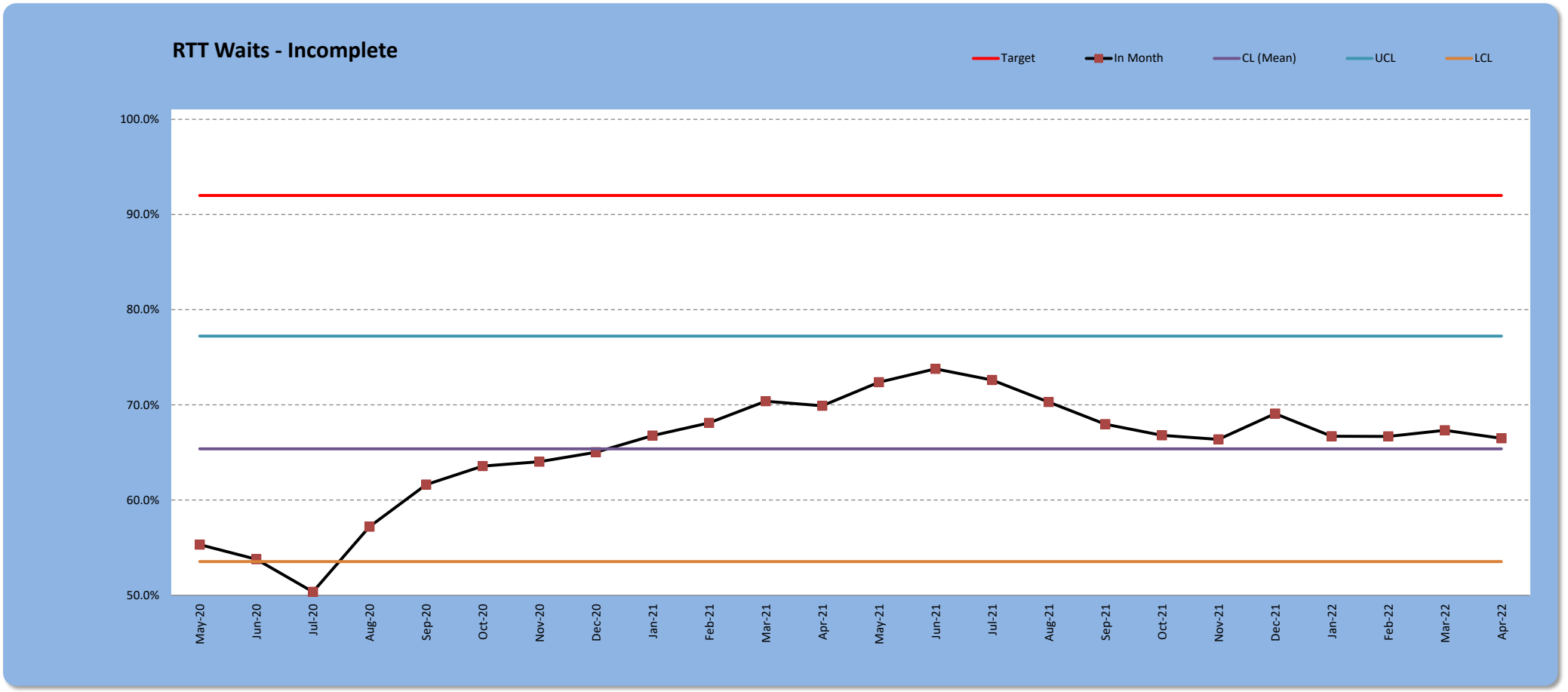
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
92%	85%	66.5%

For the period ending: **Apr 2022**

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



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

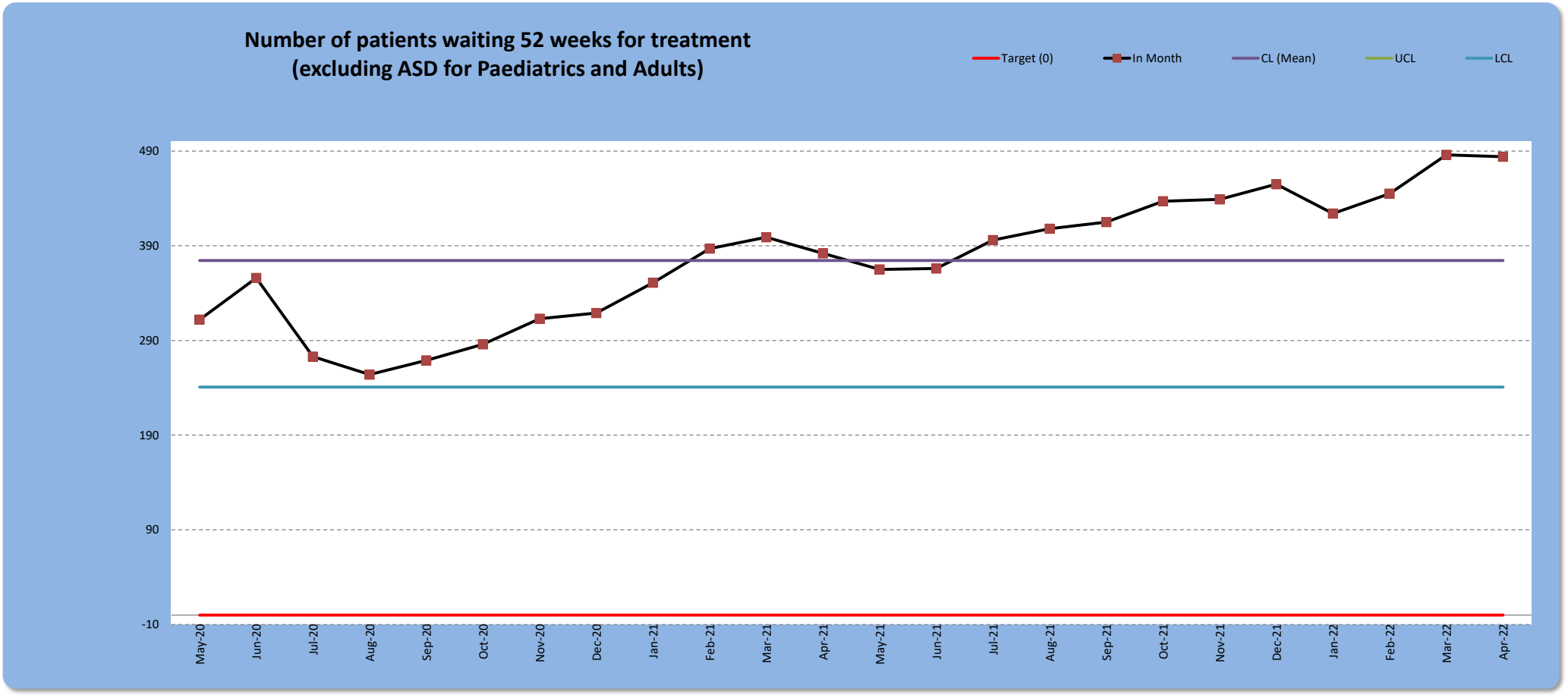
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	484

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks	Executive Lead Lynn Parkinson	OP 22x



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

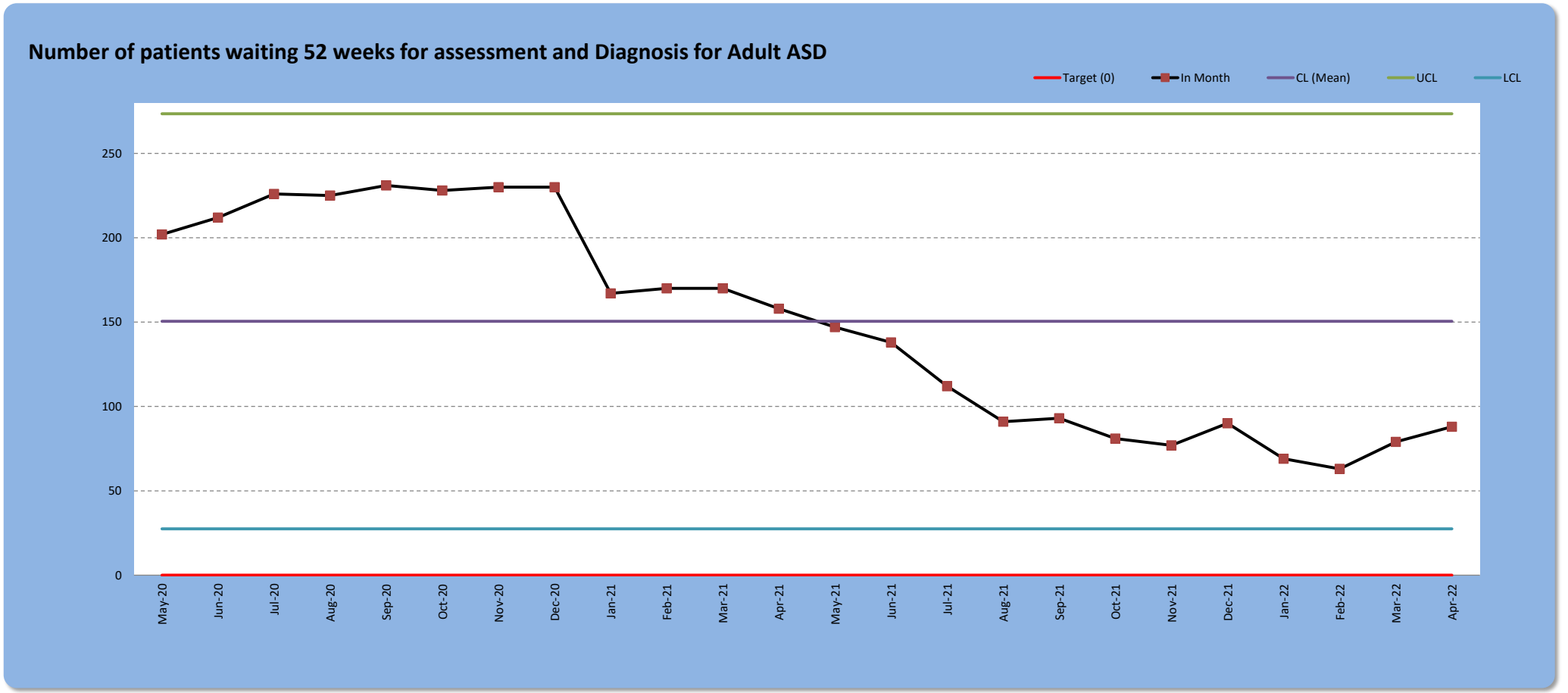
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	88

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits - Adult ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Adult and have been waiting more than 52 weeks	Executive Lead Lynn Parkinson	OP 22u



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

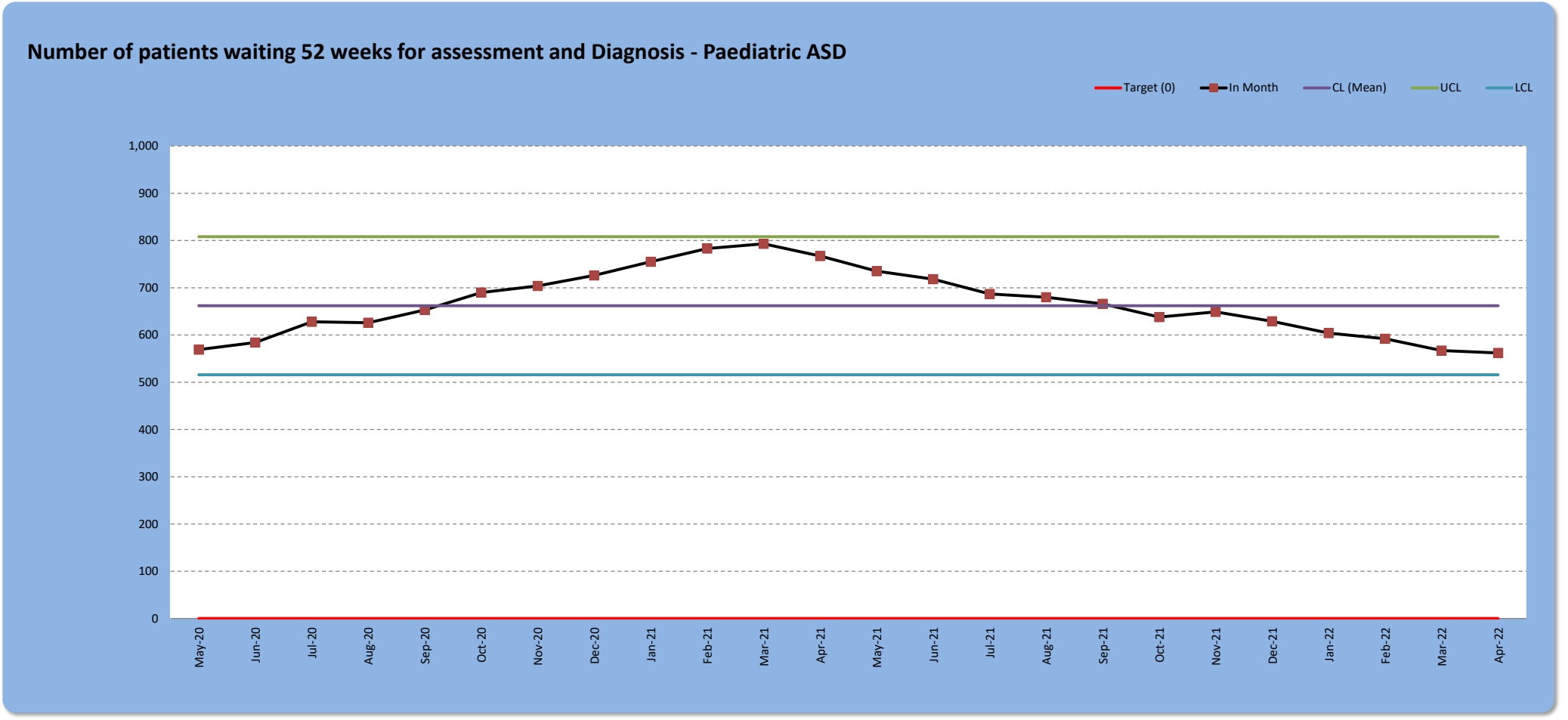
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
0	0	562

Indicator Title	Description/Rationale		KPI Type
52 Week Waits - Paediatric ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Children and have been waiting more than 52 weeks	Executive Lead Lynn Parkinson	OP 22s



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

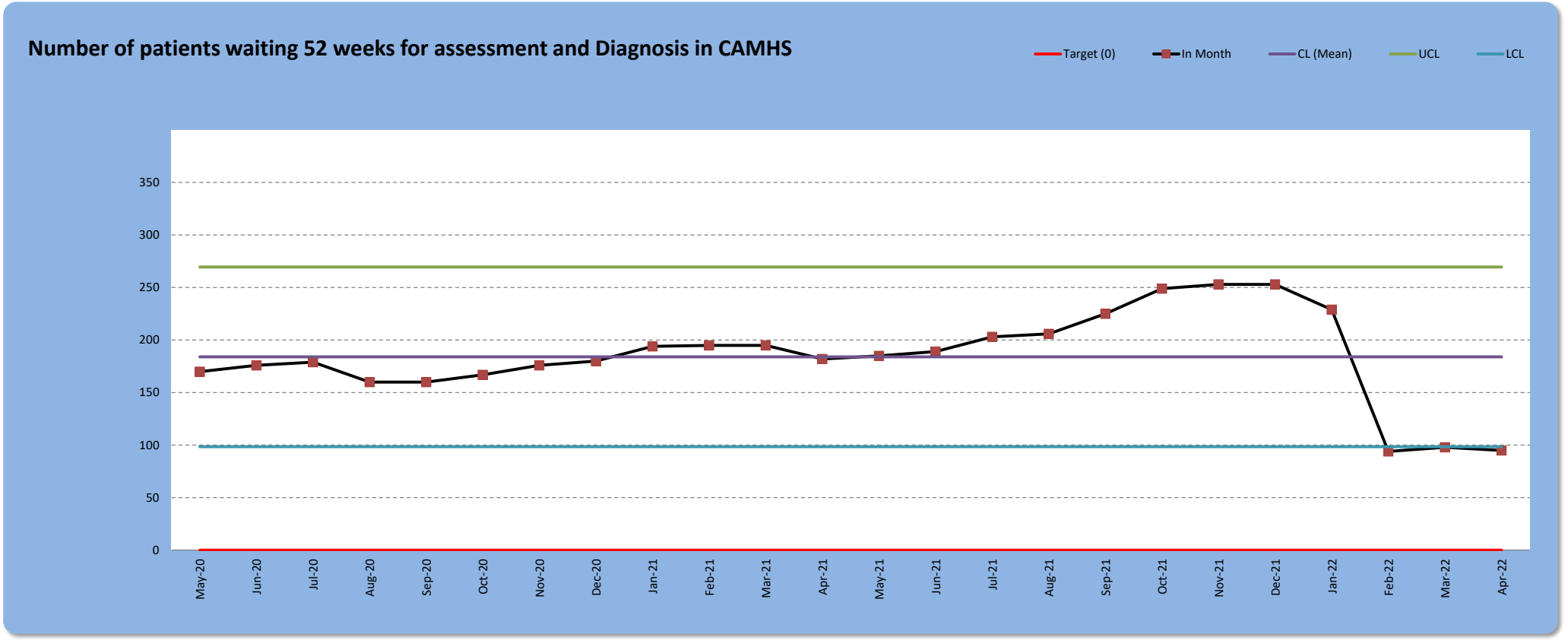
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	95

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks (excluding paediatric ASD)	Executive Lead Lynn Parkinson	OP 22j



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

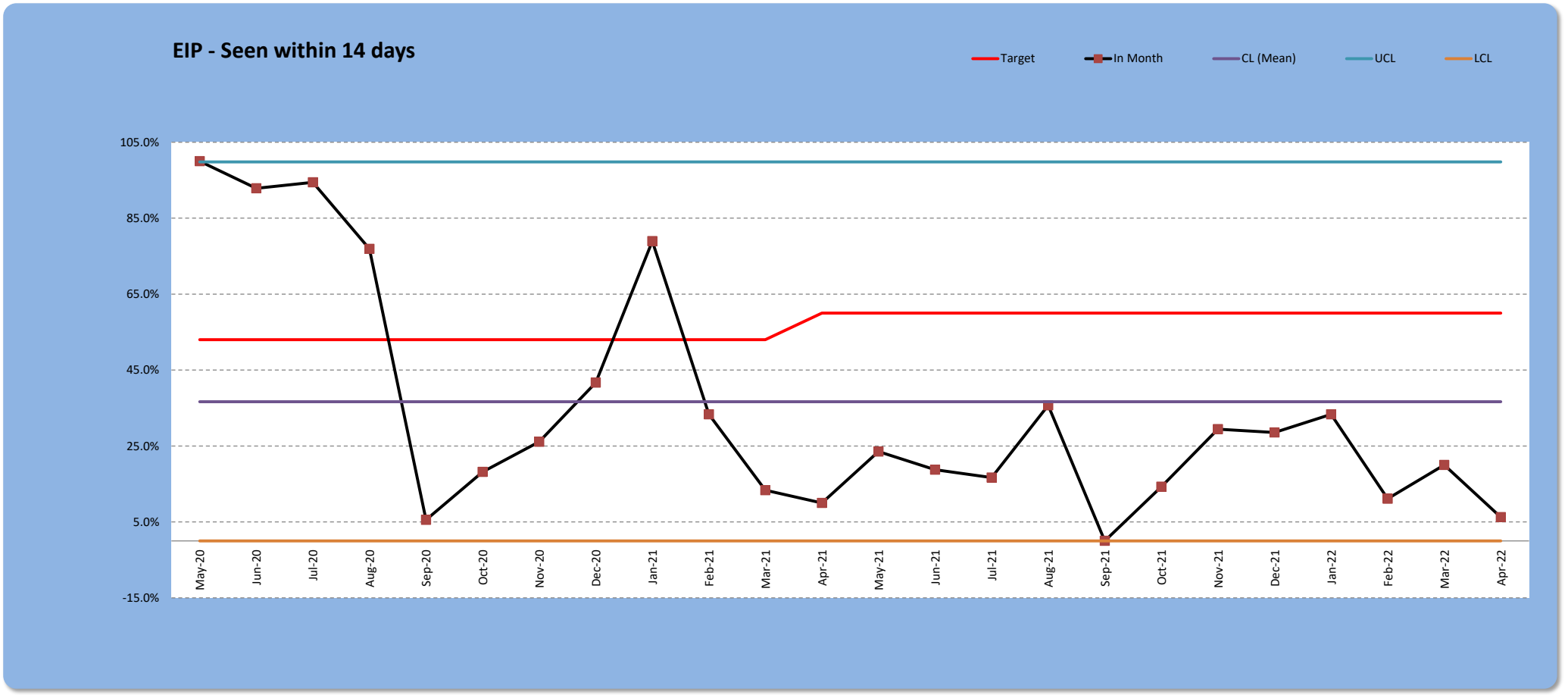
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
60%	55%	6.3%

Indicator Title	Description/Rationale	Executive Lead	KPI Type
Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	Lynn Parkinson	OP 9



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

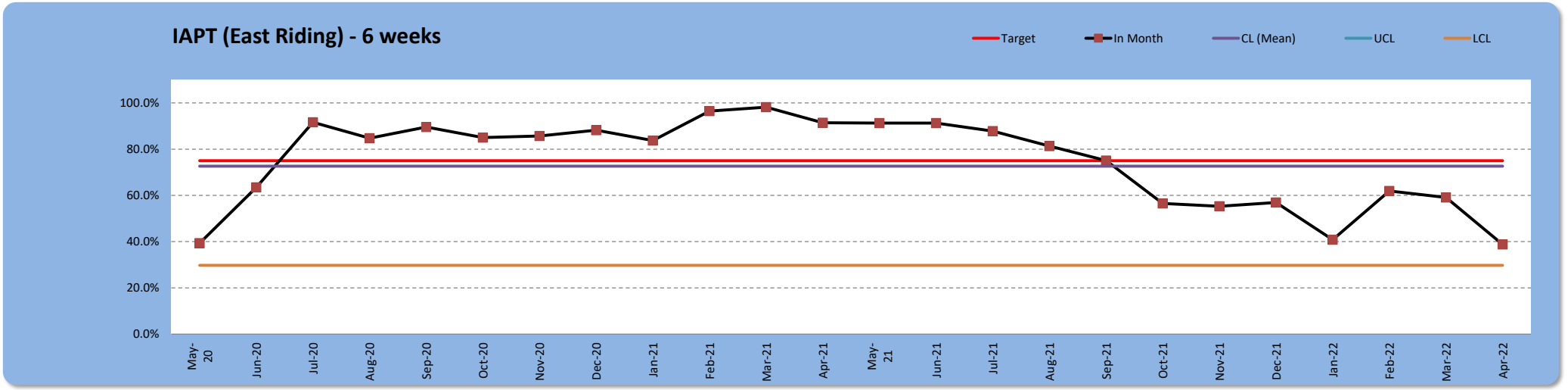
PI RETURN FORM 2022-23

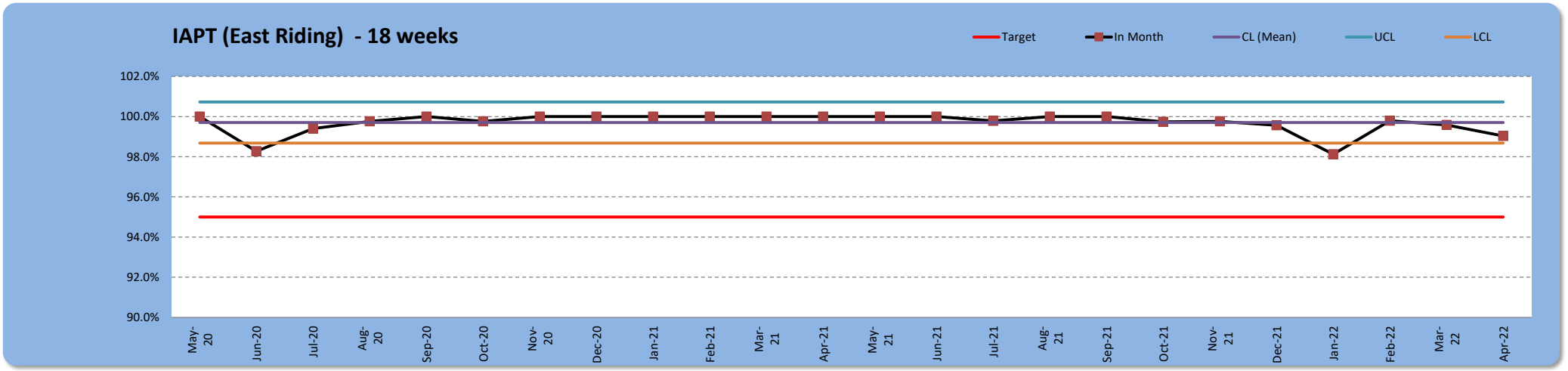
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2022**

Target:	Amber:	Current month 6 weeks stands at:	Target:	Amber:	Current month 18 weeks stands at:
75%	70%	38.8%	95%	85%	99.0%

Indicator Title	Description/Rationale		KPI Type
Improved Access to Psychological Therapies	Two graphs to show percentage of patients who were seen within 6 weeks and 18 weeks of referral (East Riding)	Executive Lead Lynn Parkinson	OP 10a





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

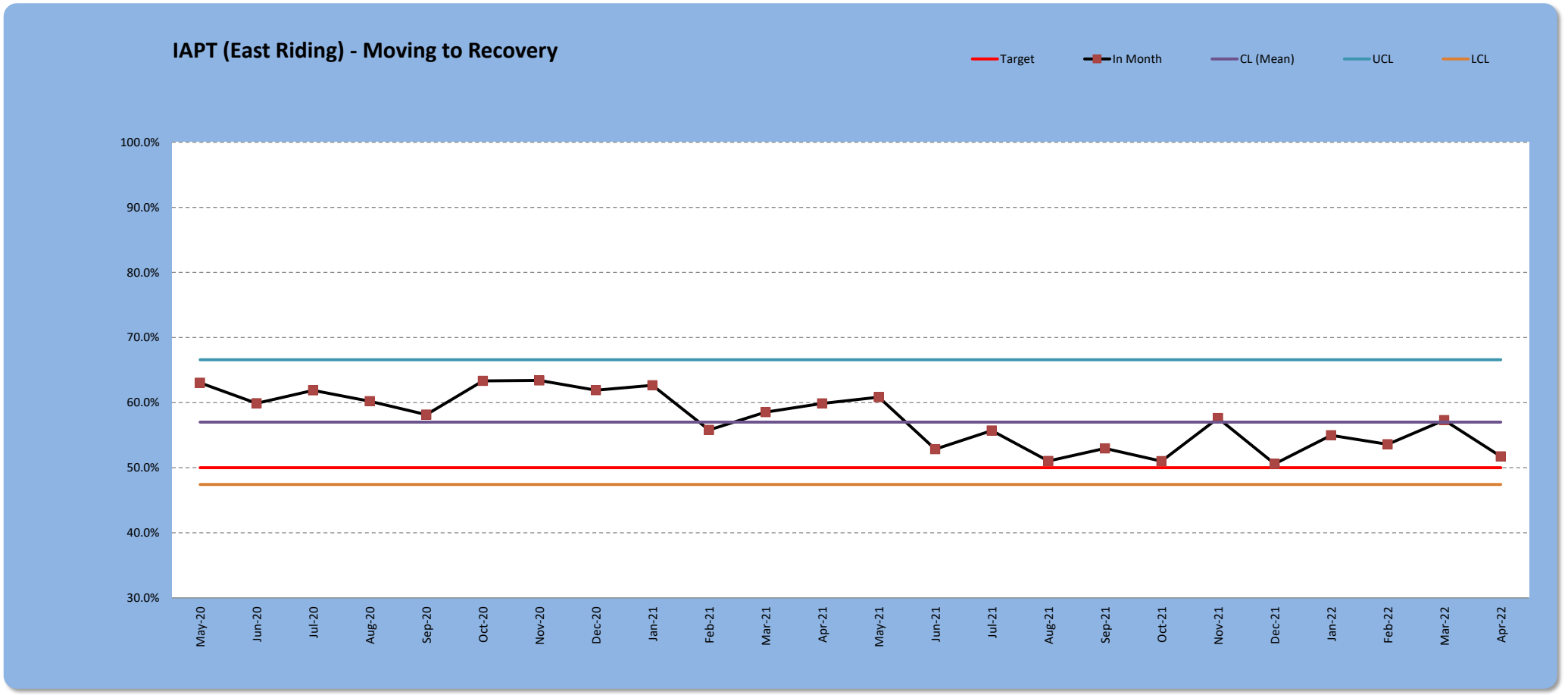
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
50%	45%	51.7%

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
Improved Access to Psychological Therapies	This indicator measures the Recovery Rates for patients who were at caseness at start of therapeutic intervention (East Riding)	Executive Lead Lynn Parkinson	OP 11



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

PI RETURN FORM 2022-23

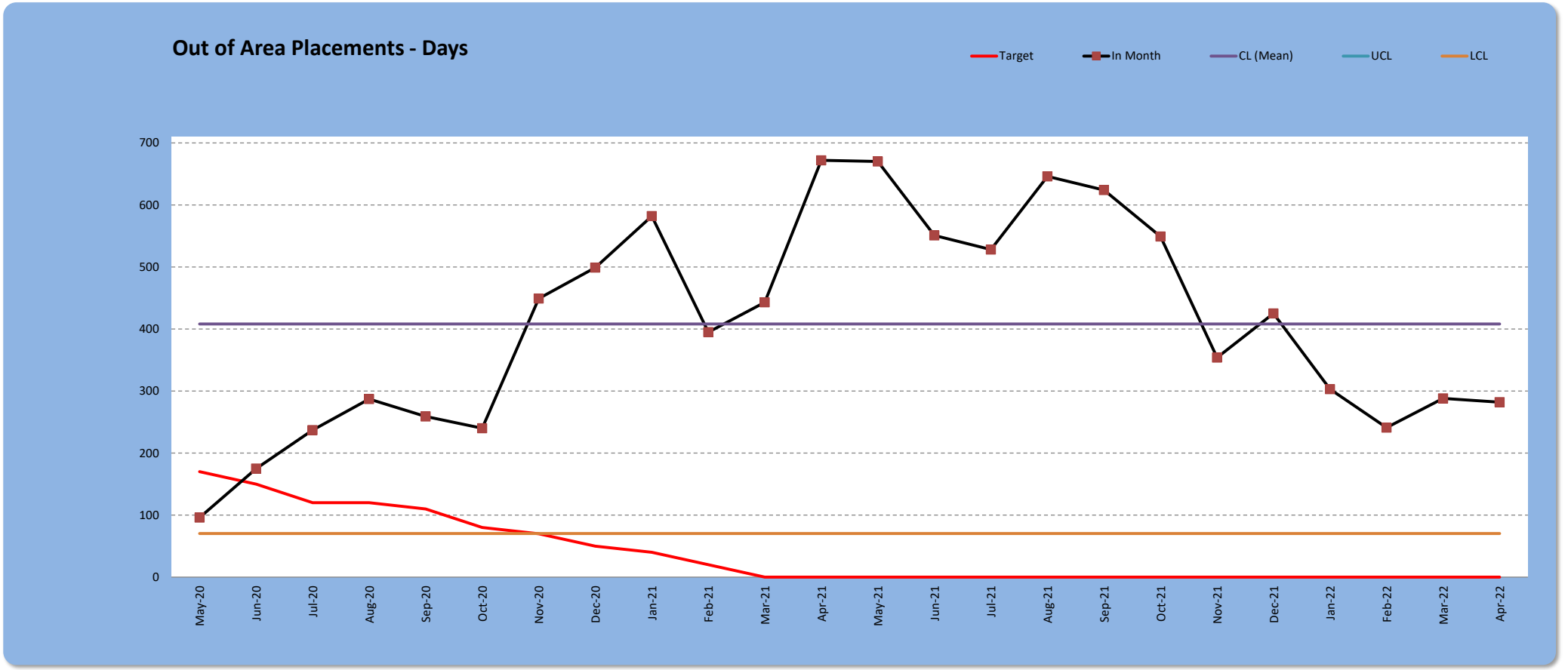
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Apr 2022**

Target:	Amber:	Patients OoA within month:
0	0	13

Split:	# days	# patients
Adult	42	5
OP	120	4
PICU	120	4

Indicator Title	Description/Rationale		KPI Type
Out of Area Placements	Number of days that Trust patients were placed in out of area wards	Executive Lead Lynn Parkinson	ST 4b



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

PI RETURN FORM 2022-23

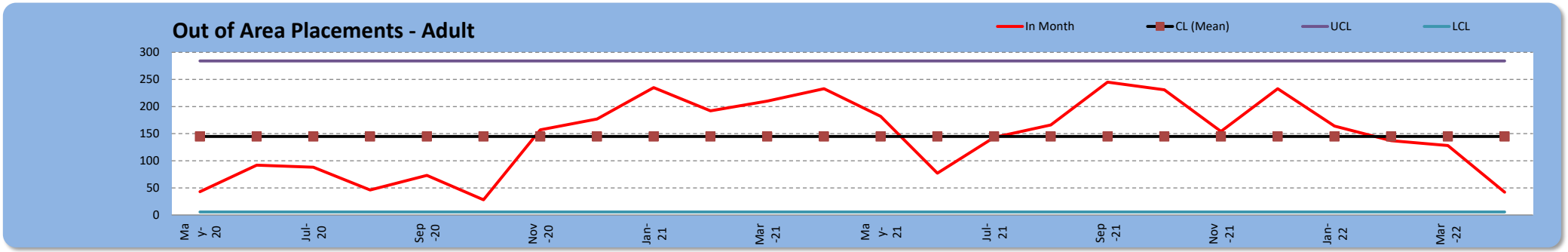
Goal 3 : Fostering Integration, Partnership and Alliances

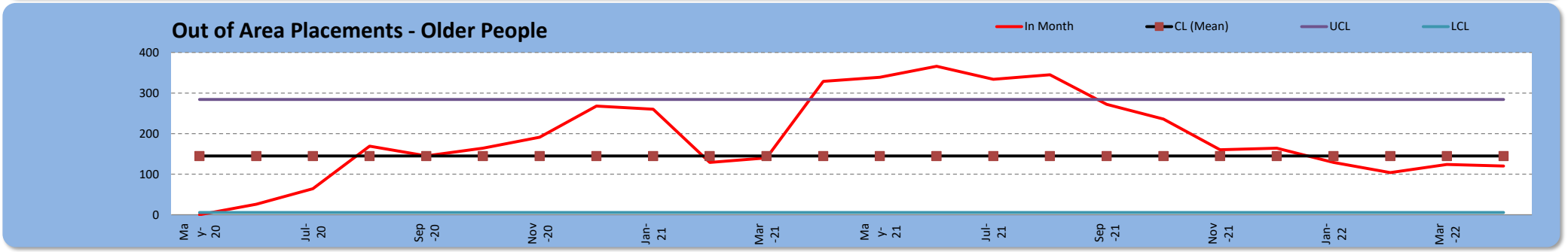
For the period ending: **Apr 2022**

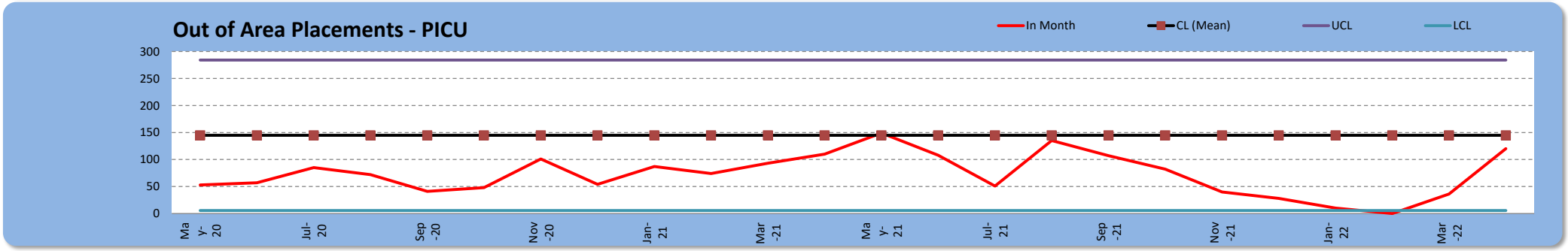
Split for Current month:

Apr-22	
42	Adult
120	OP
120	PICU
282	Total

Indicator Title	Description/Rationale		KPI Type
Out of Area Placements	Number of days that Trust patients were placed in out of area wards - split by service	Executive Lead Lynn Parkinson	ST 4 split







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

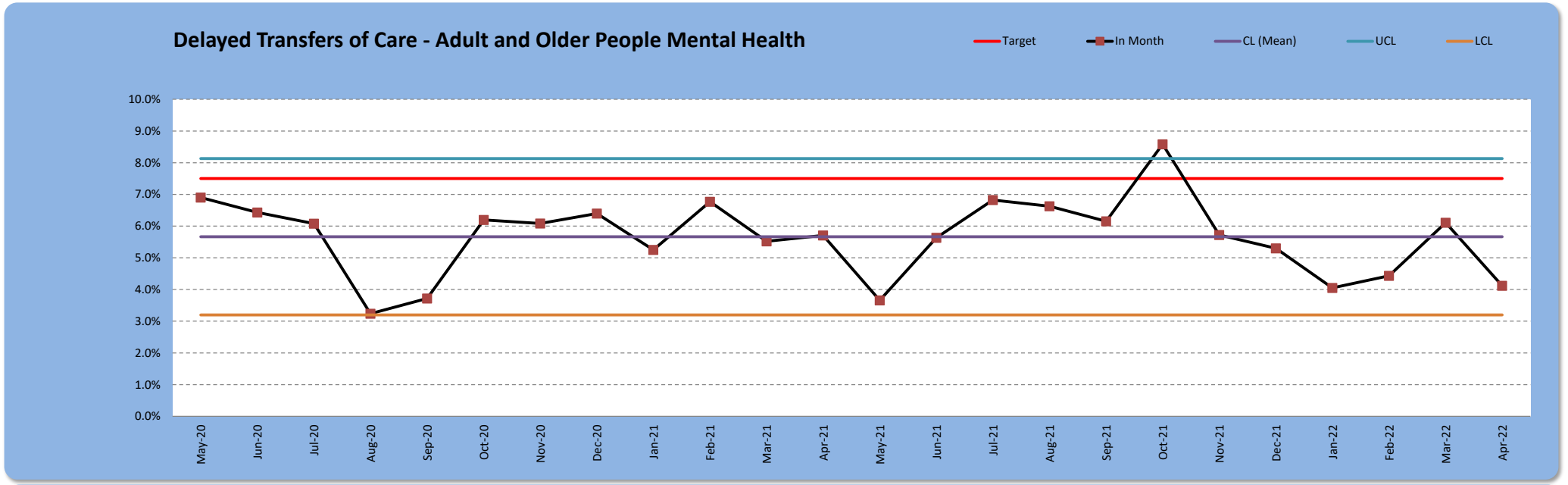
PI RETURN FORM 2022-23

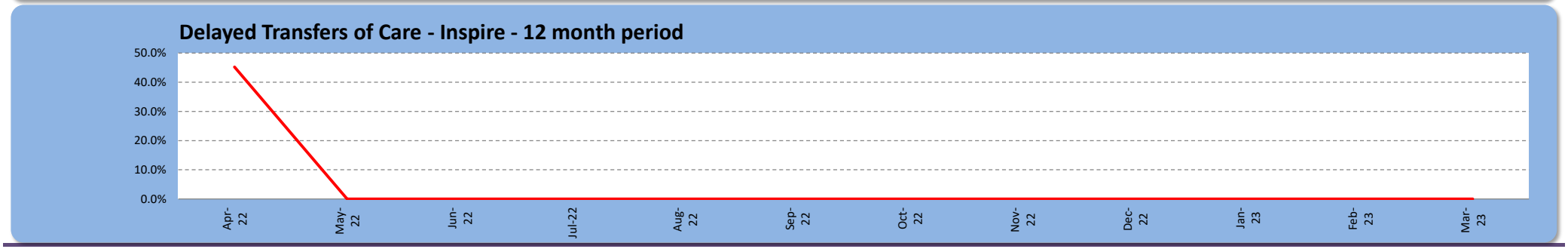
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
7.5%	7.0%	4.1%

Indicator Title	Description/Rationale		KPI Type
Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care	Executive Lead Lynn Parkinson	OP 14





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

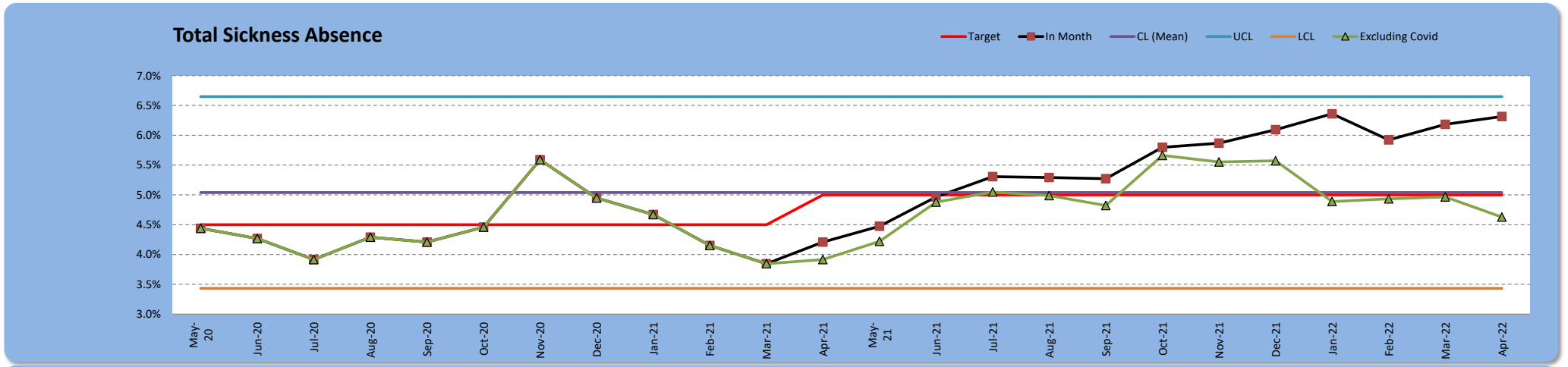
PI RETURN FORM 2022-23

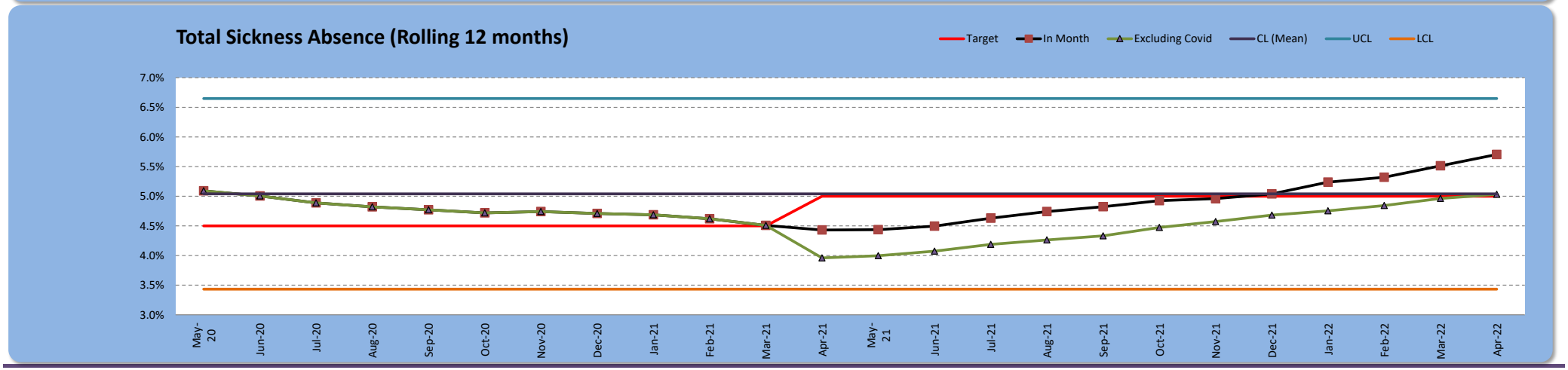
Goal 4 : Developing an Effective and Empowered Workforce

Target:	Amber:	Current month stands at:
5.0%	5.2%	6.2%

For the period ending: **Apr 2022**

Indicator Title	Description/Rationale		KPI Type
Sickness Absence	Percentage of staff sickness across the Trust (not including bank staff). Includes current month's unvalidated data	Executive Lead Steve McGowan	





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

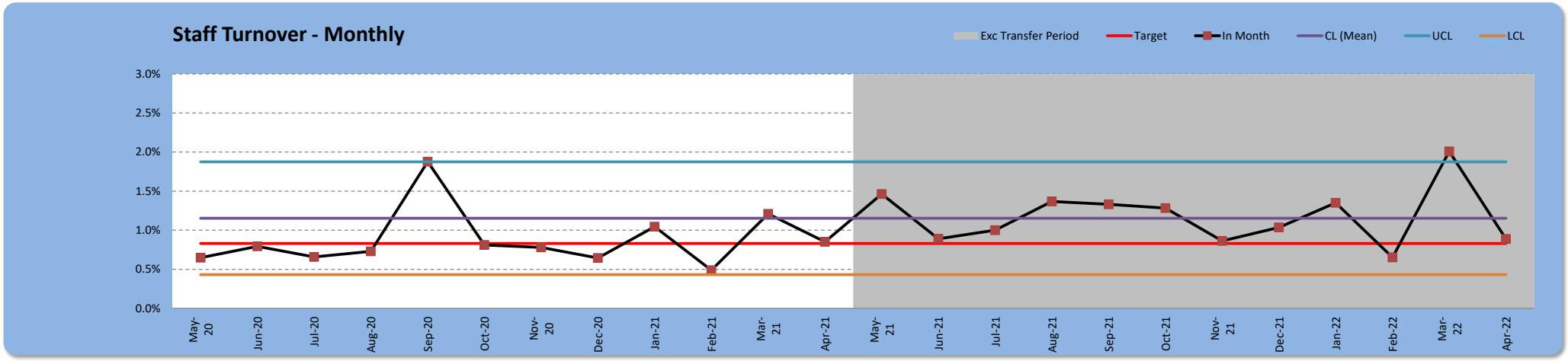
PI RETURN FORM 2022-23

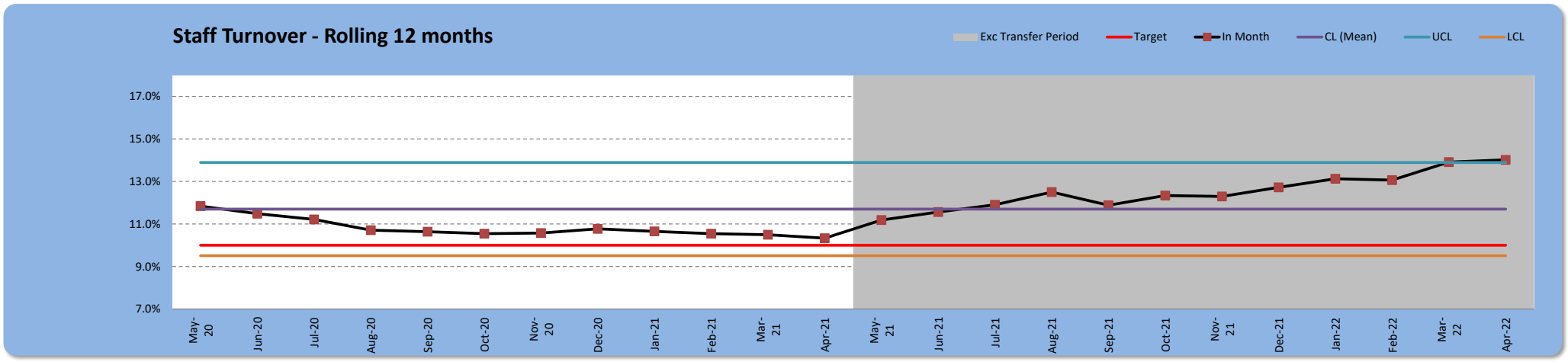
Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:	Target:	Amber:	Rolling figure stands at:
0.8%	0.7%	0.889%	10%	9%	14%

Indicator Title	Description/Rationale		KPI Type
Staff Turnover	The number of full time equivalent staff leaving the Trust expressed as a percentage of the overall full time equivalent workforce employed. Leavers include resignations, dismissals, transfers (up to Mar21), retirements and staff coming to the end of temporary contracts. It doesn't include junior doctors on rotation. From April 2021 Employee Transfers Out have also been excluded	Executive Lead Steve McGowan	WL 3 TOM Exc TUPE





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

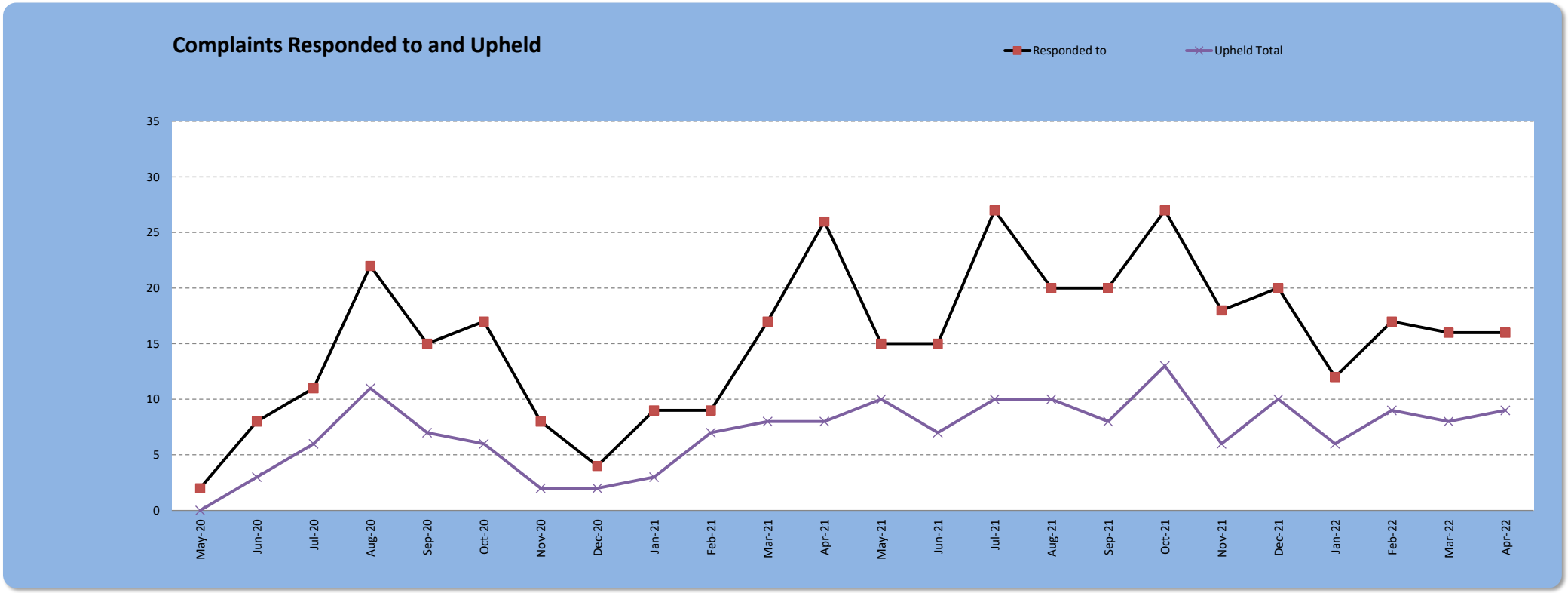
PI RETURN FORM 2022-23

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Apr 2022**

YTD Upheld	No. of Complaints upheld in month	Current month upheld stands at:
50.0%	n/a	1

Indicator Title	Description/Rationale		KPI Type
Complaints	The number of Complaints Responded to and Upheld.	Executive Lead John Byrne	IQ 1



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

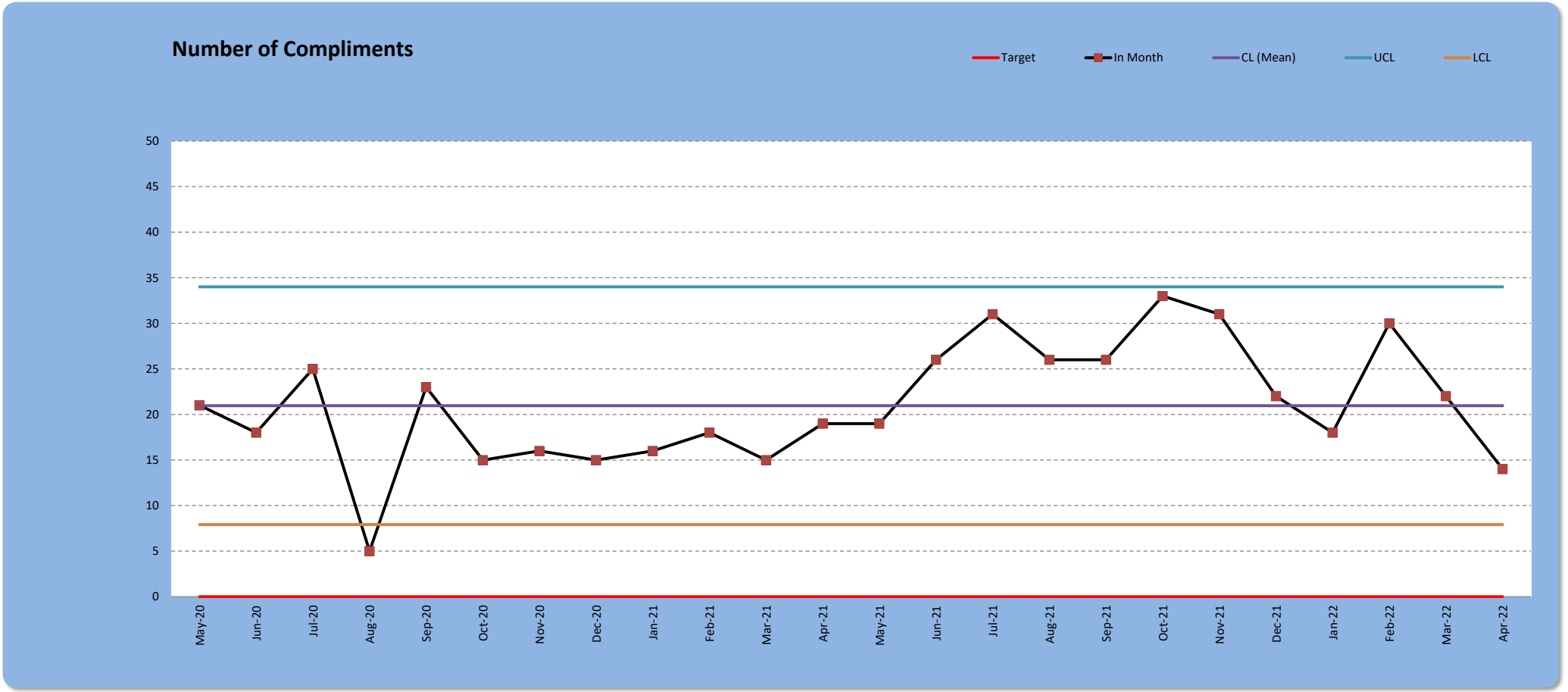
PI RETURN FORM 2022-23

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Apr 2022**

Target:	Amber:	Current month stands at:
n/a	n/a	14

Indicator Title	Description/Rationale	Executive Lead	KPI Type
Compliments	Chart showing the number of compliments received into the Trust	John Byrne	IQ 7



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

Humber Teaching
NHS Foundation Trust

Executive Team:

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

Caring, Learning
& Growing Together

Issue Date: 18/05/2022

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 10

Title & Date of Meeting:	Trust Board Public Meeting - 18th May 2022
Title of Report:	Finance Report April 2022
Author/s:	Name: Peter Beckwith Title: Director of Finance
Recommendation:	To approve [ ] To receive & note [✓] For information [ ] To ratify [ ]
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	This report is being brought to the Trust Board to provide the financial position for the Trust as at the 30th April 2022 (Month 1). The report provides assurance regarding financial performance, key financial targets and objectives.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No matters to raise	**Key Actions Commissioned/Work Underway:** • The Trust has uploaded a budget to deliver a planned deficit of £1.011m for the 2022/23 financial year.
Positive Assurances to Provide: • At Month 1 a financial position consistent with plan has been recorded • Cash balance at the end of April was £32.008m.	**Decisions Made:** • The Trust Board are asked to note the Finance report for April 2022, and comment accordingly.

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

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

Monitoring and assurance framework summary:

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

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

FINANCE REPORT – April 2022

1. Introduction

This report is being circulated to the Trust Board to present the financial position for the Trust as at the 30th April 2022 (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 first draft Humber Coast and Vale financial plan was submitted on time and this identified a £140m deficit plan submission.

Further work has taken place across the ICS, and the most recent financial plan submission (28th April 2022) had improved to a £56.28m deficit position.

A summary of the current ICS deficit by organisation is summarised in the table below, this identifies for the Trust a planned deficit of £1.011m:

Table 1.
ICS Deficit Plan by Organisation

Organisation	(Deficit)/ Surplus £000
NHS EAST RIDING OF YORKSHIRE CCG	(10,247)
NHS HULL CCG	12,052
NHS NORTH EAST LINCOLNSHIRE CCG	(6,380)
NHS NORTH LINCOLNSHIRE CCG	(10,417)
NHS VALE OF YORK CCG	-
NHS NORTH YORKSHIRE CCG	-
CCG TOTAL	**(14,992)**
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	(6,000)
HUMBER TEACHING NHS FOUNDATION TRUST	(1,011)
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	(19,101)
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	(11,835)
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	(3,297)
PROVIDER TOTAL	**(41,244)**
ICB TOTAL	**(56,236)**

3. Position as at 30th April 2022

The Trust has loaded a budget consistent with the previous financial planning paper to Trust Board, updated to match the ICS target of a £1.011m deficit.

Under the planning guidance, block payments arrangements remain in place and this has been factored into the Trusts overall financial plan, as previously reported.

For the period ended 30th April 2022 the Trust has recorded a deficit position of £0.135m, a position consistent with the ICS plan.

3.1 Income and Expenditure

The Trust closed its leger on the 11th May 2022, therefore detailed analysis of income and expenditure variances were not available at the time of writing.

3.2 COVID Expenditure

Within the Trusts financial plan income of £4.239m has been agreed for covid related expenditure. Future reports will include details of expenditure against this allocation, which will also inform returns to NHS England/Improvement.

4. Cash

As at the end of April 2022 the Trust held the following cash balances:

Table 2:
Cash Balance

Cash Balances	£000s
Cash with GBS	31,677
Nat West Commercial Account	283
Petty cash	48
Total	**32,008**

Included within this amount is the Provider Collaborative cash amount of £2.752m.

5. Recommendations

The Trust Board are asked to note the Finance report for April 2022, and comment accordingly.

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 11

Title & Date of Meeting:	Trust Board Public Board Meeting – 18 Mary 2022
Title of Report:	Quality Committee Assurance Report – May 2022
Author/s:	Mike Smith, Non-Executive Director, and Interim Chair of Quality Committee
Recommendation:	To approve: ; To receive & note: X ; For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Quality Committee is one of the sub committees of the Trust Board This paper provides a summary of discussions held at the meeting on 4th May 2022 with a summary of key issues for the Board to note. The approved minutes of the meeting held on 2nd February 2022 are presented for information.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

The CQC key findings following their inspection of Princes Medical Centre were reviewed. A report of progress will be reported to the Quality Committee in August.

Key Actions Commissioned/Work Underway:

- Discussion held regarding the Patient Safety Strategy refresh with some key areas for inclusion going forward. The Committee were informed that consultation across Trust services and with our patients and carers will also be undertaken.
- The Quality Committee received the findings following a safeguarding review that had been undertaken noting the actions are all being progressed. Report of progress will be submitted to the August meeting.
- Review of the findings from the Ockenden report is underway. Report to the August meeting.

Positive Assurances to Provide:

- The Medicines Management work from the 2021 Community Mental Health Survey
- The QIA process against the BRS schemes has been undertaken.

Decisions Made:

- The Draft Quality accounts were approved. Q4 data to be added
- The Committee approved the Effectiveness Review and Terms of Reference for presentation to Trust Board
- The Committee approved the QPaS Effectiveness review and Terms of Reference

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation		Operational Delivery Group	

	Committee			
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail) Report produced for the Trust Board	

Monitoring and assurance framework summary:

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

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

Executive Summary - Assurance Report:

Key Issues

The key areas of note arising from the Quality Committee meeting held 3rd May 2022 are as follows:

The minutes of the meeting held 2nd of February 2022 were agreed as a true record. The action log noted eight actions closed with one remaining item in relation to zero events deferred to the next meeting as part of the annual reports. As part of this action, it was agreed the zero events being presented to EMT the following week would be taken to the July Board meeting for noting with ongoing monitoring via the Quality Committee. The Quality Committee Assurance report was noted, and the updated work plan was noted and agreed.

Discussion item – Patient Safety Strategy – progress update and next steps
CC gave a presentation on the progress made against the six priorities from the current Patient Safety Strategy noting the work scheduled for this year. It was agreed the links to the Patient Safety training and White Ribbon champions and Ambassadors were to be resent to all members of the Committee. A discussion was held regarding the refresh of the strategy and the Committee agreed to one overarching quality strategy document to be developed to describe the Trust approach to quality to sign post to the Patient and Carer Engagement, Research, Quality Improvement and Patient Safety plans to be delivered as part of a strategic approach to quality.

Quality Insight Report
The Committee was updated on the Resuscitation Officers annual update, clinical supervision, a safeguarding investigation and the Princes Medical Centre CQC Inspection. Assurance was received that executives were dealing with these matters and progress reports in relation to the findings from the safeguarding review and the Princes Medical Centre would be presented to the August Quality Committee meeting.

Humber Teaching NHS FT Well-Led External Audit Report
The report was noted as part of an action from Trust Board for all sub-committees to include the paper in their next meeting. The action for the chair to attend the Quality and Patient Safety Group has been booked for July 2022.

Draft Quality Accounts
The Committee discussed the draft document noting there was still some Q4 data to be added. Suggestions for some amendments required with wording and additional information was given. The Committee approved the draft quality accounts with the amendments discussed noting the positive feedback from stakeholders received to date.

Research and Development six monthly report (May-22)
The Committee received an update on the R&D work over the last six months including the nomination for regional research awards being shortlisted in four of eight categories and the first student nurse placement which received fantastic feedback and the team have agreed to take more students in the future.

Waiting list trajectory and performance update.
The Committee received the update on the progress made noting the pressures covid has created. The report led to a discussion on use of out of area beds and continuing staffing pressures.

2021 Community Mental Health Survey – medications management work
The Committee agreed the presentation was very informative showing some of the great work done and felt we should maximise publicity on this work.

Mental Health Units (Use of Force) Act 2018
The Committee was updated on the change in policy regarding the Use of Force Act which came into effect on 31 March 2022. It was agreed the implementation will primarily be monitored through the Mental Health Legislation Committee

Quality Committee Risk Register Summary and Board Assurance Framework
The risk register summary was interrogated and welcomed observing the eight risks rated nine or above with two new risks under Primary Care and Forensic Services, and two risks being closed since the last Quality Committee. It was noted the risk in relation to recording next of kin should reduce in the next report as compliance is improving. It was felt this is a dynamic document with risks moving. A discussion was held regarding the process of risks being reviewed lower down on the register, with confirmation that QPaS and ODG gave challenge where required giving reassurance the risk register is dynamic from team level up to Trust Board. LP confirmed the risk registers were also reviewed at the divisional accountability reviews.

The Board Assurance Framework was noted with no queries raised.

Quality Committee Effectiveness Review
The final Effectiveness Review and Terms of Reference was approved and will be presented to the Trust Board in May 2022 for final approval.

Quality Committee Terms of Reference
Following a discussion, the meeting approved the refreshed Terms of Reference, and these will be presented to the May Trust Board alongside the Committee Effectiveness Review.

Risk Management Strategy update / Annual report
The Committee noted the report, confirming this has been to the other sub-committees prior to it being presented to Trust Board and focused on the risks which have not reduced over the last year.

QPaS Annual Effectiveness Review and Terms of Reference
The Effectiveness review and Terms of Reference for QPaS were approved by the Quality Committee.

Minutes from reporting groups
The latest approved minutes from the Quality and Patient Safety Group (QPaS) was noted along with summaries of the last meetings, with no queries raised.

The approved minutes from the 2nd of February 2022 are attached below as appendix one

Humber Teaching NHS Foundation Trust

Quality Committee

Minutes

For a meeting held on Wednesday 2nd February 2022
9.30 – 12.30 (Virtual meeting via MS Teams)

Present

Core Members		
Mike Smith	Non-Executive Director (interim Chair)	MS
Dean Royles	Non-Executive Director	DR
Francis Patton	Non-Executive Director	FP
Hilary Gledhill	Director of Nursing, Allied Health & Social Care Professionals	HG
John Byrne	Medical Director	JB
Lynn Parkinson	Chief Operating Officer	LP
Kwame Fofie	Clinical Director and Deputy Medical Director	KF
Tracy Flannagan	Deputy Director of Nursing	TF
Michele Moran	Chief Executive	MM
Su Hutchcroft	Compliance Officer (minute taker)	SH
In attendance		
Sue Cordon	External Auditor – Grant Thornton	SC
Mandy Dawley	Head of Patient and Carer Experience and Engagement	MD
Paul Johnson	Divisional Clinical Lead, Adult Mental Health Services	PJ
Cathryn Hart	Assistant Director Research & Development	CH

1/22	**Apologies for Absence** Apologies were received from: - • Sam Jaques-Newton, Head of Allied Professionals and Practice Development • Colette Conway, Assistant Director of Nursing, Patient Safety and Compliance • Trish Bailey, Divisional Clinical Lead for CAMHS and LD Services Sue Cordon was attending the meeting as a guest to observe the meeting as part of the Grant Thornton External Governance review.
2/22	**Minutes of the Last Meeting (November 2021)** The minutes of the meeting held on 2nd November 2021 were accepted as a true and accurate record once a minor amendment has been updated.
3/22	**Action List and Matters Arising** The action log was noted with six items closed. The two open actions were discussed and updated on the action log.
4/22	**Quality Committee Board Assurance Report (November 2021)** The assurance report, which was presented to the January 2022 Trust Board, was noted. It was agreed the approved minutes do not need to be included with the meeting papers going forward as these have already been approved by the Committee at the previous meeting.
5/22	**Work Plan (Feb-22)** The work plan has been updated for 2022-23 as part of the actions from the previous meeting as discussed in the action log. The Committee confirmed they were happy with the workplan.
6/22	**Presentation – Community Mental Health Team Transformation** PJ took the Committee through a summary of the slide presentation (full presentation sent out with papers) concentrating on slide four and five – 'what has been achieved so far' Comments were then taken from the meeting: -

	• FP noted a fantastic piece of work and a credit to PJ and the team, with the passion shining through, congratulations on everything that has been achieved so far, and enquired what PJ felt were the biggest success, biggest challenge and learning from this work PJ – noted the biggest success is difficult to select. Co-production has been a great success, but also getting primary care involved and SMI health checks, with East Riding having the highest number currently of people having health checks. The biggest challenge is culture, and this will take some time to change. Learning wise, it has been acknowledged that we cannot stand still, and we cannot carry on if something's not working but must adapt when required as well as listening to everyone in the system when things need to change • DR noted a great presentation, and asked regarding the success, is there an idea in growth in workforce and culture, what are the types of behaviours that are needed to change and is this about training or leadership. Finally regarding the leadership team, during the pandemic we have learnt we can speed up if required and is this one of the areas to focus on. PJ noted some modelling has been done but things are changing as we progress, the wellbeing coaches have seen over 1800 people, these are not replacing secondary mental health, but a new role with a new population and these people would have been regular attenders at the GPs, so have increased the capacity of support for those at the lower end of mental health problems in getting the right intervention and focus on recovers with a person-centred approach. • MM thanked PJ for his enthusiasm and the great progress, and enquired regarding data, stating it would be useful to see a data dashboard of how current information looks now against how it used to look, as this would be really help both internally but also externally to the organisation. Secondly, wondering what the key headlines are around what staff thought about the huge change in the relationship of how we manage the CMHTs, and lastly how we are sharing this with the wider system, as we are a pilot site, so it is important that we continue. PJ responded by stating our teams continue to amaze us on what they are doing and how they adapt. Regarding the data dashboard, it is something of a struggle, there are quarterly submission but have found that as we transform, this has shown anomalies on how we report data due to the coding challenge to get the data correct and have had to revert to manual reporting. Due to changes on how we are reporting as CMHT and primary care networks, the structures have had to be collapsed, and currently working on getting the reporting right. Hopefully the data dashboards will be really useful once the SnowMed codes are rolled out. Regarding changes, information from service users and quotes from staff have been collected. Like any change, some staff are really open to change and others not so open and there was a period of high staff turnover, but staff are coming back now they see the change working and can see the benefits, wanting to be part of it. • MD noted the service user involvement and commented how brilliant this has been, noting the service user reference group but also noted a staff reference group, giving them a safe place to participate in co-production. PJ noted the charter was put together, not just by users but staff and partners as well, covering all outcomes. MS thanked MD for her support with this programme LP wanted to ensure this was put into context, noting this is a huge programme and agreed with PJ that this was misnamed as CMHT transformation as it encompasses the whole system. LP explained the transformation programme will have its first full evaluation in April this year, which is very much around the data discuss today, but also importantly service user outcome data as well as the impact of the programme and thought DR's point around what can be learnt around pace of change is important to take away along with what has been achieved despite the pandemic over the last two years. The relationship with Primary Care has been key along with the co-production piece, which was imbedded in the transformation with a dedicate lead. The impact with the SMI work in terms of outcomes for patient is significant and good news story and felt the evaluation report should come through to Quality Committee. LP noted she has not seen a change like this in the last 30 years of mental health. MS commended the presentation, showing a lot of work had been done and the honesty of stating it was not completely there yet. PJ was thanked for his attendance and delivery. **ACTION – To add to the work plan – August 2022 - CMHT Transformation evaluation report**
7/22	**Quality Insight Report** The report was noted with HG highlighting the following items: - • Nurse Led research – following the Chief Nursing Officers for England's strategic plan for research in November 2021, HG has met with Cathryn Hart to discuss the strategy and capture nurse led research that is ongoing at the Trust. A nurse specific professional forum chaired by TF is going to be established in April to focus on increasing the nursing research. • Cawston Park update – As part of the national review, we have had reviews undertaken at Townend Court and Secure Services with positive feedback received so far. These will go to the ICS panel in February, and we await further feedback from this. Our Safeguarding team continue to attend all

	seclusion reviews ensuring physical health as well as mental health needs are being addressed. • Safeguarding Training update – an update to the verbal report given to the Workforce and OD Committee regarding the changes to the training package, which is being reviewed in conjunction with the training team was provided. Compliance trajectories will be available in April 2022 • Clinical Audit and Service Evaluation activity was noted. It is pleasing to see work has continued despite the pressures over the last couple of years • Zero events – good progress is being maintained with a reduction in pressure ulcers acquired in our care and reduction in failing to recognise the deteriorating patient. There has been a slight increase around falls, but these have all been reported in the older people's mental health services with a reduction to zero in our physical health services this year. Currently looking at some new zero events for next year and reviewing which current ones can be dropped. This will be reported when the work is complete. Comments received from the group include: - • DR noted the safeguarding training update and trajectories would be discussed at Workforce and OD Committee and enquired, following noting media coverage of an NMC case where the staff member had not done any training for several years, whether we had an idea of where we had staff who were not compliance in a number of areas and perhaps this should be reported to the Workforce Committee. HG confirmed this information is reviewed regularly and managers are aware of which staff are not compliant in which areas with action taken. • FP stated well done to HG and the team for the really good work on the zero events • There was an enquiry if any areas were outliers on the Family and Friends Test (F&F). MD noted primary care is an outlier which is why this information has been segregated from the rest of the organisation due to MJOG, which is a text service meaning more responses are received and skew the results due to volume. December had a particularly low response rate due to two of our surgeries having issues with the texting service and were unable to download the results in the allocated time. As a result, this has shown the satisfaction score has increased to nearly 90%, which is nearly at the target rate. It was noted that the has also been a gradual improvement in the satisfaction response • MM observed it was great to have the insight reports at all the sub-committees and was good to see the positive news on the clinical audit with sustained progress. She commented it would be good to have a full comprehensive reports looking at the zero events and looking at some fresh ones with the data of what is going to be pulled out. It was agreed a report would come to the next Quality Committee. **ACTION** • **Zero Event report to be presented to the May Quality Committee (HG)** • **Report to the WF&OD Committee regarding monitoring of staff who fail to undertake statutory and mandatory training. HG to inform Steve McGowan of the request (HG)**
8/22	**Quality Committee Risk Register summary** HG presented the Quality Risk Register, including the Board Assurance Framework, noting the Quality Risk Register is presented at QPaS every 12 weeks prior to Quality Committee. The following information was highlighted and discussed: - • One new risk under LD services • NQ50 (Next of kin recorded) which has been on the register for a few months is being monitored. This started at 70% of information not being recorded and last report has shown progress down to 53% not recorded. This will be reviewed at the next data set and then look at reducing the current risk score. MS enquired if this transfers across to nearest relative and TF confirmed this is slightly different and compliance with nearest relative is at 100% due to the checks through Mental Health Legislation. LP confirmed due to the scrutiny process any lapses would be picked up immediately • FP enquired if we will have a review of last years risks and sign off a new version of the risk register, to allow understanding of the impact of the actions, we tried to mitigate last year, if they were successful or if not do, we need a new approach going forward. HG confirmed she has asked Oliver Sims to do a full end of year review around the corporate risk register. This will include a reflection on the last 12 months with an overview of how we have managed the risks and future actions. FP commented that both the risk register and the Board Assurance Framework (BAF) have included risks present both last year and this year and it would be good to see a review of what has been done over the past few years including those risks we know we cannot change, noting the safe domain which appears in the risk register and BAF will have the result of the Grant Thornton review which may show mitigation in what we are doing. HG confirmed it would certainly transfer across. • DR enquired about the new/escalated risks on page 5 of the report, with LDC51 and enquired if there could be more explanation as the initial and current risk score are 12 but have decided not to put resource in or that the resource was not available. LP confirmed this risk connects to the position set out at the Trust Board last week with the LD social workers and the decision the council has taken

	because of the expediential rise for various reasons around impact on LD social workers particularly around the legal framework. The contract is with the council and has been escalated for some time and haven't received additional funding from the council. However they do recognise the situation around increase demand. To some degree this supports the decision that the council has made, because they need to invest in it, their decision is to take back the service in house, which should mitigate from our prospective. LP also noted a lot of users with the services are still with us in other ways, so it still matters to the Trust that their needs are being met so the risk score may change in the future.
9/22	**CERG Report – Inpatient ligature – Review of doors** LP presented the report explaining that she had been tasked by EMT to look at the options in reducing the risk posed specifically in relation to ligature anchor points and doors. The report sets out the current review and recommendations made by the Clinical Environments Risk Group (CERG) which has been reviewed by EMT. Costing will be added to the capital plan for 2022-23 which will be going back to EMT shortly. It was noted there is some national guidance, but this will not specify what device to use. Information from other Trusts is showing very mixed picture. TF confirmed the draft of the national guidance has been circulated to those involved in the chapter of development but does not give any steer on what we should adopt. Focusing very much on the value of the therapeutic relationship and engagement and that is the best safety net. Where they talk about any unit ligature measures it is very vague. The information is still embargoed and may change in the future. MS thanked LP for the report and investigative work.
10/22	**Research and Development – six-month update report (Cathryn Hart)** MS noted this report has been considered at the last Trust Board meeting. The report was noted as read. CH highlighted to the meeting how research impacts on our community – and explained Wendy, a research champion has just produced a Times best-selling book, which is a good example of how research has changed her life around. By using research at Market Weighton Practice to add something extra to the community, a research champion has just been appointed with another two interested to go through the process. A study has been opened and 19 people have signed up already. This shows we are doing something extra that a lot of GP practices across the area are not doing, and are looking at two further studies in our practices Comments received: - • MS noted seeing a presentation a few years back regarding the social network of research having positive mental health benefits. CS confirmed on of the dementia studies research group kept on meeting after the research stopped and booked coach trips to keep the friendship going as well. It was noted there are load of examples of where research has helped people and noted that research is sometimes able to offer something where there is no treatment available to offer MS thanked CH for her report.
11/22	**Patient and Carer Experience – six-month report (Mandy Dawley)** The report was noted as read. MD updated the meeting with the following information: - • Working with Catheryn Hart on research has linked MD to the Royal Collage in London meeting one of the top surgeons and team who have just undertaken stage one of the F&F test and have invited Humber to participate in stage two of this programme, which is a fantastic opportunity for the organisation. The analytical tool analysis the feedback from the F&F which can lead to quality improvement programmes so in alignment with the QI Team, Cath Hunter will be involved and will progress through QI charters with teams • Humber Youth Action Group – this is one of many Trust forums which has really taken off and we have some fabulous young people working with the organisation. They have developed their own network and their own way of running a Board. At their next meeting in February they have asked for one of the mental health practitioners to come and talk to them, to give them advice to help them support their peers. They have designed their own Humber Youth Action Group logo and three of them are leading on the Trust Instagram account with support from Comms, as well as an induction package which is on the website. • The Carers involvement forum has been developed over the last year where carers and staff who are

	championing the carers agenda along with carer partners join in a room together to talk about carers • Yesterday the team hosted and networked with over 60 people in two PACE forums and MD noted the great support received from members of the public and staff who continue to champion the agenda • The team is concentrating this year on refreshing the PACE strategy which will be four years old in March 2022. A working group has been set up for people to get involved in the refresh over the next 12 months. HG observed the fantastic changes over the past five years and noted the Patient Safety strategy is also due review this year so will be brought into the same arena doing some co-production work with MD. MD confirmed they discussed with staff and patients at the forums yesterday how carers and families and staff would best like to support the refresh and virtual forums and surveys were the two priorities that came out which gives a good platform to build engagement events over the next 12 months. FP noted an excellent piece of work with great co-production and enquired on further details about the training platform. MD confirmed the PACE training will be hosted on the recovery college platform so anyone can access it. Work on it was completed yesterday with eight modules around how to get involved in Trust activities and is there for both staff, to be aware of the involvement opportunities so they can share with their carers and service users but also for the public who support us with interest in activities to give them further information in what they can get involved in. It has been co-produced with patients and carers who are already involved with the Trust. FP enquired if a package for those interested in being a governor could be established and MD noted Caroline Flint attended the forum yesterday picked up on this and is keen to go something for the governors. DR thanked MD for the report, stating it was really good reading, and enquired regarding Equality, Diversity and Inclusion, stating several initiatives are underway. MD confirmed there is a lot more work being done especially around the inequality's agenda and last year created our operation group which is called the equality, diversity, inclusion and inequalities operation group, where all divisions are represented, and our patient carer governor is on the group. With regards to the Armed Forces covenant agenda we have an established veteran's forum, with members of the community, staff, veterans as well as current serving personal, friends and family. The intranet site has been developed to give lots of information to signpost staff on to support services for veterans and armed forces serving members. MM confirmed great work as always, and it was lovely to be part of the forum yesterday. With regards the strategic element, as a reminder, we are doing a complete overhaul of our organisational strategy now and wanted to make sure all the timelines link together with the Trust strategic objectives threaded through the organisation. MS thanked MD for the report, echoing the great work and noted the complaints section showing a laudable degree of honesty together with what had been learnt from them.
12/22	**Divisional Quality improvement Plan (QIP) update report** KF updated the meeting, noting this paper was a summary of all the Divisional QIPs contributed to by the clinical divisional leads, noting the full QIPS are much larger documents. All the QIPS are underpinned by good challenge within the divisional clinical networks and feed into the Trust Organisational Development Group (ODG) and QPaS meetings for quality assurance. The main themes running through all four divisions include: - • Normal quality and control strategy which includes local and national audit and the use of My Assurance, • Use of supervision for reflection • Patient feedback • Benchmarking again other Trusts • Use of CQC self-assurance strategies • Improvement in clinical models and service development e.g., trauma informed care, community forensic transformation, CMHT transformation etc noting these are all the strategies developed to use more effecting working within the divisions • Development of staff, not only clinical development but also CDP etc • Staff wellbeing programmes especially in the wake of Covid KF noted the full divisional plans are available on request for anyone wishes to view them.

	Comments from the meeting include: - • JB noted the QIPs are also discussed in the divisional accountability reviews • HG requested that the report is taken to all the clinical networks to show what is done in each division for shared learning. KF is using the summary when meeting with Clinical Leads and has shared with each clinical division lead but will pick it sharing up at the next catch up. FP enquired on further detail of the autism work and enquired about cross fertilisation on each of the areas. KF noted the autism strategy which has been presented to the board and work is going on in most of the divisions with a neurodiversity service in CAMHS. The same type of work is also underway in the adult mental health division. DR commented it was good to see the report on the various initiatives. In terms of discussion and overall assurance, enquired about the embedding of the QI approach across the organisation, equipping the staff with the skills to do quality improvement. JB responded that QI means different things to different people but noting the CMHT transformation programme, this is also QI improving the outcomes for patients, but a second type of work is seen on the QIP being pieces work happening within the team which we pick up through charters. From a workforce and training point of view there is data to show people have reached a certain level of training and more recently we have put some QI and patient safety training on the ESR platform. MS thanked KF and his colleagues for the report.
13/22	**National Confidential Enquiry on Suicide update presentation (NCISH)** TF took the meeting through the presentation (including in the meeting papers) with the report noted as read. The following comments were received: - • MS commented we had taken note of this update a few years ago when the stats were showing the crucial time for suicide after discharge was at the three days mark so moved our assessment from seven to three days and performance is good on this. • DR thanked TF for the useful update. Seeing information in the press about suicide and young men and noting a section in the report about female patients but could not work out if that was about methods used or overall and asked is there anything about gender, we should be aware of? TF confirmed the breakdown of gender is more predominantly male but looking at the breakdown in type of suicide the report gives the national figures but also focuses in on services and in general the male population are not necessarily in contact with services. The trends nationally are still rising but with people in contact with services the trend is downward. It is hard to make a statement about gender as it needs to be taken in context and unpicked in terms of service planning to meet those needs. KF noted in terms of ethnicity the report was quite intelligent this year in terms of breakdown of ethnicity and which ethnic groups, methods and illnesses presented with as in the past would have been put into one group. • FP noted lots of interesting information and liked the '10 ways to improve safety' in the presentation and wondered if that diagram could be used with information of where are we, best practice and plans to move forward which may be a simple way to move forward. JB commented that it was an interesting suggestion and would favour this but noted the conversation this morning regarding safer wards and the environmental risk, in terms of ligatures but there are also other environmental issues to consider, staffing implications ensuring staff are using appropriate guidelines, etc. It was noted the national report does state that inpatient units have never been safer, which does not dismiss the tragedy of death by suicide on an inpatient unit, but must not lose sight that in many ways, along with decreased numbers of admissions, puts that risk out in the community which has a combination of safeguarding risk, dual diagnosis with drugs and alcohol service, and some areas we do not run the service, which makes it more difficult to get people the help they need. Out of area pressure were also discussed with the unintended consequence moves the risk to out of area placements • MM commented that it might be helpful to circulate the full report. Reiterating the following points, noting we need to be clear that the majority of suicides are not known to mental heath services and inpatient facilities have got better, with the risk changed and moved to community so is equally important that we focus on community as well. MM felt the 'ten ways to increase safety' should link into our patient safety strategy rather than the suicide strategy as it's all about our patients' agendas and should be a thread through all patient safety work. It was asked if it would be possible to have the timelines on the actions in the report and presentation for these review pieces which could be brought back to the Quality Committee. It was also noted that the revised strategy will need to feed into the overarching ICS strategy that was developed around 18 months ago which picks up the various areas. **ACTION – it was agreed for the timelines on actions, to be brought back to a future Quality Committee meeting (JB) To be added to the work plan (SH)**

14/22	**Self-assessment against CQC KLOE Briefing Report and Final CQC Must do and Should do Action plans** HG presented the paper in the absence of CC, giving the CQC focus for the Committee. HG explained the 2019 Must do and Should do action plans had been closed as the pandemic started. This was picked up at the end of last year with some additional monitoring to check the actions were now embedded in practice. We have now asked for the divisions to go through the report and undertake further checks to ensure the work remains embedded in practice. The Audit and Effectiveness group have been asked to gather the information from the divisions to check which areas they are going to do further checks on to keep the monitoring going. Every key line of enquiry (KLOE) from the CQC was also reviewed, as a self-assessment to see where we could take additional actions to further strengthen compliance. There are currently nine open actions with five on the safe domain, including investing in patient safety and risk management training. These will then be monitored to ensure everything is embedded in practice. HG noted this is an interactive action plan and can be added to when necessary. MS felt this was a really positive report and there is a great deal of assurance from the detail. MM remarked that we have completed a full external audit report on how we were managing the CQC which was positive but feels it would be helpful to schedule this report in to the EMT workplan. MM enquired about the two dates on action 2.9 which state 'to be confirmed' along with enquiring if the actions to be completed by March are realistic. HG confirmed the actions are completed but the dates are for ongoing monitoring. Regarding action 2.9 showing 'to be confirmed', this is due to the new End-of-Life lead starting in post before those dates can be set. **The Quality Committee approved the KLOE briefing report and must and should do action plans.**
15/22	**Briefing Paper – Out of hours contract** LP noted the paper is in response to the Trust Board action asking the Quality Committee to review the quality aspects of the out of hours contract from the previous indications of concerns and the purpose of the paper sets out those concerns what action is taken in response to these issues. It was noted all concerns are reported on datix system and when the issues were identified, Datix was amended to allow these incidents to be easily reported on. The incidents are related to challenges which the provider has experienced with staffing recruitment issues and have been either no harm or low harm and all have the theme relating to when a GP has not been available or shifts not covered adequately resulting in delays in seeing our patients. The medication issues have all been no harm, bar one, which was low harm regarding a delay in prescribing. The issues have been raised with the provider and they have now submitted a plan to address these. LP can confirm currently this year up to 26 January, we have had not incidents reported via datix. This is being monitored very closely and the Trust can take more contractual measure if required, but the action plan is working as required. The provider has taken measures to address the staffing issues and we have seen improvements with this. It will continue to be monitored very closely. It was felt the paper gave assurance on the board action. JB confirmed it was a very helpful paper and noted when he had talked to the staff on the ground, had heard their frustration it felt may be a good opportunity to share this paper with them to show the 'you said, we did'
16/22	**Hull and East Riding Annual Learning Disability Mortality Review (LeDeR)** The report was noted. HG presented the report following apologies received from Trish Bailey who is the lead for LeDeR. The report is the Annual review for the Humber Region and TB had sent some key points over to note which include: - • People with learning disabilities are still dying too young, with the average age for women being 57, and men 57 • Themes in the local report do match the national report with aspirational pneumonia and cancer being the highest causes of death • Recommendations include to improve aspirational pneumonia particularly across care homes and to improve the uptake of annual health checks and screening. TB has noted the GP who was recently employed in the LD service is really making a difference with a focus on the physical health aspect of the service users and funding has been received for a Band 6 nurse to work in primary care to support around the health checks for those with the most complex LD patients. MS noted the report is a sobering reading on the national picture but is encouraging reading for some of the

	statistics on our area. MM noted this is a really important report and does need detailed actions. Two leads have just been appointed in the ICS to take forward this work which the organisational plans will link into. MM left the meeting
17/22	**Draft Quality Committee Effectiveness Review (for May Trust Board)** The draft report was noted and discussed. MS noted that today's meeting felt an exemplar of what we should be discussing with a good mix of strategic issues and our response operationally with our plans to move forward in a proactive way. The meeting agreed the Committee was functioning well and the Chair would draft the final parts of the review form, after today's meeting, with the assistance of HG and SH, for review at the next Quality Committee prior to presenting to Trust Board in May 2022 HG noted the need to check the membership in the Terms of Reference is still correct and this was discussed. **Action – completed pro-forma to be approved at the May Quality committee**
18/22	**Quality Committee Terms of Reference review (for May Trust Board)** The meeting was asked to review the document and let the Chair know any potential changes prior to the next meeting so this could be approved ready for Board approval in May 2022 **Action – Members to review and send any comments prior to the next Quality Committee meeting - revised Terms of Reference to be approved at the May Quality committee**
19/22	**Quality and Patient Safety Group (QPaS) minutes (25 May 2021)** The minutes of the September and November 2021 meetings and summary of the December 2021 meeting was noted with no queries raised.
20/22	**Items Arising from the meeting requiring Communication, Escalation or Risk Register consideration and any lessons learnt** The following items were agreed for escalated to the Trust board via the Assurance report: • The LeDeR report to be recommended to the Trust Board to give the opportunity to have a conversation around LD services in general (JB)
21/22	**Any Other Business** There was nil raised at today's meeting. MS asked Sue Corden if she had any feedback from today's meeting. She confirmed it was a really good meeting with some impactful papers and good discussion. She liked the way that any new reports or strategies are linked to the Trust strategy and feel this was done well. The Research and the QI papers demonstrate the breadth and depth of work continuing through the pandemic. The meeting was well chaired and a strong committee and feels the quarterly meetings work well at Humber Sue enquired regarding the research paper going to Trust board prior to Quality Committee and enquired if this was just a timing issue. JB confirmed that was a timing issue which sometimes happens, and we try and get papers through the right place. MS confirmed there would have been a much deeper discussion if the paper had not been to Board first.
22/22	**Date and time of next meeting** The next meeting has been arranged for Wednesday 4th May 2022 via MS Teams. The meeting invite details will be updated nearer the meeting date.

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Agenda Item 12

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Mental Health Legislation Committee Assurance Report following meeting of 05 May 2022.
Author/s:	Name: Michael Smith Title: Non-Executive Director and Chair of Mental Health Legislation Committee
Recommendation:	To approve: ; To receive & note: √ For information: √ ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Mental Health Legislation Committee (MHLC) is one of the sub-Committees of the Trust Board This paper provides assurance to the Board with regard to the agenda issues (agenda attached) covered in the committee held on 05 May 2022.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- Implications of MCA consultation particularly in terms of workforce capacity

Key Actions Commissioned/Work Underway:

- Noted ongoing work of the Mental Health Legislation Steering Group and work that is taking place collaboratively with regard to the move away from Care Programme Approach (CPA) and future implementation
- Agreed to receive a presentation on consent to treatment at the next meeting
- The Use of Force Act was discussed with regard to its implications, and it was discussed this workstream is already being covered off through the Reducing Restrictive Interventions (RRI) Group which provides assurance to the Committee in this area

Positive Assurances to Provide:

- Reviewed RRI report and triangulated the data with the latest Care Quality Commission (CQC) publication: Monitoring the Mental Health Act (MHA) in 2020 - 2021
- Thorough review of Mental Health Legislation (MHL) Steering Group minutes of 2 meetings by Chair of MHLC
- Inpatient Search Policy discussed and assured with regard to balance between security and Human Rights
- Reviewed MHL performance report and found no current issues of concern
- Multi Agency Public Protection Arrangements (MAPPA) – positive assurance and linked to Multi Agency Risk Assessment Committee (MARAC)

Decisions Made:

- To agree the effectiveness review to go to Board
- To approve the Inpatient Search Policy
- To disseminate the CQC Monitoring the MHA Report

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

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

Monitoring and assurance framework summary:

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

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

Key Issues:

Committee noted key items and assurances:

- Bi-annual MAPPA report received and presented. Recent system wide audit undertaken; Trust completed an audit of its records and identified some areas which would benefit from refinement to enhance process, but nothing major identified and a plan of action in place. Refreshed MAPPA protocols almost completed and will be placed on intranet for which MAPPA now has its own section.
- Insight report - The Committee was informed about:
    - Mental Capacity (Amendment) Act 2019 – Draft MCA Code of Practice – published 17 March 2022. Code of Practice consultation closes 7th July followed by six month period to consider responses and final Code of Practice, and possibly a further six months before new Mental Capacity Act comes into play. As the 'Responsible Body' (previously the Local Authority) the Trust has large piece of work to undertake, including identifying roles, training and resources requirements. Capacity issue for Trust identified.
    - Care Quality Commission - Monitoring the Mental Health Act in 2020/21. Internally the information in the CQC MHA visit reports can provide assurance Trust does not have a particular issue or an identified issue has been addressed. Action taken to rectify any issues raised and learning shared across inpatient units. Trust undertakes its own governance through Mental Health Legislation Steering Group and audits based on regulations.
- Performance Report:-
    - Zero use of S4s for a number of months. Trust had historically been an outlier for S4, but recent work by Dr Fofie in amending medics rota has resolved the issue.
    - Referencing CQC report on inappropriate admission of under 17s to adult wards, over last six months there has been no such admissions for Trust.
    - Numbers of CTOs are reducing for Trust.
- MHL Committee ToR reviewed and approved.
- RRI ToR, MHL Steering Group ToR, and Associate Hospital Managers' Forum ToR presented as part of Committee Effectiveness Review paper.
- MHL Committee Effectiveness Review paper and workplan approved.
- Agreed reviewed Inpatient Search Policy.
- RRI report Q4 –
    - Quarter 4 data is within normal variations overall.
    - Clinically applied CAFO relates to cohort of patients awaiting placements in more appropriate care settings; this has been raised as an issue across system particularly for service users with complex autism and learning difficulties. Use of restrictive interventions for seclusion,

long term segregation and CAFO undergo regular reviews.
    - Case studies will be continued as these present a helpful context for reducing restrictive practices approach.
- Associate Hospital Managers Annual Progress Report noted - work to increase diversity of representation is ongoing.
- Commended all MH legislation related policies up to date.
- Committee noted the minutes of the MHL steering group.

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NHS Foundation Trust

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022			
Title of Report:	Audit Committee Assurance Report			
Author/s:	Stuart McKinnon-Evans Chair of Audit Committee & Non-Executive Director			
Recommendation:	To approve		To receive & note	✓
	For information		To ratify	
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	A meeting of the Audit Committee took place via MS Teams on the 11 May 2022. It is a requirement of the Terms of Reference and the NHS Audit Handbook for an assurance report to be prepared for the Trust Board as soon as is practical after the meeting takes place and presented at the next Trust Board meeting.			

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- A review of the Trust-wide risk register reconfirms that the salient residual risks relate to staffing, and local supply-side capacity for CAMHS
- The Committee recommends continuous consideration of the relationship between risk appetite, the realism of target risk levels, and the actions and resource being applied across all executive areas in risk management
- Single tender waivers indicate supply-side capacity constraints in relation to autism services due to the current increase in demand.
- Adopting the Counter Fraud plans methodology means the Trust's arrangements will be immature and therefore technically non-compliant with the aspired-to standards for 3-5 years, this is not dissimilar to other Trusts
- Mazars' external audit opinion will be issued after the normal deadline because of needing to wait for assurance from the Local Government Pension Scheme (NHSE/I are aware of this issue with affects numerous NHS Trusts)

Key Actions Commissioned/Work Underway:

- The Committee encourage continuous improvement of the entries in the BAF
- Well Led Review actions for the Committee will be taken forward
- The Committee supports the commitment of Executive to clear outstanding audit actions, a very small number of which long-dated
- Benchmarking of gift and hospitality declarations with other trusts
- Requested a rolling cumulative total of extant Single Source Waivers in future reports
- Work is progressing with Inspire CAMHS management following the limited assurance audit report.

Positive Assurances to Provide:

- The Audit Committee remained effective in 2021/22, and the Terms of Reference unchanged aside from updates to terms/role descriptors
- Single tender waivers reported and discussed

Decisions Made:

- Endorsed the BAF report, especially for Strategic Goal 3
- Approved Internal Audit Plan for 2022/23
- Endorsed the risk management strategy
- Approved Counter Fraud work programme for

• Significant assurance from Internal Audit on the Board Assurance Framework • Substantive discussion of Trust-wide and Mental Health Services division register, and good evidence from management on how risk management is woven in to operations • Review of risk management during 2021/22, and of the risk management strategy, concluded good evidence of active risk management, with generally, the level of residual risk declining over the year. This self-assessment is corroborated by Significant assurance from Internal Audit • Losses and special payments are reasonable • Gift, hospitality, declarations and sponsorship report considered • Active management of cyber security issues under the leadership of SIRO supported now by Information Asset Owners • Asset values have been revalued for accounting purposes • Good progress implementing internal audit programme and actions, corroborated by strong performance compared to peers • Positive Internal Audit Opinion for 2021/22 • Counter Fraud activity continues with over 600 staff regionally having attended Masterclasses • External Audit work for 2021/22 accounts proceeding to plan • Trust policies are being reviewed to plan	2022/23 • To report back to Governors in respect of forensic-related risks

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

	Date		Date
Audit Committee	This paper is a summary of the meeting of 11.5.22, and was written following the meeting.	Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

Monitoring and assurance framework summary:

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

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

Executive Summary

See headings above

Key Issues:

The Committee discussed, received for assurance and noted reports on the following matters:

- Review of the Audit Committee's effectiveness
- Well-Led Review
- Single tender waivers
- Board Assurance Framework, with focus on Strategic Goal 3 (Fostering integration, partnership and alliances)
- Trust-wide Risk Register, plus a deep dive into the Mental Health Services divisional risk register
- Risk management annual report for 2021/22, and risk management strategy generally
- Losses and special payments
- Gifts, hospitality, declarations and sponsorship
- Cyber security
- Asset values
- Internal audit: implementation of current programme, the Head of Internal Audit's opinion for 2021/22,and the 2022/23 plan
- Counter fraud: progress to date and plan for 2022/23
- External audit progress report
- Policy compliance
- Changes to contracts and agreements

Risks and Issues

This salient progress, risks and issues discussed under each item were;

- Review of the Audit Committee's effectiveness, with the conclusion that the Committee's work meets the standards aspired to, but is not complacent. Minor changes were made to role descriptors

- Well-Led Review – noted actions for the Audit Committee to focus on, all of which in the spirit of continuous improvement, from this very strong external endorsement from Grant Thornton of the Trust's governance

- Single tender waivers – the Committee scrutinised the justification for recent waivers, endorsing the action taken. Single tender waivers indicate supply-side capacity constraints in relation to autism services. Further, we encouraged planning in procurement to avoid STWs due to time constraints. The emerging guidelines on collaborate approaches to delivery may have an impact on procurement regimes over time, and the Committee were concerned that these would not dilute value for money management. In addition

- Board Assurance Framework, overall and then with a focus on Strategic Goal 3 (Fostering integration, partnership and alliances), which scoring we endorsed. The report showed that the Board Assurance Framework for Enhancing Prevention, Wellbeing and Recovery continues to show Limited (Amber) Assurance; that said, the highest residual risk is a 12. We reflected on how each Committee contributes to the overall BAF, and gained comfort from processes in play. We identified the need to continuous improvement in the timeliness and English of some of the entries.

- We discussed the Trust-wide Risk Register, plus a deep dive into the Mental Health Services divisional risk register. Managers explained their approach to risk management, supported by Risk expert; discussion about distinction between risk and issue management; realism of target risk; and, linking a recent Governor forum discussion about public safety, forensic-related risks in mental health patient management. We will report back to Governors on this.

- On the Trust-wide register, we noted a review by FIC of one risk underway, and the link between salient trust level risks, and action being taken in workforce and budget strategy to reduce them. The NEDs'

view is that there is need to continuously reflect on the interplay and congruence between risk appetite and target score, action being taken to achieve the target, and considerations of resources, to ensure realism and consistency across the performance, risk and control framework; and that this should be done at Executive/Committee level.

- Risk management annual report for 2021/22, and risk management strategy generally: discussed why some quality, workforce and finance risk ratings had not moved during the year despite actions taken. For the future, endorsed the ambition to continuously improved Board-to-ward risk management, and to otherwise maintain the standards and momentum of risk management in evidence.

- Losses and special payments, noting the justification for the c £3K payment made in 2021/22.

- Two instances of gifts, hospitality, declarations and sponsorship were noted. The low incidence of reporting was discussed, and the Committee asked for benchmarking to be undertaken.

- The Committee considered the work of the SIRO, including the Cyber security work and the activities of the Information Governance Group, and concluded good progress in a domain which is characterised by a dynamic threat environment, and the need for action on infrastructure, skills, process/policy, and especially behaviour

- The most recent revaluation of assets concluded in a net increase of land of £0.952m and a decrease in the value of buildings has decreased by £7.084m, most notably the £6.07m of the Humber Centre, due to the adoption of revised valuation methods. We noted there would be minimal impact at finance operational level, this being more a balance sheet and below-the-line adjustment.

- We welcomed the new Internal Audit management team, who confirmed their starting position, that the Trust takes internal audit matters seriously.

- We considered implementation of the current programme, with 8 reports completed since the last update, with very encouraging conclusions apart from Limited assurance at Inspire's management of CAMHS, relating to elements of cash and physical resources control. All Internal Audit programme KPIS are achieved. It is important to note Significant assurance of the key systemic control mechanisms of risk management and the BAF, though with the need for ongoing training on both recommended.

- None of the recent Internal Audit reports signalled major recommendations, most leading to a small number of moderate/minor, with the exception of capital programme management, with 13 actions despite its Significant assurance overall.

- Stage 1 of the assessment of the Data Security and Protection Toolkit concludes good progress

- The most recent audit to see if recommendations had been implemented was positive, with 7 overdue from a population of 160. The Committee agreed to press managers to resolve delays, noting a Executive discussion about this had already taken place. No recommendation deadline had been rescheduled. The Committee thanked managers for seeing implementation through of a long list of recommendations

- Benchmarking of internal audit recommendations: compared to peers, HTFT performs well in implementing recommendations

- the Head of Internal Audit's opinion for 2021/22 (to be finalised) is that significant assurance of the internal control system overall, , ie that "there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. " This is a welcome conclusion.

- Finally, we considered the proposed 2022/23 Internal Audit plan. The plan, already discussed by the Executive Team, proposes especial focus on post-Covid-19 recovery, is for 208 days compared to 237 for 2021/21. The Committee questioned the balance of focus on governance, partnerships, mental health legislation and workforce. Specific terms of reference would deal with the focus on post-Covid-19 recovery. We agreed to approve the plan, but to keep an eye to flexibility in its deployment as the risk landscape emerged.

- Counter fraud: the Committee received a detailed retrospective progress report of activity across the Trust, supported by the local Counter Fraud specialist team at Audit Yorkshire. Over 600 staff have now attended the Counter Fraud masterclass, and regular briefings and alerts are distributed to staff. The proposed 62-day work plan for 2022/23 was reviewed and approved. The Committee considered the implication of adopting the Plan's underpinning methodology, which will mean the Trust's Counter Fraud arrangements and track record will not be mature enough for 3-5 years to allow it to be considered "compliant". We accepted the explanation for this approach.

- The External Audit progress report confirmed Mazars' work is on track to complete the annual audit and highlighted a number of external reports and best practice guidance. Mazars' final opinion depends on receiving information and assurance about the Local Government Pension Scheme from East Riding – and therefore will not be issued per the normal deadline. The Committee agreed to work pragmatically with Mazars on the timing of their audit clearance report.

- The Committee reviewed when the policies under its remit were last reviewed, and was satisfied with the review mechanisms and practice.

- Nil changes to agreements and contracts were reported

A summary of the Committees deliberations and Key Issues is provided at the front of this report.

Humber Teaching NHS Foundation Trust

Agenda Item 14

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Collaborative Committee Assurance Report
Author/s:	Michele Moran – Chief Executive

Recommendation:

To approve		To receive & note	x
For information		To ratify	

Purpose of Paper: To provide the Board with feedback from the April meeting and assurance regarding the relevant subjects discussed, namely quality, finance and performance of the Lead Provider.

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	28.4.22
		Other (please detail)	

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:
- Shoen Clinic – CQC report

Major Actions Commissioned/Work Underway:
- Learning process in respect to the recent CQC report
- Community development of eating disorder pathway to reduce reliance on beds and develop a more preventative pathway
- Risk Register review and restructure

Positive Assurances to Provide:
- Quality reviews – safe and well progressed well
- Performance of providers on plan
- Financial plan in place.

Decisions Made:
- Not Quorate

Monitoring and assurance framework summary:

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

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

Key Issues:

Key areas for noting from the meeting on **28 April 2022:**

Quality Assurance and Improvement

- Safe and Wellbeing Reviews – the final review has been completed and assurance has been given by the ICS board on final cases presented.

Work Streams

Key issues to note from each workstream -

CAMHS

- A piece of work is being undertaken in relation to delayed discharges.
- There are currently 8 delayed discharges of Humber Coast and Vale young people; one of whom is an out of area young person who will be discharged back into area; one person is at Mill Lodge and 5 at Inspire.
- An ICS meeting is in the process of being established which the Directors of Children's Services (DCSs), CCGs and lead providers will be invited to.

Update on Mill Lodge Business Case:

The Mill Lodge business case has been approved and Mill Lodge will be submitting a brief mobilisation plan around timescales. An inspection of the rooms has been undertaken by Estates and the work will take approximately 6 weeks to complete. There are no confirmed dates, but we are looking at no later than September for it to be functioning.

Adult Eating Disorder

- Rharian Fields are currently at full capacity.
- Meetings continue every Friday to review referrals collectively.
- Cases will continue to be reviewed individually.
- The CQC report has been reviewed and at present it has not been recommended that the Schoen Clinic close to admissions. This is because a significant amount of assurance work has taken place since the CQC inspection in January 2022 and changes and improvements have been made by the provider. Members of the CPaQT have spent a considerable amount of time on the unit; they have spoken to service users and staff, and they have reviewed the action plans, and data submissions.
- The proposed plan going forward is for weekly case manager visits on the unit including service user contact, review of care packages, review of risk assessments, attending MDT, and review of the environment.
- There will also be fortnightly meetings with the provider lead by Mr Flanders to review data submissions, and the action plan including any concerns or delays regarding the action plan.
- Service Involvement Leads have also been asked to go in and to contact service users with staff and carers.
- A formal quality review will be undertaken at two months, four months and six months. The safeguarding lead from the CCG has been invited to be part of this process and is keen to support. Dr Harvey is due to meet with the CCG on 29 April to finalise a plan around their involvement.
- There will also be some unannounced visits over the coming months.
- Oversight of the action plan will ideally be through the collaborative's Quality Assurance & Improvement Group which involves all providers.

Adult Secure

- 153 patients are in medium and low secure services from Humber Coast and Vale. Currently 6 patients are on the waiting list; 5 of which are for low secure beds and one looking to come from high to medium. Prison transfers which take priority are the majority of the waiting list.

Risk Register

The Committee requested a forensic piece of work to be undertaken on all the risk registers for the next meeting, to include:

- The date when the risk is added to the register
- Clear articulation of what the risk is
- Gaps in control to describe anything additional needed to mitigate
- Assurances – metrics for monitoring
- Assurance in connection with waiting list numbers
- Anything which can be monitored

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 15

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Committee Effectiveness Reviews 2021/2022
Author/s:	Name: Michelle Hughes Title: Head of Corporate Affairs
Recommendation:	To approve / To receive & note For information / To ratify
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To present completed effectiveness reviews for the Trust Board and each of the Board's sub committees for 2021/22. To present Committee Terms of Reference for Board approval.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- No issues to raise.

Key Actions Commissioned/Work Underway:

- No issues to raise

Positive Assurances to Provide:

- The effectiveness reviews demonstrate good governance with committees and Board meeting the requirements of their terms of reference throughout the year.
- All committees have undertaken an annual effectiveness review and these are attached as appendices with their terms of reference.

Decisions Made:

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

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

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

Monitoring and assurance framework summary:

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

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

Committee Effectiveness Reviews 2021-2022

1. Introduction

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

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

	Non-Executive Director Committee Chair
Quality Committee	Mike Smith
Finance and Investment Committee	Francis Patton
Workforce & Organisational Development Committee	Dean Royles
Charitable Funds Committee	Stuart McKinnon-Evans
Collaborative Committee	Stuart McKinnon-Evans
Mental Health Legislation Committee	Mike Smith
Audit Committee	Stuart McKinnon-Evans
Remuneration and Nomination Committee	Trust Chair
Trust Board	Trust Chair

2. Completed Reviews

The effectiveness reviews and terms of reference for each committee are attached as appendices:

Appendix 1: Quality Committee
Appendix 2: Finance and Investment Committee
Appendix 3: Workforce & Organisational Development Committee
Appendix 4: Charitable Funds Committee
Appendix 5: Collaborative Committee
Appendix 6: Mental Health Legislation Committee
Appendix 7: Audit Committee
Appendix 8: Remuneration and Nomination Committee
Appendix 9: Trust Board

Each sub-committee has a work plan for the 2022-2023 year ahead and are available on request.

3. **Summary**

- The Trust Board and all sub committees have undertaken a committee effectiveness review for 2021-2022 and have reviewed their Terms of Reference.
- A key change in year was that the Executive Management Team (EMT) were made the approving body for all Trust policies in November 2021. However, sub committees continue to receive assurance on policies at least annually, that details the status of all policies within the scope of that Committee.
- The Trust Board and all sub committees have a work plan for the 2022/23 year ahead.

4. Recommendations

- To receive and discuss effectiveness reviews for the Trust Board and its sub committees.
- To approve Terms of Reference for the Trust Board and sub committees.

May 2022

Humber Teaching
NHS Foundation Trust

Quality Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

The purpose of the Quality Committee is to assure the Trust Board that appropriate processes are in place to give confidence that;

- Quality, patient safety performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks.
- Performance in relation to research and development requirements is monitored effectively with appropriate actions being taken to address any performance issues and risks.
- The quality impact of proposed business change proposals (i.e. new models, budget reductions) are fully reviewed for their impact on quality
- The impact of quality improvements and audits are clearly tracked through performance and experience data.

1. Executive Summary

The Quality Committee was convened on five occasions throughout 2021- 2022. All sessions have been quorate with high interaction from all colleagues.

The Quality Committee has worked hard to maintain business as usual during unprecedented clinical pressures providing 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. The Committee has proactively contributed to Humber's continued coronavirus response and has continued our work on quality improvement whilst also promoting research and development, Patient and Public Involvement and a number of quality improvement initiatives.

We are underpinned by excellent work from the Quality Patient and Safety Group which supports the Committee and its wider contribution to assurance systems.

The whole organisational response from Humber Teaching NHS Foundation Trust to Coronavirus combined with recent winter pressures has been proactive and outstanding with staff engagement throughout.

Grant Thornton observed the Committee on 2 February 2022 as part of the external well led review. Feedback was positive in respect of the agenda, debate and challenge and information to support positive assurance with papers intrinsically linked to the Trust enabling strategies supporting the overarching Trust strategy.

2. Delivery of functions delegated by Board

	Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
1	To provide the strategic overview of clinical governance, risk and patient and carer experience and engagement issues in the Trust	Annual reports for Safeguarding, Patient Safety ,Healthcare Acquired infection, Patient and Carer Experience report (which includes Complaints, PALS and E&D), Clinical Audit, Control Drugs, Zero Events and Ligatures, Research and Development reported to the Committee. Quality Accounts 2020-21 oversight and approval prior to Board submission Quality Risk Register and BAF reported to each committee meeting.	
2	Drive improvements in the approach to quality improvement, innovation and quality assurance informed by the internal governance reporting structures and external horizon scanning and learning from others.	The committee reviewed the divisional quality improvement plans. Received presentations/discussion topics and information– including – Clinical supervision – Provider collaborative and quality assurance process – Pharmacy transformation – White Ribbon Accreditation – Autism Strategic Approach – Learning Disability standards – CMHT transformation – CQC compliance work and updates Reviewed findings from internal audit in respect of divisional clinical governance frameworks. The Committee receives a Quality Insight Report at each meeting detailing national policy and Trust quality improvements and performance/actions taken.	Continued oversight of divisional quality improvement plans and CQC compliance work..

3	To provide assurance to the Trust Board that risks and governance issues of all types are identified, monitored and controlled to an acceptable level.	Report of assurances and minutes of the meeting submitted to the Trust board. Kept the Coronavirus Trust response under review and contributed assurance through reports to the Board. Escalated key assurances for Board review/ratification e.g. annual reports for Safeguarding, Infection Control, R&D, Patient and Carer Experience. Review of Quality related risks and the BAF prior to submission to the Board. Patient Safety Staff story recommended for presentation to the Board. Patient safety processes recommended for Board time out following receipt of the annual patient safety report.	Ongoing review of our response to the Pandemic
4	To provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives	Review of the Board Assurance Framework quality related risks at each meeting. BAF presented quarterly to the Board. Quality related risks reported to each meeting via the Quality Committee Risk Register	Ongoing review of the BAF and identification of risks for inclusion on the risk register.
5	To provide advice to the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action.	Discussion topic in relation to a specific quality related issue at each Committee, agreed with the chair prior to each meeting Waiting list quality issues reviewed at the request of the Board Review of long term segregation (LTS) Review of Friends and Family test data to provide Board Assurance Risks and actions taken during COVID 19 reviewed and reported to the Board	

6	To ensure that there is an effective mechanism for reporting significant risks and governance issues to the Trust Board in a timely manner.	Monthly reports to the Board via the executive briefings in the Chief Executive board briefing. The Committee Board Assurance report. The Board Assurance Framework	
7	To provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction	Six monthly Patient and Carer Strategy progress report and work plan submitted	Consider use of patient/carer stories going forward
8	To monitor and advise on the Trust approach to Research and Development	R&D Strategy and progress reports submitted. Supported annual conferences and events	Continued support given to R&D events
9	To 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.	Minutes received from Quality and Patient Safety Group. Chair of Quality Committee has observed the meeting. Requests from other Committees to review some areas of work from a quality perspective ie waiting lists/ligature work	
10	To monitor Trust compliance with the required standards for regulation and registration with the Care Quality Commission and other national guidelines	CQC updates included in the Quality Insight report CQC compliance work reported.	

3. Attendance

3.1 The Quality Committee met on 5 occasions during 2021/22

Members:	No of meetings attended
Non-Executive Director (Chair)	*5 / 5*
Two Non-Executive Directors	*5 / 5*
Director of Nursing, Allied Health and Social Care Professionals	*5 / 5*
Medical Director	*3 / 5*

Chief Operating Officer	*5 / 5*
Clinical Director Professional Leads	*5 / 5*
Head of Allied Health Professionals and Practice Development	*3 / 5*
Deputy Director of Nursing, Allied Health and Social Care Professionals	*3 / 5*

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

Membership is effective, participation is good and has been strengthened with regular inputs from others.

3.3 Include any recommendation for change to membership & reasons why

No recommendations to change membership.

4. Quoracy

The Committee was quorate on all occasions

5. Reporting / Groups or Committees

Which groups report to The Quality Committee?

- Quality & Patient Safety Group (QPaS)

Has the Committee approved the Terms of Reference for each of these groups?
Yes [X] No [ ] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [X] No [ ]

Has the Quality Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [X] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

Has the Quality Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2021/22?
Yes [X] No [ ]

6. Conduct of meetings

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

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*
  Yes

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

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

7. Review of Terms of Reference

Terms of reference updated to include roles and responsibilities of the committee as agreed at the Trust board meeting in March 2022 specifically that the Committee will provide oversight and assurance to the Board in relation to all activities relating to Quality, Patient Safety and Patient Experience on behalf of the Trust Board to include but not limited to learning from deaths, palliative and end of life care, care of children and young people, resuscitation, safeguarding, infection control .

The frequency of the meeting has also changed from every two months to quarterly.

8. Workplan for 2022/23

Has a workplan for the year ahead, 2022/23 been prepared? yes

Yes [X] No [ ]. *If no, when will it be presented to your committee?* _____

The work plan is presented at each meeting.

9. Any Actions Arising from this Effectiveness Review? YES [X] NO [ ]
If any, please summarise in bullet point format below

It was agreed the Chair will visit reporting groups and has arranged to attend the QPaS meeting in July 2022.

Humber Teaching NHS Foundation Trust

Terms of Reference
Quality Committee

Constitution & 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.
Role / Purpose	The purpose of the Quality Committee is to assure the Trust Board that appropriate processes are in place to give confidence that:- • Quality, patient safety performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks. • Performance in relation to research and development requirements is monitored effectively with appropriate actions being taken to address any performance issues and risks. • The quality impact of proposed business change proposals (i.e. new models, budget reductions) are fully reviewed for their impact on quality • The impact of quality improvements and audits are clearly tracked through performance and experience data.
Scope & Duties	To provide the strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues in the Trust • To provide a strategic overview of Clinical Governance, Risk and Patient Experience to the Trust Board • To provide oversight and assurance to the Board in relation to all activities relating to Quality, Patient Safety and Patient Experience on behalf of the Trust Board to include but not limited to learning from deaths, palliative and end of life care, care of children and young people, resuscitation, safeguarding, infection control. • To provide an assurance to the Trust Board that risks and governance issues of all types are identified, monitored and controlled to an acceptable level. • To provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives • To provide a regular review of the Board Assurance Framework relating to Quality • Drive improvements in the approach to quality improvement, innovation and quality assurance informed by

	the internal governance reporting structures and external horizon scanning and learning from others. • To receive regular assurance reports that ensure all areas/departments of the Trust produce a risk register that relates local risks to achieving the Trust's strategic objectives. • To advise the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action. • To ensure that there is an effective mechanism for reporting significant risks and governance issues to the Trust Board in a timely manner. • To provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction • The Quality Committee will ensure that there is an integrated approach to quality and effectiveness, and patient and staff safety throughout the Trust. • To ensure that work plans are produced, and a range of actions are undertaken by other meetings, reporting to the Quality Committee to provide assurance to the Trust Board. • To monitor Trust compliance with the required standards for regulation and registration with the Care Quality Commission and other national guidelines • To monitor required actions to achieve regulatory and registration standards. **Learning Lessons** • Receive assurances that systems are in place across the organisation to embed learning from the consideration of actions and recommendations. • Advise the EMT and or Trust Board, directly on urgent risk management issues. **Sharing Good Practice** • Encourage learning to take place from the consideration of themes and Trust-wide recommendations on Clinical or non-clinical issues arising from Directorates, Care Groups and sub-committees. **Accountable for:** • Quality Accounts • Care Quality Commission processes
Membership	• Non-Executive Director (Chair) • Two Non-Executive Directors • Director of Nursing, Allied Health and Social Care Professionals (Management support to the Committee) • Medical Director • Chief Operating Officer

	• Clinical Director and Deputy Medical Director • Head of Allied Health Professionals and Practice Development • Deputy Director of Nursing, Allied Health and Social Care Professionals • Assistant Director of Nursing, Patient Safety and Compliance. All members are required to attend a minimum of three meetings a year. Deputies will be identified to represent core Quality Committee members in their absence. The Chief Executive has a standing invitation to attend. The Chair of Audit Committee – optional. Other relevant personnel will be invited to attend as required by the Committee
Quorum	2 Non-Executive Director, 1 Executive Director and 1 other board member. The agenda will be agreed by the Chair, via the Director of Nursing, Allied Health and Social Care Professionals
Chair	Non-Executive Director
Frequency of meetings	The Quality Committee will meet as a minimum 4 times a year.
Agenda & Papers	An agenda for each meeting, together with relevant papers, will be forwarded to committee members to arrive 1 week before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the Committee Secretary.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and presented to the Board with the assurance report. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which minutes have not yet been approved. The Quality Committee will provide an annual Quality Account to the Trust Board.

Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	5 May 2022
Board Approved	*to be updated once approved at Trust Board*
Review Date	*to be updated once approved*

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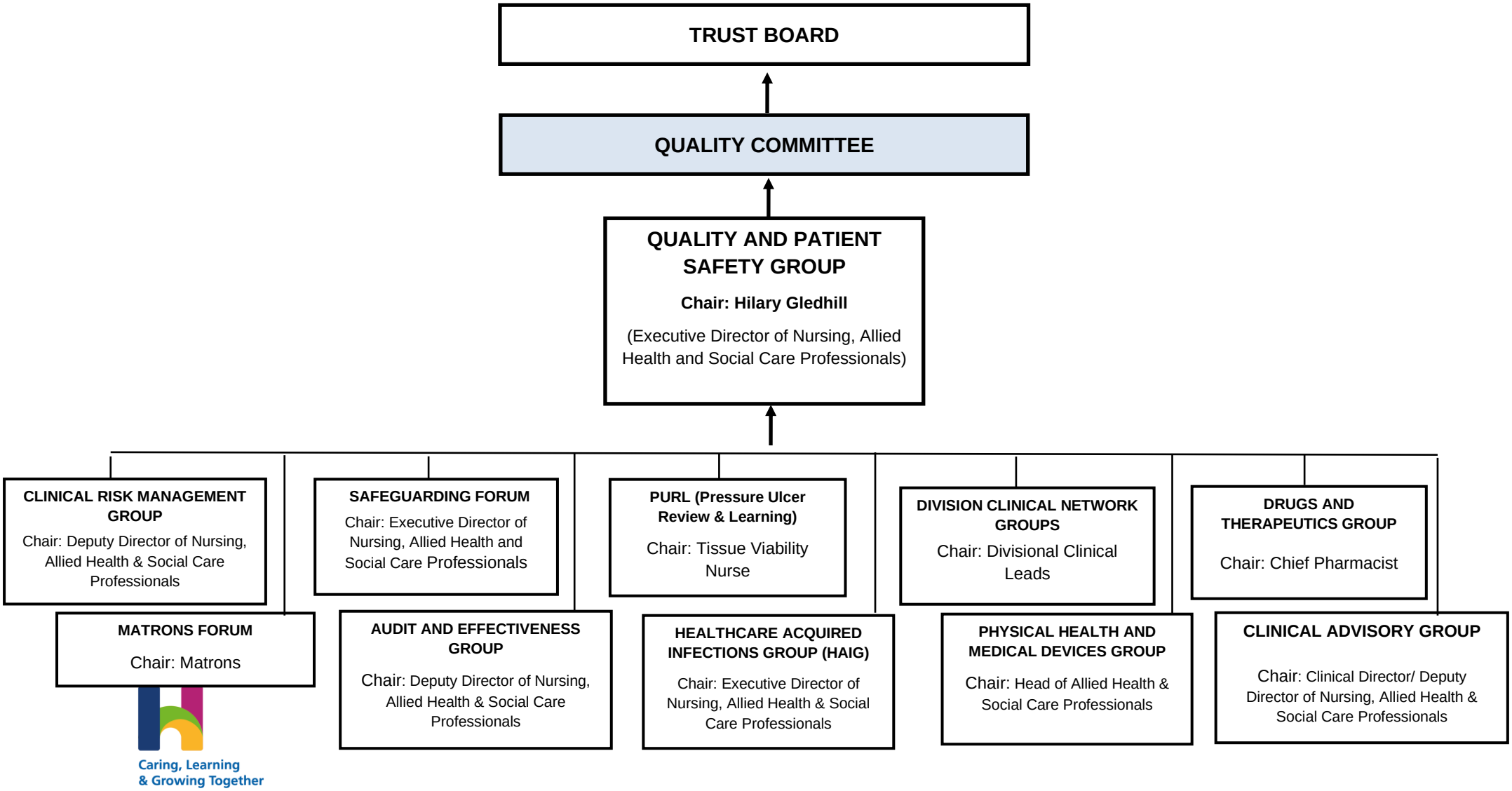
CLINICAL & QUALITY GOVERNANCE REPORTING STRUCTURE



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Finance and Investment Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

The purpose of the Finance and Investment Committee is to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across all financial areas and any potential investment decisions

1. Executive Summary

The year ending March 2022 yet again was dominated by Covid-19 meaning that all meetings were held virtually on Teams. Despite this the committee functioned well with good attendance and input by all committee members and guests/presenters to the committee. Feedback from last year's effectiveness review was taken on board and incorporated into the way the committee was run.

The committee has delivered against all its functions within its ToR as evidenced below apart from a delay in the Planning Guidance leading to a delay in the Trust's annual plan. A formal review of the workings of the committee has been undertaken and a summary of this has been attached. Overall, the feedback is very positive and includes a suggestion that perhaps the committee could be more strategic with more focus on looking forward rather than backward/historically, outturn forecasts more than in year positions and what in year issues are influencing the forecasts. In terms of the issues raised in last year's review they have all been addressed. As a result of Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles the committee will also pick up the areas allocated to it.

In summary I am happy that the committee has the right membership (apart from the additional NED), is working effectively and efficiently and is delivering sound, solid assurance to Board in terms of the financial performance of the Trust, its capital expenditure, its business planning, its estate planning and the delivery of its IT strategy.

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
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.	Challenge undertaken at each meeting. Actions allocated regarding assurance in a rolling tracker with a Chair's log going to the Board after each meeting.	None

Scrutinise all financial plans, including the Trust's annual financial plan, prior to seeking Board approval	Limited planning guidance from NHSI/ E allowed for a draft Financial Plan to be brought to FIC in January. A further report in was presented in March	Due to Planning Guidance setting the timetable for final plans to be submitted at the end of April a report will be presented to FIC in April 2022
Monitor delivery of the Trust's budget reduction strategy (BRS) and other financial savings programmes	Monitoring of the Trusts BRS has been undertaken at every meeting	None
Approve the processes and timetable for annual budget setting, and budget management arrangements	As highlighted above the FIC in January 2022 considered a Draft Plan and then a further detailed report was agreed at the additional March Meeting with final approval of the plan in April	Final approval to FIC in April for 2022/23
Review and challenge delivery of the Trust's Capital Investment Programme and approve the processes for managing the Trust's capital programme	Capital programme monitored with detailed reports at October, December, and January. Prior to that the position was presented through the Capital and Estates Group meeting papers	None
Review and endorse the Trust's medium- and long-term financial plans prior to Board approval	Approved as part of the Financial Planning Papers in January and March and as part of the Budget Reduction Strategy in December 2021 and January 2022	None
Monitor the detailed monthly income and expenditure position of the Trust, overall financial performance (capital and revenue) against plan, and projected final outturn	Monitored at every meeting	None
Receive assurance from the Operational and Corporate Directors in respect of performance against annual budgets, capital plans and the BRS, quality, innovation, productivity and prevention plans, commissioning for quality and innovation plans (CQUIN), activity and key performance indicators, corporate governance activities and responsibilities;	COO attends the committee and Divisional Mangers are invited to review the specific issues within their Directorate	None

Monitor effective balance sheet management, including asset management and cash planning	Monitored at every meeting	None
Monitor financial performance indicators, including compliance with Public Sector Payment Policy	Monitored at every meeting	None
Monitor the development, application and delivery of financial recovery plans	Primary Care Recovery Plan monitored as a deep dive specifically as part of the October 2021 and January 2022 meetings. Specific focus on Granville Court monitored through every meeting.	None
Review the robustness of the risk assessments underpinning financial forecast	Risk assessments are included within the BRS monitored at every meeting. Risk assessments are undertaken in terms of the BRS scheme proposals as per the BRS reviews.	None
Review the Finance Directorate risk register, including delivery of action	Reviewed at every meeting	None
Approve financial policies & procedures, including standing financial instructions	Policies and procedures reviewed when required as per the deadlines.	None
Work with the Audit, Workforce and Quality Committee's advising on the non-clinical aspects of risk management.	Committee Chair worked closely with Chairs of Audit Committee and Quality Committee to advise on non-clinical risks. Committee Chair also sits on Audit Committee and has attended Quality Committee.	None
Identify opportunities for improvement and encourage innovation	This is being undertaken with the Committee review form.	None
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	Regular reviews are provided as part of the Insight Report	None

requirements of regulators and other bodies.		
Review and challenge both the Estates & Facilities Work Programme, Policies & Procedures and the delivery of the Trust's Estate Strategy. Will review and challenge the Digital Delivery work programme, policies and procedures	Delivery of the Trust Estate Strategy and the Trust Digital Strategy is reviewed on a quarterly basis with an annual full review produced and an update of the Estates Strategy which was copied in to Board.	None
Have due regard to the public sector equality duty and the Trust's equality objectives	Equality considered as standard practice throughout the Finance and Investment Committee's reporting. Particular reference to the BRS and QIA process (QIA overall responsibility is Quality Committee).	None
Refer issues arising to other Trust committees or group	This is done through the Chair's log, through the Chair attending other Committees and through conversations at NED meetings.	None
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.	An annual work plan has been produced which is reviewed at each meeting.	None
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 and patients staff • budget holders • other stakeholders, e.g. other Trusts, local authorities	The Committee agreed for a Chair's log to be produced for Board which is also used with Governors and is available on the public website for all stakeholders.	None

Scrutinise all business cases for new business and investment, in line with the Trusts Scheme of Delegation and Standing Financial instructions 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: o Capital expenditure over £500k o New business development projects with an annual value in excess of £500k in total o Any reconfiguration project which has a financial and/or resource implication over £500k per annum o Leases, contracts or agreements with revenue, capital and/or resource investment/commitment in excess of £500k per annum o The purchase or sale of any property o The purchase or sale of any equipment above £250k	All opportunities over £500k have been submitted as business cases to the Committees for discussion and a decision, taking account of the Trusts Strategy and long term plan. Full reviews of benefits delivered are also undertaken.	

○ 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.		

3. Attendance

The Finance and Investment Committee met on 7 occasions during 2021/22

Members:	No of meetings attended
Francis Patton - Non-Executive Director	*07/07*
Peter Baren - Non-Executive Director	*07/07*
Lynn Parkinson - Chief Operating Officer	*07/07*
Peter Beckwith - Director of Finance	*07/07*
Iain Omand - Deputy Director of Finance	*07/07*
In attendance:	
Michele Moran - Chief Executive Officer	*04/07*
Di Roberts – Deputy Director of Finance	*07/07*
Jonathan Duckles – Head of Business Development	*04/07*
Stuart McKinnon-Edwards	*01/01*

3.2 The committee works well with all members contributing well providing good constructive challenge.

3.3 It is recommended that one more NED is added to the committee as per the recommendations of the Governance review from Grant Thornton, that the role of clinical director be removed from membership of the committee and that the ToR reflects that confidential/sensitive items only come to Part Two Board.

4. Quoracy

The Committee was quorate on all occasions

5. Reporting / Groups or Committees

Which groups report to Finance and Investment Committee *(these should be clearly identified on the schematic on your ToR)*. Please list:

The Committee receives reports from the Digital Delivery Group and the Capital Programme Board but these report into other Committees who will provide assurance around these groups.

Has the Committee approved the Terms of Reference for each of these groups?
n/a

Are ToR annual reviews for each reporting group on your Committee workplan to approve? n/a

Has the Finance and Investment Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [ ] No [ ] n/a

If no, please provide an exception report on concerns/recommended changes below:-

Has Finance and Investment Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2020/21?
Yes [ ] No [ ] n/a

6. Conduct of meetings

A full workplan was developed for the committee at the start of the years and despite Covid-19 issues has been delivered in full with all agenda's appropriately scheduled.
Reports and papers have been issued in a timely manner with any minor delays being driven by closing down the month end. The quality of papers has been good with Executive summaries continuing to improve.
The Committee has had excellent secretarial support providing high quality minutes and action logs in a timely manner. All actions are clearly recorded and assigned to individuals and dealt with in a timely manner.

7. Review of Terms of Reference

It is recommended to add one more NED to the membership of the committee as per the Governance review from Grant Thornton, that the role of clinical director be removed from membership of the committee and that the ToR reflects that confidential/sensitive items only come to Part Two Board.

8. Workplan for 2022/23

Has a workplan for the year ahead, 2021/22 been prepared?

Yes [X] No [ ].

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

If any, please summarise in bullet point format below

- Review strategic role of committee with more focus on looking forward rather than backward/historically, outturn forecasts more than in year positions and what in year issues are influencing the forecasts.
- As a result of the Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles review the committee will pick up the new areas allocated to it.

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Terms of Reference

Finance and Investment Committee

Authority	The Finance and Investment 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 and Investment 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 and Investment 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.

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	• Monitor the detailed monthly income and expenditure position of the Trust, overall financial performance (capital and revenue) against plan, and projected final outturn.
	• Receive assurance from the Operational and Corporate Directors in respect of performance against annual budgets, capital plans and the BRS, quality, innovation, productivity and prevention plans, commissioning for quality and innovation plans (CQUIN), activity and key performance indicators, corporate governance activities and responsibilities.
	• Monitor effective balance sheet management, including asset management and cash planning.
	• Monitor financial performance indicators, including compliance with Public Sector Payment Policy.
	• Monitor the development, application and delivery of financial recovery plans
	• Monitor the development, application and delivery of financial contingency plans.
	• Review the robustness of the risk assessments underpinning financial forecasts.
	• Review the Finance Directorate risk register, including delivery of action plans.
	• Approve financial policies & procedures, including standing financial instructions.
	• Work with the Audit, Workforce and Quality Committee's advising on the non-clinical aspects of risk management.
	• Identify opportunities for improvement and encourage innovation.
	• Monitor contract negotiation and performance noting the position of contracts and raising any concerns; receiving assurance from the Executive Directors in respect of the organisation meeting the contractual requirements and expectations of commissioners, meeting the legislative / regulatory requirements of regulators and other bodies'.
	• Will review and challenge both the Estates & Facilities Work Programme, Policies & Procedures and the delivery of the Trust's Estate Strategy. Will review and challenge the Digital Delivery work programme, policies and procedures.
	• Oversee the work of the Special Purpose Vehicle (SPV) Task and Finish Group.
	• Scrutinise all business cases for new business and investment, in line with the Trusts Scheme of Delegation and Standing Financial instructions 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

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	○ 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. • 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). • Chief Operating Officer. • Director of Finance. • Deputy Director of Finance/Financial Controller. • General Managers and Deputy Directors will not be members but will attend for all or any part of a meeting as appropriate. Senior Clinical Leadership will be requested / invited to attend the Committee a minimum of 3 times per year, a reciprocal arrangement will be in 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.

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	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 one Non-Executive Director.
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 present at that meeting shall act as Chair for that meeting. Deputies may attend by agreement with the Chair.
Frequency	• The Committee shall meet quarterly, however additional meetings will be diarised and held as necessary. • There is a requirement for flexibility when working to new Business deadlines and virtual meetings may be required for investment decisions.
Agenda and Papers	• Notice of each meeting, including an agenda and supporting papers shall be forwarded to each member of the Committee not less than 5 working days before the date of the meeting. • Minutes of all meetings of the Committee shall be taken by an appropriate and identified secretary and will kept by the Trust Secretary. • A record shall be kept of matters arising and/or issues to be carried forward at each meeting. • A record shall be kept of all investment decisions for the purposes of performance monitoring and reporting. • All investment papers submitted must be considered by the Executive Management Team prior to consideration by the Committee in line with the flow of investment decision making. • All meetings of the Committee shall be called at the request of the Chair. • Meeting agenda will be agreed with the Committee Chair before circulation and when circulated it will confirm the venue, time and date.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and presented to the Board Part Two with the assurance report presented to Board Part One unless commercially sensitive or confidential in which case those elements will be presented to Board Part Two. 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.

Deleted: Non-Executive

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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	21 April 2021
Board Approved Date	19 May 2021
Review Date	April/May 2022

Schematic below:

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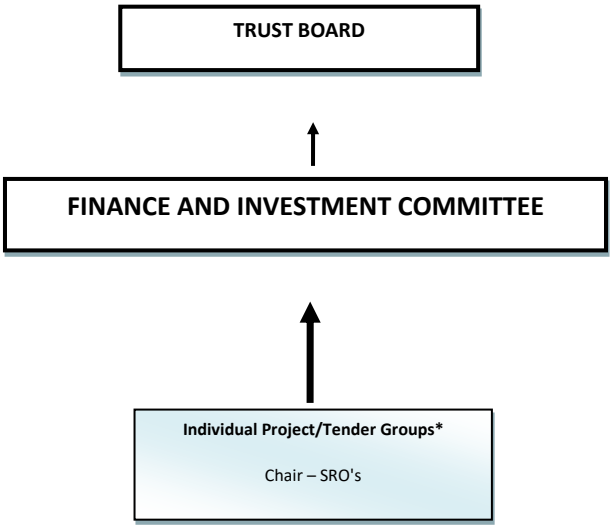
FINANCE AND INVESTMENT COMMITTEE REPORTING STRUCTURE



** Not a formal subgroup of the Finance and Investment Committee, relevant groups established based on each tender requirement.*

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Flow of decision-making process re Investments

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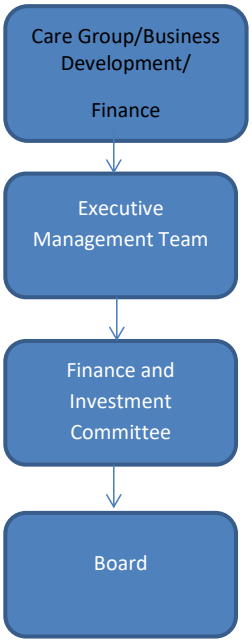

Initial consideration of opportunity – to progress or not

Consideration of schemes to be progressed and advise F&I Committee

Consideration of schemes to progress and advise Board

Consideration of schemes to progress

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FINANCE & INVESTMENT COMMITTEE (FIC) EFFECTIVENESS REVIEW FORM

Numbers shown below reflect the number of members which responded to each column and any additional comments made:

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ actions
Theme 1 – Committee Focus						
I am clear about the objectives the Committee has set itself each year.	Xxxxx					Workplan useful
I understand how the Committee wants to operate in terms of the level of information it would like to receive for each of the items on its annual work plan.	Xxxx	X				
I have a full understanding of the Terms of Reference of the Committee.	xxxx	X				
Theme 2 – Committee Team Working						
The Committee membership has the right balance of experience, knowledge and skills to fulfill the role described in its Terms of Reference.	Xxx	Xx				
The Committee has structured its agenda to cover financial control, investment and investment business cases and key strategic areas of focus.	Xxxx	X				
The work plan is revisited at the end of every meeting to ensure it is accurate and up to date.	Xxx	xx				Work plan is not updated at every meeting, however agenda for next meeting is always discussed.
I am clear with regards to the agenda items I am expected and required to contribute to.	Xxxxx					
I am clear with regards to the requirements for my attendance at the Committee.	Xxxxx					
Non-attendance by members/ regular attendees is addressed by the Chair of the Committee.	x	Xxx			x	Not experienced members not attending whilst I have been involved.
It is clear to me why I am a member/ attendee of this Committee and what information I am required to provide to the Committee.	Xxxxx					
I feel sufficiently comfortable within the Committee environment to be able to express my views, doubts and opinions.	xxxxx					
Members/attendees are held to account for late or missing information.	xx	xx			x	I've not experienced this scenario but have confidence in the Chair to hold people to account where needed
When a decision has been made or action agreed I feel confident that it will be implemented as agreed and in line with the timescale set down.	xxxx	x				

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Unable to answer	Comments/ actions
Theme 3 – Committee Effectiveness						
The quality of Committee papers received allows me to perform my role effectively.	Xxxx	x				
Members/attendees provide real and genuine discussion and challenge which is of benefit to the effectiveness of the Committee.	Xxx	xx				
Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.	Xxxxx					Always a good meeting, Chair is very inclusive
Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc, and how it is being monitored.	Xxxx	x				The meeting is well managed in this respect by the Chair
Throughout the meeting and/or at the end of each section on the agenda, we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.	Xxxx	x				We do this so much better than other NHS organizations I have worked in – its very useful
The Committee provides a written summary report of key points from its meetings to the Board of Directors.	Xxxxx					Assurance reports work well and have been adopted for subgroups Very good report and in timeframes
There is a formal appraisal of the Committee's effectiveness each year which is evidence based and takes into account my views and wider views.	Xxxxx					
The Committee actively challenges information providers during the year to gain a clear understanding of progress and achievement.	Xxxxx					
Theme 4 – Leadership						
The Committee's Chair has a positive impact on the performance of the Committee.	Xxxxx					
Committee meetings are chaired effectively and with clarity of purpose and outcome.	Xxxxx					Chairing skills excellent. Inclusive meeting and good level of debate
The Chair allows debate to flow freely and does not assert his/her views too strongly.	Xxxxx					

General	
Please use this section for further feedback. Is there anything you think would help the Committee run more smoothly? Any ideas for future development / working differently?	The meeting is important in terms of the focus of the Executive and provides me with guidance in terms of what is specifically required for reassurance The Well Led feedback could help inform this. We could reflect on whether we are "strategic" enough on the finance side of the committee's business. Whether we feel we have the right balance of detail in respect of in-year v strategic and forward looking. For example maybe concentrating on outturn forecasts more than in year

	positions and what in year issues are influencing the forecasts. Good committee and has progressed work even during these challenging times

FIC Self-assessment form

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Workforce and OD Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

The purpose of the Workforce and OD Committee is to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and organisational development that supports the Trust to deliver its strategic objectives and provide high quality care. Its purpose is also to provide assurance to the Trust Board in relation to the health and wellbeing of staff and to provide assurance on the delivery of the relevant strategic objective assigned to the Workforce and Organisational Development Committee - Goal 4 – Developing an effective and empowered workforce.

1. Executive Summary

The Committee undertakes its delegated functions on behalf of the Trust Board. The Committee is relatively new and still developing. The Committee achieved its objectives for 2020/21 and delivered on delegated functions. In addition, it has considered;

- Workforce Insight Reports
- Risk Registers
- Freedom to Speak Up Annual Report
- Presentations on 2020 Staff Survey Results
- Recruitment Task and Finish Group updates
- Trust COVID reset and recovery plan
- NHS People Plan
- Lease Car Policy and freedom to speak up procedure approval
- Annual Equality Diversity and Inclusion Report
- Workforce Race Equality Standards and Workforce Disability Equality Standards reports
- Safer Staffing reports
- Gender Pay Gap report
- Leavers and Absence Deep Dive reports
- Trust Workforce Plan
- Statutory mandatory training recovery plan
- Guardian of safe working updates

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
Provide oversight and assurance to the Board in relation robust processes for the effective management of	Monthly Insight report Workforce Scorecard Risk Register	

Workforce and Organisational Development;		
Scrutinise structures in place to support workforce and organisational development to be assured that the structures operate effectively and action is taken to address areas of concern.	Insight report Sub group updates	
Receive assurance on the delivery of the Workforce and OD Strategy	Insight report Revised strategy to go to WOD once NHS People Strategy launched.	
Be assured on the management of the high operational risks on the corporate risk register which relate to workforce and organisational development and ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner.	Risk register provided (recently included in Insight report)	
Be assured of the Trust's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health, NHS Improvement and other regulatory bodies / external agencies to gain assurance that they are appropriately reviewed and actions are being undertaken and embedded.	Insight report	
Receive assurance that the Trust has effective and transparent mechanisms in place to monitor workforce and organisational development performance.	Insight Report Workforce Scorecard	
To be assured that the views of staff are captured, understood and responded to.	Staff survey reports	
Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for equality and diversity.	Annual EDI Report Staff survey reports	

Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for staff health and wellbeing.	Updates from the H&W Group (Lynn Parkinson chair)	
Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for safe working for junior doctors	Junior doctors report	
Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for freedom to speak up.	FTSU included in the Insight report	

3. Attendance

3.1 The Workforce and OD Committee met on 5 occasions during 2021/22. The meeting took place bi monthly in 2021 and is now taking place quarterly in 2022.

Members:	No of meetings attended
Dean Royles - Non-Executive Director (Chair)	*05/05*
Mike Cooke - Non-Executive Director (Deputy Chair) (left Trust August 2021)	*02/05*
Steve McGowan - Director of Workforce and Organisational Development	*04/05*
Lynn Parkinson - Chief Operating Officer	*04/05*
John Byrne - Medical Director	*05/05*
Hilary Gledhill – Director of Nursing	*05/05*
Francis Patton - Non-Executive Director (New Deputy Chair)	*04/05*
Michele Moran - Chief Executive	*04/05*
In attendance:	
Karen Phillips – Deputy Director of Workforce and OD	*05/05*
Caroline Flint – Chairman	*01/05*
Katy Marshall – Head of Learning and Organisational Development	*01/05*
Peter Baren - Non-Executive Director	*01/05*
Abbie Rendell – Senior HR Business Partner	*03/05*
Hanif Malik - Non-Executive Director	*01/05*

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

The membership composition is effective, and all members have contributed to effective debate and discussion. Chairs of staff networks are also invited on a rolling basis. One of the responses to the questionnaire said we should review membership, and this will be discussed at the April Meeting.

4. Quoracy

The Committee was quorate on all occasions

5. Reporting / Groups or Committees

Which groups report to Workforce and OD Committee? *(these should be clearly identified on the schematic on your ToR)*. Please list:

- Staff Health Wellbeing and Engagement Group
- Equality, Diversity, and Inclusion Group
- Medical Education Committee

Has the Committee approved the Terms of Reference for each of these groups?
Yes [X] No [ ] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [X] No [ ]

Has the Workforce and OD Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [X] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

Has Workforce and OD Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2021/22?
Yes [X] No [ ]

6. Conduct of meetings

Chair to consider the following questions

- *Was a workplan agreed at the start of the year and have meetings and agendas been appropriately scheduled to meet the work plan?* Yes. Work plan has been approved and we have considered additional deep dives and assurance as appropriate

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?* Yes. Feedback from members is that papers are well prepared and useful.

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

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

7. Review of Terms of Reference

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

No changes are proposed – the ToR are attached for approval.

8. Workplan for 2022/23

Has a workplan for the year ahead, 2022/23 been prepared?

Yes [X] No [ ]. *If no, when will it be presented to your committee?* _____

9. Any Actions Arising from this Effectiveness Review? YES [ ] NO [x]
If any, please summarise in bullet point format below
A review of membership.

NHS
Humber Teaching
NHS Foundation Trust

Workforce and Organisational Development Committee

Terms of Reference

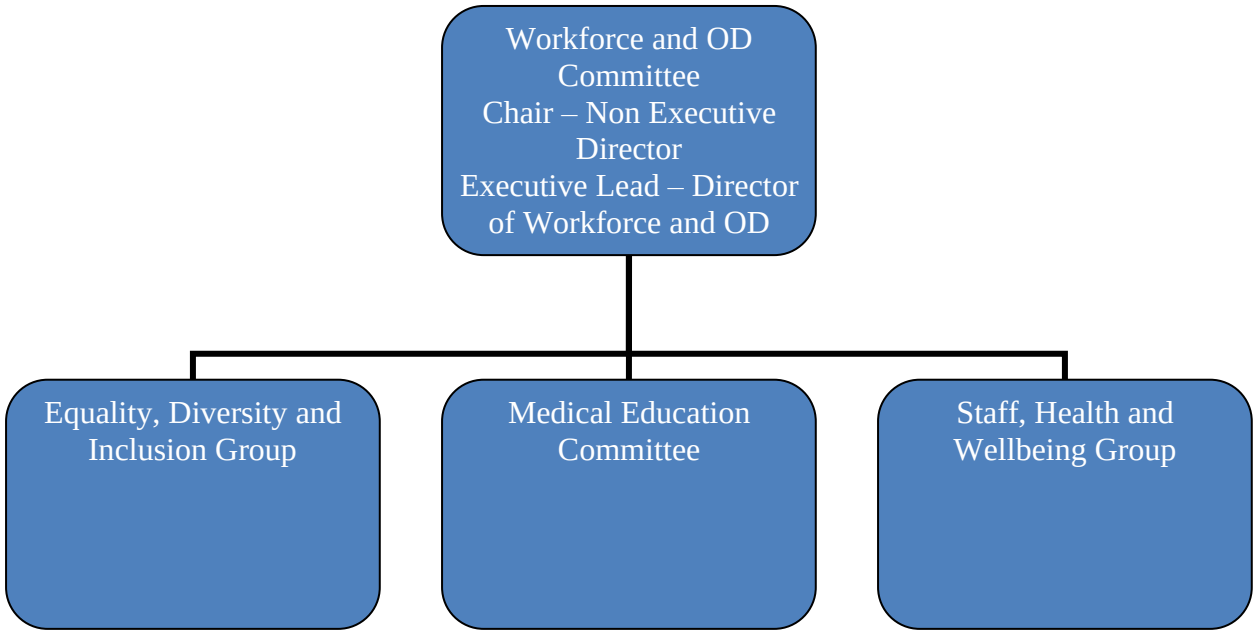
Constitution & Authority	The Workforce and Organisational Development Committee is constituted as a standing committee of the trust's board of directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings. The Workforce and Organisational Development Committee is appointed by the Trust Board in line with the powers set out in the Trust Standing Orders. The Workforce and Organisational Development Committee holds only those powers as delegated in these Terms of Reference as determined by the Trust Board.
Overall Aim/Purpose	The Workforce and Organisational Development Committee exists to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and organisational development that supports the Trust to deliver its strategic objectives and provide high quality care. To provide assurance to the Trust Board in relation to the health and wellbeing of staff. To provide assurance to the Trust Board in relation to PROUD. To provide assurance on the delivery of the relevant strategic objective assigned to the Workforce and Organisational Development Committee - Goal 4 – Developing an effective and empowered workforce.
Scope & Duties **Functions**	The Workforce and Organisational Development Committee will: • Provide oversight and assurance to the Board in relation robust processes for the effective management of Workforce and Organisational Development. • Scrutinise structures in place to support workforce and organisational development to be assured that the structures operate effectively and action is taken to address areas of concern. • Receive assurance on the delivery of the Workforce and OD Strategy. • 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. • Be assured of the Trust's response to all relevant Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the Department of Health, NHS Improvement and other regulatory bodies / external agencies to gain assurance that they are appropriately reviewed and actions are being undertaken and embedded. • Receive assurance that the Trust has effective and transparent mechanisms in place to monitor workforce and organisational development performance. • To be assured that the views of staff are captured, understood and responded to. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for equality and diversity. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for staff health and wellbeing. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for safe working for junior doctors. • Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for freedom to speak up. • The Committee will advise the Audit Committee on the adequacy of assurances available and contribute to the Annual Governance Statement.
Membership	The members of Committee are: • Non-Executive Director (Chair) • Non-Executive Director (Deputy Chair) • Non-Executive Director • Director of Workforce and Organisational Development • Chief Operating Officer • Medical Director • Director of Nursing The following roles will be routine attendees at the committee: • Deputy Director of HR and Diversity • Organisational Development Lead • Workforce Equality and Diversity Lead All Board members are able to attend meetings of the Committee but will be recorded as "in attendance".

	The Chief Executive has a standing invitation to attend committee meetings.
Quorum	The Committee will be quorate when three of the membership are present if this includes one non-executive director and one executive director. Where members are unable to attend they should ensure that a deputy is in attendance who is able to participate on their behalf.
Chair	The Chair of the Committee will be a Non-Executive Director
Frequency of meetings	The Committee will meet bi- monthly.
Agenda & Papers	Agendas and supporting papers will be circulated no later than 7 days in advance of meetings. Any items to be placed on the agenda are to be sent to the secretary no later than 8 working days in advance of the meeting. Items which miss the deadline for inclusion on the agenda may be added on receipt of permission from the Chair. Minutes will be taken at all meetings, presented according the corporate style, circulated in draft to members within 7 days and approved by agreement of members at the following meeting. A schedule of business reflecting the annual work programme shall be developed annually. Agenda and Papers can be accessed via the Committee Secretary.
Minutes & Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and presented to the Board with the assurance report. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which minutes have not yet been approved.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference. The Committee will on an annual basis review and approve the terms of reference, work plan and work programmes of all its reporting groups. The Committee will operate using a work plan to inform its core agenda. The agenda will be agreed with the Chair prior to the

	meeting.
Agreed by Committee	12/5/21
Approved by Trust Board	18 May 2022 tbc
Review	April 2022

Workforce and Organisational Development Committee Schematic



Humber Teaching
NHS Foundation Trust

Charitable Funds Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

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

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

- *ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Board.*

- *review fund-raising and consider and recommend investment policies.*

1. Executive Summary

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

During 2021/22 Charitable Funds Committee has:-

- Continued the Whitby Hospital Appeal to support the ongoing transformation of Whitby Hospital, the committee continued to support the Task and Finish groups and Health Stars engaged with the local community in Whitby.

- Encouraged the Trust to identify a new fundraising appeal for Health Stars for the next financial appeal.

- Encouraged further Circle of Wishes requests to be submitted through departments across the trust, increased the number submitted to the highest in Health Stars history.

- Thanks to an NHS Charities Together grant the committee has continued to support the development of the "Dost" project. This is to support the health and wellbeing of Black, Asian, and Minority Ethnic staff members and out in the wider community.

- Continued to challenge and oversee the remaining spending of the Impact Appeal as the funds raised are spent on the items requested and brining the appeal to a close.

- CEO & Executive Lead reviewed KPIs within the year and asked the committee to review the KPIs and agree changes.

- Reviewed the indicators from the work programme and will continue to monitor these for another financial year.

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
The Committee will review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame.	In 2021/22 Health Stars received 181 wishes. Health Stars are grateful to the PACE team who contributed to 93 of those wishes being submitted. Of the 181 wishes submitted, 141 are in progress or granted. Two of the wishes were declined, one wish was withdrawn, and 37 wishes were found to be duplicates.	Health Stars are keen to maintain this level of wish requests next year and improve the quality to ensure less duplicate wishes are received.
The Committee will ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Trust Board.	The Accounts were presented to the Charitable Funds Committee in September 2021 and approved by the Trust board. The committee receives a finance update on fund zones and balances at each meeting. Within the year the Fund Guardians of the	Training/Induction for new Fund Guardians will take place in the next financial year.

	Funds were reviewed, and new Fund Guardians have been appointed.	
The Committee will review fund - raising and consider and recommend investment policies.	Fundraising has been more challenging in the last year than the first year of the pandemic. The initial influx of grants and donations have finished and there were limited months for in person fundraising activities to take place outside of lockdown. The charity team have focused on grant applications, progressing NHS CT grant applications, communications and preparing events for 2022. The team have also focused on the Whitby Hospital Appeal, the fundraising bricks were launched, and community fundraising was able to take place briefly in the Summer of 2021. A total of £63k was raised during the 2021/22 financial year.	The team have focused on implementing the communications and fundraising plan and will continue to do so. Planning for in person fundraising events has resumed beginning with the CEO challenge in June 2022 and the Golf Day in September 2022. The Committee will challenge the team to identify ways of significantly increasing the turnover of fundraising and use of funds.

3. Attendance

3.1 The Charitable Funds Committee met on 5 occasions during 2021/22. 18th May 2021, 20th July 2021, 22nd September 2021, 16th November 2021, and 15th March 2022.

Members:	No of meetings attended
Professor Mike Cooke, Non-Executive Director	2/5
Peter Baren, Non-Executive Director	5/5
Peter Beckwith, Director of Finance	5/5
Steve McGowan, Director of Workforce & OD	4/5
Attendees:	
Andrew Barber, Chief Executive Officer, HEY Smile Foundation	3/5
Victoria Winterton, Head of Smile Health, HEY Smile Foundation	4/5
Kristina Poxon, Head of Smile Health, HEY Smile Foundation	5/5
Rachel Kirby, Marketing and Communications Manager	2/5

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

Membership is effective with joint membership and links with other committees. Co-production has given a real flavour within the organisation and committee structure.

3.3 Include any recommendation for change to membership & reasons why
No recommendations for change.

4. Quoracy

The Committee was quorate on 5 occasions.

5. Reporting / Groups or Committees

Which groups report to Charitable Funds Committee? *(these should be clearly identified on the schematic on your ToR)*. Please list:

There are no committees/ groups reporting to Charitable Funds Committee.

Has the Committee approved the Terms of Reference for each of these groups?
Yes [ ] No [ ] *Not applicable – no groups formally report to CFC*
Are ToR annual reviews for each reporting group on your Committee work plan to approve?
Yes [ ] No [ ] *Not applicable – no groups formally report to CFC*

Has the Charitable Funds Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance?
Yes [ ] No [ ] *Not applicable – no groups formally report to CFC*

Has Charitable Funds Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2020/21?
Yes [ ] No [ ] *Not applicable – no groups formally report to CFC*

6. Conduct of meetings

Chair to consider the following questions

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

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting? Yes*

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

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

7. Review of Terms of Reference

No changes proposed to ToR.

Please attach a full copy of your agreed ToR for approval by the May Board as part of the committee effectiveness reviews.

8. Workplan for 202/23

Has a workplan for the year ahead, 2022/23 been prepared?

Yes [✓] No [ ]. _____

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

If any, please summarise in bullet point format below

Caring, Learning
& Growing Together

Humber Teaching
NHS Foundation Trust

Charitable Funds Committee
Terms of Reference

Constitution and Authority	Humber Teaching NHS Foundation Trust is the Corporate Trustee of the charity known as Health Stars. The Charitable Funds Committee is established as a Committee of the Trust Board to oversee the charity's operation on behalf of the Corporate Trustee. The Trust Board may delegate to the Committee or to the Director of Finance matters relating to the operation of the funds, but decisions regarding the investment of funds must be made within an overall strategy determined by the Trust Board taking account of the recommendations made by the Committee.
Role / Purpose	The overall role of the Charitable Funds Committee is to oversee the operation of the charitable funds on behalf of Humber Teaching NHS Foundation Trust's Board of Directors – the Corporate Trustee. Registered charity number …
Scope and Duties	The committees key roles are: • To monitor and review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame. • To ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Trust Board as Corporate Trustee. • To develop the strategy and objectives for the charity for consideration by the Board • To assist the Board in meeting its responsibilities as the corporate trustee of the fund by overseeing the operation and development of charitable funds, expenditure and any investment plans • To monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements • To make decisions on behalf of the Board within the defined delegation and financial limits set out in the trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions. The Committee has delegated authority to approve expenditure of charitable funds in accordance with the financial delegation limits are set out below: **Scheme of Budgetary Delegation:**

<table>
<tr><td></td><td>
<table>
<tr><th colspan="2">Expenditure on Charitable and Endowment Funds</th></tr>
<tr><td>Up to £1000</td><td>Fund Manager, Health Stars Charity/Fundraising Manager</td></tr>
<tr><td>£1000 - £4,999</td><td>Fund Manager, Director of Finance</td></tr>
<tr><td>Over £5,000*
**Any expenditure over £5,000 is subject to procurement rules and budgetary delegation</td><td>Fund Manager, Director of Finance and Charitable Funds Committee</td></tr>
<tr><td>Over £25,000</td><td>Fund Manager, Director of Finance and Charitable Funds Committee (reported to Trust Board for information within Chairs Assurance Report)</td></tr>
<tr><td>Over £100,000</td><td>Trust Board as Corporate Trustees</td></tr>
</table>

Operational issues that relate to the work of the charity should be discussed in Executive Management Team meetings and operational decisions fed into discussions and decision making at the Committee.
</td></tr>
<tr><td>Membership</td><td>The Charitable Funds Committee shall be appointed by the Trust Board and consist of up to:
• 3 Non-Executive Directors
• Director of Finance.
• Director of Workforce and Organisational Development

The Chief Executive has a standing invitation to attend any committee meeting.

The following will be invited to attend the committee:
• The Charity Manager
• Smile Representatives
• The Communications Manager
• Deputy Chief Operating Officer

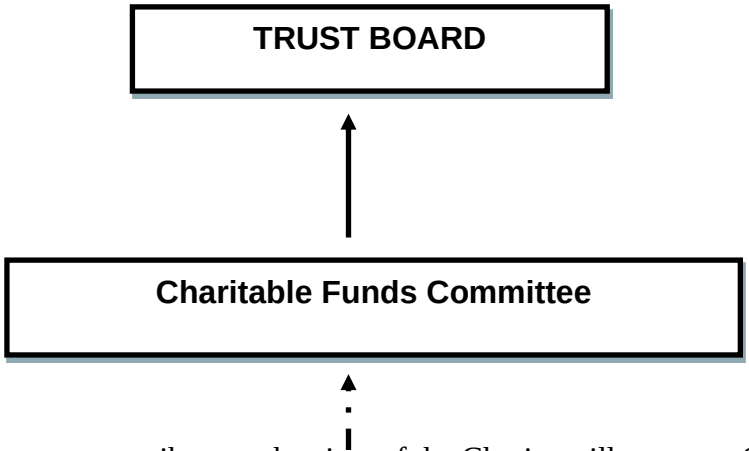
The Committee will appoint a Chairman and Vice-Chairman to be reviewed annually.</td></tr>
<tr><td>Quorum</td><td>The quorum necessary for the transaction of business shall be if two members are present including at least one Non-Executive Director from Humber Teaching NHS Foundation Trust.

Deputies may cover in the absence of the nominated member.</td></tr>
<tr><td>Chair</td><td>The Committee shall be chaired by a Non-Executive Director.</td></tr>
<tr><td>Frequency of Meetings</td><td>The Committee shall meet as and when required, but at least four times a year.</td></tr>
<tr><td>Agenda and Papers</td><td>The agenda is to be agreed with the Committee Chairman taking account of the annual cycle of Committee business.

All papers are to be forwarded to members and those attending no later than 5</td></tr>
</table>

	working days before the date of the meeting unless otherwise agreed by the Chairman. Minutes are taken of the proceedings and resolutions of the Committee including recording the names of those present and in attendance. Minutes shall be promptly circulated to all members. A record is kept of matters arising and issues to be carried forward.
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and presented to the Board with the assurance report. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which minutes have not yet been approved. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure or require executive action. The Committee's annual report and annual accounts will be considered by the Committee prior to submission to the Board.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	April 2022
Board Approved	18 May 2022 - tbc
Review Date	March/April 2023

CHARITABLE FUNDS COMMITTEE REPORTING STRUCTURE



Project groups set up to contribute to the aims of the Charity will report to Charitable Funds Committee throughout the lifespan of the group/s (as at April 2022 these include):

Whitby Project Oversight Group

Caring, Learning & Growing Together

Humber Teaching
NHS Foundation Trust

Collaborative Committee – Humber Coast and Vale Specialised Provider Collaborative

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

The purpose of the Collaborative Committee is to

The purpose of the Collaborative Committee is to assurance to the HTFT Board on matters of quality assurance, finance, and performance. This is to ensure delivery of the overall HCV Specialised Provider Collaborative aims to transform care for people in low and medium secure mental health services, CAMHS in-patient and Adult in-patient eating disorders services.

Day to Day provision of patient care is the responsibility of Providers within the Provider Collaborative Partnership. Services will be commissioned utilising NHS Standard Contracts with clear Key Performance Indicators (KPIs) and Outcomes. Via the PCOG the Collaborative Committee will take a partnership approach to working with Providers within the Provider Collaborative to deliver our overall strategic aims which are to improve care pathways and patient care outcomes.

The Provider Collaborative aims to continuously improve service user access, experience, and outcomes. Through this it will 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 turn it will aim to generate financial savings. These savings will be reinvested in other parts of the Secure, CAMHS and Eating Disorders mental health and learning disability pathways through formal contracting and commissioning arrangements.

This approach will ensure delineation between the Provider Partnership and Commissioning functions of the Provider Collaborative and enable our overall partnership to be conducted in an open and transparent way and follow due process.

1. Executive Summary

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

The Collaborative Committee had its inaugural meeting on 8 December 2020 and was initially titled the Commissioning Committee. The Committee was established to provide internal assurance and oversight to Humber Teaching NHS Foundation Trust as the Lead Provider and accountable to NHS E/I on the performance of the Provider Collaborative.

The Collaborative Committee has met 11 times over the last 12 months and has overseen the due diligence (finance and quality) required to enable the Provider Collaborative progressing to Go Live on 1 October 2021.

The Committee has worked efficiently in the delivery of its objectives and duties:

- As Lead Provider provide assurance to the HTFT Board –that it is fulfilling its duties and obligations within the HCV Specialised Mental Health Learning Disability and Autism Provider Collaborative
- Be assured that there are appropriate arrangements in place in respect of Serious Incidents, Safeguarding and a system is in place to ensure quality of care and to continuously learn and improve
- Working closely with PCOG linking in with the wider commissioning, planning and quality assurance system including other Provider Collaboratives and local and national commissioners to improve services along whole pathways of care and manage pressures within the wider system
- Overall Contract management, including quality assurance across NHS and independent sector. This will be the first line of arbitration/mediation between partners

As part of HTFT's role as a provider of health and social care within the Collaborative and its role as commissioner of the overall Provider Collaborative there is a governance framework in place which ensures clear delineation of the two functions. All members of the committee who are employed by HTFT as a provider declare their interest at each meeting and any sensitive information shared and discussed at the meeting is dealt with appropriately.

In January 2022, as part of wider HTFT audit and assurance, Sue Cordon from Grant Thornton was an observer at the committee and provided initial verbal feedback of her assurance of the committee role and the delineation of HTFT as a provider of healthcare and the host of the collaborative, planning and quality team (commissioning).

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
Financial planning ▪ Provide assurance to the HTFT Board that the planning programme is effectively established and managed and that risks to delivery of the plan and any significant service impacts, or	Financial reports for each work stream area and projected financial position are shared at each monthly meeting for information and discussion. The CC were kept updated	None

risks are effectively managed or mitigated ▪ Along with PCOG and with Risk and Gain Share partners review in year performance against commissioned services and financial plans and examine the effectiveness of any remedial action plans. ▪ Provide assurance to the HTFT Board (as lead provider) on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money.	with progress on financial due diligence prior to Go Live As above Since Go Live in October 2021 the CC has 'enacted' 1 new contractual change which will provide improved patient care and financial benefit – FREED Champion	None None – although it is anticipated that further proposals will be shared as we progress as a Provider Collaborative in 2022/23
Transactional • Following review and support by the Provider Collaborative Oversight Group; will ratify business cases (for both new service proposal and reduction of service delivery) and investments and/or disinvestments - provide financial assessment and scrutiny which will then be translated into contractual agreements which are held by the Lead Provider	Since Go Live in October 2021 the CC has 'enacted' 1 new contractual change which will provide improved patient care and financial benefit – FREED Champion	None – although it is anticipated that further proposals will be shared as we progress as a Provider Collaborative in 2022/23
Contracting • To be assured that contracts are in place to address risk in relation to the quality and performance of commissioned services and thereby undertake the duties as expected of the Lead Provider.	Lead Provider Contract signed by HTFT. Sub-contracts and lead provider to lead provider contracts have been shared with partners and other provider collaborative. Sub-contract performance and	None

• Following agreement at PCOG enact Contract Variations and necessary formal Commissioning Intentions dialogue with Provider Collaborative	quality meeting have commenced with partners in the collaborative Yes – FREED Champion as per outlined in Finance and Transactional	
Risk Management: • To note, review any modifications to the risk registers, including ownership and delivery of action plans against defined timescales • Discuss and review of any issue likely to require inclusion on, or modification to, any risk register	Risk Registers are developed at each of the 3 work stream meetings and are shared at each CC meeting along with the overall PC risk register. Discussions are held and amendments made as per meeting discussion.	None
Quality Assurance • To be assured that quality, clinical governance, patient, and public engagement issues are appropriately addressed in all service developments/reconfiguration of services and are in line with statutory requirements, national policy, and guidance.	Information and reports are shared at each meeting to ensure oversight. There is a Quality Assurance and Oversight work stream as part of the Provider Collaborative governance framework.	None

3. Attendance

3.1 The Collaborative Committee – Humber Coast and Vale Specialised Provider Collaborative met on 11 occasions during 2021/22

Members:	No of meetings attended
Members: **Humber Teaching NHS Foundation Trust – Lead Provider** • Non-Executive Director, Peter Baren (Chair) • Associate Non-Executive Director, Hanif Malik (who joined the Committee part way through 2021/2022) • Chief Executive, Michele Moran (Vice Chair) • Director of Finance, Peter Beckwith • Director of Nursing, Allied Health and Social Care Professionals, Hilary Gledhill • Programme Lead – HCV Provider Collaborative – Planning and Quality Team, Melanie Bradbury • Clinical Director, Dr David Harvey	*e.g. 10/12* *11/11* *7/9* *9/11* *9/11* *10/11* *11/11* *10/11*

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

The Collaborative Committee has had excellent attendance during 2021/22 – please note that Hanif Malik joined the committee during 2021/22. All members have contributed positively, and all have asked relevant questions and provided suggestions to ensure positive progress and outcome.

3.3 Include any recommendation for change to membership & reasons why

To be reviewed following the outcome of the Well Led Review - Audit

4. Quoracy

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

The Committee was quorate on 10 of the 11 occasions (not quorate in August 2021)

5. Reporting / Groups or Committees

Which groups report to Collaborative Committee *(these should be clearly identified on the schematic on your ToR)*. Please list:

- Adult Secure Work Stream
- CAMHS Work Stream
- Adult Eating Disorder Work Stream

Whilst the Provider Collaborative Oversight Group does not report to the Collaborative Committee there is a link between the 2 meetings and within the Provider Collaborative Partnership Agreement it is acknowledged that the Collaborative Committee enacts decision and recommendation from the Provider Collaborative Oversight Group

Has the Committee approved the Terms of Reference for each of these groups?
Yes [X] No [ ] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [X] No [ ]

Has the Collaborative Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance? Yes [X] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

Has Collaborative Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2021/22?
Yes [ ] No [X]

6. Conduct of meetings

Chair to consider the following questions

- *Was a workplan agreed at the start of the year and have meetings and agendas been appropriately scheduled to meet the work plan?*
  A workplan has been agreed, however due to the delay in Go Live the work plan has been amended and adjected accordingly

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*

Yes
However, on occasion papers have been scheduled on the day or shared 2 days before hand. This has been by exception and agreed appropriate – primarily due to financial discussions with NHS E during 2021.

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

Yes

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

Yes

7. Review of Terms of Reference

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

The terms of reference were reviewed as the Collaborative Committee moved to an assurance committee following the Provider Collaborative Go Live on 1 October 2021.

Agenda Item 12 CC
ToR updated by MB

8. Workplan for 2022/23

Has a workplan for the year ahead, 2022/23 been prepared?

Yes [X] No [ ]. *If no, when will it be presented to your committee?* _____

9. Any Actions Arising from this Effectiveness Review? YES [ ] NO [ ]
If any, please summarise in bullet point format below

Humber Teaching NHS Foundation Trust
Provider Collaborative Committee

Terms of Reference

Constitution & Authority	Humber Teaching NHS Foundation Trust (HTFT) is the Lead Provider within the Humber Coast and Vale (HCV) Provider Collaborative (PC) and will hold the Lead Contract with NHS E/I. HTFT as Lead Provider will sub-contract with a range of healthcare providers in the delivery of: • Child and Adolescent Mental Health In-Patient services • Adult Low and Medium Secure services • Adult Eating Disorder Services. As detailed in the *NHS Mental Health Implementation Framework*, from April 2020 NHS England and NHS Improvement aim to mainstream the New Care Models approach for specialised mental health, learning disability and autism services, enabling local service providers to join together under NHS-led Provider Collaboratives. The Collaborative Committee has been established by the Lead Provider as an internal committee to provide assurance to the HTFT Board as Lead Provider within the Collaborative in relation to Contracting, Planning and Quality Assurance functions of the Provider Collaborative . These functions have been traditionally grouped under the label of commissioning. The Collaborative Committee is constituted as a standing committee of the Humber Teaching NHS Foundation Trust's Board of Directors. The Committee is delegated by the Board to exercise decision-making powers in discharging its duties, whilst recognising those matters reserved elsewhere. Key Relationships – The Humber Coast and Vale Provider Collaborative Oversight Group (PCOG) is the forum in which we come together as a Partnership with collective expertise in provision, planning and quality assurance. The PCOG holds collective accountability and responsibility to steer the strategy and support the operational delivery of the Provider

	Collaborative programme across the partnership in line with the principles and requirements of the partnership agreement on clinical quality and business requirements. The Collaborative Planning and Quality Team (reporting to the provider Collaborative Oversight Group and the Collaborative Committee) – is an enabler supporting all partners within the Collaborative to ensure appropriate health care services are commissioned to serve the needs of the HCV population and in so doing, improve the efficiency, effectiveness, economy, and quality of services, reduce inequalities, and promote the involvement of patients, our partners, and the public alike in the development of our services. The Collaborative Committee will provide overview to enable HTFT to meet its legal and statutory requirements as the HCV PC Lead Provider and will operate within the delegated powers to complete any activity within the parameters of these Terms of Reference. The Committee will have the authority to establish sub-groups as necessary to fulfil its objectives however it may not delegate any powers delegated by the HTFT Board and will remain accountable for the work of any such sub-group.
Role / Purpose	The purpose of the Collaborative Committee is to assurance to the HTFT Board on matters of finance, quality assurance and performance ensuring delivery of the overall HCV Specialised Provider Collaborative aims to transform care for people in low and medium secure mental health services, CAMHS in-patient and Adult in-patient eating disorders services. Day to Day provision of patient care is the responsibility of Providers within the Provider Collaborative Partnership. Services will be commissioned utilising NHS Standard Contracts with clear Key Performance Indicators (KPIs) and Outcomes. Via the PCOG the Collaborative Committee will take a partnership approach to working with Providers within the Provider Collaborative to deliver our overall strategic aims which are to improve care pathways and patient care outcomes. The Provider Collaborative aims to reduce reliance on in-patient care, reduce out of area treatments, increase provision of care closer to home and reduce the expenditure on bed-based care; in doing so it will aim to generate financial savings. These savings will be reinvested in other parts of the Secure, CAMHS and Eating Disorders mental health and learning disability pathways through formal contracting and commissioning arrangements. This approach will ensure delineation between the Provider Partnership and Commissioning functions of the Provider Collaborative and enable our overall partnership to be conducted in an open and transparent way and follow due process.
Scope & Duties	The objectives and duties of the Committee are to:

	• As Lead Provider provide assurance to the HTFT Board – that it is fulfilling its duties and obligations within the HCV Specialised Mental Health Learning Disability and Autism Provider Collaborative • Be assured that there are appropriate arrangements in place in respect of Serious Incidents, Safeguarding and a system is in place to ensure quality of care and to continuously learn and improve • Working closely with PCOG linking in with the wider commissioning, planning and quality assurance system including other Provider Collaborative and local and national commissioners to improve services along whole pathways of care and manage pressures within the wider system • Overall Contract management, including quality assurance across NHS and independent sector. This will be the first line of arbitration/mediation between partners Specific responsibilities *Financial planning* ▪ Provide assurance to the HTFT Board that the planning programme is effectively established and managed and that risks to delivery of the plan and any significant service impacts or risks are effectively managed or mitigated ▪ Along with PCOG and with Risk and Gain Share partners review in year performance against commissioned services and financial plans and examine the effectiveness of any remedial action plans. ▪ Provide assurance to the HTFT Board (as lead provider) on the delivery of agreed improvement programmes to reduce cost and increase efficiency including assurance on benefits realisation and value for money. *Transactional* ❖ Following review and support by the Provider Collaborative Oversight Group; will ratify business cases (for both new service proposal and reduction of service delivery) and investments and/or disinvestments - provide financial assessment and scrutiny which will then be translated into contractual agreements which are held by the Lead Provider *Contracting* ❖ To be assured that contracts are in place to address risk in relation to the quality and performance of commissioned services and thereby undertake the duties as expected of the Lead Provider. ❖ Following agreement at PCOG enact Contract Variations and necessary formal Commissioning Intentions dialogue with Provider Collaborative *Risk Management:* ❖ To note, review any modifications to the risk registers, including ownership and delivery of action plans against defined timescales

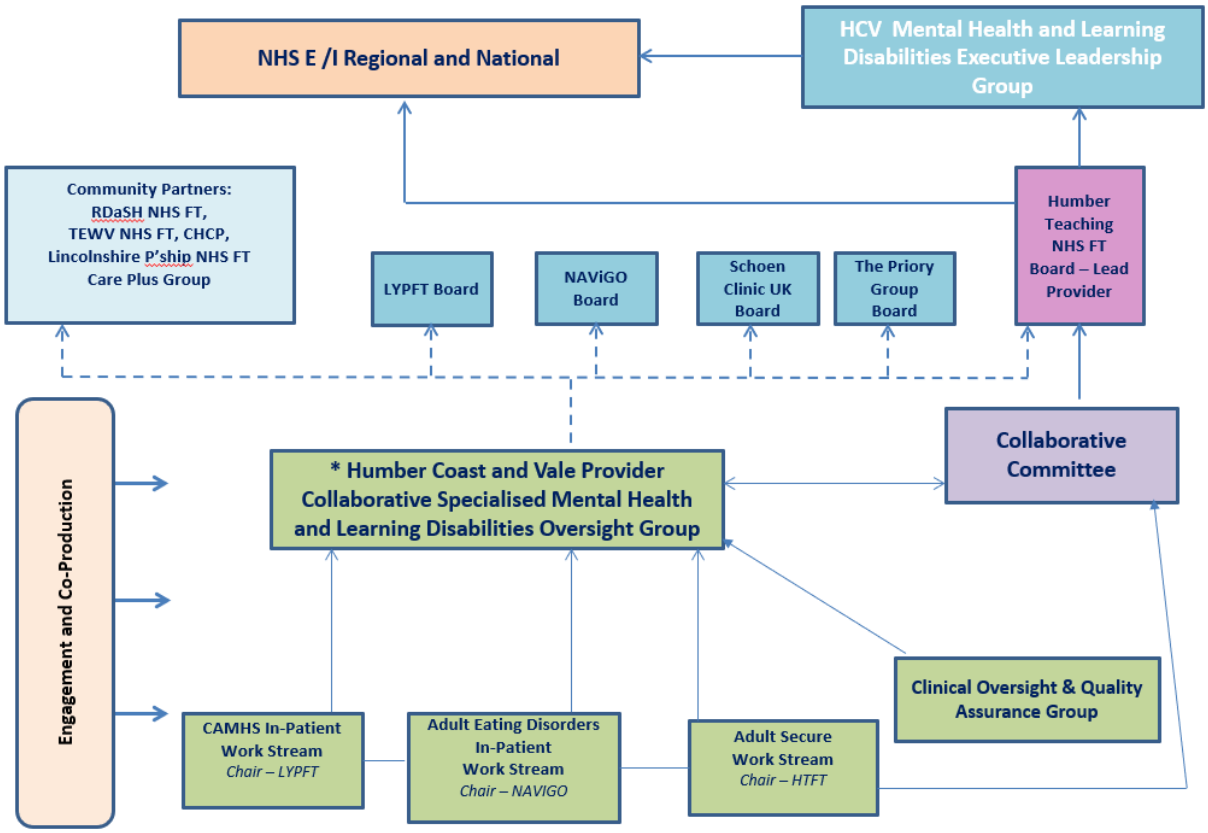
	❖ Discuss and review of any issue likely to require inclusion on, or modification to, any risk register *Quality Assurance* ❖ To be assured that quality, clinical governance, patient and public engagement issues are appropriately addressed in all service developments/reconfiguration of services and are in line with statutory requirements, national policy and guidance. The Collaborative Committee will receive minutes and/or reports from sub-groups of the PCOG and the PCOG – for review and overall assurance. The Collaborative Committee will have relationships with other groups and committees that will inform its work including links with - ▪ Transforming Care Alliance Network/Forum to ensure the needs of patients with learning disability and autism are understood and service developments are in line with the wider system developments. Further work will be necessary to define and agree definitive links once engagement with the Forum commences ▪ Humber Coast and Vale Clinical Commissioning Groups 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 ▪ Humber Coast and Vale Integrated Care System ▪ NHSE/I
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, Peter Baren (Chair) • Associate Non-Executive Director, Hanif Malik • Chief Executive, Michele Moran (Vice Chair) • Director of Finance, Peter Beckwith • Director of Nursing, Allied Health and Social Care Professionals, Hilary Gledhill • Programme Lead – HCV Provider Collaborative – Planning and Quality Team, Melanie Bradbury • Clinical Director, Dr David Harvey
Attendance	**HCV Provider Collaborative Planning and Quality team** • Quality Assurance and Improvement Lead, Gareth Flanders • Head of Secure Commissioning, Steven Shaw • Head of CAMHS and Adult Eating Disorder Commissioning, Angie Ward • Contracts and Business Manager, Tizza Dowuona • Expert by Experience, name tbc

	Clinical Work Stream Leads • Clinical Lead, Adult Secure - tbc • Clinical Lead, Adult Eating Disorders, Amanda Simpson – NAViGO • Clinical Lead, CAMHS inpatient Care, Nicola Green – Humber Teaching NHS FT
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 Peter Baren, HTFT Non-Executive Director Vice-Chair will be Michele Moran to deputise for the Chair when necessary.
Frequency of meetings	Meeting will be held monthly, however frequency may increase during the annual planning cycle to ensure that the work undertaken by the Collaborative Planning and Quality Team are timely, reflecting the fast pace nature of contract negotiations. Meetings may be held in person or utilising technology (Microsoft Teams)
Accountability and Reporting Arrangements	The Collaborative Committee is responsible for providing an assurance report and the minutes after each Collaborative Committee meeting this will be to Part 1 of the Trust Board on its areas of responsibility of commercial confidentiality identified areas for Part 2 of The Board Members will be invited to declare any conflicts of interest.
Agenda & Papers	The Business Manager or Programme Lead will be responsible for arranging meetings. An agenda for each meeting, together with relevant papers, will be forwarded to members to arrive 1 week before the meeting. Unapproved minutes will be circulated to the membership. Record Keeping - Agenda and Papers can be accessed via the Collaborative Planning and Quality Team Secretary.
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)	26 February 2021 Approved
HFT Board Approved (Date)	29 September 2021
Review Date	September 2022

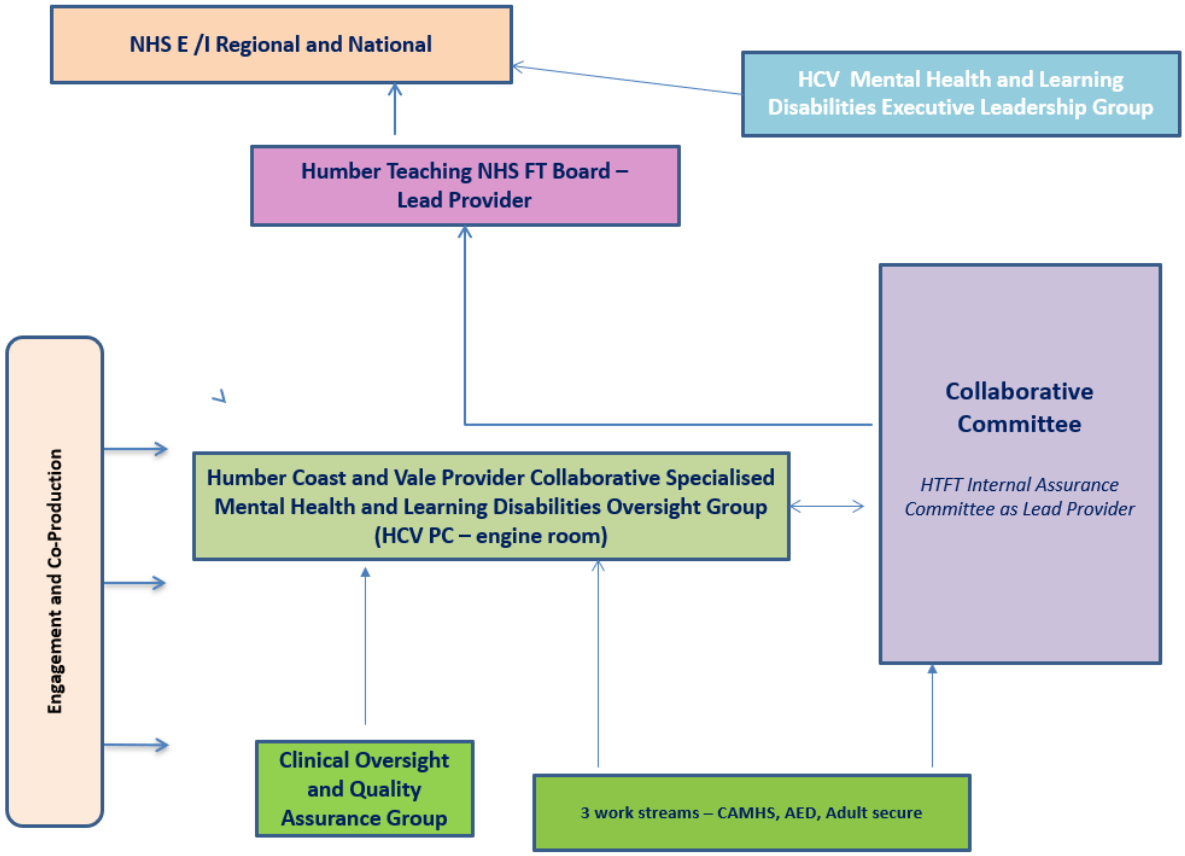
Reporting Schematic:

Overall Provider Collaborative Governance Framework



** The Provider Collaborative Oversight Group is the engine room and partnership decision making group for the HCV PC. Each partner will report and be accountable into their own organisation Board on the activities of HCV PC. All members of the PCOG are also members of the HCV MH and LD Executive Leadership Group and as PC Partners will represents and promote the Provider Collaborative at the HCV Exec Leadership Group*

Lead Provider Delineation Governance Framework



Appendix 1

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

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 HCV Provider Collaborative work programme. These are:

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

In addition, we have specific Vision, Mission and Goals for our Planning and Quality Assurance work –

Our Vision (where we are going)
We will be effective and innovative planners of positive health outcomes by delivering the principle of care is provided within the least restrictive environment.
We will commission robust care pathways for our population working in partnership with (NHS, Independent Care providers, voluntary sector, and social care). We will enable people to feel empowered to care for themselves and remain independent for as long as possible.

Our Mission (why we are here)
We commission safe, accessible, high quality services to improve the health outcomes and meet the clinical needs of the people of Humber Coast and Vale.

Our Goals (how we will get there)
- Safe, Accessible, High Quality Health Outcomes
- Seamless Alliances and Integration
- Empowering Staff to deliver the high-quality care
- Responsible Use of all Resources available

Values (how we will behave)
- We *Do the Right Thing* by making decisions that are clinically safe
- We *Acknowledge Difficulties* and seek creative solutions
- We *Empower Staff* by encouraging them to be innovative, receptive to change and courageous in the way they work
- We are *Caring and Compassionate* by always putting the person at the heart of all decision making.
- We are *Approachable, supporting our Commitment* to our people who access services
- We *Acknowledge and Promote* the work of our colleagues and partners
- Planning and Care Provision are a partnership, and We *Listen to and Support* each other
- We work *Openly and Transparently*

Humber Teaching
NHS Foundation Trust

MENTAL HEALTH LEGISLATION COMMITTEE

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

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
- Approve and review mental health legislation procedures and policies
- Promote and encourage joint working arrangements regarding the implementation of mental health legislation with partner organisations
- Receive reports regarding inspecting authorities and to monitor the implementation of action plans in response to any recommendations made.

1. Executive Summary

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

- The Committee undertakes its delegated function on behalf of the Trust Board in relation to the discharge of duties and responsibilities under the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and all other mental health related legislation. The Committee achieved its objectives for 2021-22 and delivered the functions delegated by the Board as outlined in section 2 below.
- The Committee approved various policies/procedures, including the Human rights and Equality Policy, and the S117 Aftercare Protocol. It also noted various other SOPs and policies reviewed or amended and approved via the MHL Steering Group. The Committee received assurance that all Mental Health Legislation policies were up-to-date.
- Received informative MAPPA reports, commended good work and noted chair's attendance at recent meeting.
- The Committee noted how there has positively been zero use of S4 for several months, showing that availability of AMHPs and Doctors has improved.
- Received internal audit in relation to consent to treatment under the MHA that provided a good deal of assurance. Action plan implemented to concentrate on the completion of the capacity to consent to treatment form (Z48) moving to digital approach.
- Mental Health Legislation Committee Terms of Reference reviewed.

- Noted effectiveness and quoracy of the Mental Health Legislation Steering Group under the leadership of the Clinical Director.
- Received regular MHL Quarterly Performance Report and noted no obvious outliers with regards to key metrics.
- Received detailed insight reports highlighting relevant documents of interest and impending changes to mental health legislation. Also noted Norfolk Safeguarding Adults Review report and assurance received through discussion at board and quality committee.
- Committee received an excellent presentation from CQC – extremely valuable to know how to use data in terms of patient improvement and best practice.
- Received RRI annual report for 2020/21. Good assurance with the case studies adding to understanding. Quarter RRI reports informed committee that PATS and DMI training were getting back on track as a new venue had been sourced regarding social distancing
- Committee gained Board approval for the decision to not exclude Governors in the criteria to be a Hospital Manager.
- Received the 4th Equality and Diversity Annual Report – Mental Health Legislation Steering Group has discussed ONS data and this paper is a summary with main focus on Section 2, 3 and 4, also noting for "other" sections the skewing effect of out of area patients in relation to secure services. The report included a comparison of young people under 16 population to those admitted or detained. Other data showed use of MHA for women was higher than for men; possible explanations being depression and personality disorder more common to women.

  A small trend was noted showing ethnic minorities more likely to be admitted as informal rather than formally detained but numbers are so small it is difficult to make sense of. In this regard, Steering Group has asked for continued discussion in network and with consultants, with particular focus on issue that ethnic population not accessing services and how this can be addressed. EDI & Health Inequalities group has also discussed and noting ethnic minorities not using services voluntarily asked if Local Authority social care services has similar findings. If this is the case perhaps Trust could consider how to work with its local authorities in a community focussed approach and there are other models available. In another Trust one voluntary organisation representing ethnic minority groups was commissioned to look at this particular issue, which led to creation of Community Development workers attached to particular populations and their communities with a remit to determine in what ways mental health services were stigmatised and how to destigmatise among ethnic communities.

  Future reports are likely to be expanded to include some analysis of the Eastern European population, and work has taken place looking at how clinicians can collect data in order to enrich the community data set

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
To approve Trust-wide policies and procedures relating to Mental Health Legislation.	Minutes detail policies and procedures approved, and also detail regular updates on status of required policies in line with the Mental Health Act Code of Practice.	Policy plan approved and adhered to.
To receive reviews of assessment reports and recommendations from external bodies relating to Mental Health Legislation in the Trust.	CQC reports and visits included within MHL subgroup report. Action tracker for requirements and evidence available for in-depth scrutiny.	To continue to monitor compliance and evidence logs for CQC MHA action plans.
To monitor key indicators capable of showing Trust compliance with Mental Health Legislation.	New style report for performance monitoring of key indicators. Discussed and analysed quarterly at committee following scrutiny at steering group.	Ongoing review of current statistical presentation of data in performance report - recent use of statistical process control (SPC) charts.
To receive regular data on key indicators underpinning delivery of the Trust's duties and responsibilities under Mental Health Legislation.	Ward level MHA audits are completed on My Assurance monthly. Deep dive MHA audit completed annually on every ward by MH Legislation team.	Audit results reported via the MHLSG and action taken where necessary.
To receive minutes and/or reports from the Mental Health Legislation Steering Group and the Associate Hospital Managers' Forum.	MHL Steering Group minutes submitted to Committee and summary of AHM Forum minutes provided in subgroup report.	MHL Steering Group minutes presented for information and AHM summary of key issues arising included in Committee update.
To regularly review the Board Assurance Framework (BAF).	Minutes detail discussion of BAF in each Committee.	To continue to review and monitor.

Where appropriate to commission specific pieces of work and audits relating to Mental Health Legislation	RRI work - quarterly improvement reports against restrictive practices received by MHLC	To continue to review and monitor.

3. Attendance

3.1 The Mental Health Legislation Committee met on 4 occasions during 2021/22- May, August & November 2021 and February 2022 all chaired by Mike Smith. The meetings have benefitted from the Clinical Director, Dr Kwame Fofie, leading on reporting and providing clinical leadership to the Committee. Dr Fofie will continue to provide the clinical leadership as the Clinical Director.

Members:	No of meetings attended
Non-Executive Director, Mike Smith	*4/4*
Non-Executive Director, Dean Royles	*4/4*
Executive Medical Director, Dr John Byrne	*4/4*
Deputy Director of Nursing, Tracy Flanagan, representing Hilary Gledhill, Director of Nursing/Caldicott Guardian from August 2018	*4/4*
Deputy Chief Executive and Chief Operating Officer, Lynn Parkinson	*4/4*
Mental Health Act Clinical Manager, Michelle Nolan	*4/4*
Mental Health Legislation Manager, Sara Johns	*4/4*
Clinical Director, Dr Kwame Fofie	*4/4*
Local Authority Representative (East Riding Local Authority) Derek Newton	*0/4*
Local Authority Representative (East Riding Local Authority), John Heffernan	*3/4*
Local Authority Representative (Hull Local Authority), Caron Hodgson	*1/4*
Named Nurse for Safeguarding Adult/MCA Lead, Rachael Sharp	*1/2*
Named Nurse for Safeguarding Adult/MCA Lead, Rosie O'Connell	*2/2*
Principal Social Worker, Fran Ashton (HFT)	*2/4*
Patti Boden (Clinical Lead, Specialist Care Group), RRI Lead	*4/4*
Kirsten Bingham (AMHP Service Lead)	*3/3*
In addition to the members list Ms Kate Yorke (Associate Director of Psychology) attended the MHLC in May 2021 for item 11; Ms Giovanna Polato, Analytic Team Leader Intelligence, CQC, Mr Simon Plummer, CQC Mental Health Act Reviewer, Mr Che Hector, Analytics Team Leader, CQC, and Ms Su Hutchcroft, Clinical Governance and Compliance Administrator attended the meeting in August 2021 for item 16; and Ms Sue Corden (Director Clinical Governance Grant Thornton, Well Led Review) observer, Dr Iqbal Hussain (GP Lead Primary Care &	

Community Services Division) observer, Dr Olayinka Fadahunsi (Non-executive Director and Chair Mental Health Legislation Committee, Sheffield Children's NHS FT) observer, attended the Committee in February 2022.	

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

The membership composition is effective and all members have contributed well. The lack of representation from Hull Local Authority remains a concern and is being progressed again as it is important to have their input and advice in order for all providers to maintain and develop effective services and good practice. As they have the legal responsibility for ensuring appropriate coverage for AMHPs in Hull their input is important.

3.3 Include any recommendation for change to membership & reasons why

Kirsten Bingham now in attendance as the new AMHP Lead for Hull AMHPs (employed by the Trust). There is no other indication to change to membership other than to engage Hull Local Authority.

4. Quoracy

The Committee was quorate on all four occasions

5. Reporting / Groups or Committees

Which groups report to Mental Health Legislation Committee? *(these should be clearly identified on the schematic on your ToR)*. Please list:

- Mental Health Legislation Steering Group.
- Associate Hospital Managers' Forum
- Reducing Restrictive Interventions Group

Has the Committee approved the Terms of Reference for each of these groups?
Yes [ ] No [✓] *If no, action/timescale for receipt:*_____

Are ToR annual reviews for each reporting group on your Committee workplan to approve?
Yes [✓] No [ ]

Has the Mental Health Legislation Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group provided the required level of assurance?
Yes [✓] No [ ]

If no, please provide an exception report on concerns/recommended changes below:-

The Mental Health Legislation Committee has received sufficient assurance that its reporting groups are operating effectively. Attendance at the Mental Health Legislation Steering Group has improved as has quoracy. In respect of mental health legislation the Steering Group has an important role giving operational input to the Committee. The Clinical Director now has the task of chairing and overseeing attendance at the Steering Group; this post has sufficient authority to ensure attendance and a review of the Terms of Reference has been undertaken. A summary of the minutes from this meeting was aggregated into the assurance report; however it was agreed at the November Committee that provision of the minutes from the MHL Steering Group, along with other areas of mental health legislation would provide the Committee with the required level of assurance.

The Committee will keep under review the recruitment and retention of Associate Hospital Managers (AHMs), ensuring that an adequate number are retained and that their training and performance are regularly reviewed. The Committee recommends the appointment / re-appointment of AHMs for periods not exceeding 3 years.

Has Mental Health Legislation Committee requested / received an annual assurance report or effectiveness review from each of the reporting groups for 2021/22?
Yes [✓] No [ ]

Annual report received for Hospital Managers Forum; quarterly assurance report received for the RRI group, and recently agreed that the committee would receive the minutes of the MHLSG for assurance rather than a quarterly summary.

6. Conduct of meetings

Chair to consider the following questions

- *Was a workplan agreed at the start of the year and have meetings and agendas been appropriately scheduled to meet the work plan?*
    - A work plan, as outlined in the Cycle of Business, was agreed at the start of the year and meetings and agendas have been appropriately scheduled to meet that.
- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*
    - The reports and papers presented have been of a high quality and prepared in time for issue 5 working days ahead of the meeting.
- *Is the quality and timeliness of the minutes satisfactory?*
    - The quality and timeliness of the minutes are of a very good standard.
- *Is an action log maintained and are actions clearly recorded, assigned to individuals with timelines and followed through?*
    - An action log has been maintained and actions are clearly recorded, assigned to individuals with timelines and followed through.
    - Relationships have been established with the Quality Committee and issues have been cross referenced between committees e.g. prone restraint, AMHP plan. This avoids duplication and aids escalation.

- Insight report provided, combining themes and issues report with publications and policy highlight report. This has established a contextual backdrop at each meeting.
- Strong relationships with clinicians and MH Teams.
- MHLC taken as the authoritative voice on issues, taking a sophisticated view looking at both the external world and internal processes and seeking to understand and act upon issues.

7. Review of Terms of Reference

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

The Terms of Reference were reviewed by the MHA Clinical Manager on 04th February 2022 and reviewed at the MHL Committee in May, then to be approved as part of Committee Effectiveness Review submission to May 2022 Trust Board. These are attached for reference

8. Workplan for 2022/23

Has a workplan for the year ahead, 2022/23 been prepared?

Yes [ ] No [ ]. *If no, when will it be presented to your committee?* _____

- seek assurance concerning preparations for the implementation of the Liberty Protection Safeguards (LPS)
- monitor the progress of the Mental Health Act Review
- consider the impact / learning points of CQC inspections relating to other Mental Health active Trusts
- improve input and involvement of colleagues, partners and stakeholder via the opportunities provided by new ways of working
- MH transformation
- further work on ethnicity
- monitor impact of capital programme and research on ligatures points

9. Any Actions Arising from this Effectiveness Review? YES [ ] NO [✓]
If any, please summarise in bullet point format below

NHS
Humber Teaching
NHS Foundation Trust

Terms of Reference

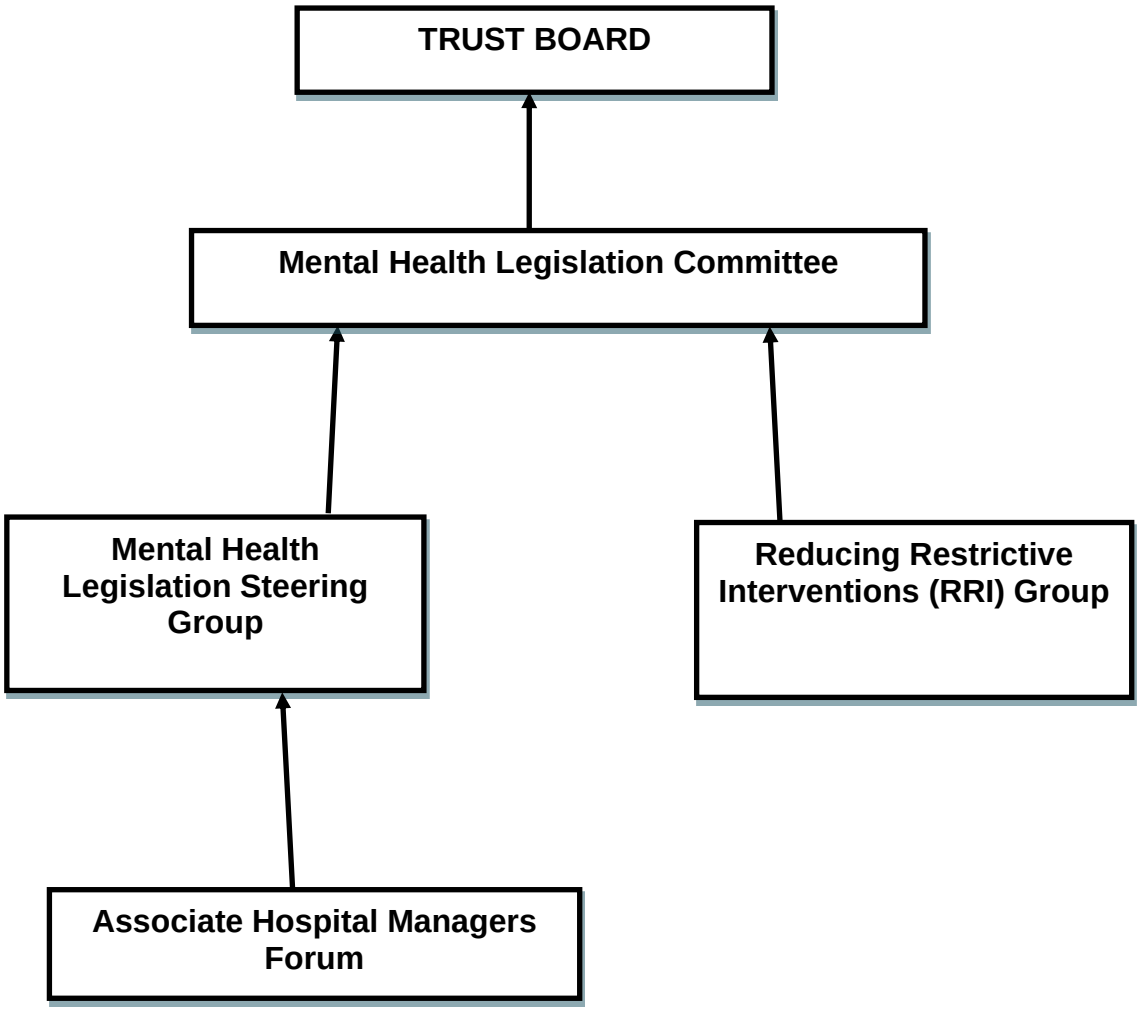
Mental Health Legislation Committee

Constitution and Authority	The Mental Health Legislation Committee is constituted as a standing Committee of the Trust's Board of Directors. Its Constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors meetings. For the purpose of these Terms of Reference, Mental Health Legislation refers to the Mental Health Act 1983, the Mental Capacity Act 2005 and other related primary and secondary mental health legislation. This includes government and regulatory policies, procedures and codes of practice which the Trust is bound to observe as a matter of law. The Committee is authorised by the Board of Directors to seek assurance on Mental Health Legislation. It is authorised to seek any information it requires from the relevant Director. The Committee is authorised by the Board of Directors to request the attendance of individuals with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
Role / Purpose	The purpose of the Mental Health Legislation Committee (MHLC) is to: • Provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective codes of practices and other mental health legislation as required. • Monitor, provide challenge and seek assurance of compliance with external standards relating to mental health legislation • Approve and review 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 approve Trust-wide policies and procedures relating to Mental Health Legislation. • To receive reviews of assessment reports and recommendations from external bodies relating to Mental Health Legislation in the Trust.

	• To monitor key indicators capable of showing Trust compliance with Mental Health Legislation. • To receive regular data on key indicators underpinning delivery of the Trust's duties and responsibilities under Mental Health Legislation. • To receive minutes and/or reports from the Mental Health Legislation Steering Group. These will be presented by the Clinical Director. • To receive a summary of key issues arising from the Associate Hospital Managers Forum • To receive 6 monthly and annual reports regarding the reduction of restrictive practices. These will be presented by the Clinical Lead Secure Services/RRI Lead. • To regularly review the Board Assurance Framework (BAF). • Where appropriate to commission specific pieces of work and audits relating to Mental Health Legislation
Membership	The Committee will have full membership of: • At least two Non-Executive Directors (one of which is also a designated Associate Hospital Manager) • Medical Director • Chief Operating Officer • Clinical Director • Deputy Director of Nursing and Quality • Clinical Lead Secure Services/RRI Lead • Mental Health Act Clinical Manager • Assistant Director of Nursing (Operations) • Mental Health Legislation Manager • Named Professional for Safeguarding (Adults), MCA and Prevent Lead • Principal Social Worker • 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 • one Non-Executive Director, • the Medical Director (or authorised deputy) and • another who must be a qualified clinician. Members of the Committee must attend at least 3 meetings in each financial year but should aim to attend all scheduled meetings.
Chair	The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chairman. 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 chairman or any five members of the MHL Committee.
Agenda and Papers	The Mental Health Act Clinical Manager (with appropriate support), will ensure that: • There is agreement of the agenda with the Chairman of the Committee, and that the necessary papers are produced, collated and circulated; • Minutes are taken of the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance. • Minutes shall be circulated promptly (within 20 working days) to all members of the Committee; • A record is kept of matters arising and issues to be carried forward; • An annual cycle of business is established
Minutes and Reporting	A written assurance report will be provided to the Board following each meeting. Formal minutes will be taken of the meeting and presented to the Confidential Board, whilst the assurance report will go to the Public Board. The Chair of the committee will provide a verbal summary/exception report to the Board in respect of meetings held for which minutes have not yet been approved.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference.
Agreed by Committee	05 May 2022
Board Approved	
Review Date	February/March 2023

MENTAL HEALTH LEGISLATION COMMITTEE REPORTING STRUCTURE



NHS
Humber Teaching
NHS Foundation Trust

AUDIT COMMITTEE

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

The purpose of the Audit Committee is to scrutinise and review the Trust's systems, risk management, and internal control. It reports to the Trust Board on its work in support of the Annual Report, Quality Report, Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, in particular Strategic Goal 3, the completeness of risk management arrangements, and the robustness of the self-assessment against Care Quality Commission (CQC) regulations.

1. Executive Summary (*Required from the Chair – draft for editing*)

As incoming chair of the Audit Committee, a review of this effectiveness review has clearly demonstrated the committee has delivered against all the functions within its Terms of Reference.

For the year ending March 2022, despite it being a year dominated by Covid-19, all meetings took place virtually and were well attended with the committee quorate on all occasions.

During the year the committee have had oversight of the annual report and accounts (prior to submission to Board) which were received and approved with an unqualified audit opinion. Alongside this at each audit committee there have been updates on Internal Audit Actions (for which strong performance has continued), Counter Fraud Progress, Information Governance and Procurement, all of which have been produced to a high standard.

At the time of writing our External Auditors (Mazars) are conducting in the External Audit of the accounts, and I look forward to progress updates as this work continues.

To summarise, it is evident the committee is working effectively and has the right membership, and I look forward to chairing this committee and continuing this strong performance throughout 2022/23.

Stuart McKinnon-Evans
Chair of the Audit Committee

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
Keep an overview of the key elements of the Trust's governance and finance.	This forms the main work of the committee with updates from internal and external audit at each meeting, highlighting areas of concern and any actions required.	None
Monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them	The Audit Committee in June reviewed the Trust's Annual Accounts and External Audit Opinion, prior to these documents being submitted to the Trust Board	None
Review the Trust's Internal Controls	Internal Controls reviewed through the Internal Audit Reporting mechanism	Non
Review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;	External Audit produce an update to each committee and attend to present	None
Monitor risks that are identified by the systems of internal control;	Updates are received at each Audit Committee on completed audits and audit follow up work. Updates are provided at the meeting on recommendations made and actions taken.	Actions from audits that are overdue for implementation are updated at each meeting
Make recommendations to the Council of Governors through the Governor Finance and Audit Group, regarding the appointment, re-appointment and removal of the external auditor, including tender procedures	The contract for External Audit was let in November 2019 – Governor Finance and Audit Group involved in the appointment and a recommendation made to the Governors	None
Develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm	The Policy for Use of Audit for Non Audit Services was approved by the Audit Committee in June 2020. Use of External Auditors for non-audit work is reported in the Trust's Annual Report.	None
Approve the appointment and/or removal of the internal auditors;	The Trust Appointed new Internal Auditors (Audit Yorkshire) on 1 October 2020 through a competitive tender process	None
Report to the Council of Governors, identifying any matters in respect of which it	Regular updates are provided to the Finance,	None

considers that action or improvement is needed, making recommendations as to the steps to be taken	Audit, Strategy and Quality Governor Group following each audit committee.	
Produce an annual report for the Trust Board	On June Agenda.	None

2.1 The Committee has specific ownership of Strategic Goal 3 (Fostering Integration, partnership and alliances). This was reviewed throughout the year by the Audit Committee as part of the Board Assurance Framework which is a standing item on the agenda.

3. Attendance

3.1 The Audit Committee has met on 5 occasions to date during 2021/22

Members:	No of meetings attended
Peter Baren – Non Executive Director (Chair)	*5/5*
Francis Patton – Non-Executive Director	*5/5*
Mike Smith – Non-Executive Director	*4/5*
In Attendance:	
Michele Moran – Chief Executive	*5/5*
Peter Beckwith – Director of Finance	*5/5*
Stuart McKinnon Evans (Incoming Audit Chair)*	*1/1*
*denotes optional attendance at committee	

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.

4. Quoracy

The quorum necessary for the transaction of business is two.

The Committee was quorate on **all** occasions.

5. Reporting / Groups or Committees

The Information Governance Group is a sub group of the Audit Committee and all minutes and reports received have given the required level of assurance.

A review of the Information Governance Group's ToRs is being undertaken at its February meeting. This will be available for review at the Audit Committee's May meeting.

The Information Governance annual effectiveness review will be undertaken in May 2022 and reviewed at the committees August meeting.

6. Conduct of meetings

Chair to consider the following questions

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

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?* ***Yes***

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

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

7. Review of Terms of Reference

The latest version of the Terms of Reference are included at Appendix 1.

8. Workplan for 2021/22

Has a workplan for the year ahead, 2022/23 been prepared?

Yes [✓] No [ ]. *If no, when will it be presented to your committee*

9. Any Actions Arising from this Effectiveness Review? YES [/] NO [ ]
If any, please summarise in bullet point format below

One of the actions arising from the external review of governance was for non-executive director chairs of committees to observe the sub-meetings/groups that feed into their committee to gain a view on how business is undertaken. This is currently being progressed and a schedule for 2022/23 will be in place by the end of May.

NHS
Humber Teaching
NHS Foundation Trust

Terms of Reference

Audit Committee

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

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

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

Scope and Duties	The Audit Committee's duties are detailed below under the following headings:
	
	• The Chair
	• The Audit Committee
	  ○ Governance, Risk Management and Internal Control
	  ○ External Audit
	  ○ Internal Audit
	  ○ Other Assurance Functions
	  ○ Counter Fraud
	  ○ Management
	  ○ Financial Reporting
	• Trust Secretariat
	
	<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 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 Protect.
- arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

	In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it. As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other Committee's must not usurp the Committee's role. **External Audit** The Council of Governors will take the lead in agreeing with the Audit Committee the criteria for appointing, reappointing and removing auditors. The Audit Committee will make recommendations to the Council of Governors via the Finance and Audit Governor Group who will then make recommendations to the full Council on these matters, and approve the remuneration and terms of engagement of the External Auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the Audit Committee. The Audit Committee shall develop and implement policy, in collaboration with the Finance Directorate, regarding the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance. All requests for the supply of non- audit services must be presented to the Audit Committee for noting. The Audit Committee shall review and monitor the External Auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements. The Audit Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:- • consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit. • review and agreement, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan • discussion with the External Auditors of their local evaluation of audit

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

	Other Assurance Functions The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.). In addition, the Audit Committee will review the work of other Committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. **Counter Fraud** *The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and bribery, in accordance with Service Condition 24 of NHS Standard Contract. The Audit Committee will review the outcomes of work in these areas against the standards set by NHS Counter Fraud Authority (as referenced in Standard Condition 24.2).* **Management** The Audit Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Audit Committee will receive assurance reports from the Information Governance Group, which is a delegated sub group of the audit committee. They may also request reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements. **Financial Reporting** The Audit Committee will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. The Audit Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

	• changes in, and compliance with, accounting policies and practices and estimation techniques; • major judgemental areas; • significant judgements in the preparation of the financial statements; • significant adjustments resulting from the audit; • the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Audit Committee; • letters of representation; • explanations for significant variances; • unadjusted mis-statements in the financial statements. Providing mandatory issues (as detailed in paragraph 1) are reserved for the attention of the full Committee in session, other matters including review of the Annual Report and Summary Financial Statements may be dealt with as the Audit Committee deems appropriate through a process co-ordinated by the Audit Committee Chair. The Audit Committee should also ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Trust Board. **Trust Secretariat** The Audit Committee shall be supported administratively by the Trust Secretary 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

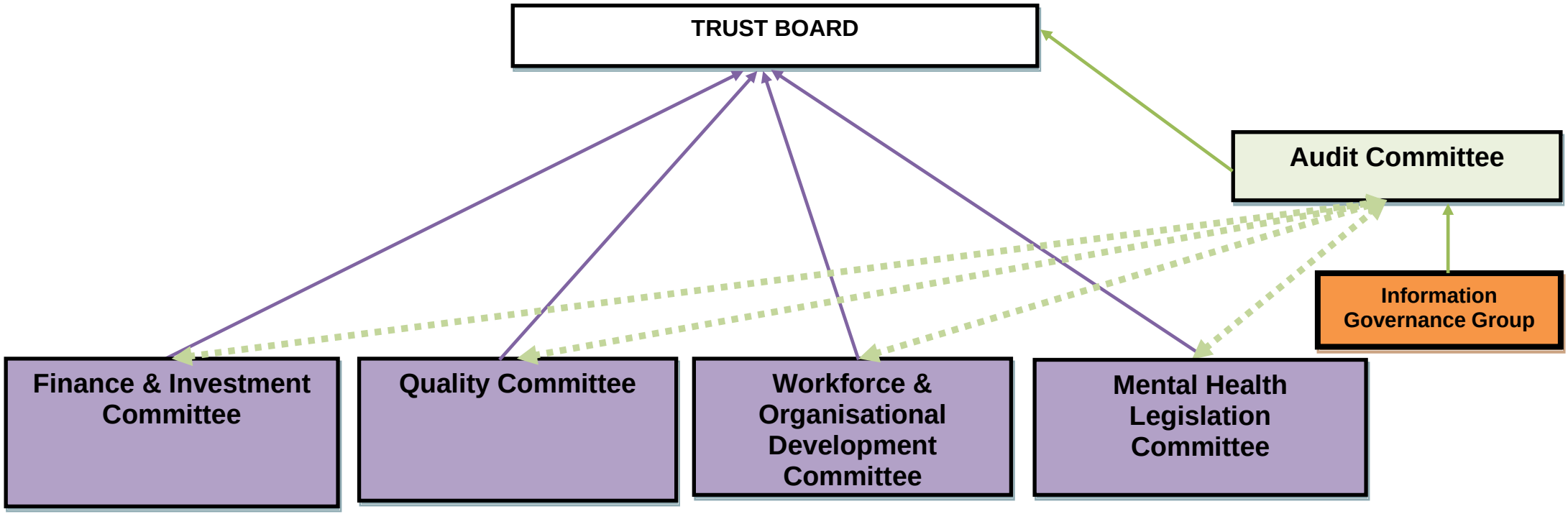
	interest/policy developments • ensuring that action points are taken forward between meetings • supporting any ongoing training requirements for Non-Executive Directors as appropriate for their membership of the Audit Committee. Reference should be made, as appropriate to the Trust's Standing Orders, 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 Chairman. **Attendance by others at Meetings** External and Internal Auditors, and a representative of the Counter Fraud specialists are required to make themselves available when required for a private meeting with the Audit Committee Chair as required . The Director of Finance is the Executive lead for this Committee. The Director of Finance, Trust Secretary and Internal and External Audit and Counter Fraud representatives shall normally attend Audit Committee meetings. Other Executive Directors may be invited to attend, particularly when the Audit Committee is discussing areas of risk or operation that are the responsibility of that Director. The Chief Executive will have a standing invitation to attend Audit Committee meetings. The Chief Executive will usually attend the Audit Committee meeting where the end of year reporting, auditor's opinions, the Annual Governance Statement, the Annual Report and Annual Accounts are delivered. The Trust Secretary 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 Protect)

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

	meeting. The minutes of Audit Committee meetings shall be formally recorded by the Trust Secretary and submitted to the members of the Audit Committee. The Chair of the Audit Committee shall provide an executive summary report for the next Trust Board meeting that highlights substantive issues and recommendations. Minutes of the meeting will also be reported to the Trust Board in the part II session. The Audit Committee Chair shall draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or require executive action. Specific actions arising from one committee affecting the work of another Committee will be detailed in the minutes and notified to the Chair of the other Committee. The Audit Committee will report to the Trust Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the extent to which risk management is fully embedded in the organisation, the integration of governance arrangements and the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business and the robustness of the processes behind the quality accounts. An annual review of effectiveness will be undertaken and included in the annual report. The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
Monitoring and Review	An annual effectiveness review will be undertaken which will include a review of attendance and a review of the Committee's Terms of Reference. This will cover the following duties:- • Accountability including reporting arrangements to the Trust Board • Membership, including nominated deputy where appropriate • Frequency of meetings • Requirements for a quorum • Required frequency of attendance by members • Process for monitoring compliance with all of the above • The work and achievements of the Audit Committee • Outcome of the Audit Committee's annual self-assessment • An action plan, if appropriate, to rectify any deficiencies (to be monitored by the Board). The Audit Committee shall report to the Board, identifying any matters within the its remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.

Agreed by Committee	11 May 2022
Board Approved	18 May 2022 - tbc
Review Date	May 2023

AUDIT COMMITTEE REPORTING STRUCTURE



Caring, Learning & Growing Together

Humber Teaching
NHS Foundation Trust

Remuneration and Nomination Committee

Annual Review of Committee Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

The purpose of the Remuneration and Nomination Committee is to provide a forum for agreement of remuneration and terms of service for Trust Executive's in accordance with national requirements and Executive Director appointments.

1. Executive Summary

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

The Committee's duties fall under 3 key headings in the table below at section 2. The committee has operated effectively and there is evidence of each of these functions being delivered in year within the agendas, minutes and decisions recorded.

2. Delivery of functions delegated by Board

Functions within ToR	Evidence to support delivery	Outstanding issues / action plan
National Requirements	Within meeting agendas and minutes - decisions adhered to national requirements when appointment/remunerating.	none
Appointments Role	Within meeting agendas and minutes - executive director appointments made	none
Remuneration Role	Within meeting agendas and minutes - executive remuneration agreed	none

3. Attendance

3.1 The Committee met on 6 occasions during 2021/22

Members:	No of meetings attended
Sharon Mays, Chair (to September 2021) Caroline Flint, Chair (wef September 2021) Peter Baren, Non-Executive Director Mike Cooke. Non-Executive Director (to August 2021) Francis Patton, Non-Executive Director	3/3 3/3 6/6 2/2 5/6

Mike Smith, Non-Executive Director	5/6
Dean Royles, Non-Executive Director	6/6
Hanif Malik, Non-Executive Director (wef July 2021)	3/4
Stuart Mckinnon-Evans, Non-Executive Director (wef February 2022)	2/2

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

Membership is made up of all Non-Executive Directors. All Non-Executive Directors attended meetings and contributed in year. The minutes of the meeting reflect engagement and challenge of members.

The Chief Executive attends each meeting, except when discussing matters relating to the Chief Executive.

The Director of Workforce and Organisational Development attends as required and provides advice and support to the committee

3.3 Include any recommendation for change to membership & reasons why

No recommendations for any change.

4. Quoracy

The Committee was quorate on all occasions.

5. Reporting / Groups or Committees

Has the Remuneration and Nomination Committee received sufficient assurance that its reporting groups or committees are operating effectively? Have the reports and minutes received from the reporting group/committee provided the required level of assurance?

The nature of the Committee means it does not have any reporting groups and there are no proposals for change. Executive advice on matters for committee discussion is provided through attendance by the Chief Executive or Director of Workforce & Organisational Development as appropriate.

Abridged versions of the minutes or summary notes of key discussions and decisions have been presented to the Part II Trust Board but not consistently (see recommendation at section 8 below).

6. Conduct of meetings

Chair to consider the following questions

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

  The committees work is largely reactive and an outline work plan is in place to reflect essential annual discussions ie review of ToR, effectiveness review etc but remains a reactive document.

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*
  Yes

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

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

7. Review of Terms of Reference

The ToR have been reviewed and the following changes proposed (the proposed changes below have been highlighted in the attached updated draft ToR in blue font for ease):

(I) Minutes to Trust Board

Whist this requirement is currently in the Rem Comm ToR these have not been routinely presented to Board. The wording has been strengthened to ensure an assurance report with abridged minutes are presented to Board after each Rem Comm meeting.

(II) Consultant Appointments:

The extract from Rem Comm ToR in the Standing Orders (SO) re the Board's role to ratify consultant appointments is no longer in Rem Comm ToR – it is not clear when this was removed. However, after considering the guidance and there being no requirement for Board's to ratify consultant appointments it is proposed that this is not included in the ToR and the extract of Rem Comm Tor in SO will be updated.

It is recommended the Rem Comm ToR include the requirement for the Board to be advised of consultant appointments in public Board.

(III) Recruitment and Retention Premia

Currently the role of Rem Comm in our Standing Orders states:

> 4.8.3 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).

This requirement is not in Rem Comm ToR and it is not clear when it was removed but it is proposed the ToR are updated to reflect this requirement and that:-

- Rem Comm are advised of any R&R premia awarded.
- Approval of Rem Comm will be required for any R&R over £25k.
- Anything of £25k and under for up to 4 years the CEO will be required to approve and the award will be reported to Rem Comm to note at the next available meeting.

(IV) National Requirements

It was agreed to simplify the detail within ToR and add a general comment for 'national requirements' to state that they should be 'in accordance with pay guidance'.

The ToR are attached for approval.
Once agreed and approved the changes will be reflected in the review of SOs.

8. Any Actions Arising from this Effectiveness Review?

To ensure that an assurance report is provided to Part II Board after each meeting.

Humber Teaching
NHS Foundation Trust

Remuneration and Nomination Committee

Terms of Reference

Constitution and Authority	The Remuneration and Nomination Committee is constituted as a standing Committee of the Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board meetings. The Committee is authorised by the Board to act, in accordance with Standing Orders, Scheme of Delegation and Standing Financial Instructions, and within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its' functions. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
Role / Purpose	To provide a forum for agreement of remuneration and terms of service for Trust Executive's and Trust Very Senior Managers (VSM) in accordance with national requirements.
Scope and Duties	The Remuneration committee has delegated responsibility for setting remuneration for all Executive Directors (and also for those senior managers on the Very Senior Managers contract of employment) including pension rights and any compensation payments The Remuneration and Nomination Committee's duties are detailed below under the following headings: • National Requirements • Appointments Role • Remuneration Role **National Requirements** The Committee should ensure that any remuneration awards covered within the terms of reference of the committee should be in accordance with national pay guidance in effect at the time of decision making. ~~In line with NHS Improvement's Guidance on pay for managers on Very Senior Manager Contracts (VSM) in NHS trusts and foundation trusts, the Committee is required to seek the opinion via nhsi.vsmcases@nhs.net of NHS Improvement, DHSC and the Minister of State for Health before confirming VSM salaries at~~

~~appointment or any individual/group VSM pay increase (outside of any nationally recommended cost of living increase).~~

~~The Committee should ensure that, in accordance with guidance on NHS very senior managers pay (March 2018) or subsequent guidance, that where it is intended to recruit VSMs on salaries of £150,000 or above or wish to increase the pay of current VSMs to £150,000 or above, or wish to increase the salary of current VSMs already paid £150,000 or above they should refer to the pay ranges in Annex A of the guidance. As an FT the opinion of NHSI should be sought in such cases but approval is not required.~~

~~The Committee should also seek opinion on any discretionary payments proposed as part of a chief executive/director's salary, where the total salary is or exceeds £150,000 pa, but approval is not required. NHS Improvement should be advised of the total salary and its make-up.~~

~~The Chair of the Trust will ensure that they are personally satisfied with the scrutiny applied before the approval of new Very Senior Manager (VSM) appointments. Any appointment to a VSM contract must be agreed by the Trust Chair and approved by the Remuneration and Nomination Committee. The Committee must be satisfied when making any offer of appointment to a VSM that there is no requirement to repay contractual redundancy payments if the candidate has received redundancy within a 12 month period. The Committee will require the candidate to identify the previous NHS Employer and require the candidate to make arrangements to repay the contractual redundancy payment. The Committee will not make an unconditional offer without having received confirmation from the previous NHS Employer that a binding agreement is in place to repay the redundancy payment as set out in the NHS Standard Contract 2016/17.~~

~~In line with the NHS Improvement guidance for the use of off-payroll interims, the Committee is expected to appoint on payroll unless in exceptional circumstances. If it is proposed to appoint a VSM on off-payroll terms, NHS Improvement should be consulted.~~

~~The Committee will adhere to the appropriate guidance, in the event of a redundancy situation or termination impacting on a Very Senior Manager and will apply the appropriate redundancy cap and ensure every attempt is made to search for suitable alternative employment in order to retain valuable skills and experience.~~

Appointments Role

The Committee will:

- Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations to the Board and Appointment, Terms and Conditions Committee of the Council of Governors, as applicable with regard to any changes
- Give full consideration to and make plans for succession planning for the Chief Executive taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. The same consideration will be given to other Executive Directors on the advice or recommendation of the Chief Executive.
- Receive assurance reports from the Chief Executive as required to ensure the executive level leadership needs of the Trust are kept under review to ensure the continued ability of the Trust to operate effectively in the health economy.

	• It is a requirement of the 2006 Act that the Chair, the other Non- Executive Directors and – except in the case of the appointment of a Chief Executive – the Chief Executive, are responsible for deciding the appointment of Executive Directors. The appointments panel will consist of the Chair and one non-executive director from the Remuneration and Nomination Committee and the Chief Executive, except in the case of the appointment of a Chief Executive. The panel has responsibility for identifying suitable candidates to fill executive director vacancies, including shortlisting, assessment and selection and they make recommendations to the Remuneration and Nomination Committee. • It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors. The Governors are responsible for the appointment, re-appointment and removal of the Chair and the other Non-Executive Directors. • To approve appointments of all Executive Director positions on the Board determining their remuneration and other terms of service and monitoring their performance. • When appointing the Chief Executive, the Committee shall be the Committee described in Schedule 77, 17(3) of the National Health Service Act 2006 (the Act). When appointing the other Executive Directors the Committee shall be the Committee described in Schedule 7, 17(4) of the Act. • When a Board level Executive vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation ensure that a description of the role and capabilities required for the particular appointment is prepared. In identifying suitable candidates the Committee shall ensure the use of open advertising or the services of external advisers are used to facilitate the search. The Committee will ensure the Trust considers candidates from a wide range of backgrounds and consider candidates on merit against objective criteria. • Ensure that a proposed Executive Director's "other significant commitments" (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise. • Ensure the proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported. • Be advised of and consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. • In considering appointments, receive assurance to ensure that all Directors meet the "fit and proper" person test of the general conditions of Monitor's provider licence. • An Appointments Advisory Committee (AAC) will be established by the Trust when required to progress consultant recruitment and appointments. Any recruitment and retention premia approved by the Chief Executive will be reported to the Committee. The Committee will be required to approve any recruitment and retention premia over £25,000. • Consultant appointments will be reported to the public board meeting. **Remuneration Role** The Committee will: • Have delegated responsibility for setting remuneration for all Executive Directors (and also for those senior managers on the Very Senior Managers

	contract of employment) including pension rights and any compensation payments. Those managers within this definition who are not on the Very Senior Managers Contract or Executive Directors are on national pay and terms and conditions and their posts are subject to job evaluation in line with the national scheme. *NB: The rights of all staff on the VSM contract who are in the NHS pension are bound by the national pension rules.*
	• To receive proposals from the Chief Executive relating to the remuneration of the other Executives.
	• In accordance with relevant laws, regulations, Trust policies and Standing Financial Instructions (SFIs) decide and keep under review the terms and conditions of office of the Executive Directors and those senior managers on the Very Senior` Managers contract of employment, including:
	  • Salary, including any performance related pay or bonus.
	  • Provision for other benefits, including pensions and cars *NB rights of all staff on the VSM contract who are in the NHS pension are bound by the national pension rules.*
	  • Allowances.
	  • Payable expenses.
	  • Compensation payments.
	
	In adhering to all relevant laws, regulations and Trust policies:
	
	• Approve levels or remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully without paying more than is necessary for this purpose, and at a level which is affordable to the Trust.
	• Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors (including senior managers on the Very Senior Managers contract of employment) while ensuring that increases are not made where Trust or individual performance do not justify them.
	• Be sensitive to pay and employment conditions elsewhere in the Trust.
	• Monitor and assess the output of the evaluation of the performance of individual executive directors and consider this output when reviewing changes to remuneration levels.
	• Advise upon and oversee contractual arrangements for Executive Directors (including senior managers on the Very Senior Managers contract of employment) including but not limited to termination payments to avoid rewarding poor performance.
	• In accordance with Trust Standing Orders the Committee will be informed of all recruitment of retention premia awarded by the Chief Executive to any member of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants). The Committee will be required to approve any recruitment and retention premia over £25,000
	• To receive a report from the Chair on the objectives and performance of the Chief Executive.
	• To receive a report from the Chief Executive on the objectives and performance of the Executive Directors and senior managers on the Very Senior Managers contract of employment.

Membership	The membership of the Committee shall consist of all Non-Executive Directors 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 Director of Workforce and Organisational Development. Other persons may be invited by the Committee to attend a meeting to assist in deliberations. Any non-member, including the Secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.
Quorum	The Committee shall be deemed quorate if there is representation of a minimum of two Non-Executive Directors plus the Chair (or person deputising for the Chair). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Committee.
Chair	The Trust Chair shall chair the Committee.
Frequency of Meetings	Meetings shall be held not less than twice a year and at such other times as the Chair of the Committee shall require.
Agenda and Papers	The Trust Secretary shall be the Secretary to the Committee and prepare and distribute papers and keep minutes of the Committee.
Minutes and Reporting	Formal minutes shall be taken of all Committee meetings. ~~Once the minutes have been approved by the Committee,~~ An assurance report and abridged minutes summarising key discussions and decisions will be presented to the Board of Directors following each meeting.
Monitoring and Review	**The Committee shall monitor and review its performance through** • An annual effectiveness review against its terms of reference. The annual effectiveness review will be provided to the Board of Directors. • The Terms of Reference of the Committee shall be reviewed annually.
Agreed by Committee	27/4/22
Board Approved	18 May 2022 tbc
Review Date	May 2023

REMUNERATION AND NOMINATION COMMITTEE REPORTING STRUCTURE

TRUST BOARD


Remuneration and Nomination Committee

Trust Board
Annual Review of Trust Board Effectiveness and Terms of Reference
1st April 2021 to 31st March 2022

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

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

The Chief Executive is the Accountable Officer for the Trust.

1. Executive Summary

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

The global coronavirus pandemic continued throughout 2021/22 and continued to affect the way in which a range of Trust services were delivered. Throughout this time, the Board continued to fulfil its duties and monthly Board meetings continued.

Adhering to covid restrictions the Board continued to meet virtually over Microsoft Teams and meetings were live streamed in order for members of the public to continue to have access to 'attend'. Virtual meetings also provided the opportunity to increase involvement by providing the opportunity for members of the public to join in without having to travel to venues. The Board met in person for two of the Board meetings, July and November as these preceded months where there were no meetings – ie August and December.

Patient or staff stories at the beginning of each Board were included on each agenda.

Board development days were held throughout the year that provided an opportunity to discuss more fully accountability and culture of the organisation and Board development. Regular strategy sessions were also provided which allowed regular informal discussions to inform the preparation of the Trust strategy.

The Trust Board has a forward-looking annual work plan set each year that clearly outlines mandatory and regular reports required for the meeting and a copy of this is included with monthly board papers.

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-year an external review of governance was undertaken as required under NHSI Guidance. Grant Thornton were appointed and commenced their review in November 2021, producing their report in March 2022. The report was positive and reflects a much improved organisation to that of the previous external review in 2017. The recommendations within the report will progressed and reported to Board through to delivery.

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

- very high attendance and engagement and continuity the Board has brought throughout the pandemic
- very good outturn and all-round performance for 2021/22 reflective of progress made by board
- the effective relationship, skills and experience of all Board members
- continued good links and proactive stance taken in responding to Coronavirus pandemic and in support of the command arrangements in place
- the promotion of the Trust's reputation in the system
- delegation of governance issues to sub committees has worked well and allowed better more focussed Board meetings in those areas and has created time to discuss more strategic issues
- the quality of papers presented to Board have continued to improve thus focussing the Board on the key issues
- recruitment to non-executive director vacancies

2. Delivery of functions delegated by Board

n/a - a number of functions are delegated *to* sub committees and assurance is provided at each Board.

3. Attendance

3.1 The Board met on 10 occasions during 2021/22

Members:	No of meetings attended
Chair, Caroline Flint (wef 16 September 2021)	6/6
Chair, Sharon Mays (to 15 September 2021	4/4
Chief Executive, Michele Moran	10/10
Peter Baren, Non-Executive Director	9/10
Francis Patton, Non-Executive Director	10/10
Mike Smith, Non-Executive Director	9/10
Dean Royles, Non-Executive Director	9/10
Mike Cooke, Non-Executive Director	4/4
Hanif Malik, Associate Non-Executive Director *(Non-voting)*	7/7

Stuart Mckinnon-Evans, Non-Executive Director Director of Finance, Peter Beckwith Medical Director, John Byrne Director of Nursing, Allied Health and Social Care Professionals Hilary Gledhill Chief Operating Officer, Lynn Parkinson Director of Workforce & OD, Steve McGowan *(Non-voting)*	2/2 10/10 10/10 10/10 10/10 10/10

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

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

3.3 Include any recommendation for change to membership & reasons why

Given the increased role the Trust is contributing at system level through specialist commissioning, and the associated governance architecture this creates, extra capacity was introduced in year as agreed when reviewing Board effectiveness last year. As agreed, an Associate NED role has been introduced in 2021/22. This role also brings the advantage of supporting succession planning.

No recommendations for change for the year ahead.

4. Quoracy

The Committee was quorate on all occasions

5. Reporting Committees to Board

The following committees report to the Board:-

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

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

Yes.
The annual review of committee effectiveness and terms of reference for these committees for 2021/22 will be presented to the Board in May 2022 for approval.

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

Yes, 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 2021/22?

Yes - These are scheduled for presentation at the May 2022 Board meeting.

6. Conduct of meetings

Chair to consider the following questions

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

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

- *Are the reports and papers presented of a high quality and prepared in time for issue 5 working days ahead of the meeting?*

Yes.

However, in order to ensure committee assurance reports provide up to date assurance after a sub-committee meeting, where meetings are held around despatch day these may follow a day or two after papers have been despatched 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 despatched 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.

No changes are proposed.
The ToR are attached as Appendix 1 for approval.

8. Workplan for 2022/23

Has a workplan for the year ahead, 2022/23 been prepared?

Yes.
The workplans are included in the monthly Board papers

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

No issues arising from the 2021/22 effectiveness review.

Humber Teaching NHS Foundation Trust

Terms of Reference

Board of Directors

Authority	The Trust is required to establish a Board of Directors in accordance with the requirements of the NHS Act 2006 (as may be amended by the Health & Social Care Act 2012), and paragraph 22 of its 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 on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose. The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a sub-committee of the Board or to an Executive Director. Arrangements for the reservation and delegation of powers are set out in the Standing Orders, Scheme of Delegation and Standing Financial Instructions. The Board will ensure regular reviews of its effectiveness and that of its sub committees that have been delegated powers by the Board via annual committee effectiveness reviews and as part of an established ongoing Board development programme. The Board will achieve its purpose by:

	• Setting and overseeing the strategic direction of the organisation within the overall policies and priorities of the Government, the Trust's regulators, and its commissioners, having taken account of the views of the Trust's members (through the Council of Governors), and the wider community • 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 so as 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 –** our shared commitment to be an Accountable organisation, seeking collaborations with other to support and grown health and social care systems. In addition, members of the Board must ensure compliance with the Health and Social Care Act (Regulated Activities) Regulation 2014 in relation to the Fit and Proper Persons Test.
Duties	The duties set out below shall not preclude the Board of Directors from reserving powers and duties to itself. These powers and duties shall be set out in the Standing Orders, Scheme of Delegation and Standing Financial Instructions and for the avoidance of doubt where there is a conflict, Standing Orders, Scheme of Delegation and Standing Financial Instructions will take precedence over these Terms of Reference. The duties of the Board of Directors are to:

	• Set the values and strategic direction of the Trust; and ensure the Trust's Strategy is reviewed as necessary. • Provide leadership to the Trust to promote the achievement of the Trust's Principal Purpose' as set out in the Constitution (i.e. the provision of goods and services for the purposes of health services in England), ensuring at all times that it operates in accordance with the Constitution and the terms of the license as issued by Monitor (now part of NHS Improvement) • Promoting 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, in particular, 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 Coast and Vale (HCV) Provider Collaborative 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 to, receive and consider reports of such Committees. Minutes or reports from the Committees below, and any others that the Board so requests, shall be presented to the next scheduled meeting of the Board of Directors following the Committee meeting. • Audit Committee • Charitable Funds Committee • Finance & Investment Committee • Mental Health Legislation Committee • Quality Committee • Remuneration and Nomination Committee • Workforce & Organisational Development Committee • Commissioning Committee Members of the Board of Directors must ensure that wherever possible they attend every Board meeting (including extraordinary Board meetings when convened). An explanation of non-attendance should be made to the Chair. Attendance at meetings will be monitored by the Trust Secretary and shall be reported to the Chair on a regular basis and shall also be reported annually in the Annual Report. Where, exceptionally, a Director is absent from a meeting they may not normally send a deputy in their place, although attendance in these

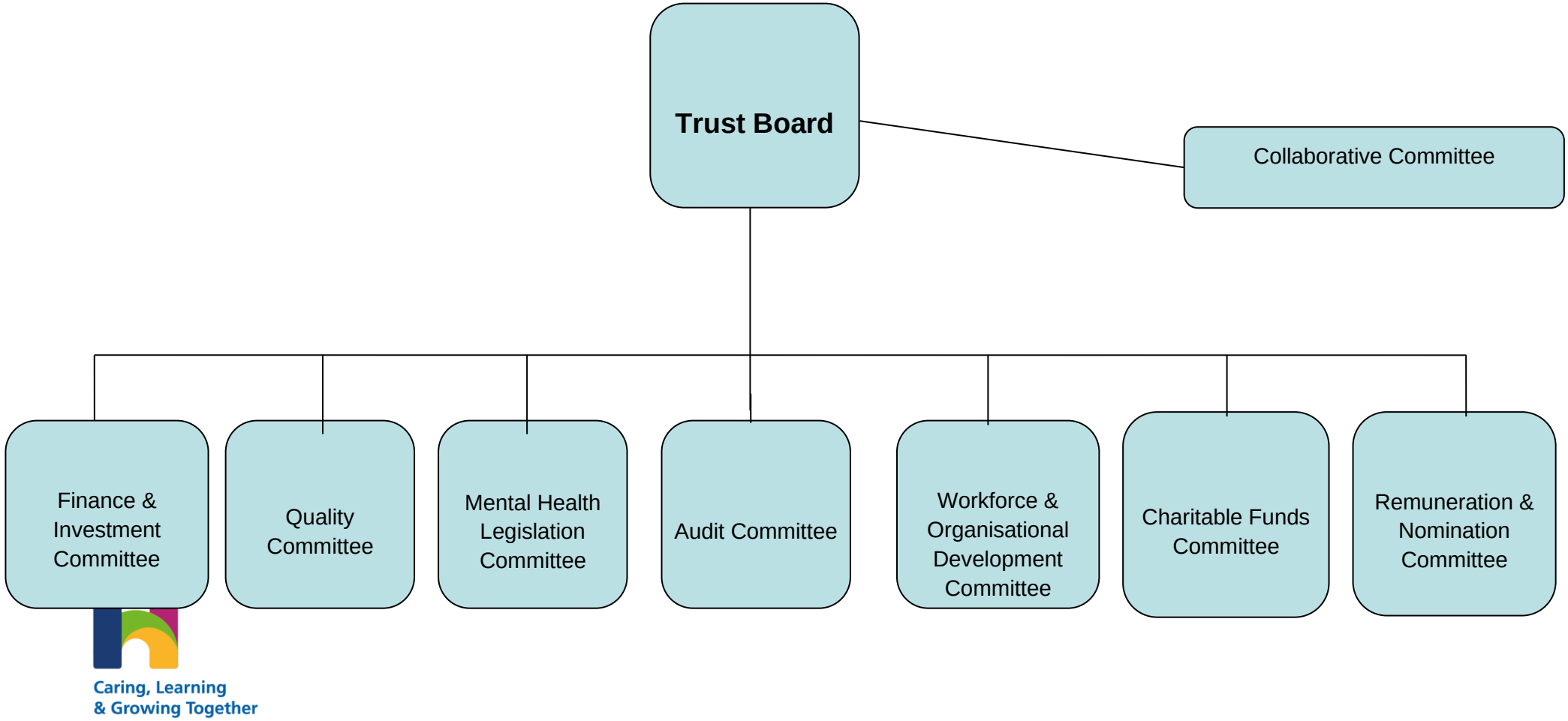
	circumstances will be at the discretion of the Chair. Where there are formal acting up arrangements in place the person acting up may attend and will assume the voting rights of the Director they are acting up for. If no formal acting up arrangements are in place the person attending may not assume the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

	• Contact with the Chair, Director of Finance or Chief Executive is inappropriate • Discussing the Chair's performance appraisal, remuneration or allowances The SID is also a contact point for staff 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 Paragraph 23 of the Trust's Constitution and, shall comprise both executive and Non-Executive Directors. Membership shall be as follows: • A Non-Executive Chair • Up to 6 other Non-Executive Directors • Up to 6 Executive Directors • 1 Associate Non-Executive Director (non-voting)* *Associate Non-Executive Director appointments will be non-voting and not count towards the 6 other Non-Executive Director positions. At all times at least half of the Board of Directors, excluding the Chair shall be Non-Executive Directors. For clarity the Executive Directors who are members of Board of Directors are: • Chief Executive (voting) • Director of Finance (voting) • Medical Director (voting) • Director of Nursing, Allied Health and Social Care Professionals & Caldicott Guardian (voting) • Chief Operating Officer (voting) • Director of Workforce & Organisational Development (non-voting) All full members of the Board of Directors shall have one full vote each, with the Chair having a second or casting vote should the need arise.

	The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be the Senior Independent Director. In consultation with the Chair of the Trust, the Council of Governors may also appoint one of the Non-Executive Directors as a Deputy Chair.
Quorum	No business shall be transacted at a meeting unless at least one third of the whole number of the Chair and Board members (including at least one Executive Director and one Non-Executive Director) is present.
Chair	Chair of the Board of Directors
Frequency	Monthly (minimum of 10 per year)
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 every month (minimum 10 per year). The Board may agree to vary that frequency; however, this shall not preclude meetings being convened in accordance with Standing Orders 1.2 and 1.3 in Annex 8 of the Constitution. All meetings shall be held in public, at which members of the public and representatives of the press shall be permitted to attend. Members of the public are not permitted to ask questions during the meeting as it is a meeting held in public, not a public meeting. However, questions can be submitted to the Chair at the end of a meeting. Responses to the questions may be given at that time or in writing within 5 days of the meeting. Members of the public may be excluded from a part II meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. Such matters will be discussed in a separate closed session which will not be attended by members of the public. The public may attend each meeting of the Board of Directors, but shall be required to withdraw upon the Board of Directors resolving:- *'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'*

	A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in Standing Order 3 in Annex 8 of the Constitution (or as agreed by the Chair) to all Directors. A link to the public agenda and papers and a copy of the private agendas will be sent to members of the Council of Governors prior to any meeting. The Trust Secretary shall take the minutes and shall ensure these are presented to the next Board of Directors' meeting and signed by the person who presided at the meeting. Minutes from meetings of the Board of Directors will be presented to the Council of Governors when practicable, in accordance with a process agreed by the Council of Governors. The public agenda, papers and minutes of each meeting shall be displayed on the Trust's website.
Monitoring	A review of attendance and effectiveness will be undertaken annually. To comply with NHS Resolution Risk Management standards (which now incorporates the functions of the organisation formerly known as the NHS Litigation Authority (NHSLA), the Trust has to include certain details in all its terms of reference documents. The Trust also has to collect evidence of compliance with these areas.
Approval Date	18 May 2022 tbc
Review Date	May 2023

Sub Committee Structure



NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 16

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Council of Governors Public Meeting Minutes 13 January 2022
Author/s:	Caroline Flint Chair
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The minutes of the Council of Governors meeting held on 13 January are presented for information.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No issues raised	**Key Actions Commissioned/Work Underway:** • N/A
Positive Assurances to Provide: • Meeting was quorate • Grant Thornton attended as part of the Well Led Review work • Positive Patient Story • Governor Elections	**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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) Council of Governors Mins	✓

Monitoring and assurance framework summary:

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

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

Minutes of the Council of Governors Public Meeting held on Thursday 13 January 2022 via Microsoft Teams

Present:	Rt Hon Caroline Flint, Chair Michele Moran, Chief Executive Andy Barber, Appointed Governor, Smile Foundation Eric Bennett, Hull Public Governor Sue Cooper, East Riding Public Governor John Cunnington, East Riding Public Governor Mandy Dawley, Staff Governor Tim Durkin, Wider Yorkshire & Humber Public Governor Craig Enderby, Staff Governor Anne Gorman, Staff Governor Jean Hart, Service User & Carer Governor Gwen Lunn, Appointed Governor, Hull City Council Paul McCourt, Appointed Governor, Humberside Fire & Rescue Sam Muzaffar, East Riding Public Governor/Lead Governor Tom Nicklin, Staff Governor Doff Pollard, Whitby Public Governor Fiona Sanders, East Riding Public Governor Helena Spencer, Hull Public Governor Jacquie White, Appointed Governor, University of Hull
In Attendance:	Peter Baren, Non-Executive Director Dean Royles, Non-Executive Director Mike Smith, Non-Executive Director Peter Beckwith, Director of Finance Lynn Parkinson, Chief Operating Officer Graham (for item 04/22) Jenny Jones, Trust Secretary Katie Colrein, Membership Officer James Collier, Apprentice Communications Officer Sue Cordon, Grant Thornton (observing)
Apologies:	Jenny Bristow, Appointed Governor Humberside Police Nigel Wilkinson, Appointed Governor East Riding of Yorkshire Council

The meeting was held virtually via Microsoft Teams due to the restrictions of Covid 19. The meeting was also live streamed.

The Chair welcomed everyone to the meeting and explained that as Governors are aware the Trust is starting the new year with an External Well Led Review in line with NHS Improvement guidance to externally review governance. Grant Thornton is carrying out the review and the Chair introduced Sue Cordon who will be observing our meeting today as part of that process.

It was confirmed that the meeting was quorate.

01/22 **Declarations of Interest**

Any changes to declarations should be notified to the Trust Secretary. The Chair requested that if any items on the agenda presented anyone with a potential conflict of interest they should declare the interest and remove themselves from the meeting for that item.

02/22 **Minutes of the Meeting held on 7 October 2021**

The minutes of the meeting held on 7 October 2021 were agreed as a correct record with the following amendment:

56/21 Performance Update

A sentence was added to the 3rd paragraph after the second sentence to read “Mr. Durkin also queried what he considered to be a missing graph from the Neurodiversity document, relating to the E.R." The minutes will be amended to reflect this addition.

03/22 **Matters Arising and Actions Log**

The action log was noted.

56/21 Performance Update

Mr Durkin was grateful to the ASD graph that had been included in an update to himself and Governors. He appreciated the work that has been done at a difficult time for the Executive team. There was a lot of information to be understood and he hoped there would be time at a future Governor Development session to explore this further. He recognised that more resources are being put into services but did find the information provided difficult to understand. The Chair explained that the e mail paraphrased an earlier e mail that was shared with Governors. At the last Governor Development session it was agreed that an update would come back in six months for another discussion to see how the work had progressed. This will be scheduled in for March/April. The Chief Operating Officer and the team are reporting back to the Board at each meeting and looking at this situation on a weekly basis.

The Chief Executive explained that the Executive team is working hard constantly and takes Governor concerns seriously. There is lots of information in Statistical Process Charts (SPC) that show the work being undertaken and an update in a couple of months will be helpful for Governors.

Mrs Pollard thought it would be helpful to understand what the plans are and that Governors are keen to hear more and look forward to having the next session with more detail.

04/22 **Patient Story- Graham’s Story – “If you Get Your Health Right, Everything Else Will Follow”**

Graham joined the meeting to share his experiences as a service user and service adviser with the organisation. Supported by Tom, Service Engagement Lead (and Staff Governor), Graham told Governors how he took part in interviews and talked to people about his life, the struggles he has had from a young age and what his life is like now.

Graham has had health issues from a young age which have left him with hearing and speech problems. He worked for several years at Remploy making all kinds of useful things such as clothes props. When he was growing up he did not understand the medical terms and felt intimidated by doctors and health professionals. His life changed when he met Mandy a nurse in the Learning Disability services and she helped him to move on and to get the health care he needed. Graham believes that if you get your health right everything else will follow.

Mrs Hart thanked Graham for his story and for sharing his experiences and achievements. Her husband has a health changing condition and is determined not to use a wheelchair although most people with his condition must use one from an early age.

Mrs Cooper felt that Graham’s story was extraordinary especially with the adversity he had gone through to get to where he is now. She also congratulated the staff involved in helping Graham to reach his ambitions.

Dr White was interested to hear how the nurse mentor helped Graham and that his physical health needs were addressed. She asked Graham if he had spoken to students as it is important that they know to look at the whole person in their roles as doctors and nurses. Graham has attended the University to speak to students in their first days at a Tea and Talk event to tell his story. Dr White thanked Graham for his story and that he would be very helpful

to students and welcome to attend future events. Graham enjoys meeting people and helping people and felt that if he can share his story, it will go a long way to helping people.

The Chief Executive thanked Graham for his story and it had been a pleasure to meet him earlier today.

The Chair appreciated Graham attending the meeting to share his story with the Council of Governors.

05/22 **Chair's Report**

The Chair provided a verbal update on her recent activities.

Council of Governors Changes

As it is their last COG meeting, the Chair wanted to take the opportunity on behalf of everyone present to thank the following Governors who have come to the end of their term of office for their service and to wish them all well for the future.

Sam Muzaffar – 6 Years
Eric Bennett - 6 Years
Anne Gorman – 6 Years
Mandy Dawley – 6 Years
Fiona Sanders – 3 Years

The Chair also expressed her thanks to Huw Jones and Jack Hudson who stepped down from being Governors towards the end of last year.

An additional thank you was extended to Mr Sam Muzaffar in his role as Lead Governor for his advice and support. The Chair looked forward to working with Mrs Doff Pollard who put herself forward as the next Lead Governor and is appointed unopposed. Congratulations Doff!

Mr Muzaffar felt the time has passed so quickly and it had been a privilege to meet some wonderful people and see how the Trust has improved its performance over the years. It had been an enjoyable experience for him.

From February the Council of Governors will be joined by the following new Governors:-

- Antony Douglas - East Riding
- Soraya Hutchinson - East Riding
- Ruth Marsden – East Riding
- Trevor Hackett – Hull
- Patrick Hargreaves - Hull

Governor Groups

The Chair reported that with Governors coming to the end of their terms of office, their places will need to be filled on Governor groups with two requiring a Governor to chair them.

- Appointments, Terms and Conditions Committee – Governors and a chair needed. This is a statutory group that looks at Non-Executive Director terms and conditions including appointments.
- Finance, Audit & Strategy – Governors and a chair needed
- Workforce, Quality & MHL
- Engaging with Members

If anyone is interested, please contact Katie Colrein, Membership Officer for more details.

Governor Elections

As there are still some vacancies on the Council of Governors we will be going out to election in the coming weeks. We are looking for

2 Staff Governors one Non-clinical and one Clinical,

1 East Riding,
1 Hull
1 Service User and Carer

If you know of anyone who may be interested, please ask them to contact Katie, the Membership Officer.

The Chair has been discussing with Katie the different ways that we can publicise these elections, for example through local media and to coincide with an edition of Humber People alongside the usual channels. More details will be provided to Governors to share with your networks.

Follow up from Governor Development Session
Following on from the last Governor Development session additional information, as requested, has been provided on ASD/ADHD Children and Young People waiting times for assessment and changes to improve the service. As agreed, we will use another Governor Development Session to look at progress in a few months.

Governor Induction Programme
Also, work has been taking place on changes to the Governor Induction Programme following input from Governors. The plan is for this to be in place in time for the new Governors Induction in February and the changes will be shared with Governors for their views.

Governor Vaccination Status
As you will no doubt be aware, the Government has announced that many NHS staff will need to be fully vaccinated against Covid-19 by 1 April 2022 unless an exemption applies. This decision has been made to protect our patients, our families and our NHS workforce.

Our Trust, as a registered provider of CQC regulated activities, is legally bound by the new regulations and have no powers to refuse to implement them. We will therefore comply with this decision and implement the new regulations as required.

As part of this process, the Trust is required to hold records of the vaccination status of all our staff which includes volunteers and visiting professionals and anyone who may have incidental contact with our service users. I appreciate that Governor activities have been primarily online, but it is hoped that there will be the opportunity for more in person meetings, sessions and visits in the future.

The information is needed as soon as possible as 3 February is the last date that the first vaccination can be held to enable the April date to be met. On that basis I will be writing to Governors individually explaining how to provide information on your vaccination status to enable the Trust to satisfy the criteria relating to our Governors. Staff Governors will already be covered by Trust procedures.

Mrs Spencer asked if new Governors are aware of the vaccination requirement. The Chair explained they will be made aware, and the requirement will be made clear in any future elections going forward. Mrs Hart has already provided information as she is part of the volunteers for the vaccination programme through the Patient and Carer Experience team.

Resolved: The verbal updates were noted

06/22 **Chief Executive's Report**
The Chief Executive presented her report which gave an update on the local issues. An overview of the current pressures that are being faced was also given to Governors.

It is an extremely busy time which has increased over the last few weeks due to the Omicron variant of Covid. The organisation has tried to be ahead of the curve and staff have been remarkable and outstanding in the way they continue to deliver great patient care. Over the Christmas period business continuity plans were used and additional staff arranged. Demand plateaued over the Christmas period, but as is usual, increased in the new year. Work is

taking place with all sectors on delayed discharges which is putting a strain on community services. The absence rate was running at 10% due to Covid related illness. PCR testing escalation took place around receiving results to try and get staff back to work safely. The Trust managed to purchase some lateral flow tests for staff and these have been distributed around the organisation.

Staff continue to be supported from a health and wellbeing perspective and the intranet has lots of information on on how to access support.

The system is under enormous stress and the organisation itself is standing at Opel levels ¾. The whole system is "hot" and there are pressures from Primary Care and GP practices and more recently the ambulance service which recently was running at a 60% sickness rate.

Local Authorities are struggling with placements because if a care home has a case of Omicron it must shut for 14 days (was 28 days). There are also staffing issues and work continues with colleagues across the system to ensure there is no reduction in patient care or quality of care and staff health and wellbeing.

The organisation continues to operate most of its services although staff from some corporate areas have had to be moved to the front line due to absence. The region has not seen the peak in infection rates yet and has been commended by the Local Resilience Forum for its details plans. Gold and Silver command meetings have been reconvened, but no major incident has had to be declared which is down to the truly amazing staff.

The Deputy Chief Operating Officer, Mrs Parkinson, provided a further update on Covid issues. The national operational level is currently at 4 and has been for some time due to to the Omicron variant. It has been proved this variant is transmitted faster than the Delta variant and the vaccination is less effective against Omicron requiring the need for a third booster dose of the vaccine. There is a national requirement for the NHS to support this booster campaign and following the closure of the Lecture Theatre vaccination centre, the Trust HQ dining room was mobilised into an appropriate facility. As mentioned previously the Emergency Planning arrangements were put in place through Gold and Silver command.

Some increased absence was seen before Christmas which was managed over the two bank holiday weekends. Staffing was increased although there was an increased reliance on bank and agency staff to support this position. Covid related absence was high and combined with non Covid related absence rose to 10.38%. this has reduced slightly and is standing at 8.34% as the Covid related absence has reduced. The last couple of weeks has seen a rise in the number of Covid positive patients and an increase in demand for mental health beds which is typical for this time of the year. However, these did put pressure on operational services. The staffing position is being maintained and staff have responded effectively and mitigated against some of the risks. Opel level 3 is reported currently with system pressures rising last week. Hull University Teaching Hospital and York & Scarborough Hospitals were are Opel level 4. The Local Authority is supporting the acute hospitals with discharges, but services are stretched. High levels of activity is being seen in community services and support is being offered in Scarborough and York in relation to discharges. Bed occupancy increased across all beds last week and slightly improved during the week.

As the Chief Executive mentioned, some business continuity plans were deployed. Currently no services have been stood down, but this is reviewed daily in line with the pressures being seen. Guidance is changing rapidly on PCR/lateral flow tests, but is being managed in line with the guidance.

The booster programme has now finished, but vaccinations are available for staff. A session for children has been arranged over the weekend.

Mrs Pollard noted that the Board Assurance Framework and Risk Register maintained level of activity and risks and asked if Governors could have sight of the Risk Register. The Chief Executive responded that both of these documents are reviewed by the Board Sub Committees and also the Board on a regular basis. In the first Covid wave there was a

separate risk register, but these are now incorporated into the regular document and can be shared with Governors.

Mrs Cooper asked if there was any update on how the mandatory vaccination requirement is going to impact on the general workforce. The Chief Executive explained that this applies to Social Care staff although a larger programme of work is in place to look at everyone who fall into the category of requiring a vaccination. Mr McGowan, Director of Workforce and Organisational Development, is the Senior Responsible Officer and the data from the Centre and the organisation is being reviewed. 97% of staff have been doubly vaccinated and the remainder are being worked through. Vaccination clinics for staff and for staff family and friends have been put on. Managers are working with individuals around the mandatory vaccination requirement. More guidance is expected in this area. Some organisations have been challenged by their staff side workers, but we are working closely with our staff side.

Mr Royles reported that updates and discussion took place at the recent Workforce & Organisational Development Committee. The Committee has asked and is receiving regular updates to gain reassurance of the work and that risks around Omicron and mandatory vaccinations are picked up on the Risk Register and reviewed by the Executive team.

Mr McCourt referred to sickness absence asking if there is any correlation being seen in the change of self certification reporting to 28 days and non-Covid. Mrs Parkinson explained that this is an area that is being closely monitored. However, we are not seeing at the moment a significant correlation. With the changes to PCR tests requirements this is also being monitored. Mr McCourt commented that it was a credit to Dr Byrne, volunteers and the team for the running of the vaccination centre and the speed of the service.

Dr White asked how staff are doing and whether the use of resilience hubs is being captured. The Chief Executive explained that a lot of initiatives have been done for staff including the Shiny Minds app, Musculo-skeletal support. Staff were also given £50 per head to do something either individually or as a team to help with their health and wellbeing. Staff have been asked if there is anything else they feel they need.

The system resilience hub will continue to be funded for the HCV. The Chief Executive has also fed into the Covid 19 strategic group the need to do more marketing and promotion of the resilience hubs. The priorities are to support staff, patient care and staff health and wellbeing. The new staff practitioners are in place and Mrs Parkinson chairs the Health and Wellbeing group which looks at innovate ways to support staff. It has also been fed back to the national teams that national money should continue as a national priority to continue the resilience hubs.

Chief Executive Updates

- The first BAME AGM was held and opened by the Chief Executive.
- The Flu programme continues although the uptake is lower than this time last year. Work to increase the uptake is being discussed.
- Initial results of the staff survey have been received. These are under embargo currently
- Work is taking place on the Trust HQ site at Willerby. A big programme of work is underway with staff involvement. The Blend and Thrive project is looking at the benefits of flexibility, working from home and the social interaction. A floor in a building across from Trust HQ has been secured with an open plan design which has been consulted on with staff.
- Capital work continues on the capital programme.
- The Communications team is working hard on the website and promoting awareness sessions. More details were included in the report.
- Rebecca Price has been awarded the Queens Nurse Award – congratulations!
- 0 – 19 services – the Trust was successful in its bid in the East Riding and has now also been awarded the Hull services tender allowing synergy of the two services.

Mr Durkin asked about staffing in the CAMHS and PICU teams. He was informed that a Consultant has been recruited in CAMHS on a permanent basis. Health Care Assistants were

recruited in December and are going through the required checks. As part of business continuity plans, prioritisation is being given by the recruitment team to get people into post sooner. When they are in place it is expected that the remaining two beds will be opened.

Resolved: The report and verbal updates were noted.
Risk Register to be circulated to Governors **Action MM**

07/22 **Public Trust Board Minutes September and October 2021**
The minutes of the public Board meetings for September and October 2021 were provided for information.

Resolved: The minutes were noted.

08/22 **Performance Update**
Mr Beckwith presented the performance as at the end of November 2021. Information was provided on the areas which had fallen outside the normal variation range.

Mr Enderby referred to Improving Access to Psychological Therapies (IAPT) noting that this was just for the East Riding. He felt it would be useful for Governors if it was clarified in the future that it was just for the East Riding. Mr Beckwith agreed and will include this in future reports.

Mrs Gorman suggested that it may also be helpful going forward to include benchmarking information around national performance. She explained that something could be viewed in isolation and may not be compared with the national position, and it could be viewed as less positive for the Trust and misinterpreted by external sources. The safer staffing inpatient dashboard shows the PICU and Avondale violence and aggression figures and demonstrate what staff are contending with. She asked if there was any scope for work to be undertaken to show the challenges staff working in these environments face working in mental health services. Mr Beckwith felt this was a useful suggestion and something which may not be brought out in the SPC charts. He suggested that where there are exceptions and movement in trajectories that reference is made to national benchmarking in the commentary. Benchmarking is used as much as possible which is shared with staff. Staff have also produced videos about their jobs which are published. The Chief Executive will discuss with Mrs Gorman if there is anything else that can be done and will also ask the Communications Teams to have another look at this area.

Mrs Parkinson assured Mrs Gorman that benchmarking is used at team level for operational services. Mrs Gorman asked if this is communicated to staff as it is more about the perception outside the Trust. People love a negative story as it gets more interest and perhaps more information on social media could be used to give a more positive look for services.

Mr McCourt noted the out of area placements figures and the Key Performance Indicator (KPI) target of zero. Mrs Parkinson explained that this figure has been broken down by groups. Improvement plans are in place for areas of variation. There is a national requirement to reduce out of area placement to zero and before Covid benchmarking showed the Trust to be one of the best in the country for this achievement. Covid meant bed numbers had to be reduced due to outbreaks and isolation requirements. The number of beds has increased with the opening of Maister Court. Sometimes the patient mix creates issue for example on PICU which is for both male and females. Improvement plans for each of these areas are in place and overall the trend is reducing. The plan is very focussed on this and a zero position for out of area placements is the aim in the coming months. Mr McCourt was reassured with the response provided and wondered if a temporary adjustment was required to reflect the Covid scenarios given. Mrs Parkinson reported that discussions are taking place with the ICS about this for local providers.

Resolved: The report and verbal updates were noted.
Clarification on IAPT services that it is just for East Riding to be added to future reports **Action PBec**
For exceptions and movement in trajectories reference to be made to national benchmarking in

the commentary in future reports. EMT to discuss **Action PBec**
The Chief Executive to have a discussion with Mrs Gorman around public information to help promote the challenges associated with working in mental health services **Action MM**

09/22 **Finance Report**

The report provided the Council of Governors with a summary of financial performance for the Trust for the period September 2021 to November 2021. Mr Beckwith drew the Council's attention to the following areas: -

- Block income payments continue to be received and the Trust has been set a break even target for the full financial year
- As at the end of November 2021, the Trust recorded an overall operating surplus of £0.210m which is in line with the ICS targets.
- Within the reported position at Month 8 is Covid expenditure of £3.160m and income top up of £1.716m.
- The cash balance at the end of November 2021 was £27.855m.

Mr McCourt asked if it was anticipated that Covid money is coming to an end. Mr Beckwith explained that planning guidance was published on 24 December and the technical guidance to accompany this is awaited. A reduction in Covid funding is expected in the next financial year and if this happens there will be a return to the previous level of production. Some Covid funding has been used to fund out of area beds which normally would be picked up by the system. There is a strong argument if Covid funding is reduced there needs to be a return to pre pandemic arrangements.

Resolved: The report was noted.

10/22 **Governor Groups Feedback**

The report provided feedback from the Governors Groups that have been held recently. Mrs Cooper reported that due to illness, the Quality, Mental Health and Workforce Governor Group meeting in November was cancelled and will be rearranged. As previously mentioned, the group would benefit from more Governors attending as at the last meeting held there were only two people including herself. Mrs Cooper raised that in the Board minutes under the Mental Health Legislation item, there was clarification on Associate Hospital Managers that may be of interest to Governors and also the Quality Improvement strategy which she will feed into the next Quality Governor Group.

Mrs Pollard reported that the Engaging with Members group welcomes any Governors to attend the meetings. The group has been looking at ideas for engaging with members and different ways in which this can be done. The Chair acknowledged the work that is taking place in this group and that there may be an opportunity to co-ordinate with work being done to engage with members elsewhere in the Trust.

Resolved: The report and verbal updates were noted.

11/22 **Responses to Governor Questions**

No questions had been raised since the last meeting.

Resolved: The verbal updates were noted.

12/22 **Any Other Business**

No other business was raised.

13/22 **Date and Time of Next Meeting**

Thursday 14 April 2022, 2.00pm by Microsoft Teams

Signed……. Date

Chair

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting– 18 May 2022
Title of Report:	Risk Management Annual Report and Risk Management Strategy Update
Author/s:	Executive Lead Hilary Gledhill, Director of Nursing, Allied Health & Social Care Professionals Oliver Sims Corporate Risk and Compliance Manager
Recommendation:	To approve: ; To receive & note: √ For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The report provides an overview of risk management activity across the Trust for 2021/22 summarising the developments and year-end position for risks on the corporate risk register as well as providing an update on the implementation of the Trust Risk Management Strategy and delivery of risk management ambitions.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

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

Key Actions Commissioned/Work Underway:

- No specific actions commissioned or additional areas of work underway.

Positive Assurances to Provide:

- A summary of the total number of risks by the recorded current rating for April 2021 and March 2022 to highlight the movement in-year for 2021/22 and reflect the 'confirm and challenge' arrangements in place within the Trust.
- In April 2021 there were a total of 7 risks on the Trust-wide Risk Register (risks where the current rating is 15 or above. At the end of year for 2021/22 there were 7 risks although the ratings have changed.
- Breakdown of the Trust-wide Risk Register at the end of 2021/22 and summary of the risks that have been reduced / deescalated from this register in-year for 2021/22 has been provided.
- There are **169** risks held across on the Trust's risk registers and represents year-

Decisions Made:

- An update on the implementation of the Trust Risk Management strategy ambitions has been included within the report to detail further actions for 2022 to further embed and strengthen risk management processes within the organisation going into the new financial year.

end position for 2021/22. • A summary of the total number of risks by directorate / division for April 2021 and March 2022 to highlight the movement in-year for 2021/22. • Breakdown of the risks where the current risk rating has remained the same from April 2021 to March 2022.	

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	05/2022	Workforce & Organisational Development Committee	04/2022
Finance & Investment Committee	04/2022	Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

Monitoring and assurance framework summary:

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

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

1. Year-end Risk Register Position

The Corporate Risk Manager maintains a Trust-wide Risk Register which holds risks identified that may impact delivery of the Trust's principal objectives incorporating risks accepted onto the Trust-wide register following escalation from Directorates and Divisions. As such, the organisation's risk registers have been continuously reviewed in-year for 2021-22 and regular reports have been submitted to Trust Board summarising the overall position for the Trust in terms of total risks and the risk profile regarding current rating.

The overall risk position reported at the start of the year and the closing position is highlighted in the table below:

Table 1 - Total Risks by Current Risk level – 2021/22 In-year comparison

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	1	0
16	2	1
15	4	4
12	55	43
10	6	11
9	44	34
8	27	27
6	36	40
4	1	2
3	2	4
2	4	3
1	0	0
Total Risks	**182**	**169**

2. Trust-wide Risk Register

The Trust-wide risk register contains key strategic risks and risks escalated from Trust Directorates / Divisions that are currently significant (current rating at 15 or above).

The Trust has identified the risks associated with its strategic goals and these have been scored in accordance with the Trust's risk matrix. Each risk is considered to have the potential to impact significantly on the achievement of one or more of the Trust's strategic objectives and/or local delivery plans. These risks are also aligned to the Board Assurance Framework (BAF). A refresh of this process will be undertaken as the Trust's new strategy is developed in 2022 and the associated strategic goals are updated.

Risks identified within Directorate / Divisional risk registers are escalated for inclusion within the Trust-wide risk register based on residual (current) risk level. However, each Director is responsible for identifying significant risks within their business area risk register with risks with a current rating of 15 or more escalated for inclusion on the Trust-wide register. The risks

that form the Trust-wide risk register are then reviewed by the Executive Management Team to ensure that they correctly reflect the current level of risk facing the Trust and that appropriate mitigating controls are in place, with robust plans for further actions to address identified gaps in control.

The owner of the Trust-wide risk register is the Chief Executive. The register is collated by the Corporate Risk Manager and reviewed by the Executive Management Team prior to submission to the Board on a quarterly basis. In addition, risks pertaining to each of the Board sub committees are reviewed at each committee meeting.

At year-end for 2021/22 there were **6** risks reflected on the Trust-wide risk register which records all risks currently scored at a rating of 15 or above.

Table 2 - *Trust-wide Risk Register March 2022*

Risk ID	Date Opened	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
WF03	10/06/2019	With current national shortages, the inability to recruit qualified nurses may impact on the Trust's ability to deliver safe services and have an effective and engaged workforce.	**20**	**15**	**10**
WF04	10/06/2019	With current national shortages, the inability to retain qualified Nurses impacts on the ability to deliver services and/or puts financial pressure through the use of agency staff.	**20**	**15**	**10**
WF10	10/06/2019	With current national shortages, the inability to retain GPs may impact on the Trust's ability to deliver safe services.	**20**	**15**	**10**
FII205	15/06/2018	Risk to longer-term financial sustainability if tariff increases for non-acute Trusts are insufficient to cover AFC pay award and if sustainability funding is not built into tariff uplift for providers who are not using PBR tariff.	**25**	**15**	**10**
OPS11	04/05/2021	Failure to address waiting times and meet early intervention targets which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain	**20**	**16**	**8**
OPS13	21/06/2021	Due to the increasing complexity of CAMHs inpatients nationally and an increasing demand for CAMHs inpatient beds far exceeding capacity, there is increased use of out of area beds for young people which may lead to delayed discharges, insufficient management of patients in line with complexity and admission to inappropriate settings.	**20**	**16**	**8**

3. Trust-wide Risk Register Closed / Deescalated / Reduced Risks 2021/22

Table 3 - *Trust-wide Risk Register Downgraded/ Closed Risks 2021/22*

Risk ID	Description of Risk	Current Status

Risk ID	Description of Risk	Current Status
WF25	Current Consultant vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact on the credibility/reputation of the organisation.	**Risk re-scoped to capture only the quality / safety impact linked to current Trust consultant vacancy rate. Current risk score captured as 10 High (Unlikely x Catastrophic) and does not meet threshold for inclusion on the Trust wide risk register. Risk continues to be managed via the WFOD Directorate and updates will continue to be provided to the Workforce and OD Committee.**
SR29	Increased clinical activity - Scarborough Community core service provision, including increase in number, acuity, and complexity of referrals. The risk identified is that we do not have increased resource or capacity to deliver this increase in clinical activity. There is also a risk of negative impact on staff health and wellbeing related to the additional demand, which may also impact on staff recruitment and retention, and training compliance.	**Risk reduced to 9 (Possible x Moderate) to reflect controls implemented locally and further mitigation to the risk. The risk continues to be managed on the Primary Care and Community Services Divisional Risk Register.**
SR15	As a result of current vacancies on Fitzwilliam Ward there may be insufficient qualified staff to manage current patient need, which could result in a delayed response in patient care, reduced quality, and risk to patient safety and reduction in beds to ensure safe patient care.	**Risk reduced to 8 (Unlikely x Severe) to reflect further mitigation to the risk including recruitment to vacant posts and international nurse recruitment activity. The risk continues to be managed on the Primary Care and Community Services Divisional Risk Register.**
OPS11	Failure to address waiting times and meet early intervention targets which may result increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.	**Risk reduced to 12 (Possible x Severe) to reflect current mitigations in place and the overall improvements Trust waiting list position. The risk remains on the Operations Directorate Risk Register.**
LDC49	Ongoing pressures within Hull CAMHS Core Team with high acuity of patients and high volumes of referrals resulting in long waiting times.	**Risk reduced to 12 (Possible x Severe) to reflect controls implemented within the service. The risk remains on the Children's and Learning Disability Divisional Risk Register and will continue to be monitored via the Trust's Operational Delivery Group.**
LDC50	Increased number of referrals and high acuity of patients for the eating disorder team, as well as young people being referred to the team requiring immediate medical attention which may impact their ability to meet NHS England waiting time standards.	**Risk reduced to 12 (Possible x Severe) to reflect controls implemented within the service. The risk remains on the Children's and Learning Disability Divisional Risk Register and will continue to be monitored via the Trust's Operational Delivery Group.**

4. Operational Risks Year-end Position

4.1 Operational Risks Register year-end position

Table 4 – *Total operational risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0
16	1	2
15	0	0
12	0	1
10	1	1
9	3	1
8	0	0
6	0	2
4	0	0
3	0	0
2	0	0
1	0	0
Total Risks	**5**	**7**

Table 5 – *Total operational risks with unchanged current risk rating April 2021 – March 2022*

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	End of Year Update
OPS12 Risk Added – 01/04/ 2021	Risk of ligature due to prevalence of lower-level anchor points across the Trust's estate which may increase the possibility of fixed ligatures and impact to the safety of patients	15	10	5	Work has been undertaken in year and ligature anchor point risk assessments undertaken and updated annually or where changes to environments occur. Policies and procedures are in place to support assessment and management of risks and a review of the Ligature risk policy, intended to promote patient safety, risk management, and ensure compliance. Estates works have been reviewed by CERG and funding has allocated to ligature works programme. Dates arranged for testing of devices and proposal for roll out of work to higher risk areas in first instance as per roll out plan. Any new build specification will include alarmed doors for bedrooms and some communal areas where required. En-suites will be fitted with anti-ligature doors as agreed by CERG.

4.2 Quality Risks Year-end Position

Table 6 – *Total quality risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0
16	0	0
15	0	0
12	2	1
10	0	0
9	4	3
8	3	1
6	1	2
4	0	0
3	0	0
2	0	0
1	0	0
Total Risks	**10**	**7**

Table 7 – *Total quality risks with unchanged current risk rating April 2021 – March 2022*

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	End of Year Update
NQ50 Risk Added – 03/03/ 2021	As a result of ongoing issues with the recording of next of kin information on Trust patient care records, there may be impact to the quality care within Trust services in terms of carer /next of kin involvement in decision making and meeting patient needs, as well as implications to duty of candour requirements and potential reputational impact for the organisation.	**12**	**12**	**3**	Next of kin information included as part of record-keeping audit arrangements and Duty of Candour policy in place with requirements for capturing next of kin information. Practice note sent to staff. A monthly compliance report has been developed and is monitored through the Clinical Risk Management Group. Ongoing monitoring of NOK compliance data via Clinical Risk Management Group until compliance rate improves. Latest data indicates improvement. Current risk rating will be reviewed when March data obtained to consider whether the current rating can be reduced.

4.3 Workforce Risks Year-end Position

Table 8 – *Total workforce risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	1	0
16	0	0
15	3	3
12	3	3

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
10	0	1
9	8	4
8	0	1
6	4	5
4	0	0
3	0	0
2	0	0
1	0	0
Total Risks	**19**	**17**

Table 9 – *Total workforce risks with unchanged current risk rating April 2021 – March 2022*

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	End of Year Update
WF03 Risk Added – 10/06/ 2019	With current national shortages, the inability to recruit qualified nursing may impact on the Trust's ability to deliver safe services and have an effective and engaged workforce	20	15	10	Detailed Recruitment plan in place (progress against which reported to EMT and Workforce and OD Committee). Recruitment task and finish group in place and international recruitment programme in place. Workforce planning process and overarching plan monitored by WFOD Committee Plan in place for further attendance at overseas recruitment fairs further expanding the reach of recruitment activities. As at March 2022 vacancy rate 10.33% (87.8 vacancies) compared with 11.85% (100.4 vacancies) in March 2021. Risk to be re scoped.
WF04 Risk Added – 10/06/ 2019	With current national shortages, the inability to retain qualified Nurses impacts on the ability to deliver services and/or puts financial pressure through the use of agency staff	20	15	10	Appraisal process in place and Leadership and management development programmes across the Trust including PROUD programme. Staff Health & Wellbeing Group in place and action plan. Trust Retention Plan and review completed for new year staff survey results and development of departmental / divisional action plans monitored through accountability reviews. EMT signed off band 5 retention

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	End of Year Update
					scheme March 2022. Current turnover 10.98% as at February 2022 (10.79% January 2022)
WF10 Risk Added – 10/06/ 2019	With current national shortages, the inability to retain GPs may impact on the Trust's ability to deliver safe services.	**20**	**15**	**10**	Staff engagement though TCNC (Trust Consultation and Negotiation Committee). Staff Health & Wellbeing Group and action plan. Trust retention plan as agreed with NHSI. PROUD programme and recruitment and retention incentives HR Business Partners ongoing review of exit questionnaire results to identify any hot spots. Ongoing PROUD programme implementation plan - ongoing 3-year programme. Programme of 6 monthly deep dives into Leaver data to be undertaken and reported into WFOD Committee
WF17 Risk Added – 02/02/20 21	Risk to patient safety due to low compliance rate of Adult Basic Life Support training and Immediate Life Support	**12**	**12**	**4**	Courses available for self-booking through ESR. Incorporated into DMI training to reduce the time out of operational areas. Compliance scores shared with subject leads to take action and improve compliance levels. Compliance information available through ESR self-service and managers ESR Portal. Compliance as of February 2022 for BLS at 68.45%, which is below the organisational target of 85%. ILS compliance is 67.26%, against a Trust target of 85% Plan to improve compliance with the additional of a further trainer signed off by EMT- March 2022.

4.4 Finance Risks Year-end Position

Table 10 – *Total finance risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0
16	0	0
15	1	1
12	5	0
10	1	1
9	9	7
8	5	6
6	11	6
4	0	0
3	1	2
2	0	0
1	0	0
Total Risks	**33**	**23**

Table 11 – *Finance Directorate total risks with unchanged current risk rating April 2021 – March 2022*

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	End of Year Update
FII205 Risk Added – 15/06/ 2018	Risk to longer-term financial sustainability if tariff increases for non-acute Trusts are insufficient to cover afc pay award and if sustainability funding is not built into tariff uplift for providers who are not using PBR tariff.	25	15	10	Budgets agreed and monthly reporting, monitoring and discussion with budget holders. BRS reporting to FIC Small contingency / risk cover provided in plan. MTFP developed to inform plans. Regular reviews with NHSE/I and relevant Commissioners Budget Reduction Strategy established with MTFP. Detailed budget reduction strategy plans for 2022/23 to be developed

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score	End of Year Update
FII220 Risk Added – 08/06/ 2020	The financial effect of COVID-19 and the risks that the full costs will not be recovered.	**12**	**8**	**4**	Trust is accurately recording the costs of COVID-19 and recovering the costs of COVID-19 through ICS A level of Top up funding and COVID has been secured for month 1 - 6 (H1) 2021-22 to enable ICS target to be achieved. Regular contact is being maintained with NHSI and ICS regarding the funding.
FII216 Risk Added – 12/03/ 2020	Risk of fraud, bribery and corruption.	**12**	**9**	**3**	Risk added to register at the request of internal audit Counter Fraud Manager due to requirement for trust to recognise risk on the risk register. Counter-fraud work plan developed including resource allocation and counter-fraud risk planning tool (operational risk plan). Counter fraud progress reporting to Audit Committee. Regular meetings to be held between key trust staff (i.e. Director of Finance, Risk Manager) and the Audit Yorkshire counter fraud specialist to review existing and emerging risks and to ensure effective executive level monitoring

4.5 Medical Directorate Risks Register Year-end Position

Table 12 – *Medical Directorate total risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	**0**	**0**
16	**0**	**0**
15	**0**	**0**
12	**2**	**2**
10	**0**	**0**
9	**1**	**0**
8	**1**	**3**
6	**3**	**2**
4	**0**	**0**
3	**1**	**0**
2	**0**	**0**

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
1	0	0
Total Risks	8	7

No risks with same current risk rating April 2021 – March 2022 to highlight from the Medical Directorate risk register.

4.6 Forensic Services Risk Register Year-end Position

Table 13 – *Forensic Services total risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0
16	0	0
15	0	0
12	8	8
10	3	7
9	6	2
8	10	3
6	1	8
5	0	2
4	0	2
3	0	3
2	0	0
1	0	0
Total Risks	30	35

No risks with unchanged current risk rating April 2021 – March 2022 to highlight from the Forensic Services risk register.

4.7 Mental Health Services Risk Register Year-end Position

Table 15 – *Mental Health Services total risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0
16	0	0
15	0	0
12	13	8
10	0	0
9	4	4
8	4	3
6	3	2

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
5	0	0
4	0	0
3	0	0
2	0	0
1	0	0
Total Risks	24	17

No risks with unchanged current risk rating April 2021 – March 2022 to highlight from the Mental Health Services risk register.

4.8 Children's and LD Services Risk Register Year-end Position

Table 17 – *Children's and LD Services total risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0
16	0	2
15	0	0
12	8	0
10	0	0
9	1	1
8	1	5
6	0	0
5	0	0
4	0	0
3	0	0
2	0	0
1	0	0
Total Risks	10	8

No risks with unchanged current risk rating April 2021 – March 2022 to highlight from the Children's and LD risk register.

4.9 Community and Primary Care Services Risk Register Year-end Position

Table 17 – *Community and Primary Care Services total risks by current risk level – 2021/2022*

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
20	0	0

Current Risk Level	Number of Risks – April 2021	Number of Risks – March 2022
16	0	0
15	0	0
12	11	15
10	1	1
9	8	10
8	1	3
6	8	11
5	0	0
4	1	0
3	3	0
2	0	0
1	0	0
Total Risks	**33**	**40**

No risks with unchanged current risk rating April 2021 – March 2022 to highlight from the Community and Primary Care risk register.

5. Risk Management Strategy

The Trust's continued ambition to have excellent systems and processes fully embedded across the organisation that support the delivery of the Trust's Strategic Aims requires that we support better decision making through a good understanding of our potential risks and their likely impact. In this respect the Trust is committed to maintaining a systematic approach to the identification and management of all risks surrounding our activities.

As part of its Risk Management Strategy, by March 2024 the Trust will aim to achieve the following Risk Management Ambitions:

1. To further support greater 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 further refine existing systems and processes throughout the Trust to support effective risk management and ensure that these are 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.

4. To confirm that the Trust's risk management arrangements are robust, and that excellent systems and processes fully embedded across the organisation that support the delivery of the Trust's Strategic Goals through annual Trust's Risk Maturity assessment process.

6. Risk Management Ambitions Update

Risk Management Ambition One
To further support greater devolution of decision-making and accountability for the management of risk throughout the organisation from Trust Board to point of delivery (Board to Ward) in system and partnership working.
Year End Updates
1. Dates for risk training sessions planned until end of 2022 and are being communicated to staff via ESR booking arrangements. Training sessions also offered on rolling base to divisions to specific staff group to further strengthen risk identification and management processes. Divisional risk refresher training sessions are scheduled for divisional management staff in April / May 2022. 2. Review of corporate and divisional risk management governance arrangements undertaken in-year to ensure that they are responsive and dynamic in their nature in the identification and management of all organisational risks. Further review to be completed 2022-23. 3. Development of the role of 'risk champions' throughout the trust to champion risk management locally and to help inform and guide staff has not yet been implemented. Discussions will take place with the Trust divisions during 2022/23 to identify relevant staff and to arrange training for role and mechanism of support from corporate risk team going forward.

Risk Management Ambition Two
To further refine systems and processes throughout the Trust which are in place to support effective risk management and ensure that these are integral to the day-to-day activities of Trust services including its commissioning responsibilities
Year End Updates
1. Dates for risk training sessions planned until end of 2022 and are being communicated to staff via ESR booking arrangements. Training sessions also offered on rolling base to divisions to specific staff group to further strengthen risk identification and management processes. 2. Trust induction session has been updated to reference risk management, but timeslot is limited so a detailed introduction cannot be achieved. There are plans to develop induction training resources for new starters around use of the DATIX system with introductions to both incident management and risk management during 2022. 3. Risk Management performance dashboards have been developed at divisional level, monitoring timeliness of risk register reviews, changes to risk ratings and completion of identified actions / mitigations. The dashboards are used during divisional Operational Group meetings to review and update risk registers live of the DATIX system.

Risk Management Ambition Three
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.
Year End Updates
1. Arrangements have commenced within the Trust to ensure that all staff to have access to training, guidance, and support in the delivery of effective risk management systems. Dates for risk training sessions planned until end of 2022 and are being communicated to staff via ESR booking arrangements. Training sessions also offered on rolling base to divisions to specific staff group to further

strengthen risk identification and management processes.

2. Further work is to be undertaken in 2022 to implement a process to allow for the monitoring and review of assurance limitations from internal and external audits to ensure good governance is maintained and reflected on the Trust's risk registers as required.

Risk Management Ambition Four
To confirm that the Trust's risk management arrangements are robust, and that excellent systems and processes are fully embedded across the organisation that support the delivery of the Trust's Strategic Goals through annual Trust's Risk Maturity assessment process.
Year End Updates
1. Annual assessment of risk maturity utilising the 'Alarm National Performance Model for Risk Management' to be undertaken alongside review of Trust Risk Appetite in Quarter 1 2022/23. 2. The outcome of annual Risk Maturity assessment to be used to inform annual risk management development plan for the new financial year. 3. An annual assurance report on risk management will be provided to the Audit Committee in Q1 also detailing the outcome of the Risk Maturity assessment and identified actions for further improvement.

7. Grant Thornton Well Led Review January 2022

An externally commissioned well led review in line with NHSE/Is guidance that all NHS Trusts should undertake a review of its governance arrangements every 3-5 years was undertaken in January 2022. Two recommendations were made in relation to the risk register as follows:

MED	**Risk Registers** The Trust-wide Risk Register is well maintained and was up to date at the time of our review. Divisional risk registers were also well maintained. However we noted that in all risk registers the initial risk rating was recorded but did not include a date, and this prevents the reader from understanding how long the risk had been present, and this would be useful to assess the 'journey' of the risk. **Recommendation** The risk register should be updated to include the date the initial risk was recorded.
MED	**Risk ratings and controls** We saw many risks on the risk registers where the initial rating and current rating were the same, and this may indicate that the controls in place are not effective and that other treatment is required, especially where timescales for completion are imminent. **Recommendation** Risk ratings contained on the Trust's risk registers require review to ensure they are correctly stated and reflect the current risk and that controls are sufficient to continue to reduce the level of risk as intended.

Risk 'opened date' is already captured at the point of a new risk being added to the risk register via the DATIX system. The Trust's report template for extracting risk registers has been updated to now include the risk opened date, considering how long a risk has been open at the point of review, as well as allowing for additional assurance around risk register review processes and associated timescales.

In light of the recommendations relating to risk initial and current ratings being the same for some observed risks, reporting arrangements to divisional Operational Delivery Groups have been altered commencing in April 2022, to highlight any new risks where initial and current ratings remain the same despite referenced controls / mitigations, as well as to challenge any existing risks where these ratings are the same despite mitigations being in place and evidenced.

8. Conclusion

The Trust's processes for the management of risk register undergo continuous review and a comprehensive set of ambitions have been defined within the Trust's Risk Management Strategy for 2021-2024. Work is ongoing towards delivery of the identified actions, but work has been completed in-year to lay the foundations for additional developments and significant further development is anticipated for 2022.

On review of the in-year risk management arrangements across the Trust's divisions and directorates, it clear that there has been considerable movement in terms of both risk register composition and scoring through 2021-22 which evidences a comprehensive process of the management of risk.

Although some risks have been identified with current risk ratings that have not changed in-year, all risks are subject to a process of monthly review and are also subject to scrutiny by the Operational Delivery Group, QPAS, Executive Management Team and board sub-committees on a regular basis and are taken through appropriate challenge.

Going forward, specific review of risks where the identified current rating has not changed in two quarters at a divisional level will be incorporated into current reporting arrangements for the Trust's Operational Delivery Group to ensure such risks can be regularly considered as part of the monthly risk register review. A similar process will be incorporated into the reporting arrangements for Executive Management Team so that quarterly review can be undertaken for risks with no change to current risk.

Humber Teaching NHS Foundation Trust

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	External Review of Governance Action Plan Update
Author/s:	Name: Michelle Hughes Title: Head of Corporate Affairs
Recommendation:	To approve: ; To receive & note: x For information: ; To ratify:
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To present the updated action plan to demonstrate progress against actions to address the recommendations arising from the external review of governance – Appendix 1. A review of embeddedness of the actions will be undertaken in quarter 3 and reported to Board.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- No issues to raise.

Key Actions Commissioned/Work Underway:

- All actions to address the recommendations are underway and on track for delivery within the required timeframe.
- The external review of governance was formally reported to Board in April 2022 and it was agreed the action plan to address the recommendations within the report would be reported to Board monthly through to completion.

Positive Assurances to Provide:

- At the time of writing (6 May), actions due in May are progressing to timescale and an update will be provided to the June Board.
- 23 recommendations were made – all are on track for completion by the due date.

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		Workforce & Organisational Development Committee	
Finance & Investment		Executive Management	

Caring, Learning & Growing Together

	Committee		Team		
	Mental Health Legislation Committee		Operational Delivery Group		
	Charitable Funds Committee		Collaborative Committee		
			Other (please detail) *monthly update paper to Board*	/	

Monitoring and assurance framework summary:

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

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

Action Plan to address Recommendations arising from the Well Led review of governance April 2022

This section summarises the recommendations that we have identified as a result of this review we have allocated a risk rating to each of these recommendations as per the following table.

No.	Risk	Recommendation	Overall Lead	Action/s to address recommendation	By when	Any additional comment NB a review of embeddedness of actions will be undertaken in quarter 3
KLOE 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?						
1	LOW	**Non-Executive Director recruitment** The Trust does not have a NED who has a clinical background, and this or NHS operational experience may be an area for focus for the remaining NED vacancy as this will complement the wide range skill set amongst the existing NEDs **Recommendation** The recruitment of a new NED should focus on engagement of an individual with NHS clinical or operational experience.	MM/CF	Appointment to the vacant NED post progressed and appointment made in April 2022 – the candidate has clinical experience. Recommendation being addressed via interviews - action to be updated post recruitment	April 2022	Action closed as new ned with clinical experience appointed in April 2022

2	LOW	**Succession planning** The Board has not documented its formal succession planning. The succession plans could be extended to include the senior leadership posts in the Divisional Leadership Teams and this can be helpful to focus on any required developments for staff and can assist in identifying potential risks for the future where not all aspects of individual portfolios can be met, even in the short term. **Recommendation** Succession planning should be undertaken to document plans for the immediate, 6 week and 6 month absence of any Executive or senior leadership team member. Relevant leadership training can be included on the plan for those who would require further support or development to act up or to develop into the position in the longer term.	MM	A proforma has been developed and completed to clearly identify succession planning for each board member – including named person, backfill arrangements that may be required and any development needs. EMT succession plan has been completed. The proforma is currently being completed for the senior leadership team.	May 2022	

No.	Risk	Recommendation				
KLOE 1 - Is there the leadership capacity and capability to deliver high quality, sustainable care? (continued)						
3	**MED**	**Quality and Safety Visits** A visits programme to services is established and embedded. Executives, NEDs and Governors participate in these, however the programme was suspended in March 2020 due to Covid-19 restrictions and the requirement to social distance and adhere to infection prevention control measures. Virtual visits have continued via MS Teams and some NEDs have been involved in these and report that they have worked reasonably well in the absence of face-to-face activities. It is planned for face to face visits to resume in April 2022 and the Director of Nursing is updating the relevant guidance to ensure it reflects and aligns to national guidance and the Trust's infection prevention and control measures. It may be advantageous for the Board to allocate NEDs to a geographical area or align to specific services to allow greater continuity of relationships and rotate this each year. This method is frequently seen in other similar Trusts that have geographically dispersed services. It would be timely for the Trust to consider such an arrangement and set it up as it completes its recruitment of NED Board members. **Recommendation** Safety and Quality visits should be re-established face-to-face as soon as practicable. Visits help to triangulate other	HG MM/CF	IPC guidance has been updated in order to resume face to face visits. Face to face visits re-commenced in March 2022. A schedule of services to be visited has been populated with NEDs and execs - these will continue and be expanded as appropriate to include governors in due course working to ensure infection control guidance is followed. In developing the schedule, consideration will be given to allocating NEDS to a geographical or service area, rotating each year. Face to face visits will remain part of Board/development discussions and any the revised schedule will reflect any changes to be made.	March 2022	Complete and ongoing/remains under review
			CF	Governor face to face visits are discussed in CoG, sub groups and development sessions and will be scheduled as appropriate.	June 2022	

		data sources, gaining a greater insight and understanding of the services. The Trust should consider allocating NEDs to a geographical area or specific service to build relationships, rotating each year.				
KLOE 2 - Is there a clear vision incredible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?						
4	**Low**	**Collaborative Committee membership** A Clinical Director is now in post for the Provider Collaborative working alongside the Programme Lead and this clinical input potentially reduces the requirement for the Trust's Director of Nursing to have membership on the Collaborative Committee. As operational arrangements mature the Board should revisit these membership arrangements to consider, and allow for, separation of the provider/commissioner roles. **Recommendation** As the Lead Provider role matures and the provider/commissioner roles become embedded, the Board should consider reviewing the Collaborative Committee's Terms of Reference, assessing the appropriateness and requirement for the Director of Nursing to remain a member.	MM SME	The recommendation is accepted and will be implemented as roles mature. An update will be provided to the Board in June as to possible timeframe for this change.	June 2022	

No.	Risk	Recommendation				
KLOE 3 - Is there a culture of high quality sustainable care?						
5	**MED**	**Freedom To Speak Up Guardian resource** The Trust has a Freedom to Speak Up (FTSU) Guardian in post for 1 day a week, supported by 2 part time deputies. The total resource equates to 2 days a week for this important agenda. The Guardians work with staff governors who act as ambassadors for the FTSU agenda and have received some local training and are in place to signpost staff and support the Guardians. **Recommendation** The Board should consider whether its current resource is adequate to allow for proactive work and sufficient reach to staff in its geographically dispersed services.	MM	It has been agreed (as reported to the April'22 Board) that adverts for 5 ambassadors across the divisions and corporate areas will be progressed to increase the resource available to FTSU. The adverts are schedule to go out in May.	May 2022	
6	**LOW**	A Non-Executive Director is aligned to the FTSU agenda although this NED is at the end of his term with the Trust and therefore a new NED will need to be aligned to this role. It will be important for the new NED to access the on-line training modules that are available via the national Guardian's office web-site. **Recommendation** The NED who is to be aligned to the FTSU agenda should access the nationally available training modules to promote a full understanding of	MM	A new NED with responsibility for FTSU has been aligned to this agenda (Dean Royles). Access to training modules were shared with NED lead on 14/4/22 who has undertaken to complete the training. Training will be monitored between Guardian and NED	April 2022	Training links shared in April and awaiting confirmation of ned accessing materials.

		the speaking-up process and appropriate support to the Guardian.		lead through catch up meetings.		
7	LOW	**Freedom To Speak Up Guardian and the Guardian of Safe Working Hours** Nationally data suggests medical staff tend not to use FTSU mechanisms to raise concerns, and in some trusts we see the Guardian of Safe Working Hours used to raise a broad range of issues. The FTSU Guardian should arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles and this could be of mutual benefit. **Recommendation** The FTSU Guardian and the Guardian of Safe Working Hours should schedule regular catch-up meetings to discuss any potential emerging themes from their respective roles.	MM	The first meeting between the FTSU Guardian and Guardian of Safe Working Hours was held on 25/4/22. Quarterly meetings have now been established.	25/4/22	Complete and ongoing

No.	Risk	Recommendation				
KLOE 3 - Is there a culture of high quality sustainable care? (continued)						
8	**MED**	**Assessment of detriment** It is important to ensure that people do not suffer detriment as a result of speaking-up. Currently, following the closure of a case, the CEO writes to the staff member to thank them for their concern and there is a short questionnaire for staff to complete who have raised the concern. However the response rate is low and the limited response does not adequately assess if there has been any detriment. **Recommendation** The FTSU Guardian should formalise a process to contact staff who have raised concerns three to six months following closure of the case to discuss how they are feeling and if they have suffered any detriment as a result of speaking-up. The process to address detriment should also feature in the Trust's Raising Concerns policy.	MM/AF	a) A process has been developed to ensure staff are contacted after closure of the case to assess any detriment. b) The process has been included in the updated FTSU Policy as reported to the April 2022 Board.	May 2022	Actioned and ongoing

9	**LOW**	**Freedom To Speak Up data** The FTSU Guardian submits data as required to the National Guardian's Office and reports to the Board each quarter. The FTSU Guardian does not report data to the Board by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation** The FTSU Guardian should report data by ethnic group and gender as this may highlight additional themes and trends for the Board members to consider.	MM	Recommendation accepted and future reports will include data broken down by ethnic group and gender as reported to the April Board – the next 6 monthly FTSU to Board will be in October and the requirement for breakdown has been captured in the Board action log.	May 2022	
10	**LOW**	**Quality of appraisals** Appraisal rates are currently 97.06% and this is good performance against the Trust's expectation of 100% at year end. However, the Trust has not routinely sampled completed appraisals to be assured of the quality, and this is a missed opportunity. **Recommendation** The Divisional Leadership Teams should arrange to review a sample of completed appraisals to gain assurance that they are being completed as intended to maximise the potential of the process for staff.	SMc	A recent internal audit where sample records were assessed, provided significant assurance in this regard. A couple of areas within the report are being worked through – the report will go back to Audit Committee in June As an additional action, EMT agreed on 28 March that a dip sample of appraisals will be carried out in each area by managers with the support of HR business partners where required.	June 2022	

No.	Risk	Recommendation				
KLOE 3 - Is there a culture of high quality sustainable care? (continued)						
11	**LOW**	**Staff networks** The Trust has recently set up a number of staff networks and groups to allow staff with protected characteristics, and those wishing to support them, to meet and progress work in line with the EDI strategy. **Recommendation** Board members should ensure all staff networks have a Board-level sponsor and a Chair to support and assist in the running and effectiveness of each network.	SMc	Staff networks already have a Board-level sponsor ie • BAME network board sponsor – Michele Moran • Disability Group – Steve McGowan • LGBT Group – Steve McGowan Support has been given to seek a Chair for the Disability Group. However, no one has come forward. We will continue to support, however it is reliant on someone coming forward to chair this group.	n/a	Action complete and continuous.
KLOE 4 - Is there a culture of high-quality sustainable care?						

12	**LOW**	**Action logs** For Board level Committees we note that action logs are present and well maintained. We noted that whist the action logs documented the timescale for completion of the action, the date of when the action was completed was not recorded, and this should be addressed. **Recommendation** Chairs of Committees and groups that use action logs should ensure the date the action was completed is documented.	MH	27/4/22 Email sent to ned chairs, exec leads and committee administrators. Advice provided to committee and group administrators regarding action logs to ensure the date the action was completed is clearly documented and that a consistent standard is achieved across all groups.	April 2022	Actioned and continuous
13	**LOW**	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.	MM / CF	28/4/22 Schedule of ned attendance at director reporting groups underway	May 2022	

No.	Risk	Recommendation				
KLOE 4 - Is there a culture of high quality sustainable care?						
14	**LOW**	**Allocation of Non-Executive Directors to Committees** There were only two NEDs present at some Committee (one being the Chair) and this may be due to the fact that the Trust has a NED vacancy that is currently being recruited. Once all NED positions are recruited the Board should review NED allocation and cross referencing to other Committees to maximise the opportunities of attendance and to view the interdependencies of the various Committee agendas. **Recommendation** Board members should consider the numbers of NEDs at its Committees and discuss whether membership could be increased for some of the busier Committees to facilitate further challenge and opportunities to gain greater assurance.	CF/MM	Committee membership should be a NED Chair and 2 NEDs – an exception (F&IC) will be addressed when the Terms of Reference are approved at the May Trust Board. NB The commissioning Collaborative Committee will remain with 1 NED chair and 1 other NED member.	May 2022	

15	**LOW**	**Highlight reports to the Board of Directors** Committee Chairs presented highlight reports for assurance and whilst these were comprehensive the impact and style of these could be improved. A common approach using quadrant style reporting could more effectively identify key issues and action taken. **Recommendation** Committee Chairs should consider the use of a quadrant style report to present key issues emerging from Committees to the Board meeting. Headings of the 4 quadrants are commonly: ▪ Matters of concern or key risks to escalate; ▪ Major actions commissioned / work underway; ▪ Positive assurances to provide; and ▪ Decisions made.	MH	The Chairs Log to Board highlights these key issues but the front sheet has been reviewed and agreed to provide a consistent approach in presenting using the quadrant style.	May 2022	Complete and continuous

No.	Risk	Recommendation				
KLOE 5 - Are there clear and effective processes for managing risks, issues and performance?						
16	**LOW**	**Board Assurance Framework – risk statements** The Trust has a Board Assurance Framework that is well managed and maintained. The BAF describes the Trust's six strategic objectives and details the individual risks to the achievement of these. However, although there is an overarching risk score for each of the six strategic objectives, there is no overarching risk statement that describes what could prevent the Trust achieving the strategic objective, and this should be considered. **Recommendation** An overarching risk statement should be used to describe the risk to the Trust not achieving each strategic objective.	MM	An overarching risk statement to describe the risk to the Trust of not achieving each strategic objective will be developed.	May 2022	
17	**MED**	**Risk Registers** The Trust-wide Risk Register is well maintained and was up to date at the time of our review. Divisional risk registers were also well maintained. However we noted that in all risk registers the initial risk rating was recorded but did not include a date, and this prevents the reader from understanding how long the risk had been present, and this would be useful	HG/OS	The requirement of the opened date in all risk register reports going forward and the report templates on Datix have now been updated to include this field when extracted to Excel.	March 2022	Delivered and closed.

		to assess the 'journey' of the risk. **Recommendation** The risk register should be updated to include the date the initial risk was recorded.				
18	**MED**	**Risk ratings and controls** We saw many risks on the risk registers where the initial rating and current rating were the same, and this may indicate that the controls in place are not effective and that other treatment is required, especially where timescales for completion are imminent. **Recommendation** Risk ratings contained on the Trust's risk registers require review to ensure they are correctly stated and reflect the current risk and that controls are sufficient to continue to reduce the level of risk as intended.	HG / OS	a) Risks where the initial and current ratings that are the same have been progressed through the divisional ODG meetings to ensure that this does not happen going forward unless the described controls are not reducing the risk. b) This requirement has also been specifically referenced in the risk register training to ensure staff are aware that in deciding the current risk the controls in place must be taken into account. A report to the May Board will provide evidence.	April 2022	Complete and ongoing.

No.	Risk	Recommendation				
KLOE 5 - Are they clear and effective processes for managing risks, issues and performance?						
19	**LOW**	**Management of risk** The Corporate Risk and Compliance Manager has a structured and consistent approach to risk and this was clear from the meetings we attended. However due to an unexpected short term absence at one meeting, where we were observing, the presentation of the Risk Register was not managed well and this may indicate that wider ownership of the risk management process is required and that processes do not become person dependent. **Recommendation** The Trust should ensure its arrangements regarding updating and presentation of risks are not person dependent.	HG/OS	Executives have confirmed that there is no requirement for the Risk Manager to attend each board sub committee. Lead executives on the respective committees are expected to discuss the risks on the register and answer any queries. Exec Leads to be reminded of the need for Exec Leads to present risks to respective committees.	April 2022	Complete
20	**LOW**	**Board Reports** Financial performance papers are produced to a high quality and we note that the Board receives a separate finance report. This has been a long standing arrangement that is well evaluated, with no appetite for change. However the title of the Trust's 'Integrated Board Report' (IBR) is misleading as readers may expect full coverage of performance for all portfolios, and this is not the case.	PB	The title of the Integrated Board Report has been updated to 'Performance Report' and reflected in reports to board wef April 2022 meeting.	April 2022	27/4/22 Action achieved and closed

		Recommendation The Board should reconsider the title of its Integrated Board Report to ensure it accurately reflects the purpose and content of the report.				
21	**LOW**	**Divisional Performance and Accountability Reviews** The Trust has an established Divisional Performance and Accountability Review process that is operated on an 'earned autonomy' model, with review frequency ranging from 1-6 months. Reviews have been scheduled every 3 months during the Covid-19 pandemic due to the surge in activity, however the earned autonomy model process will be reinstated in April 2022. The Clinical Director is invited to all reviews, however we note that the CD is frequently unable to attend and this may be due to clinical commitments. Reviews should be scheduled to facilitate the attendance of the Clinical Director. **Recommendation** Accountability Reviews should be scheduled to facilitate the attendance of the Clinical Director.	LP	The clinical director attended accountability reviews in March 2022. The next reviews are scheduled for 23 & 29th June 2022 and the clinical director has confirmed attendance. Going forward, future dates will facilitate the attendance of the Clinical Director.	May/Jun 2022	Achieved – and continuous

No.	Risk	Recommendation				
KLOE 6 - Is appropriate and accurate information being effectively processed, challenged and acted on?						
22	LOW	**Integrated Performance Report** The Trust's Integrated Board Report (IBR) is presented using statistical process charts (SPC) for a select number of indicators with upper and lower control limits presented in graphical format. The cover sheet of the IBR details commentary (including mitigating actions) for indicators that fall outside of normal variation, and this is a useful summary. However for the majority of metrics this detail is not included in the main body of the report alongside the data. **Recommendation 22** The Integrated performance report could be enhanced by the expansion of narrative to contain root causes, actions and impact/timescale as well as national/local benchmarking where available.	PB	The front sheet of the performance report highlights and provides an update on any areas outside of normal variation – a footer note will be added to the performance report to read the performance report with the cover sheet with explanatory narrative for any areas outside of normal variation from May onwards.	May 2022	

23	LOW	**Data Quality Assurance Indicators** Although the Trust has a Data Quality Group in place and undertakes work to assures its data quality, it does not at present utilise a Data Quality Assurance Indicator and this should be considered. A data quality traffic light or kite mark could be used to appear next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based. **Recommendation** The Trust should consider the use of Data Quality Assurance Indicators to inform users of any data quality risks attached to the data that might impact decision making	PB	Consideration will be given in the next DQ Group, to be held 8 June, as to whether traffic light or kite mark would provide a worthwhile improvement	June 2022	
KLOE 7 - Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?						
We have not made any recommendation for this KLOE						

No.	Risk	Recommendation
KLOE 8 - Are there robust systems and processes for learning continuous improvement and innovation?		
We have not made any recommendation for this KLOE		

Humber Teaching NHS Foundation Trust

Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting - 18th May 2022
Title of Report:	Annual Declarations 2021/22
Author/s:	Name: Peter Beckwith Title: Director of Finance
Recommendation:	To approve ☑ To receive & note For information To ratify
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To provide the Trust Board with a summary of the annual declarations that are required to be made by the Trust, evidence of how the Trust meets these declarations ensuring the views of Governors are taken into consideration.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- None.

Key Actions Commissioned/Work Underway:

- The Trust is required to make annual declarations after the financial year end.

Positive Assurances to Provide:

- Details of declaration and comments/evidence to support making the declarations are included within the report.

Decisions Made:

The Trust Board are asked to approve the following annual declarations, based on the evidence included in this report.:

- The Board has taken all necessary precautions to comply with its licence, the NHS Act and the NHS Constitution.
- The Trust has complied with required governance standards and objectives
- The Trust has a reasonable expectation that required resources will be available to deliver designated services

That the Trust has complied with section 151(5) of the Health and Social Care Act to ensure that governors are equipped with the skills and knowledge to undertake their role.

Governance: *Please indicate which committee or group this paper has previously been presented to:*				
		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		Workforce & Organisational Development Committee	
	Finance & Investment Committee		Executive Management Team	Jan 22
	Mental Health Legislation Committee		Operational Delivery Group	
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail) Council of Governors Trust Board	 Apr 22 Jan 22

Monitoring and assurance framework summary:

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

Trust Board (May 2022)
Annual Declarations 2021/22

1. Introduction and Purpose

This purpose of this is provide the Board with a summary of the annual declarations that are required to be made by the Trust, evidence of how the Trust meets these declarations ensuring the views of Governors are taken into consideration.

2. NHS Licence Conditions

All NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and, have complied with governance requirements.

The Trust is required to make 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.

Previous reports to the Trust Board and Council of Governors have highlighted the evidence available to support the above declarations.

2.1 Condition G6

Condition G6 requires the Trust to have effective systems and processes in place to ensure compliance with its provider licence, the NHS Act and the NHS Constitution. The Trust should identify any risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply occurring.

The Trust Licence (No 130053 – Issued 1st April 2013) contains seven sections which details conditions relating to the following areas:

- General Conditions
- Pricing
- Choice and Competition
- Integrated Care
- Continuity of Services
- NHS Foundation Trust Conditions
- Interpretation and definitions

Details of the Trust licence conditions and commentary to support compliance is attached at Appendix A.

Declaration G6 also requires the Board to declare that the Licensee continues to meet the criteria for holding a licence, there are currently 2 conditions:

- The Trust must be registered with the Care Quality Commission
- The Directors and Governors of the Trust must meet the ‘fit and proper persons test’

The Trust is compliant with these conditions.

2.2 Condition FT 4

Condition FT4 requires the Trust to apply the principles, systems and standards of good practice which would reasonably be regarded as appropriate for a supplier of health care services to the NHS.

Evidence to demonstrate the Trust's compliance against the six statements is attached at Appendix B, this is not an exhaustive list and has been updated based on feedback from previous Board and Council of Governor discussions.

2.3 Condition CoS7

As the Trust is a provider of Commissioner Requested Services, it must make a declaration under CoS7, evidence for which is included in Appendix A.

3. Additional Declaration – Training of Governors

Whilst not a specific licence condition, the Trust is also required to make an annual declaration in relation to the Training of Governors. It is a requirement of the Health and Social Care Act that requires the Trust to ensure governors are equipped with the skills and knowledge they require. The Trust is required to make the following statement

'***The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to Governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they require to undertake their role'***

Based on the statement above the following list provides evidence of the Trusts compliance:

- Governor Induction Programme
- Governor Development Workshop/Sessions
- Council of Governor Meetings

4. Next Steps

The deadline for annual declarations has yet to be published in previous years declarations have been made in May and June.

Audit Yorkshire are currently reviewing the annual declarations process as part of the 2021/22 internal audit plan, we are awaiting the draft report.

5. Recommendation

The Trust Board are asked to approve the following annual declarations being presented to Trust Board for approval, based on the evidence included in this report.:

- The Board has taken all necessary precautions to comply with its licence, the NHS Act and the NHS Constitution.

- The Trust has complied with required governance standards and objectives

- The Trust has a reasonable expectation that required resources will be available to deliver designated services

- That the Trust has complied with section 151(5) of the Health and Social Care Act to ensure that governors are equipped with the skills and knowledge to undertake their role.

Appendix A

Licence Conditions:

Condition	Explanation	Comments
General licence conditions (G)		
G1. Provision of information	Obligation to provide NHS Improvement/ Monitor with any information it requires for its licensing functions.	• The Trust complies with any NHS England and Improvement 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 and Improvement
G2. Publication of information	Obligation to publish such information as NHS Improvement/Monitor may require.	• 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. • Monthly 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. • Published Quality Accounts and 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 Candor.
G3. Payment of fees to NHS Improvement/Monitor	Gives NHS Improvement/Monitor the ability to charge fees and for licence holders to pay them.	• There are currently no plans to charge a fee to Licence holders. • The Trust's financial systems enable it to comply with this requirement in the future.
G4. 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.

Condition	Explanation	Comments
G5. NHS Improvement/Monitor guidance	Requires licensees to have regard to NHS Improvement/Monitor guidance.	• The Trust responds to guidance issued by NHS Improvement/Monitor. • Submissions and information provided to NHS Improvement/Monitor are approved through relevant and appropriate authorisation processes. • The Trust has regard to Monitor guidance and submits self-certifications as required by Monitor
G6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	• The Trust's Internal Auditors (Audit Yorkshire) considered the Board Assurance Framework and Risk Management as part of the 2020/21 audit work programme; the outcome provided 'High' assurance. • Previously governance arrangements (Board & Committee Effectiveness) were reviewed as part of the 2018/19 internal audit programme, providing 'good' assurance. • 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 2020/21 Annual Head of Internal Audit Opinion provided 'Good' Assurance • 2021/22 Draft Opinion has provided good Assurance **** This is a declaration on behalf of the Trust as part of the annual submissions***
G7. Registration with the Care Quality Commission (CQC)	Requires providers to be registered with the CQC and to notify NHS Improvement/ Monitor 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' • The Quality Committee has reviewed all evidence to support submissions made to the CQC • The Trust Board and Quality Committee has oversight of CQC Action Plans
G8. 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.
G9. Application of section 5 (Continuity of Services)	Sets out the conditions under which a service will be designated as a CRS	• CRS are defined in the Trusts contracts with Clinical Commissioning Groups • **The Trust makes a declaration under CoS7**
Pricing conditions (P)		

Condition	Explanation	Comments
P1. Recording of information	Obligation of licensees to record information, particularly about costs.	• The Trust has well established systems for coding, collection, retention and analysis of activity and cost information. • The 2020/21 Internal Audit Programme undertook an audit of the National Cost Collection provided 'High' assurance
P2. Provision of information	Obligation to submit the above to NHS Improvement/Monitor.	• The Trust responds to guidance and requests from NHS England and Improvement.
P3. Assurance report on submissions to Improvement/Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	• The Trust Board have signed off the process in relation to National Cost Collection (July 2021).
P4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	• ***Contracting arrangements between commissioners and providers within the NHS have been suspend for 2021/22*** • All Trust contracts are agreed annually and are in line with the national tariff where applicable. • The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance.
P5. Constructive engagement concerning local tariff modifications	Requires license holders to engage constructively with commissioner and to reach agreement locally before applying to NHS Improvement/Monitor for a modification	• The Trust has positive working relationships with commissioners. • *The Trust has agreed block contract values with commissioners for 2022/23 in line with the operational planning guidance*
Choice and competition (C)		
C1. The right of patients to make choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	• The Trust has in place a service directory setting out the services available. • Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.

Condition	Explanation	Comments
C2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	• The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such as mergers or joint ventures. .
Integrated care condition (IC)		
IC1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	• 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
Continuity of service (CoS)		
CoS1. Continuing provision of Commissioner Requested Services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	• The Current Contracts with commissioners require agreement with commissioners on the ways CRS services are provided.
CoS2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS Improvement/Monitor's consent before disposing of these assets IF NHS Improvement/Monitor has concerns about the licensee continuing as a going concern.	• The Trust maintains a full capital asset register. • Any disposals are reported/approved by the Trust Board

Condition	Explanation	Comments
CoS3. Standards of corporate governance and financial management	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	• The Trust has Standing Orders, Standing Financial Instructions and a Scheme of Delegation in place, refreshed September 2021. • The Board of Directors receives monthly performance reports aligned to the Trust Strategic Goals. • The Trust has a Board Assurance Framework and Risk Register • The Trust's Internal Auditors review risk management processes as part of the strategic audit plan. • The Trust has a current CQC rating of 'Good' for Well Led
CoS4. Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	• The Trust does not operate and is not governed by an Ultimate Controller arrangement, so this License 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 Protect) risk pool for clinical negligence and public liability schemes.
CoS6. Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with NHS Improvement/ Monitor.	• The Trust has not received any such notices from regulators • The Trust would full comply with this condition if required.
CoS7. Availability of resources*	Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	• The Trust has an approved budget and has remained on target throughout the financial year • The Trust continues to complete its on a going concern basis and there are no indications this will change • The Trust has an underlying bank balance of circa £20m **** This is a declaration on behalf of the Trust as part of the annual submissions***
Foundation Trust conditions (FT)		
FT1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHS Improvement/Monitor.	• The Trust has provided NHS Improvement with a copy of its NHS Foundation Trust Constitution • The Trust has provided NHS Improvement with a copy of its Board approved Annual Report and Accounts.

Condition	Explanation	Comments
FT2. Payment to NHS Improvement/ Monitor in respect of registration and related costs	The Trust would be required to pay any fees set by NHS Improvement/Monitor.	• If NHS Improvement required fees to be paid by the Trust, the Trust would comply with this condition.
FT3. Provision of information to advisory panel	NHS Improvement/Monitor has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	• The Trust would comply with this as required through the provision of any requested information.
FT4. NHS Foundation Trust governance arrangements	Gives NHS Improvement/Monitor continued oversight of the governance of foundation trusts.	**** This is a signed declaration on behalf of the Trust as part of the annual submissions. Evidence against this submission is detailed in*** **appendix B.**

Appendix B –
Condition FT4 (8): the provider has complied with required governance arrangements

	Statement	Sources of Evidence and Assurance
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Scheme of Delegation, Reservation of Powers and Standing Financial Instructions have been updated and refreshed – September 2021 Board (*Also on May board Agenda*). Constitution has been reviewed and updated
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Trust Wide Risk Register Board Assurance Framework Board Performance Reports Finance Report
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Committee Structures well established Committee Effectiveness reviews are reported to Trust Board Annually Clear Accountability through EMT and Executive Directors Portfolios. Level 3 performance reports and 'ward to board' reporting. Well Led Review has been commissioned
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory 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	*External Audit Opinion on VFM (ISA260)* *Going Concern review* *Annual Governance Statement* All Statutory requirements met Delivered Financial Targets in 2020/21 *(2021/22 on plan)* Previous use of Resource Score of 2 *(currently not recorded)* Trust plan agreed to its financial targets for 2020/21 (*prior to the suspension of operational planning*) Monthly Performance report to Trust Board Quality Report to Quality Committee Monthly returns to NHS Improvement Risk Register and Board Assurance Framework Annual Report on non-clinical safety presented to Trust Board *Annual Report and Accounts* *Annual Quality Report*

	Statement	Sources of Evidence and Assurance
	delivery; and (h) To ensure compliance with all applicable legal requirements.	
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Board Skill Mix CQC well led rating of Good Board Development Programme Standing Items to Board • Performance Report • Finance • Chief Executive Update including ○ Nursing Update ○ Operations Update ○ Medical Update ○ HR Update Refreshed Trust Strategic Objectives Patient and Staff Stories reported to Board Programme of Exec Visits (Virtual and Physical) Friends and Family Test CQC Action Plan/Improvement Plan Midday Mail/Midweek Global EMT New Headlines Board Talk Meet with Michele
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 established a Workforce Committee

	Statement	Sources of Evidence and Assurance

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 20

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Humber and North Yorkshire Health and Care Partnership – Mental Health, Learning Disabilities and Autism Collaborative Programme Update
Author/s:	Michele Moran, Senior Responsible Officer Alison Flack, Programme Director HNY HCP MH and LDA Collaborative Programme

Recommendation:				
To approve		To receive & note		
For information	✓	To ratify		

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	This report provides an update to the Trust Board for information on the work of the Humber and North Yorkshire Health and Care Partnership Mental Health, Learning Disabilities and Autism Collaborative Programme.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • Activity trajectories submitted largely do not meet LTP ambitions due to financial pressures	**Key Actions Commissioned/Work Underway:** • Key actions and achievements are contained within the report.
Positive Assurances to Provide: • 2022/23 planning documentation submitted 28th April • Requirement for recovery plans as part of planning guidance – to be submitted by 13th May • Draft workforce plans submitted 28th April. • 67 Safe and wellbeing reviews completed. Further reviews being conducted where placements were not assured.	**Decisions Made:** • The report is shared for information.

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

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

Monitoring and assurance framework summary:

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

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

Humber and North Yorkshire Health and Care Partnership
Mental Health, Learning Disabilities and Autism Collaborative Programme

Humber Teaching NHS Foundation Trust Board Update – April 2022

Summary of Key Activities

Key Activities / Achievements	
NHSE 2022/23 planning return submitted 28th April, which includes finance, activity and workforce.	Crisis liaison funding now confirmed. Plans for implementation currently in process.
67 Safe and wellbeing reviews completed as part of national Learning Disabilities Programme. Further reviews being conducted where placements were not assured.	Recovery plans now signed off by Executive Strategic Leadership Group.
Recruitment taking place regarding Integrated framework for vulnerable children and young people.	Out of Area sit rep processes embedded and information now shared weekly.

Current Work Priorities

The following is a summary of some of the key current priorities within the programme.

Safe and Wellbeing Reviews – Learning Disabilities

- 67 Safe & Wellbeing reviews have been completed.
- Two further reviews for placements that were not assured.
- TCP 3 year plans are being reviewed alongside forecasted spend for 22/23.
- Both TCPs are currently under target on inpatient numbers, but have plans in place to address.
- Feedback and learning event to be held in May 2022.

Children and Young People's Mental Health

- Strategic Plan now approved by Executive Strategic Leadership Group.
- Work with NHS digital and partners to baseline outcomes data and complete engagement work with children, young people and staff has been completed.
- ICS wide data dashboard in development.
- Health and Justice integrated framework for children and young people:
  - Governance arrangements finalised
  - Mobilisation and recruitment commenced

Perinatal MH

- Referral rates continue to increase.
- Promotional plan in Humber 4 has been successful particularly due to the service now receiving direct referrals.
- Every Mum Matters campaign and website relaunched w/c 17/01/22 – aiming to increase awareness, start conversations and encourage women to seek support if they are struggling with their mental health.
- Other promotional work underway to increase access rates for services including the Humber four moving to take direct referrals from 25/01/22.

Maternity Mental Health

- Some delays in recruitment to key posts. Go live expected June 2022.
- Induction and training plan in place with some training courses commissioned.
- Working with HUTH and NHSE to ensure data can flow to the MHSDS.
- Expect some delay to midwife roles commencing due to significant pressures in acute trusts.
- Working to develop a collaborative peer support model with VCSE organisations across the patch
- Plan developed to address health inequalities.
- Working with Navigo, VCSE organisation 'Connect' and NEL children's services to develop model to support women separated from their babies at birth. One year pilot to commence April 2022.

Community Mental Health Transformation

- CMHT submission for 22/23 plans completed.
- Executive Strategic Leadership Group agreed approach for CMHT SDF funding 22/23.
- IT interoperability for IT systems is an issue and is affecting reporting.

Urgent and Emergency Care

- Opportunity for further capital funding for UEC pathways, awaiting details of process form regional team. It has been confirmed that CICs will be able to be part of this process.
- Right Care Right Person Evaluation.
- Street Triage business case in progress, working in partnership with YAS.
- Alignment of 4 Crisis Care Concordats ongoing – each under review and refresh currently.

Physical health checks for SMI

As a result of further work in local places to address data quality and process issues in relation to collection and recording of SMI data, the number of SMI checks recorded has increased. A project manager has been confirmed to lead this implementation, as well as the distribution of devices to primary care networks.

Summary

The work of the Mental Health, Learning Disabilities and Autism Collaborative Programme will continue to be overseen by the Executive Strategic Leadership Group. As the transition to an Integrated Care Board develops, it will be necessary to review the governance arrangements.

Humber Teaching NHS Foundation Trust

Agenda Item 21

Title & Date of Meeting:	Trust Board Public Meeting – 18th May 2022			
Title of Report:	Health Stars Annual Review			
Author/s:	Andy Barber, Smile CEO and Victoria Winterton, Head of Smile Health			
Recommendation:	To approve		To receive & note	✓
	For information		To ratify	
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The purpose of this paper is to provide the Trust Board with a review of Health Stars activity during the 21/22 financial year. This report is provided to the Trust Board as Corporate Trustee of the Charity.			

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No matters to escalate	**Key Actions Commissioned/Work Underway:** - . Overview of 21/22 - People - Presence - Projects - Core Activity - Finances
Positive Assurances to Provide: • 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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee	Mar 22	Collaborative Committee	
		Other (please detail)	

Caring, Learning & Growing Together

Monitoring and assurance framework summary:

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

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

1 Introduction and Purpose

The purpose of this paper is to update the Board on the progress Health Stars is making against the agreed charity strategy for Humber Teaching NHS Foundation Trust charitable funds.

2 2021/2022 Overview

The last year has been one of the most challenging in Health Stars history. The last year was the second of the pandemic but without the initial influx of fundraising and support for the NHS. We were unable to hold events and fundraise as we had planned and ended up with a small window in the summer for in person events. This has had a big impact on income generation. During the pandemic inclusive of the last year, we focused significant emphasis on supporting our NHS teams and volunteers. We maximised NHS Charities Together funding opportunities, and wherever possible looked to move our fundraising online and focused on grants for our core appeals.

This sadly did not aid us in fulfilling our income targets for the year, as many of the funders we engaged with previously, were understandably focused on Immediate community needs, and on stimulating recovery.

Despite this we have focused on what we have been able to achieve. We focused on fundraising through grant applications and spending plans for existing funds.

We're proud of our work engaging with the community on the Whitby Hospital Appeal. We've been able to lead a Fundraising Task and Finish Group that has seen members from the local community and hospital get involved to support our fundraising efforts. We launched the Fundraising Bricks to enable the local community to put their name on Whitby Hospital and support the appeal.

We're working with the Trust to identify Health Stars next major appeal as we will see the Whitby Hospital Appeal come to a close in Summer 2022. We are also focusing on general fundraising for the next year to increase donations through pennies from heaven and lottery giving.

It has been a challenging period for all but one we feel as a team we have approached head on with a positive and effective outcome. Health Stars continue to benefit from strong leadership from the core HEY Smile Foundation (Smile) team, key individuals have developed significantly within their working roles during this evolving journey of which we are on, this has enabled us to manage the change effectively whilst allowing us to transition to the next chapter

Our thanks continue to go to Michele Moran CEO, and our executive lead Steve McGowan for their leadership of the charity along with all members of the Charitable Funds Committee. Our aim is to see Health Stars grow into its role as a strategic partner of Humber Teaching NHS Foundation Trust.

1. People

The core team of Health Stars has remained the same since the previous year. This is made up of Kristina Poxon as Fundraising Manager who is full time for Health Stars and Victoria Winterton, Head of Smile Health who manages Kristina and leads

the Charity. Chief Executive of HEY Smile Foundation Andy Barber maintains a strong involvement.

After starting in January 2021 on a twelve-month contract to focus on the Whitby Appeal, Jude Wakefield left at the end of October for another opportunity. The team are thankful to Jude for the local knowledge and support she brought to the Whitby Hospital Appeal.

Health Stars were able to utilise NHS Charities Together Stage 1 grant funds of £50,000 to appoint a BAME wellbeing coordinator which is jointly funded with sister charity The Health Tree Foundation who are also managed by the HEY Smile Foundation.

Bibhash Dash joined the team in November 2020 and contracts are managed through HEY Smile Foundation. This is an exciting piece of work and the "Dost" project was launched in January 2021 providing support for all members of the Black, Asian, Minority, Ethnic community. Thanks to an underspend in the funding we were able to extend Bibhash's work for a further six months until end of May 2022.

We've also seen a change of our finance support via HEY Smile Foundation. Previously Sarah Shepherdson looked after finances, but she has now left HEY Smile Foundation and we have welcomed Suzi Wells who leads and supports on finances. Suzi has also supported Circle of Wishes administration in the last year.

Current resource:

- Victoria Winterton (Lead, Head of Smile Health)
- Kristina Poxon (Fundraising Manager)

Additional support from Smile: Andrew Barber, Ann Newlove, Suzi Wells

- Bibhash Dash (BAME Wellbeing Coordinator)
  - Funded through NHS Charities Together Stage 1 Grant

2. Presence

Health Stars continues to be proactive on social media and has seen growing engagement on it's channels. The newest platform that we have a presence on is Instagram and this has seen the biggest increase. A new approach was implemented this year focusing on "Wish Wednesday" and awareness days. We've also worked with Trust comms to ensure social media is coordinated with their key messages.

We're pleased to have had a good presence in local media with press releases, particularly in Whitby. We've seen stories be picked up by Yorkshire Coast Radio, Whitby Gazette and Scarborough News. These have been for the Whitby Fundraising Bricks which was launched this year and community fundraising events such as the Mulgrave 10k. Huge thanks to Trust Communications team who have supported this work.

We've had a keen focus on creating case studies in the last year, these focus particularly on wishes and allow us to share the case studies internally within the Trust to inspire others to submit wishes and we share these case studies with Charitable Funds Committee. Examples of our case studies include Humber Centre Projector, St Pauls Boxing and Yoga Mindfulness Day.

We continue to aim to expand our reach internally and externally of the Trust.

- Twitter Followers: 1018
- Facebook Likes/Followers: 714/772
- Instagram Followers: 322

3. Projects

- **Whitby – *Redevelopment of existing site***

We've been a key play in the Whitby Hospital Redevelopment this last year. We've been proud to lead the Fundraising Task and Finish Group and be a part of the Naming Task and Finish Group, the Gardening Task and Finish Group and the Artwork Task and Finish Group.

We've been able to have strong engagement with the Whitby community and in the few months in Summer 2021 where people were able to fundraise, we were proud to be the charity for the Mulgrave 10k and support a local fitness group to raise funds.

We have raised over £40k for the appeal so far and look forward to raising the remaining £40k this year and celebrating the close of the appeal. We've submitted over £50k in grant applications and continue to work with the local community.

The Mayor is going to be supporting the Fundraising Bricks relaunched in the Spring and we are working closely with partner charities to attend many of Whitby's very popular events.

- **NHS Charities Together Grants**

We worked closely with the Trust teams to apply for the Stage 3 NHS Charities Together Grant for Staff Health and Wellbeing during the pandemic. We faced challenges with changing processes from NHS Charities Together but after various communications we were finally able to submit the application and received confirmation of the grant in March 2022, with funding to be received in April 2022.

4. Core activity

- **Circle of Wishes**

Since the 1st April 2021 we have received 181 wishes. We've worked hard to promote wishes this year to see an increase in those submitted. We're especially grateful to the patient experience team who worked with departments across the trust to submit 94 of these wishes.

The table provided below shows the breakdown of wishes. 48 Wishes have been granted this year, 33 of these wishes were granted by Health Stars and 15 of the wishes were referred to the Recover and Restore funds and funded by the Trust.

There are 93 wishes in progress, 66 of these wishes were grouped together to create projects. We have worked on turning some of these wishes into medium sized project for fundraising. We've done this with a cluster of 26 wishes for the Humber Centre and with 40 wishes for the Inspire Building to ensure the remaining funds from the Impact appeal are spent.Then a remaining 27 wishes are in progress.

We received a high number of duplicate wishes this year, we believe this is due to some of the wishes being received through the PACE wishes were wishes we already had, a target for us for next year will be to receive less duplicate wishes.

Finally, we declined two wishes and one wish was withdrawn. The declined wishes were for patient travel and training equipment. The withdrawn wish was for an online training platform.

Granted	In Progress	Duplicates	Withdrawn/ Declined	Total
48	**93**	**37**	**3**	**181**
33 Wishes Granted by Health Stars	27 are currently in progress	27 Duplicates within PACE wishes	2 Declined	
15 Wishes referred to recover and restore funds	Fundraising Projects 26 Humber Centre and 40 for Inspire	10 Duplicates in general wishes	1 Withdrawn	

Examples of the wishes funded by Health Stars include:

- Dementia Friendly Clocks and Chairs for GP Surgeries
- Sensory and Aromatherapy resources
- Cooking tools for patients
- Crafts for patient activities
- Lip Balms for End of Life patients in Whitby Hospital
- Murals for waiting rooms and units
- Boxing Classes for patients
- Christmas Trees
- Yoga and Mindfulness workshops for patients
- Gardening tools and other resources
- Dementia books for patients

We hope to maintain this level of wishes for the next year to ensure we are having a big impact on patient and staff experience. We also need to continue to work with the Trust to identify the next large fundraising appeal.

The skills and connections of the Health Stars and Smile teams ensure that we make funding go further, work harder and last longer.

A focus for the team in the coming year will therefore be;

- *Looking to encourage larger Wishes and potential projects*
- *Scalable projects for multi-site delivery*

5. Finances

This year has been a challenging year for fundraising and as a result spending has been a key focus. We have unfortunately not raised as much as we have spent in staff costs. We were expecting a large grant from NHS Charities Together which will now be received in the financial year 22/23. However a long term target has been to reduce the fund holding so that it is doing more for patients and staff.

In the financial year 21/22 we generated £63.4k against a target of £234.1k.

We finished the year with a fund holding of £401k against a target of £439k.

We generated £0.83 for every £1 we spent on operational costs against a target of £2.50.

We invested £285k on patient experience and staff benefit against a target of £411k.

This investment is broken down below by fund zone. The biggest spending has taken place at the Inspire Building following on from the funds raised for the Impact Appeal. Spending is generated through Circle of Wishes request that the Health Stars team receive from staff.

Fund Zone	Expenditure in 21/22	Balance at 31st March 2022
Alfred Bean Hospital	0	45,289
Big Thank you Humber	46,124	39,524
Bridlington	0	130,443
CAMHS	232,000	15,807
Central charges	68	2,693
Community Nursing	64	20,279
ERCH	0	32,525
Forensics	2,362	17
GP Surgeries	285	8,416
General HS Costs	0	4,302
Hornsea	2	4,439
Learning Disabilities	0	2,272
Malton	0	24
Mental Health	1,660	17,548
Physiotherapy	0	350
Recovery College	0	563
Scarborough & Ryedale	0	195
Speech and Language Therapy	0	784
Stroke	0	170
Volunteering	8	9,026
Whitby	2,905	60,804
Withernsea	0	5,494
Unassigned	0	140
Total	**285,479**	**401,103**

A further £80,51 was spent on operating expenses of the charity, combined with patient experience spending this brings the total expenditure in year to £365,522.

Fundraising costs were 26% of total expenditure.

Conclusion

With a tough year behind us we are looking ahead to the future. We're delighted to be brining back in person events including the CEO Challenge in June 2022 and the

Health Stars Golf Day in September 2022. These are our key events for the next year.

We're also delighted that so many Trust members of staff have been in touch to fundraise for Health Stars and a variety of community events are already planned in from walking the wolds way to music events.

We are assessing the resources required to deliver a successful Health Stars and making plans for the next three year and what the charity can achieve. We are proud of our teams resilience and looking forward to facing the next challenge head on.

We remain focused on reducing our fund holding, working with partners within the communities we serve to maximise the funding we hold for greater impact. Equally we are aware that we as the Charity of Humber NHS Teaching Foundation Trust still have more opportunities to work with internal services and departments and this is something we are actively exploring and developing.

With a continued proactive approach we can continue to develop even in tough operating circumstances, supporting our NHS teams, patients and relatives. Our Corporate Trustee continues to expand its services, and receive national accolades for service improvements and innovation. In the coming year we hope to support that continued success even further.

Humber Teaching NHS Foundation Trust

Agenda Item 22

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Health Stars Key Performance Indicators (KPI) 2022/23
Author/s:	Steve McGowan Director of Workforce and OD

Recommendation:				
	To approve	✓	To receive & note	
	For information		To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Trust Board are asked to approve the KPIs for measuring Health Stars performance in 2022/23. The purpose of this paper is to provide the Board with a proposed suite of KPIs for 2022/23 against which Health Stars performance will be measured. This report is provided to the Trust Board as Corporate Trustee of the Charity.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No matters to escalate	**Key Actions Commissioned/Work Underway:** • N/A
Positive Assurances to Provide: • Consultation on KPIs took place in January 2022. No changes were suggested. • KPIs for 2022/23 to remain the same as for 2021/22.	**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		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	

Caring, Learning & Growing Together

			Other (please detail)	

Monitoring and assurance framework summary:

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

1. Introduction

The Trust sets KPIs for Health Stars as part of the contract for managing our Charitable Funds.

The KPIs below were set for 2021/22. In January 2022 all members of the Charitable Funds Committee were asked for suggested amends to these KPIs. No responses were received.

As there has not been a recent Charitable Funds Committee, an email discussion has taken place between the Chair and the Executive Lead. Following this discussion, it is proposed to use the same KPIs for 2022/23.

Health Stars report on performance against these KPIs at each Charitable Funds Committee.

Finance: Is the charity maximising its resources? Are the funds held managed effectively? Does the resources expanded in the year represent good value for money?	**Proposed Outcomes**	**Measurement**
	Financial plan reached	Budget achieved for both income and investment into Trust services
	Fundraising costs and retaining Trust	Fundraising costs to remain below 30% of total expenditure. The remaining 70% expenditure must be for charitable outcomes*
	Income generation	A minimum target of £2.50 raised for every £1 spent on fundraising
	Benchmarking	To benchmark the charities performance annually with three other local trusts. - Tees Esk and Wear Valleys NHS Foundation Trust - Leeds Community Health Care NHS Trust - Lincolnshire Community Health Services NHS Trust

Engagement: Can our service users see the charitable impact in our services? Do our employees feel supported by the charity? Can the Trust board quantify the impact the charity is having? Is the charity representing the trust positively?	**OUTCOME**	**ACTION/MEASURE**
	WISHES: The success rate of wish requests increased year on year	Total number of wishes on average 150 per year for the next three years
		Successful rate of wishes target 80%
	APPEALS: To have regular fundraising appeals	One new Appeal established each year.
	ANNUAL SURVEY: To be able to monitor staff engagement	Improvement of understanding, confidence and engagement with the charity. Carry out a survey each year.
	POSITIONING (EVIDENCE BASED) To increase knowledge of the charity among staff,	Minimum of one media worthy stories a quarter to be taken up by media source either online or in print

	patients and general public	
		By March 2022 Reach 1200 Followers on Facebook Reach 400 followers on Instagram Reach 1500 followers on Twitter
		Engage an average of 500 people per month in social media posts.

Patient-centred & Staff-centred: Can our service users see the charitable impact in our services? Do our employees feel supported by the charity? Is the charity led by service users and our people?	**OUTCOME**	**ACTION/MEASURE**
	Wishes from patients	Number of wishes that come from a patient. To be obtained by asking staff who submit wishes and recording wishes that come from Patient experience forums. Wishes from patients to be at least 10 per year.
	To have a good balance of wishes for both patients and staff	Number of wishes for patient benefit and number of wishes for staff benefit
	To demonstrate the impact the charity is having.	Impact reporting, capture case studies as part of report. A minimum of 6 case studies per year. To be a mixture of staff focused and patient focused.
	Staff engagement	Increase staff lottery numbers by 10% each year. To start recording how many staff are attending events and to increase this number

Governance: Can the Trust board quantify the impact the charity is having? Is the charity legally compliant and sustainable?	**OUTCOME**	**ACTION/MEASURE**
	Assurance to the trust board	Monthly CEO update Engagement at two board meetings year, one from the Health Stars Team and one from the Chair of CFC
	Legally compliant and sustainable	Fundraising Regulator membership and providing updates from them to the CFC. Updated Risk Register at each CFC meeting. GDPR audit every six months.

NHS
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Agenda Item 23

Title & Date of Meeting:	Trust Board Public Meeting – 18 May 2022
Title of Report:	Standing Orders, Scheme of Delegation and Standing Financial Instructions - Annual Review
Author/s:	Name: Michelle Hughes Pete Beckwith Title: Head of Corporate Affairs Director of Finance

Recommendation:				
To approve	/	To receive & note	
For information		To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To present proposals for approval: • Subject to Board approving the revised Terms of Reference for Remuneration Committee earlier on the agenda, the Board are asked to approve the changes to the Standing Orders, Scheme of Delegation and Standing Financial Instructions to reflect the proposed changes detailed in this report. • To approve proposals to increase the financial thresholds for the Director of Finance and Chief Executive to allow for timely authorisation of invoices in recognition of the Trusts role as lead provider. The report summarises the proposed changes.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:	**Key Actions Commissioned/Work Underway:**
• No issues raised.	• N/a
Positive Assurances to Provide:	**Decisions Made:**
• The document has served the organisation well over the past year. The changes proposed are to update following a review of remuneration committee terms of reference.	• Remuneration Committee authority in Terms of Reference to be ratified by Board

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) *Report direct to Board to reflect proposed changes in remuneration committee terms of reference*	/

Monitoring and assurance framework summary:

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

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

Standing Orders, Scheme of Delegation and Standing Financial Instructions

1. Introduction:

The document was reviewed in full and last approved by Board in September 2021. The annual review has been brought forward to ensure, subject to approval of Remuneration & Nominations Committee (Rem Comm) Terms of Reference, presented earlier on the Board agenda, that the changes are reflected in the Standing Orders, Scheme of Delegation and Standing Financial Instructions (SO) document.

2. Proposed Changes:

a) Page 34 Section C: Scheme of Matters Reserved to the Trust Board and Delegation

Following agreement of terms of reference at Rem Comm it is proposed the 4th bullet point under 'Appointments/Dismissal' is removed ie remove: *"Approve proposals of the Remuneration and Nomination Committee regarding Directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration and Nominations Committee."*

b) Page 52 section 18.1.4

Following agreement of terms of reference at Rem Comm it is proposed 18.1.4 is removed ie remove: *"18.1.4 Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration and Nomination Committee.*

c) Page 61 – Table

The financial thresholds have been reviewed in recognition of the Trust operating as the Lead Provider for the Humber Coast and Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative, which has been live since the 1st October 2021 and is part of the Trusts approved budget. The revised thresholds enable the timely authorisation of invoices without the need for dual authorisation (from Non-Executive Directors), and in recognition that finance reports are provided to the collaborative committee on a regular basis.

Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment Of Goods. Contracts and Non Pay Revenue. Stock/Non-stock requisitions	
Financial Limit *(where this relates to contracts over more than one year, the annual value is delegated as per below)*	Delegated to
Up to £9,999	Senior Manager/other staff on authorised signatory list up to their delegated limit

£10,000 to £24,999	Divisional General Manager
£25,000 to £49,999	Director subject to quotes/contract
~~£50,000-£99,999~~ **£50,000-£249,999**	Director of Finance subject to quotes/contacts
~~£100,000 to £249,999~~ **£249,999-£750,000**	Chief Executive subject to tenders/contacts
~~All other invoices over £250,000 relating to approved capital projects and approved NHS creditors~~ remove row	~~Trust Board~~
~~All invoices over £250,000~~ **All invoices over £750,000**	Trust Board

3. Next Steps:

The Standing Orders, Scheme of Delegation and Standing Financial Instructions is a public document. Subject to approval the changes will take effect immediately and the updated document will be made available on the Trust website.

4. Recommendation:

To approve.

May 2022