NHS
Humber Teaching
NHS Foundation Trust

Trust Board Meeting 30 March 2022
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 30 March 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 23 February 2022	CF	To receive & approve	√
4.	Action Log and Matters Arising	CF	To receive & discuss	√
5.	Patient Story - Anthony's Story: The Importance of Openness and Honesty in Care	JB	To receive & note	√
6.	Chair's Report	CF	To note	verbal
7.	Chief Executives Report	MM	To receive, note & approve	√
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.	Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles	MM/CF	To receive & note	√
12.	Humber Coast and Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative Commissioning Committee Assurance Report	PB	To receive & note	√
13.	Charitable Funds Committee Assurance Report & 16 November 2021 Minutes*	PB	To receive & note	√
	Corporate			
14.	Staff Survey Presentation – Charlie Bosher from Quality Health attending	SMcG	To receive & note	√
15.	Board Assurance Framework – Oliver Sims, Corporate Risk and Compliance Manager attending	MM	To receive & note	√
16.	Risk Register - Oliver Sims, Corporate Risk and Compliance Manager attending	HG	To receive & note	√
17.	Peer Support Worker Update– Alexis Temple-Matthews and Louise Walker, Peer Support Workers attending	LP	To receive & note	√
18.	Infection Prevention Control Board Assurance Framework	HG	To receive & note	√

19.	Items for Escalation	All	To note	verbal
20.	**Any Other Business**			
21.	**Exclusion of Members of the Public from the Part II Meeting**			
22.	**Date, Time and Venue of Next Meeting** Wednesday 27 April 2022, 9.30am via Microsoft Teams			

* Presented to Board as Corporate Trustee

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Agenda Item 2

Title & Date of Meeting:	Trust Board Public Meeting – 30 March 2022
Title of Report:	Declarations of Interest
Author/s:	Name: Caroline Flint Title: Chair
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper:	The report provides the Board with a list of current Executive Directors and Non-Executive Directors interests.
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	✓

Key Issues within the report:	• Contained within the 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
Legal	√			
Compliance	√			

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Communication	√			as and when required by the author
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 Peter Baren, Non-Executive Director (Voting Member)	• Non-Executive Director Beyond Housing Limited • Son is a doctor in Leeds hospitals
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
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

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Item 3

Trust Board Meeting
Minutes of the virtual Public Trust Board Meeting held on Wednesday 23 February 2022 via Microsoft Teams

Present:	Rt Hon Caroline Flint, Chair Mrs Michele Moran, Chief Executive Mr Peter Baren, Non-Executive Director Mr Hanif Malik OBE, Associate Non-Executive Director Mr Stuart Mckinnon-Evans, Non-Executive Director Mr Francis Patton, 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) Michelle & Dawn, Patient & Clinical Support (for item 28/22) Mrs Alison Flack, Programme Director (for item 38/22)
Apologies:	Mr Dean Royles, Non-Executive Director

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.

The Chair welcomed Mr Mckinnon-Evans to his first meeting in his role as Non-Executive Director.

25/22 **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, Mr Baren and the Director of Finance declared an interest in items related to the Commissioning Committee.

An update was provided for assurance around the fit and proper persons requirement and the checks undertaken for Board members to ensure they are compliant.

26/22 **Minutes of the Meeting held 26 January 2022**
The minutes of the meeting held on 26 January 2022 were agreed as a correct record.

27/22 **Matters Arising and Actions Log**
The action log and work plan were noted.

The Chief Executive reported that visits for Non-Executive Director and Director visits are being planned and will be circulated shortly (action 06/22(b)

Mr Patton confirmed that he had been sent information in relation to action 08/22(a).

28/22 **Michelle's Story**

Due to patient confidentiality the story was not livestreamed

Michelle's journey and experiences were presented to the Board. Members of the Board appreciated her sharing her story and thanked her attending.

Areas for improvement were discussed and suggestions from Michelle in relation to environment and activities taken on board. it was also felt that if Michelle was willing, that her story would help others if shared further.

Resolved: The story was noted

29/22 **Chair's Report**

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

- A meeting took place with Sharon Nobbs and Val Higo on voluntary services and volunteers
- A quarterly Freedom to Speak Up (FTSU) meeting was held. It was a helpful meeting and discussion took place around the refresh of the strategy.
- A Staff Governors meeting was attended by the FTSU Guardians and ideas on how to engage staff were discussed.
- A meeting was held with Mr McIntyre, the Staff Side Representative, to provide information on his role and the work of Staff Side.
- The Governor induction session for new Governors was held. The Chair thanked everyone who was involved in this session which was well received.
- Meetings have been attended with the Integrated Care System and members to explore the progress being made

Resolved: The verbal report was noted

30/22 **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:-

Modern Slavery Statement

There is a legal requirement on the Trust to publish on our website, a Board approved modern slavery statement each year. The statement was approved by Board members and will be updated on the Trust website reflecting the statement for the year ahead.

Priorities

Senior leaders and teams continue to discuss priorities for the organisation. The top 10 key things were highlighted in the report.

Staff Health Trainer

This role links into the staff health and wellbeing work

Research

The Chief Executive declared an interest in this item as Chair of the CRN. She explained that research continues to grow in the Trust under the leadership of the Associate Director. The Primary Care elements is especially pleasing to see as it is a difficult area to attract people into.

Preliminary Inquest Hearing
The Board was informed that a Preliminary Inquest Hearing has taken place. This is in relation to the tragic death in 2014 of Sally Mays. Several investigations have been undertaken and a recent High Court ruled that a conversation in a car park would be the subject of an inquest. The preliminary hearing took place on 21 February 2022. Staff concerned continue to be supported. The Board will be kept updated on proceedings.

Capital Programme
Mr Beckwith reported that 24 staff areas have been completed and bike sheds will be installed from next month. Electric vehicle charging points are also being rolled out across the estate and a back up generator is being installed at Miranda House.

There has been some slippage with the National Mental Health Dormitory and applications have been successful for bids for Maister Lodge for the staff wellbeing areas and at Mill View for refurbishment and ventilation work.

Communications Team
The Intranet is a major source of information for staff and the platform has been viewed over 165,000 times in the last month. The next phase of upgrading to add clinical teams to the director has begun. The development of the Intranet will foster working relationships and engagement between teams.

Progress is being made with the target market goals and there is good engagement for the external website. There have been 34 positive news stories published in the month.

Mr Patton thanked the Executives for an excellent report. He noted the work on Primary Care research which was good to see. In the Chief Operating Officer update, reference was made to Mental Health Support Teams in schools. He noted that this covered 35 educational sites and wondered how many sites there were in total. Mrs Parkinson did not have the detail and will provide outside the meeting.

An update on severe mental illness annual health checks was included in the report. Mr Patton commented there has been issues raised previously around blook pressure checks. He asked how this compared to the average population and hot the two compared? Dr Byrne explained that it depended on the age and other health factors of the person, for example a person with diabetes would be expected to have two blood pressure checks a year. In relation to the severe mental illness the Care20Plus5 approach through the Plus5 part of this will help. Organisations are working differently to deliver some of these as part of the health and inequalities agenda. It was thought that it was likely that people with severe mental illness are not receiving health checks for a variety of reasons.

Mr Smith commented that these checks are important and looking at the East Riding figure which has increased to 39.9%, asked what the aspiration is looking to be achieved. The Chief Executive explained that significant funding has been given to this from the ICS as the area is an outlier across the patch. Dr Morris is leading a piece of work to look at the interface of digital platforms, recruitment and how GPs are doing. The target has been set at 85% which will continue to be worked towards.

Responsibility for the health checks sits with Primary Care. These are not new checks, but there has always been difficulty in achieving targets. Dr Byrne explained that these need to be done differently using staff skill sets to engage with people. The idea was for Health Trainers or Social Prescribers to move away from the medical model to a more holistic model. Benefit is being seen as there is specific capacity in the Health Trainer team to carry these checks out rather than being routinely delivered by Primary Care. It is hoped that significant improvement will be seen before the pilot completes at the end of March.

Mr Patton congratulated the Trust on the medical education trainees. He would like to see the

apprenticeships presentations. It was felt that this could be provided at the Workforce & Organisational Development Committee.

With the change to testing and self-isolation for Covid, Mr Baren asked how this will affect staff and visits to homes beyond the end of March? The Chief Executive explained there is no change to the guidance for NHS staff. The use of face masks and lateral flow testing continues. Discussions are being held on how this may change going forward, but until that is known the organisation will continue to follow the existing guidance. Mrs Gledhill said the Infection Prevention Control specific guidance is in place until the end of March and predates any announcements by the Prime Minister and will be followed. The blended approach with regards to working from home and coming into the office continues and is why the HQ building arrangements are being reviewed. This approach is working well and has been welcomed by teams that are further out in the geographical patch as it makes it easier for them to attend meetings.

Dr Byrne noted there is a high level of media interest around the decision made and many views from people. The Executive Management Team is discussing how to move forward but there is still a focus on personal protective equipment (ppe), vaccinations and ventilation. The collaborative learning will help for any any future variants that are identified to ensure the organisation is prepared.

It was noted in the report a Granville Court site evaluation for purchase. Mr Baren asked if the organisation is intending to buy the premises. Me Beckwith explained that following discussions at the Finance & Investment Committee around resources available for the capital work at Maister Lodge. It had been questioned whether it would be viable to own the property and grant and funding flow opportunities will be explored further.

Mr McGowan provided more detail about the Humber High performance Development Scheme. He explained that this is part of the Proud Programme for bands 2 – 7 staff. Ten individuals are part of the programme and receive dedicated training budget, mentors, work on the programme and dedicated learning time. There is investment in clinical staff who are at a point in their careers and aspire to move on and upwards. An annual celebration event is taking place on 2 March supported by the Chair and Chief Executive.

Mr Mckinnon-Evans asked how work is progressing to implement the movement of Mental Health Learning Disabilities staff to Hull City Council. He was informed that discussions with both parties are going well and the consultation process with staff has started with the Learning Disability Social Workers. Some staff are disappointed with the outcome of the review.

Resolved: The report was noted, The Board approved the Modern Slavery Statement
Total number of school sites in relation to Mental Health Support Teams to be provided to Mr Patton **Action LP**
Apprenticeships presentation to be shared with the Workforce & Organisational Development Committee **Action SMcG**

31/22 **Publications and Highlights Report**

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

Resolved: The report was noted.

32/22 **Performance Report**

Mr Beckwith presented the report relating to the current levels of performance as at the end of January 2022. Commentary for indicators that fell outside of normal variation was included in the report. Areas of highlight included:-

Safer Staffing dashboard fill rates are low although Care Hours Per Patient Day (CHPPD) rates remain high. The level of sickness remains high across most wards, but it is important to note

that the dashboard is reporting on December's position. In the wider performance report, sickness continues to increase in January and there was inclusion of the offers of support that have been made to help alleviate pressures. For IAPT the 18 week wait position is being maintained but due to the levels of sickness being seen there has been an impact on 6 week waits performance.

Improvements have been seen for out of area beds and Care Programme Approach (CPA) reviews as a result of the recovery plan in place.

In relation to waiting times the overall position for 52 week waiting times continues to improve. There is a focus on Children's ASD with the whole trajectory remaining on track and an overall reduction of 200 waits over the last year. Work continues to hasten this improvement with the additional resources that have been put in place.

East Riding waiting times shows 41 young people waiting over 52 weeks which is an improvement. The overall waiting time is now 14 months with plans to eradicate all over 52 waits over next few months.

Mr Smith noted the positive improvement. There are a number of patients waiting over 52 weeks excluding ASD is high, and the trend line is up. He asked what classes of patients are within that group. Mrs Parking explained predominantly core Child and Adolescent Mental Health Services (CAMHS) and ADHD. From March onwards to help operationally, the figures will be separated extracting the ADHD from the core CAMHS waiting times.

On the dashboard given this was December's report, Mr Baren congratulated the teams for the achievements in turning the position around. He raised comments about Inspire noting that the during the day staffing levels are down for unregistered and registered nurses and on Granville court some lines say, "not available" and he wondered why these are not populated. Mrs Gledhill explained that Granville Court is a residential home and has not previously reported on Care Hours Per Patient Day or for occupied bed days. However, this can be reviewed to see whether this information can be provided. Inspire was not fully occupied and there were times when there should have been 2 RNS but there was only one on shift and other staff that have not been pulled through. With the Delta and the start of the Omicron variants and staff sickness, it was a challenge to cover the units in December. However, through all of this Care Hours Per Patient Day remained good. Clinical Supervision indicators were red due to staff sickness and improvement is now being seen in most of January's position although there are still significant pressures. Immediate Life Support and Basic Life Support trajectories have been requested to get this back on track.

Dr Byrne explained that from 10 December when Omicron hit with an overwhelming spread through the UK. Being able to be proactive with staffing with lots of agency staff brought in. It was almost the first time in the last two years that because of transmissibility it was becoming difficult but managed to keep things safe. Still seeing some effect of this in February in terms of staff and we kept high levels of IPC in place and adherence to contract tracing and keeping people away from work if there was any suggestion that it was not safe for them to be in work, therefore protecting patients and staff. As a consequence of the pressures that are being experienced through the winter period, Mrs Parkinson has senior oversight and has regular meetings to look at all inpatient safer staffing information.

The Chair explained that on waiting times the Board has requested quarterly reports on this issue so as well as an update in this report, there will also be a separate quarterly report with more details

Resolved: The report and verbal updates were noted
Consideration as to whether indicators on the safer staffing dashboard for Granville Court can be provided **Action HG**
Quarterly reports on waiting times to be presented to the Board separate to the Performance report **Action LP**

33/22 **Finance Report**

Mr Beckwith presented the highlights from the finance paper as at 31 January 2022. Highlights included:-

- The Trust recorded an overall operating surplus of £0.153m at Month 10, a position consistent with the Trust's planning target.
- Within the reported position at Month 10 was Covid expenditure of £4.021m and income top up of £2.217m.
- Cash balance at the end of Month 10 was £27.956m of which £2.818m relates to the Provider Collaborative
- The Year-to-Date Agency expenditure was £6.193m, this is £0.534m more than the previous year's equivalent month 10 position.
- Primary Care continues to be an area of pressure and a recovery plan is being worked on.

Mr Patton noted that the Primary Care position has worsened since the last meeting. It was reported that within the Division there continues to be financial challenges around the use of locums, high levels of sickness in Practice 2 and Market Weighton. Mrs Parkinson reported that in the last week two substantive GPs have been interviewed and of this comes to fruition, will have an impact on locum use. The recovery plan will go into the Executive Management Team and then to the Finance & Investment Committee.

In previous years, a draft of the Operational Plan would have been seen by now. Mr Baren asked when this would be. Mr Beckwith explained that ordinarily a draft plan for the year would have been brought to this meeting, but it is not yet ready with the move away from the block funding regime to signed contracts between providers and commissioners. The draft funding envelope was received this week which is being considered and will go through EMT and a draft financial plan will be brought to the March meeting. The draft submission is at the end of March and the final submission date is at the end of April.

Mr Mckinnon-Evans commented that the combination of performance report on staffing levels and the financial expenditure assessment of spend on pay gives cause for concern linked to 22/23 planning priorities of staff related to recruitment. Discussions outside the meeting about what other employers are doing to attract and retain staff. As a newcomer to the report, he suggested that the cash balance figure is useful, but a cash flow forecast would also be a useful tool and will pick up with Mr Patton outside the meeting.

Resolved: The report was noted.

34/22 **Mental Health Legislation Committee Assurance Report**

An executive summary of discussions held at the meeting on 3 February was provided to the Board and included:-

- Receiving and approving the Q3 Reducing Restrictive Interventions (RRI) report. The proactive work taking place was noted.
- Issue with de-escalation training were highlighted due to Covid, however a new venue has been sourced and this is now progressing. The Trust is a positive outlier in terms of RRI
- Reporting of zero Section 4 applications
- Holding a deep dive into ethnicity. There is some way to go because of statistical make up of the population in Hull and East Riding. Trying to do more work around the actual population split particularly looking at Eastern Europe

At the last meeting there were three external attendees Sue Cordon from Grant Thornton, the Chair of MHL at Sheffield and the Trust's GP lead for knowledge sharing and some external benchmarking.

Resolved: The Board noted the report

35/22 **Audit Committee Assurance Report**

This paper provided an executive summary of discussions held at the meeting held on the 8 February 2022. Mr Baren commented that internal audit has settled in well and made some good progress since they have been in place. A phishing exercise was undertaken, and some actions agreed as a result of this. The External Auditors provide an update and their plans for the next year.

Risk Register updates were received from the LD and Children's and primary Care Divisions.

An insurance report was received which showed a significant increase of 30% for the CNST premium.

Mr Mckinnon-Evans thanked Mr Baren for chairing the meeting and highlighted the change in personnel in internal audit. He also found the discussion on counter fraud interesting and also the phishing exercise. Dr Byrne asked about the Information Governance compliance for those people who put in their details. He was informed that most of them had completed the training and an offer of additional training will be extended to them. It was noted that the Trust had to allow the e mail to be released for the exercise showing that the security arrangements in place were strong.

Resolved: The report was noted

36/22 **Quality Committee Assurance Report & 2 November 2021 Minutes**

A summary of discussions held at the meeting on 2nd February 2022 and the approved minutes of 2 November 2021 meeting were presented for information. As interim Chair, Mr Smith found it interesting to see the connection between this Committee and the Mental Health Legislation Committee (MHLC).

The learning from deaths report was reviewed and the quality implications of the 20-year gap in life expectancy for someone with a learning disability and the general population. The previous report stated that 40% of deaths were due to pneumonia and the learning from this report will help to educate people in relation to aspiration and it was interesting to see the practical information.

A deep dive was undertaken into ligatures using doors. Some organisations have technical solutions and a blended approach with technical solutions and staff training. Significant piece of work is being undertaken is still ongoing. The MHLC will look at compliance issues and the Quality Committee will pick up the quality aspects to get the best possible outcome for patients

Resolved: The report and minutes were noted

37/22 **Humber Coast and Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative – Collaborative Committee Report**

The report following the meeting held on 21 January 2022 was presented. Updates were provided from the three workstream and finances are on track as anticipated. Pressures in CAMHS were reported with nine young people with eating disorders waiting for beds. They are being actively managed, but this is a risk. Issues were also being seen in adult secure mainly due to delayed discharges which are trying to be progressed.

Resolved: The report was noted.

38/22 **HCV MH & LDA Collaborative Programme Update**

Mrs Flack joined the meeting to present the report which gave an update on the work of the Humber, Coast and Vale ICS Mental Health, Learning Disabilities and Autism Collaborative Programme.

In the midst of planning and are pulling together across the system looking at finance, activity and workforce and recovery plans against the long term plan trajectory. There is work going on at Place base levels working with Mental Health providers which will end in an ICS submission. Three priorities have been identified out of area, crisis services and children and young people.

Safe and wellbeing reviews is a national programme of work for Learning Disability patients in hospital. An assurance panel has been set up for each individual in hospital, reviewed by a case manager and brought to a senior assurance panel to ensure there is a level of assurance place that they are safe and there are plans in place for them for the future. These will all be completed by the end of February when 64 patient reviews will have taken place.

Other areas highlighted included the work of the Health and Justice Board, Right Care and Right Person work in partnership with the Police and the street triage model under development in partnership with the Ambulance Service. Health Inequalities work is taking place reviewing the population health data to help focus on areas of priority.

The team has been shortlisted for a HSJ Partnership Award for the working on the Together service for families bereaved by suicide.

The Chair suggested that a presentation be arranged from Dr Chiddick on the Health Inequalities work that is taking place.

Resolved: The report and verbal updates were noted
Presentation from Dr Chiddick to be arranged to the Board **Action AF**

39/22 **Items for Escalation**
No items were raised.

40/22 **Any Other Business**

Senior Independent Director
The Chair recommended to the Board the appointment of Mr Francis Patton as the new Senior Independent Director from 1 March 2022. The role is remunerated at £2,000 per annum. Governors have been consulted and asked for their views on the appointment.

Resolved: The Board approved the appointment of Mr Patton and extended its thanks to Mr Baren for his work in this role.

41/22 **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.

42/22 **Date and Time of Next Meeting**
Wednesday 30 March 2022, 9.30am via Microsoft Teams

Signed …… Date ……
Chair

Agenda Item 4

Action Log:
Actions Arising from Public Trust Board Meetings

Summary of actions from February 2022 Board meeting and update report on earlier actions due for delivery in March 2022 *Rows greyed out indicate action closed and update provided here*						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
23.2.22	30/22(a)	Chief Executive's Report	Total number of school sites in relation to Mental Health Support Teams to be provided to Mr Patton	Chief Operating Officer	March 2022	Information e mailed to Mr Patton 21.3.22
23.2.22	30/22(b)	Chief Executive's Report	Apprenticeships presentation to be shared with the Workforce & Organisational Development Committee	Director of Workforce & Organisational Development	April 2022	To be shared at 13 April meeting
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 been requested to look into this and will report back to the Director of Nursing
23.2.22	32/22(b)	Performance Report	Quarterly reports on waiting times to be presented to the Board separate to the Performance report	Chief Operating Officer	March 2022	Included separately as an appendix to the March report
23.2.22	38/22	HCV MH & LDA Collaborative Programme Update	Presentation from Dr Chiddick to be arranged to the Board	Programme Director/Chief Executive	June 2022	To be arranged for June Board Time Out
Outstanding Actions arising from previous Board meetings for feedback to a later meeting						

Date of Board	Minute No	Agenda Item	Action	Lead	Timescale	Update Report
27.8.21	144/21	Chief Executive's Report	Update on Peer Support Worker to come back to the Board in 6 – 8 Months	Chief Operating Officer	February – April 2022	Item on the agenda
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	**March 22 update** 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	Item not due - Update will be taken to the next Quality Committee by Paul Johnson Clinical and Weeliat Chong, Chief Pharmacist.
26.1.22	06/22(a)	Chief Executive's Report	Operational Planning bullet points relevant to Trust to have updates included	Director of Finance	March 2022	Planning paper (Including finance) to March Part II Board
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	Date to be agreed	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.

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

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Board Public Workplan 2021/2022 – *(no August or December meeting) (v19a)*

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

Board Dates:- / Reports:	Strategic Headings	LEAD	28 Apr 2021 (Strategy)	19 May 2021	30 June 2021 (Strategy)	28 Jul 2021	29 Sep 2021	27 Oct 2021 Strategy)	24 Nov 2021	26 Jan 2022	23 Feb 2022 Strategy)	30 Mar 2022
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	PB						x	x	x	x	x
Quarterly Items												
Finance & Investment Committee Assurance Report	Committees	FP	x		X		x	x		x	x	
Charitable Funds Committee Assurance Report	Committees	PB		x		x	x		x			x
Workforce & Organisational Development Committee	Committees	DR		x		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	PB		x			x		x		x	
Board Assurance Framework	Corporate	MM			X		x		x			x
Risk Register	Corporate	HG			X		x		x			x
HCV MH & LDA Collaborative Programme Update (moved from part II Nov 21)	Corporate	MM									X	
6 Monthly items												
Trust Strategy Refresh/Update(moved to June by MM from Oct)	Strategy	MM						X update				X def to June
Freedom to Speak Up Report	Quality & ClinGov	MM	x					**x**	X came in Oct			
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		

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Board Dates:- / Reports:	Strategic Headings	LEAD	28 Apr 2021 (Strategy)	19 May 2021	30 June 2021 (Strategy)	28 Jul 2021	29 Sep 2021	27 Oct 2021 Strategy)	24 Nov 2021	26 Jan 2022	23 Feb 2022 Strategy)	30 Mar 2022
Annual Agenda Items												
Review of Strategic Suicide Prevention Strategy	Strategy	JB										**X Def to April**
Recovery Strategy Update (item not yet due workplan to be updated)	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 moved to Sep 21	Quality &ClinGov	JB			x		x					
Quality Accounts (moved to June in Mar 22)	Reg.Comp	HG			x					x		
Risk Management Strategy (deferred to April 2022 in order to present an annual update for 2020-21 against the priorities in the plan)	Strategy	HG								X def		X def to April
Infection Control Strategy (moved to Sept)	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 (def due to late receipt into organisation)	Corporate	LP					X def					
Patient Led Assessment of the Care Environment (PLACE) Update – was Sept 18, but 2019 visits took place Oct	Quality &ClinGov	LP										
Health Stars Strategy Annual Review (moved to May in Apr 21)	Strategy	MM	x									
Health Stars Operations Plan Update moved to April from Mar 22	Perf & Delivery	MM										X moved to April
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 (moved to June – Apr 21)	Corporate	PBec		X def	X							
Annual Declarations Report	Corporate	PBec		x								
Charitable Funds Annual Accounts	Corporate	PBec						x				
Equality Delivery Scheme Self Assessment moved to May 22	Corporate	SMcG							X moved to May 22			
Gender Pay Gap moved to July	Corporate	SMcG			X	x						
WDES Report — reports into Workforce & Organisational Development Committee , but separate report to the Board moved to July	Reg. Compl	SMcG			X	x						
WRES Report reports into Workforce Committee,with report to Board	Corporate	SMcG				x						

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Board Dates:- Reports:	Strategic Headings	LEAD	28 Apr 2021 (Strategy)	19 May 2021	30 June 2021 (Strategy)	28 Jul 2021	29 Sep 2021	27 Oct 2021 Strategy)	24 Nov 2021	26 Jan 2022	23 Feb 2022 Strategy)	30 Mar 2022
Equality Diversity and Inclusion Annual Report moved to July	Corporate	SMcG			X	x						
Board Terms of Reference Review	Corporate	CF		x								
Committee Chair Report	Corporate	CF										x
Annual Committee Effectiveness Reviews & Terms of Reference (one paper)	Corporate	MH		x								
Reaffirmation of Slavery and Human Trafficking Policy Statement in Chief Executive report	Corporate	MM									X	
Review of Disciplinary Policy and Procedure (added March 21 to April Workforce & OD Committee and reported via assurance report	Corporate	SMcG										X move to April
Fit and Proper Person Compliance due June 2022	Corporate	CF										
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						

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Agenda Item 5

Title & Date of Meeting:	Trust Board Public Meeting: 30th March 2022
Title of Report:	Anthony's Story: The Importance of Openness and Honesty in Care
Author/s:	Anthony (Family Member) Mandy Dawley (Head of Patient and Carer Experience) Dr John Byrne (Medical Director)
Recommendation:	To approve: ; To receive & note: x For information: ; To ratify:
Purpose of Paper:	To inform the Trust Board of how Anthony's experience as the sibling of Sharon, who sadly took her own life in 2016 has aided the way in which we involve families and carers in the Trust. Dr John Byrne will lead a conversation with Anthony followed by a questions and answers session with Trust Board members.
Governance: *Please indicate which committee or group this paper has previously been presented to:*	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/Carer Story: x
Key Issues within the report:	The key messages from Anthony's story are: • Communication; listening to inform decision making • Staff openness and honesty

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*	
√ *Tick those that apply*	
√	Innovating Quality and Patient Safety
√	Enhancing prevention, wellbeing and recovery

Caring, Learning
& Growing Together

	Fostering integration, partnership and alliances
√	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

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

Humber Teaching NHS Foundation Trust

Agenda Item 7

Title & Date of Meeting:	Trust Board Public Meeting – 30 March 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:	To provide the Board with an update on local, regional and national issues.
Governance: *Please indicate which committee or group this paper has previously been presented to:*	See table below
Key Issues within the report:	• Items for approval - Intellectual Property and Copyright Policy

	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	√			

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Legal	√			To be advised of any future implications as and when required by the author
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Chief Executive's Report

1 Items for Approval

1.1 Trust Policies

The policy in the table below is 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.

Policy Name	Date Approved	Lead Director
Intellectual Property and Copyright Policy	14/3/22	Director of Finance

2 Around the Trust

2.1 Visibility

My virtual and face to face visits have continued throughout the month. Staff continue to show great care and resilience across the organisation.

2.2 Meet Michele

These sessions remain popular and will continue virtually.

2.3 Delegated Authority

At the start of the pandemic the Board gave delegated authority in March 2020 to the CEO to make urgent decisions as required during Covid. The powers have not been used since this time. It is not anticipated that emergency powers for covid will be needed going forward. Any further requests for delegated authority will be taken to Board at the appropriate time.

2.4 National Head of Patient Experience Awards

Mandy Dawley has once again received national acclaim for her work at the NHSE/I Heads of Patient experience Network awards, receiving such an award form your peers is outstanding but this is the second year Mandy has won a national award at the network awards.

Well done Mandy, well deserved.

3 Across the ICS

3.1 ICB Executive Appointments

Further appointments have been made to the remaining ICB Executive positions:

- Jane Hazelgrave, Executive Director of Finance and Investment (Jane will be joining us from Mid Yorkshire Hospitals NHS Trust)
- Karina Ellis, Executive Director of Corporate Affairs

The two Non-Executive Posts have been announced:

Stuart Watson, Non-Executive Director and Chair of the Audit Committee
- Mark Chamberlain, Non-Executive Director and Chair of the Remuneration Committee

In their roles as Non-Executive Directors, Stuart and Mark will also help to shape a long-term direction of the ICS.

4 National News

4.1 Chief People Officer

NHSE Chief People Officer, Prerana Issar has decided to step down from her role so that she can take time to recover fully from Covid related illness. Prerana has been instrumental in setting up the NHS England and NHS Improvement People Directorate and was the first Chief People Officer for NHSE.

4.2 Care Quality Commission (CQC)

It has been announced that Dr Sean O'Kelly will take on the role of Chief Inspector of Hospitals at CQC later in the Spring, taking over the position from Ted Baker, who announced his retirement in September 2021.

4.3 NHS Confederation Board Update

Ifti Majid, Chief Executive, Derbyshire Healthcare NHS Foundation Trust, and Chair of the NHS Confederation's BME Leadership Network has been announced as the new Chair.

Others joining the board are:

NHS Chief Executives:

- Caroline Donovan, Chief Executive, Lancashire & South Cumbria NHS FT
- Mel Coombes, Chief Executive, Coventry & Warwickshire Partnership Trust

Nurse Director Representative:

- Amanda Pithouse, Joint Executive Chief Nurse, Barnet, Enfield and Haringey Mental Health NHS Trust and Camden and Islington NHS FT

5 Covid-19 and Winter Plan Summary Update –March 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. Amanda Pritchard, NHS Chief Executive and Professor Stephen Powis, Chief Executive of NHS Improvement sent a letter setting out the actions every part of the NHS needs to put in place to prepare for and respond to the Omicron variant and other winter pressures. The actions are summarised below:

- Clinically prioritising services in primary care and across the NHS to free up maximum capacity to support the COVID-19 vaccination programme over the next few weeks, alongside delivering urgent or emergency care and other priority services.
- Delivering at scale whilst also retaining the focus on vaccination of those at greatest risk, including those who are housebound. Continuing to maximise uptake of first and second doses including through identifying dedicated resources to work alongside directors of public health locally.
- Creating capacity, both by maximising throughput, efficiency and opening times of existing sites to operate 12 hours per day as standard, seven days per week as well as running 24 hours where relevant for the local community, and through opening additional pop-up and new sites.
- Increasing training capacity with immediate effect to support lead employers with rapid onboarding and deployment of new vaccinators.
- Maximise the availability of COVID-19 treatments for patients at highest risk of severe disease and hospitalisation.
- Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes. The operational imperative is to create the maximum possible capacity within acute care settings to support patient safety in the urgent care pathway. Work together with local authorities, and

partners across local systems including hospices and care homes to release the maximum number of beds (and a minimum of at least half of current delayed discharges).

- Systems must focus on eliminating ambulance handover delays. Local systems should take immediate steps to maximise referrals from 999 to the two-hour Urgent Community Response services.
- Systems are asked to ensure that access to community-based mental health services and learning disability and autism services are retained throughout the COVID-19 surge to ensure that people at risk of escalating mental health problems and those who are most vulnerable can access treatment and care and avoid escalation to crisis point, with face-to-face care retained as far as possible. Healthcare colleagues are asked to make every contact count this winter with people with SMI and LD – to ensure promotion of health checks and interventions as well as access to COVID-19 and flu vaccination.
- Whilst it is not known what the demand from Omicron will be on critical care facilities it is essential that trusts familiarise themselves with existing plans for managing a surge in patients being admitted with COVID-19, with particular focus on the management of oxygen supplies, including optimising use at ward level.
- As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients –including patients on cancer pathways and those with the longest waits continue to be prioritised.
- Local systems should stress test their plans to confirm that the elements that helped to sustain cancer services in previous waves are in place, and to ensure that rapid access, including tests and checks for patients with suspected cancer, as well as screening services, are maintained.
- Support staff, and maximise their availability, revisit your staff wellbeing offer to ensure it has kept pace with the changing nature of the pandemic, with a continued focus on ongoing health and wellbeing conversations taking place for staff. Employers should be ready to communicate any changes in testing and isolation guidance associated with Omicron.
- System leaders and NHS organisations should review workforce plans for the next three months to ensure that, as per surge plan testing that the appropriate workforce is in place to deal with an increase in the number of COVID-19 patients and to support the ramp up of the COVID-19 vaccination programme. Organisations should continue to use their staff flexibly to manage the most urgent priorities, working across systems as appropriate. Trusts should seek to accelerate recruitment plans where possible, including for healthcare support workers, and where possible bringing forward the arrival of internationally recruited nurses, ensuring they are well supported as they start work in the NHS.
- Volunteers play an important part in supporting patients, carers and staff and Trusts are encouraged to take advantage of the available support to restore volunteering and strengthen volunteer management in ways which can contribute significantly to reducing service pressures, including NHS Reserves.
- Ensure surge plans and processes are ready to be implemented if needed. NHS organisations will need to review incident coordination centre arrangements, and should ensure that these are now stood up, including to receive communication and act as the single point of contact.
- Staff and organisations should continue to follow the recommendations in the UK Infection Prevention and Control (IPC) guidance.

In the Humber, Coast and Vale ICS, system leaders were identified to lead and coordinate the response to deliver the key actions set out above.

As of the 17th March 2022 the confirmed cases of Covid-19 for Yorkshire and the Humber are:

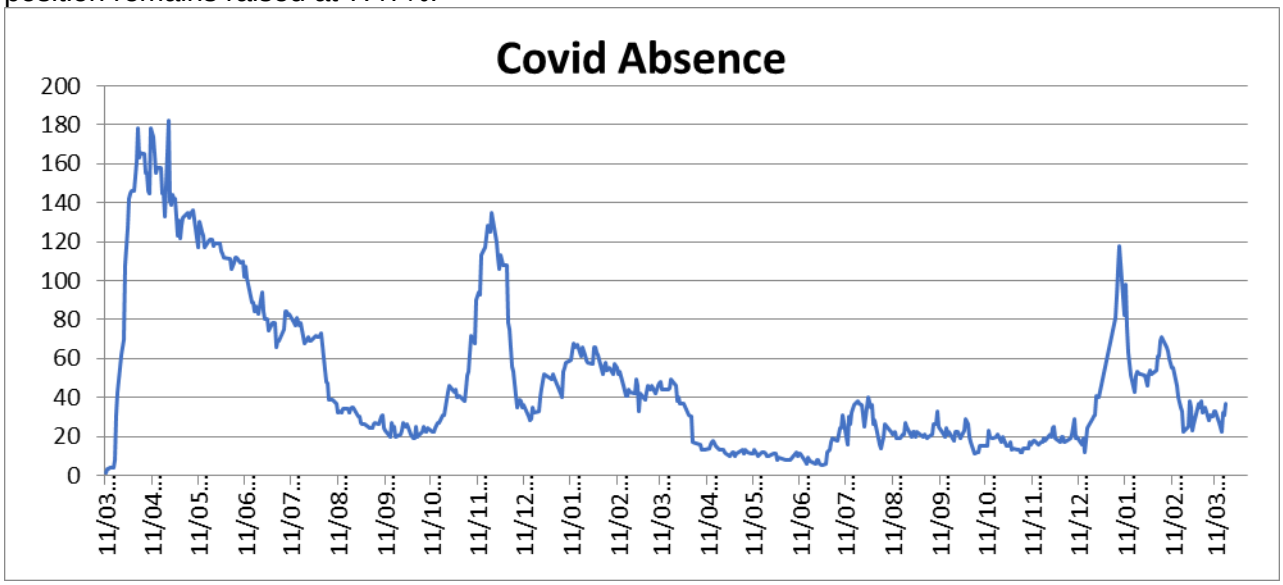
Positive Test and Trace Update – latest 7-day rate per 100,000.	
Area	**7-day rate per 100,000 for 7 days previous*** **(4th March – 10th March)**

East Riding of Yorkshire	566.1
Hull	409.1
North East Lincolnshire	358.9
North Lincolnshire	596.2
Yorkshire and Humber	437.2
England	617.0
Source: PHE Daily Briefing **Test results are updated every day and so rates are liable to change.*	

For the same period the 7-day rate per 100,000 population for Scarborough is 552.0, for Ryedale is 672.0 and Hambleton is 586.0. The overall 7- day rate for North Yorkshire is 642.0

As of 17th March 2022, there have been 1,688 hospital deaths due to COVID-19 across the Humber area. This includes 1,093 deaths registered by HUTH, 597 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 830 deaths over the same period.

The Trust has recorded a peak of 19 cases of a Covid-19 positive inpatients on 2nd February which has reduced to two cases currently. Staff sickness absence related to Covid has reduced since a peak in January and has stabilised between 20 and 40 cases daily in February and early March. Whilst this has now reduced, when combined with non-covid related sickness the overall absence position remains raised at 7.47%.



The Trust's emergency planning command arrangements were stood down on 31st January 2022 as the operational pressures due to the Omicron wave had stabilised. 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 has been reinstated.

Operational service pressures remained high in some areas in February and early March 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 further high demand from the acute hospitals for discharges to be supported along with ongoing high demand for primary care. Secure service pressures increased due to covid outbreaks at Pine View and the Humber Centre, these have now resolved. However, the Trust overall operational pressures continued to be stabilised 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 February and early March 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 and investment has been approved. Focus continues on reducing waiting times in these services, particularly in relation to autism diagnosis.

Nationally requirements are in place to eradicate the use of out of area bed mental health beds and our services are implementing plans to achieve this. It remains a challenge however as covid safe working practice guidelines remain in place across the NHS. Our out of area bed use has seen a further improved position achieved in February. This was supported by a proposal approved by Gold command in early January to temporarily adjust the cohorting arrangements in place for adult mental health beds, this was due to high demand locally for beds, no availability of mental health beds nationally and the increased number of covid positive patients in our beds. The plan was developed with and supported by the Trusts infection prevention and control leads and allowed for patients to be cohorted at Newbridges ward along with the ongoing arrangement at Millview Court. The plan was risk assessed and allowed for mental health bed flow to be maintained, it remains in place.

Our overall bed occupancy has remained high in February and early March with the pressures especially high for mental health, learning disability beds and our community beds at Malton and Whitby Hospitals, it has been between 78.1 – 86.1%. The overall number of available beds remains reduced due to the need to provide isolation/cohort beds for covid symptomatic and positive patients and infection control requirements, beds remain reinstated where alternative provision has been made in some areas for donning and doffing of PPE. To address this shortfall and ensure beds are available when required the Trust has continued to block book five independent sector beds and the position is continuing to be monitored very closely.

System pressures have remained high in North Yorkshire and York and in the Humber areas in February and early March 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 rise further due to the impact of Omicron on 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. The combined impact of these pressures has seen system overall 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 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. Staff availability remains an area of operational priority as we respond to the ongoing pandemic and winter pressures. To further address this the recruitment team has been tasked to prioritise clinical posts.

Testing and Isolation Arrangements
The Trust continues to carry out swab or **polymerase chain reaction (PCR**) tests for any patients in our inpatient beds that have symptoms of Covid-19. Isolation areas remain in place for all of our inpatient services. Mill View Court, our Covid-19 positive isolation cohort ward for our mental health and learning disability patients remains operational and isolation beds remain available on Darley ward at the Humber Centre. As set out above, a temporary change to isolation arrangements has been put in place because of the wider system pressures and the need to apply infection control guidance whilst maintaining mental health acute bed flow adequately.

Lateral Flow (asymptomatic staff testing)
The Trust continues to encourage all staff to undertake twice weekly Lateral Flow Antigen Testing. Over 88,700 tests have been reported with 247 positive results.

New self-isolation guidance for NHS staff came into effect on 16 August 2021 allowing fully vaccinated NHS staff and students who are identified as a contact of a positive Covid- 19 case to no longer be expected to isolate and to return to work if the required safeguards are met and implemented. This guidance was updated on 16th December to reflect self-isolation changes when in contact with a confirmed or suspected Omicron variant case. Staff who are a contact, have no symptoms and are fully vaccinated can continue to return work if the safeguards are met. Updated national infection, prevention and control guidance is expected before the end of March in the meanwhile current testing protocols for staff remain in place.

Covid-19 Vaccine
The Trust stepped up a vaccine centre as part of the national response to the Omicron variant and the need to expedite vaccination capacity at scale. Dr John Byrne, Medical Director remains our senior responsible officer for covid vaccinations, our hospital hub is currently stood down. The Joint Committee on Vaccination and Immunisation (JCVI) recognises that there remains considerable uncertainty with regards to the likelihood, timing and severity of any potential future wave of coronavirus (COVID-19) in the UK. There may be a transition period of a few years before a stable pattern, such as a regular seasonal wave of infection, is established. Advances in vaccine technologies and therapeutic agents in the meantime are ongoing. A spring vaccination programme is taking place as many of the oldest adults, and therefore most vulnerable, will have received their most recent vaccine dose in September or October 2021. These individuals are at higher risk of severe Covid- 19, and with the lapse of time, their immunity derived from vaccination may wane substantially before autumn. Therefore, as a precautionary strategy for 2022, JCVI advises a spring dose, around 6 months after the last vaccine dose, should be offered to:

- adults aged 75 years and over
- residents in a care home for older adults
- individuals aged 12 years and over who are immunosuppressed, as defined in the Green Book

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

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. The government moved England to Plan B on the 8th December 2021 following the rapid spread of the Omicron variant in the UK, this was moved back to Plan A on 27th January 2022. NHS England have instructed that Public Health England's infection prevention control guidelines and hospital visiting guidance remain in place for all staff and visitors. Updated National Infection Prevention and Control guidance was published in November and it specifies that:

- universal use of face masks for staff and face masks/ coverings for all patients/visitors to remain as an IPC measure within health and care settings over the winter period. This is likely to be until at least March/April 2022
- recommendation that physical distancing should be at least 1 metre, increasing whenever feasible to 2 metres across all health and care settings
- recommendation that physical distancing should remain at 2 metres where patients with suspected or confirmed respiratory infection are being cared for or managed

On 1st January 2021, national guidance for visiting inpatient settings was also updated and set out the requirement for visitors to undertake a lateral flow test prior to a visit.

Safe Working in our Environments

We continue to reiterate our guidance to staff that remote working is maintained whenever possible, that face-to-face meetings should be irregular and for a specific purpose such as clinical supervision, colleague contact and support and that social distancing and infection control guidelines need to be maintained.

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 23 months and in some areas service demand and operational pressures remain very 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. As national guidance was changing rapidly in response to the Omicron threat, weekly all staff calls had been taking place with the executive management team over recent weeks, as the position has stabilised these have now been stood down.

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. The "Reset and Recovery" plan that was developed through wide engagement with staff is being monitored by the Executive Management Team (EMT).

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 February and March, 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.

Operational Planning - Winter and 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 – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening health and community services by strengthening the compassionate and inclusive culture needed to deliver outstanding care.
- Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.
- 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– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.
- Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.
- Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.
- Continue to develop our approach to population health management, prevent ill health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
- Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.
- 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 has reviewed the winter plans across all the providers and identified services that can be reduced or stopped if surge

pressures increase. We continue to monitor the effectiveness of the Trusts winter plan through our operational processes, including those areas that have received additional seasonal investment. Operational areas that have been impacted during winter by seasonal and covid related pressures have detailed plans in place to recover activity, these continue to be monitored closely.

Trusts have been asked to prepare for a public inquiry into the government's handling of the pandemic which will commence in the spring of 2022.

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 Multi-Agency Public Protection Arrangements (MAPPA) – Update

Multi-Agency Public Protection Arrangements (MAPPA) are the statutory arrangements for managing sexual and violent offenders. Responsible Authorities (including Police, National Probation Service and Prisons) have a duty to ensure that the risks posed by these offenders are assessed and managed appropriately.

Duty to Co-operate agencies or DTC's (which includes health Trusts) work with the Responsible Authority and have a crucial role in reducing risk and protecting the public. By working in a coordinated way, individuals who pose the greatest risk to the public are identified and risk assessed with a management plan implemented via multi-agency panel meetings.

There are also a number of system meetings related to the MAPP arrangements and Humber Teaching NHS Foundation Trust is represented at the MAPPA Strategic Management Board (SMB) by the Chief Operating Officer. The Associate Director of Psychology provides senior practitioner representation at relevant panel meetings and other system meetings are attended by personnel at a suitably qualified level in the organisation.

The Trust has developed a system of Single Points of Contact or SPOCs in the Divisions, supported by the Associate Director of Psychology so that MAPPA issues can be well coordinated and communicated. The Trust continues to fulfil its responsibilities to MAPPA as a Duty to Cooperate agency achieving 100% attendance across all required meetings.

Working arrangements and aspects of the work have been amended due to the impact of the Covid- 19 pandemic however these are now being reviewed and restored as part of a planned recovery phase.

The Trust MAPPA single points of contact are well established. They can assist colleagues in their areas in all issues related to MAPPA, ensuring that new processes are disseminated and explained. They also make sure that staff are signposted to the correct MAPPA referral pathway and the alternatives for offenders or potential offenders who do not fully meet MAPPA eligibility.

A revised MAPPA protocol for the Trust has been in development and a short delay has been encountered as many of the national forms are currently being revised and it is prudent to include these. Refreshed guidance on MAPPA level 1 management is also included. MAPPA will shortly have its own communication section on the Trust Intranet to ensure easy access to updates.

Regular training between agencies is now established and access to video conferencing has helped in ensuring that the updated training can be accessed for up to 6 months (after which a refreshed training will be made available). Face to face training is now being reintroduced, this does add richness in terms of enabling conversations among attendees to share ideas and case examples. Additional training on learning disabilities and autism has been provided to the Police by

the Trust and will also be provided to probation. This helps to foster a better understanding of this potentially vulnerable patient group. A recent thematic review showed that senior staff in agencies, including the Trust, sometimes have gaps in their understanding of MAPPA, to help address this a presentation was shared at the February meeting of the Trusts Senior Leadership Forum.

Nationally reunification of Probation services is now almost complete. Offenders of all risk levels will be back within a national probation service rather than the community interest companies (CRC) in the private sector managing those with less serious offences. The CRC system was deemed to be underfunded and fragile hence the change.

6.1.2 Redesigning Adult Inpatient Mental Health Services

Plans for work to commence on the Pre-Consultation Business Case (PCBC) in May are underway, the process will take between 7 and 9 months to complete. The PCBC process is focused on the service redesign aspects of the project rather than on the building and will complement the Strategic Outline Case (SOC) which was approved by the board last year. The PCBC will include wider stakeholder engagement than was required to complete the SOC. A Humber Coast and Vale Integrated Care System led event is planned for April to explore alternative funding mechanisms should this and other projects not receive funding from the New Hospitals Programme.

6.1.3 Launch of the Hull and East Riding Children's Neurodiversity Service

The new Hull and East Riding Children's Neurodiversity Service was officially launched in March following a "soft launch" in January 2022

This service is a true partnership working together with parents and their child/young person and family to understand what support is needed and how help, advice and support can improve outcomes for their child/young person and their family. The service is being operationally led and implemented by the Trust.

The service has been co-produced with local children, young people, parents, carers, and staff who work to support them. Parents and young people (and staff on their behalf), in Hull and the East Riding will be able to request support, and access early help, information and advice, and a range of coordinated services based on the neurodiverse needs of their child/young person.

This service is not dependent upon a child/young person having a formal diagnosis; however, it will support children and young people to access further assessment if needed.

The Hull and ERY Children's Neurodiversity Service is aimed at children and young people aged 0 – 18 years (and will work with system partners to further develop the 18 to 25 years offer) with neurodiverse needs who are registered with a Hull or ERY GP, and/or attending a Hull or ERY school/educational setting.

The core services include:

- Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) Services
- Children's Learning Disabilities Service
- Sensory Processing Service
- CYP SEND Sleep Service.

The core service will be supported by the wider range of interdependent services and teams across children's health, education and care services, and local voluntary and community sector services.

Support will be coordinated by the service and/or a Named Worker for children and young people with more complex needs, who will meet with the child/young person and their parents/carer to

facilitate an individual discussion around the child/young persons' needs. This discussion will take place within 4 weeks from the request for support.

Based upon this, the service and key partners from across Hull and East Riding of Yorkshire will recommend and provide support designed to empower and meet the individual needs of the child/young person, and their parents/carers.

Requests for support can be made directly by young people, parents, and carers themselves (and staff/professionals, with consent) in person, via the telephone, or online using the contact details below.

The new service can be contacted using the details below:

Telephone: 01482 692929
Email: **hnf-tr.herneurofrontdoor@nhs.net**

Further information about the service can be found online here: www.humber.nhs.uk/Services/hull-and-east-riding-childrens-neurodiversity-service.htm

The benefits of the service for Children, Young People (CYP) and families include:

- A single point of contact to gain earlier help and support with neuro diverse needs accessible by a single phone number and email address.
- A system's change which allows CYP and families to access support without the worry of thresholds or diagnosis but based on immediate presenting need.
- Delivery and management of a multi-disciplinary team (MDT) made up of professionals from health, education, voluntary sector, and social care to ensure the right support or intervention is offered including risk identification and management before any signposting to assessment pathways takes place.
- Increasing the range of early help, information, advise and resources available to CYP and families with neuro diverse conditions.
- To ensure that communication with service users and referrers is timely, relevant, appropriate to need and maintained throughout the care experience.
- Increased engagement and personalisation in support plans and during the care experience.
- Having a named worker who will be a key point of contact and who supports care-coordination eliminating the need for families to 'navigate' the system themselves.
- Offer support during the transition into adult services

By offering early support the new service will transform the previous provision which was only commissioned to provide a diagnosis and will support the reduction in current waiting. Ongoing work and additional measures to reduce the current long wating times will continue alongside the launch of the new service.

6.2 Director of Nursing, Allied Health and Social Care Professionals

6.2.1 CQC Announces New Chief Inspector of Hospitals

The Care Quality Commission (CQC) has appointed Dr Sean O'Kelly as the new Chief Inspector of Hospitals. Sean will take over from Ted Baker later in the Spring. Sean is currently Medical Director and Chief Clinical Information Officer for NHS England and Improvement East of England, where he has driven NHS efforts to support the roll out of Integrated Care Systems and promote quality improvement across the region.

Previously, Sean has held several clinical leadership positions across provider, commissioning and regulatory organisations in both America and the UK. Former roles include: Associate Clinical Professor and Director of Paediatric Cardiac Anaesthesia at the University of Michigan; Associate Medical Director at the Department of Health and Social Care; Non-executive Director at Somerset CCG, Medical Director at Salisbury NHS Foundation Trust; Medical Director at University Hospitals Bristol NHS Foundation Trust and Medical Director for Professional Leadership at NHS Improvement.

He was chair of the Department of Health and Social Care's National Steering Group on Cosmetic Surgery Regulation between 2005 and 2008 and has worked as a special adviser to the CQC, chairing a number of comprehensive inspections.

6.2.2 Quality Accounts 2021-22

A Quality Account is a report about the quality of services offered by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is reported using mandated sections and narrative and is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. Quality Accounts are required to be published by 30 June 2022.
The NHS foundation trust annual reporting manual for 2021/22 has been released indicating removal of the quality report section of annual report stating quality reports are no longer a required part of an NHS foundation trust's annual report. Quality accounts are to continue to be prepared under separate arrangements.

We have commenced preparation of the Quality Accounts with the first draft planned to go to EMT on April 4th 2022 for review and approval prior to circulating to key stakeholders (CCG, Healthwatch, OSC) for their comments which when received will be published verbatim in the report.

The draft accounts will be presented to the Quality Committee in May for approval and will be presented to the Board for final ratification in June to meet the reporting deadline.

6.2.3 Patient Safety Strategy 2019-2022

The Patient Safety Strategy 2019-22 consists of six key priorities aligned to the overall trust strategy.

- Priority 1- To develop a positive and proactive safety culture.
- Priority 2- To reduce the number of Patient Safety Incidents resulting in harm
- Priority 3- To work with patients, carers, staff and key partners to continuously improve patient safety
- Priority 4- To ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents.
- Priority 5- To ensure a culture of continual improvement
- Priority 6- To work with the wider community to improve patient safety

The strategy was developed through extensive consultation and was approved by the Trust Board on 31 July 2019. Progress against the priorities has been reported to both the Quality and Patient Safety Group and the Quality Committee.

Summary of achievements
The PROUD leadership programme is in place with good feedback from participants. Patient safety data has improved through the development of patient safety 'real time' dashboards for each service. More staff are reporting they feel supported when an incident occurs. Safety huddles have been established across services. We have seen a steady increase in the number of near miss incidents reported- a sign of a good patient safety culture. 65 staff have been trained in a systems-based approach to incident investigation. The feedback from the training has been exceptional. We have further strengthened our approach to working with partners with a particular emphasis on partnership working across the safeguarding agenda.

Benchmarking indicates we continue to be in the upper quartile for reporting incidents with low/no harm. Again, an indication of a good patient safety culture.

In July 2021 the patient safety team held a 'Learning the Lessons' week, over 200 staff attended the virtual events and positive feedback was received. The team have now introduced Learning the Lessons days incorporating 'National Raising Awareness Day's' which fit with the Trusts learning from serious incidents and held an awareness event on learning the lessons from diabetes, incorporating World Diabetes Day.

The plan for 2022 is as follows:

- March 2022 – Is National Nutrition and Hydration week, learning will come from deteriorating patient incidents.
- May 2022 – Mental Health awareness week, learning will come from incidents regarding suicide.
- September 2022 – A patient safety week shall be held to incorporate World Patient Safety Day which will include learning from falls prevention, suicide prevention and sepsis.

World Patient Safety Day, celebrated every year on 17th September, is a campaign for all stakeholders in the health care system to work together and share engagement to improve patient safety. Last year's theme was **Safe Maternal, and New-born Care** and we raised awareness via social media and internal comms and the social media platforms had 1764 hits, which is really promising.

Next Steps
Further work is underway in 2022 to provide specific patient safety training for staff via the online NHS Patient Safety Syllabus in conjunction with in- house training informing staff how to recognise and report a reportable patient safety incident. In line with the national strategy, we are also continuing to work on the establishment of Patient Safety Partners which are patients/carers who work with us on our patient safety agenda.

The full progress report will be presented to the Quality Committee in May for discussion and consultation on the areas we would like to see in the refreshed strategy for 2023-2026. Further consultation on the refreshed strategy will be undertaken during the summer of 2022 with staff, partners and through our patient and carer forums ensuring it is aligned to the overarching Trust Strategy which is currently being refreshed.

6.3 Medical Director Updates

6.3.1 Medical Education.
The directorate has been holding a series of in person events over the past most as part of our 'restore and recover' agenda. This culminated in an 'in person' medical education conference on the 23rd. The team is actively working on making sure our approach to education retains the best elements of a blended approach including remote and face to face. These events will form part of an annual calendar which has been developed under the guidance of the medical education committee. Plans are in hand with regard to colleagues attending the international congress of the

Royal College of Psychiatrists in Scotland. In a joint piece of work we will be supporting medical staffing with hosting a recruitment stand which continues to play a role in raising the trust profile to potential recruits over the years ahead.

6.3.2 Medical Revalidation

NHSE and the GMC have announced that they will continue to adopt the changes made to medical appraisal documentation (MAG 2020 form). This is a well welcome announcement as feedback from colleagues is that the new documentation is much more conducive to capturing learning and reflection from an individual's perspective. In addition, more formal guidance will follow with regard to how the Annual Organisational Audit will be reported.

Dr John Powel who has been the Trust's employment liaison advisor from the GMC has moved to a new GMC role and has been replaced by Paul Rafferty (previously deputy chief nurse and Y&S NHS trust)

6.4 Director of Workforce & Organisational Development Update

6.4.1 Humber High Potential Development Scheme

February saw the graduation on cohort one of the Humber High Potential Development Scheme. It was recognised that it had been difficult delivering this in a COVID year, but learning has been taken away and will be applied to Cohort 2. Ten colleagues have secured a place on the second cohort and the induction day will take place in April.

6.4.2 Government Consultation Outcome Document for VCOD Released

Regulations revoking VCOD came into force on 15th March 2022 in order to provide certainty for employers. The national position continues to be that vaccination is the best way to protect yourself, your family, your colleagues, and patients from the virus.

6.4.3 NHS Pension Scheme Regulations Suspension now Extended to 31st October 2022

The government has agreed to extend the temporary pension rules for retired and returned member of staff up to 31st October 2022, so that if they return to work after retirement their pensions will not be affected.

6.4.4 Financial Wellbeing Resources for NHS Colleagues

With inflation, gas prices and general cost of living increases, we have reminded colleagues of the resources available. Mind provide advice on managing debt and the positive steps to address this. Citizen's Advice offer some specific Covid-19 advice on what to do if struggling to pay bills. This includes rent, council tax, mortgage, energy bills, court orders and tax bills. National Debtline offer free, confidential and independent advice on dealing with debt problems.

The Money Advice Service is an independent service set up by government that works to improve people's financial wellbeing across the UK. It gives free, impartial money advice.

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

Details of notifications received during 2022 are summarised below:

- CareCERT notices issued during 2022: 39 (Inc. 14 in February)
- High Priority CareCERT notices Issued during 2022: 3 (Inc. 1 in February)
- CareCERT Notices with patch(s) NOT approved for deployment: 0
- CareCERT notices with patch(s) applied to all devices: 29
- CareCERT notices with devices still to check in to patch: 10

The Trust has implanted a new assurance system, future months report will include additional details to raise awareness and assurance.
There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during February 2022.

6.5.2 Blend and Thrive

The response to tenders for the refurbishment of the of the new office premises are awaited and a new timescale for occupation will be set once contractors are appointed, current estimates are that June will be an achievable date and manager and staff support activities will be timed to fit with the revised date.

A review of Audio Visual provision is in progress to provide flexible meeting options to support the blended approach.

6.5.3 Capital Works Update

27 Staff areas have now been completed, with a further 14 in progress. Enabling works for secure bicycle storage has commenced with installations scheduled for April.

Works to enhance the oncall doctors accommodation at Miranda House has completed.

Works have commenced on the Miranda House backup generator, it is expected to have an operational facility by the end of April.

Works have commenced at Westend to provide accommodation for the Hull Core CAMHS Team, and this is expected to be completed by the end of March.

The cohort Ward at Millview lodge has been reinstated to adult beds, test results are awaited before reoccupation.

6.5.4 Business Development

Following the advent of Integrated Care Systems, the role of the Business Development team has changed significantly in a short period of time. The focus has moved towards a partnership driven role that requires strong relationship management skills, an understanding of developing systems and an ability to support Divisions with opportunities to develop services to better support our patients.

For this reason, it is now felt within the team that in the changing landscape, “Business Development” as a title could be perceived as outdated and predatory by partners, and that a change of team name would better describe the team and its role.

Following discussion at ODG the team will be known as the Partnerships and Strategy team from the 1st of April.

6.5.5 ANPR at King Street Medical Centre

Following the extension completion works at King Street Surgery, Cottingham, there has been increased activity within the car park area, which is for the use of staff, patients and visitors. Due to the proximity to the local school and shops, car parking is being used by third parties making it difficult for our own patients to park.

The introduction of ANPR (without pay and display meters) means only legitimate visitors to the site will be able to enter their car registration details onto the iPad that will be held at reception, feeing up parking spaces for genuine users and issuing fines for those who are parking without permission.

The system is due to go live be the end of March 2022 to allow time for patients staff and visitors to take on board the new requirements, and adequate signage will be displayed.

6.5.6 National Standards of Healthcare Cleanliness

The new standards for cleanliness in all healthcare environments (clinical & non-clinical) were released in May 2021 and all NHS Trusts must ensure they are implemented by 4th May 2022.

The national 10 point plan (issued by NHSEI) is being followed and the Healthcare Acquired Infection Group are monitoring progress, which is currently on plan.

Introducing the new standards should have no material implications for the Trust as it was already compliant with the previous (2007) standards.

7 Communications Update

PACE Training Programme Launch

On 1st March, the PACE Training Programme 'How to get involved in Trust activities' launched on our Recovery and Wellbeing College platform.

The team worked with PACE and Recovery College to produce a comms plan, to boost the training programme and encourage more people to sign up. The programme was covered in the local media and on our social media channels. Over 50 people clicked the link to the programme in the first week.

Breastfeeding Bridlington & East Yorkshire Breastfeeding Support

Throughout February and March we supported the Infant feeding team with two very closely linked projects. The first project's aim is to make Bridlington East Yorkshire's official first Breastfeeding friendly town. We helped shape and deliver a comms plan to communicate key messages. We helped arrange media interviews on local radio stations, issued a press release to the local and regional press and set up a dedicated web page where businesses could find out more information about the scheme: Bridlington Breastfeeding (humber.nhs.uk). Sign-up figures for the scheme to date look really positive and we've had good levels of engagement via our social media channels.

In addition, we helped the ISPHNS team launch the dedicated 'East Yorkshire Breastfeeding Support' web page. This is a dedicated hub with lots of support and advice for new and expectant mothers. So far, the page has received the following visits (dated from launch on 1st Feb – 17th March):

566 page views (in total)
476 unique page views (individual visitors to the page)
1:49 average minutes spent on page per session (this is a really encouraging stat as it demonstrates that the content is useful and people are reading it!)

Ongoing support

We continue to offer comms support for the following key projects which are currently in different phases of delivery:

- Bridlington GP Surgery Merger
- Hull 0-19 Service (new!)
- E.Riding 0-19 Service (continuation)

External Communications

- **Service Support**

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

Translated Friends and Family Test Online Form and Leaflets

To support our patients who use English as their second language we have created an online Friends and Family Test form that can be translated into any language using the Reachdeck tool on our Trust's website.

Following data provided to us by our GP practices, people who visit our FFT web page will see some introductory text which has been translated into the top seven languages spoken within our geographical area – Arabic, Kurdish Sorani, Latvian, Polish, Romanian, Slovak, and Spanish.

The text explains to the reader the steps they need to take to translate the form into their preferred language.

Our FFT leaflets have also been translated into these seven languages and will be available for our services to give to their patients.

Hull & East Riding Neurodiversity Service – Launch

We have worked closely with service teams and Hull CCG to set up a new section on the Trust website which houses all the information about the new front door service for the Hull & East Riding Neurodiversity Service. The page went live on Monday 14th March and a vanity URL has been created for use on service specific marketing collateral/ communications.

- **Trust Website Update**

	Target	**Performance over period**
Bounce Rate	50%	63.66%
Social Referrals	12% (a 10% increase in 2019 position)	3.2%*

Other key stats of note:

Users: 20,111 (of which 17,163 were new)
Pages per session: 2.07
Average session duration: 1:41 mins

- **Social media**

	Target	**Performance over period**
Engagement Rate	4%	7%
Reach	+50,000 p/m	184,699
Link Clicks	1500 p/m	3,654

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 our Emotional Wellbeing Service and Safer Sleep Week.

Positive new stories published		**Negative new stories**	
Local media	14	Local media	1
Humber website	8		
TOTAL	**22**		**1**

- **Awareness Days**

March is one of our busier months for awareness days. Recently, we have covered a wide range of different events, including Social Work Week, Social Prescribing Day, No Smoking Day and Safer Sleep Week.

No Smoking Day (9 March)

This year's theme from the host organisation 'Today is the Day' was 'Don't give up on giving up' and the theme outlined how, every time a person tries to stop smoking, they're a step closer to success.

We supported this national message by using a comms toolkit to spread the core campaign and used a local perspective to signpost people to local services that can support them to quit.

Safer Sleep Week (14 – 20 March)

This year, we partnered with over ten services across Hull and the East Riding, including the local Safeguarding Children Partnerships, CCGs, Councils, Trusts and CHCP, to present a far reaching campaign that was focused on out of routine sleeping.

As guidance around Covid-19 for the public has loosened in recent months, we acknowledged that more parents will be going away, visiting relatives and so on, and how this could impact their sleeping routine with baby. We wanted to provide simple and accessible guidance that would help any parent to provide a safe sleep space for their baby, in any new environment.

By the end of the week, we had ran 7 daily sub-themes each day on our social media channels, which focused on the core elements of reducing the risk of SIDS in a broader sense. Signposting to national services and resources to further support those who wanted to learn more and take the knowledge with them into the future. This campaign was well received by local press, with several media interviews taking place throughout the week in addition to publications.

Internal Communications

COVID-19 Communications

We continue to issue COVID-19 news bulletins to staff on a Wednesday and Friday as part of our Global Newsletter, as and when required. We will continue to review the frequency of these bulletins to ensure that staff are kept up to date with the latest COVID-19 news and guidance.

Office 365 Migration

We continue to support the internal project team with the communications around the migration to new Office 365 software.

Cyber Security
As part of a wider awareness campaign around cyber security, we helped to deliver some communications regarding phishing emails, the dangers they pose and how to spot them.

Poppulo – Internal Emails
Between 12 February and 17 March 2022, we issued 28 internal communications to staff. This month our Open Rates increased by 10.5% our click through rates saw a 1.4% decrease.

	Trust average engagement rates this month	**National Average**
Open Rate	60%	65%
Click Through Rates	6.26%	10%

It's worth noting that a number of emails we send out don't include links for staff to click on which could attribute to our lower than average click through rates. The table below outlines the engagement rates during this reporting period for our main staff news bulletins.

	Open Rates %	**Click Through Rates %**
The Global	65	11
EMT Headlines	65	2
Practice Notes	45	10
Ad Hoc Messages	66	2

Panel Volunteer Initiative
We have worked closely with the Patient and Carer Experience team to ensure the Panel Volunteer Initiative launched as per schedule in March. The database holds contact information for all patients, carers and service users who have opted "in" to be contacted by the Trust for interviews which will help inform service improvements.

We created a page on the Intranet where the database can be accessed, along with supporting information about how/ when to use the database and templates for staff to download and use when contacting people to take part in interviews. The database will be updated monthly. Communications about the new database have been sent to all staff via Global communications.

Intranet

- **Intranet Project – Stage 2**
  We have started the next phase of our intranet upgrade project to add a clinical teams directory. The aim of directory, which will feature every clinical team in the Trust, is to help teams learn more about each other and what their referral criteria is.

  It's hoped that this new resource will help to build on the amazing working relationships that some teams already have with each other and help to foster new ones.

- Our intranet platform has been visited 179,533 times between 12 February and 17 March 2022.

	Target	**Performance over period**
Bounce Rate	40%	57.44%
Visits	+20% on 2020 average	-5.32%

Second to our home page which had 130,897 visits, our Document Library was the second most visited page with 10,906 page views within this period.

8 Health Stars

Events

This month Health Stars are very excited to be named as the charity being supported at this years Smailes Goldie's 'Big Fat Quiz of The Year'. The event will take place on the 31st March 2022 at The Country Park, Cliff Road, Hessle. This is an annual event ran by Smailes Goldie Group and has seen 25 teams sign up to take part, at £175 per team. Health Stars hope to raise awareness of the Charity and the work it carries out within the Trust and gain new corporate supporters for the future.

Plans have now been confirmed for the 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 and invitations have now started to be circulated.

As a Trust we are delighted that more staff are choosing to fundraise and support our very own Trust Charity, Health Stars. This year Steve Jolly, Senior Digital Project Manager of the Trust has arranged several events to support Inspire, our CAMHS Inpatient Unit Hull. The first event was a race night which took place earlier this month and raised £503.87. Further events are due to take place throughout this year with the main event taking place on the 9th July 2022. This will be a music festival and already has 9 acts supporting this worthy cause. Further details on Steve's fundraising can be found here: Inspire Festival of Music

This year's CEO Challenge has been confirmed for the 20th June 2022, so please mark this in your diary, and I look forward to sharing more details with you all over the coming weeks.

For further information or to register your interest on any of the events please contact Fundraising Manager Kristina Poxon: Kristina.poxon@nhs.net

Whitby Hospital Appeal

Health Stars continue to fundraise for £43,184.02 to meet the fundraising appeal target for Whitby Hospital.

This period a total of £35,256.62 has been applied for through grant applications, and plans are underway for further applications to be made throughout April.

The team continue to work closely this period with Whitby Governor Doff Pollard and Whitby Hospital Service Manager to further plans for the Fundraising bricks campaign. A letter of support has been sent to the Mayor of Whitby, Cllr. Wild, requesting her support alongside senior leads and executives of the Trust to refresh the fundraising campaign for the personalised bricks. Cllr. Wild expressed her desire to support the appeal at the community arts exhibition which took place throughout November and December 2021.

Michele Moran
Chief Executive
March 2022

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 8

Title & Date of Meeting:	Trust Board Public Meeting – 30 March 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:	To update the Trust Board on recent publications and policy.
Governance: *Please indicate which committee or group this paper has previously been presented to:*	Audit Committee [ ] Date Quality Committee [ ] Date Finance & Investment Committee [ ] Date Mental Health Legislation Committee [ ] Date Charitable Funds Committee [ ] Date Remuneration & Nominations Committee [ ] Date Workforce & Organisational Development Committee [ ] Date Executive Management Team 15/3 Operational Delivery Group [ ] Date Collaborative Committee [ ] Date Other (please detail) [ ] Date
Key Issues within the report:	I. Mental health clinically-led review of standards II. Reforming the national Clinical Excellence Awards scheme III. Regulations making COVID-19 vaccination a condition of deployment to end IV. Effects of the pandemic continue to add pressures on mental health services, worsening access to care and longstanding inequalities V. DHSC annual report and accounts timetable VI Health and Care Bill Factsheets

Monitoring and assurance framework summary:

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

Caring, Learning
& Growing Together

	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
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. **Mental health clinically-led review of standards** NHS England 22 February 2022

This report sets out the wide-ranging support received through the national consultation on the proposed new standards for mental health care, and highlights some of the key considerations to support their successful implementation https://www.england.nhs.uk/wp-content/uploads/2022/02/mental-health-clinically-led-review-of-standards.pdf

Lead: Chief Operating Officer

These proposed new standards for mental health care have been considered in a number of forums in the Trust. As a Trust we are generally supportive of them and in some areas are already/close to achieving them. The report recognises the impact that the Covid- 19 pandemic has had on mental health demand, that parity of esteem is still an area requiring focus but that services will also need to be sufficiently resourced in order to reach them. The report states that responses on how best to advise on and communicate the proposed new measures, as well as the opportunities provided by and challenges to implementation, will be considered as part of an implementation plan, subject to government agreement to implement the proposals. More work to define and embed the new standards, including by improving data quality as implementation plans are developed will be undertaken.

2. **Reforming the national Clinical Excellence Awards scheme** Department of Health and Social Care 24 March 2022

The government hosted a public consultation on proposals to reform the current National Clinical Excellence Awards scheme. This is the formal government response to that consultation.
https://www.gov.uk/government/consultations/reforming-the-national-clinical-excellence-awards-scheme/outcome/reforming-the-national-clinical-excellence-awards-scheme-response-from-dhsc-and-welsh-government

The government's response sets out a series of reforms which aim to broaden access to the scheme and to make the application process fairer and more inclusive.

Lead: Medical Director

This is information will be shared with the head of medical staffing and will discussed at the next Local Medical Committee.

3. **Regulations making COVID-19 vaccination a condition of deployment to end** Department of Health and Social Care 1 March 2022

The legal requirement for health and social care staff to be double jabbed will be removed from 15 March.

- Regulations requiring COVID-19 vaccination to work in Care Quality Commission (CQC) registered care homes to be lifted from 15 March
- Legal requirement for health and social care staff to be double jabbed from 1 April to be removed
- Health and Social Care Secretary reminds the minority of unvaccinated health and care workers of their professional responsibility to be vaccinated

Following a public consultation, where 90% of responses supported the removal of the legal requirement for health and social care staff to be double jabbed, the government is revoking the regulations. When the original decision was taken to introduce COVID-19 vaccination as a condition of deployment, Delta was the dominant variant. This has since been replaced by Omicron which is less severe, with the percentage of those requiring emergency care or hospital admission approximately half that of the Delta variant.

Lead: Director of Workforce & OD

We have applied the change accordingly.

4. **Effects of the pandemic continue to add pressures on mental health services, worsening access to care and longstanding inequalities** Care Quality Commission 21 February 2022

The Care Quality Commission (CQC) is highlighting the ongoing impact of the pandemic on mental health services, their staff and the people using them.

In its Monitoring Mental Health Act (MHA) report 2020/21, the CQC highlights concerns that reduced access to community mental health services during the pandemic may in part have contributed to an increase in the number of people being detained under the MHA. In 2020/21 there was a 4.5% increase in use of the MHA to detain people with mental health problems in hospital for assessment and treatment.

CQC has previously reported on the impact of COVID-19 on children and young people's mental health and services' ability to meet this increased demand. This report raises concerns about children and young people being placed in unsuitable environments while they wait for an inpatient child and adolescent mental health (CAMHS) bed.

Longstanding inequalities persist, with Black or Black British people over four times more likely than White people to be detained, have more repeated admissions and be more likely to be subject to police holding powers under the MHA. Rates of

detention in economically deprived areas are worryingly high too, being more than three and a half times higher than in the least deprived areas.

This year's report includes findings from Independent Care (Education) and Treatment Reviews for people with a learning disability and/or autistic people which reveal the impact of a lack of community alternatives and poor commissioning decisions which led to people being admitted to hospitals that were a long way from home for prolonged periods of time. Over a third of the IC(E)TR patients reviewed had been in hospital for between 10 and 30 years.

Lead: Medical Director

This report will be shared with members of the Mental Health Legislation Steering groups and Committees for discussion which has recently reviewed our own ethnicity data as well as looking at detention trends in our services on an ongoing bases.

5. **DHSC annual report and accounts timetable** Department of Health and Social Care 2 March 2022

Timelines for the Department of Health and Social Care's annual report and accounts plan.
Issue and submission dates for the Department of Health and Social Care's annual report and accounts, covering the financial year 2021 to 2022. Read the timetables for the department's agreement of balances.

Lead: Director of Finance

The accounts timetable was presented to the Finance and Investment Committee earlier this year, the deadline for submission of accounts is 22nd June 2022 and a board meeting is set for this date.

6. Health and Care Bill factsheets Department of Health and Social Care 10 March 2022

A number of factsheets have been updated and are available below for information.

- Health and Care Bill: adult social care provider information (data)
- Health and Care Bill: arm's length body transfer of functions power
- Health and Care Bill: capital spending limits for NHS foundation trusts
- Health and Care Bill: competition
- Health and Care Bill: discharge
- Health and Care Bill: Health Services Safety Investigations Body

Lead: For information

Humber Teaching NHS Foundation Trust

Agenda Item 9

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting– 30th March 2022</td></tr>
<tr><td>Title of Report:</td><td>Performance Report - Month 10 (February)</td></tr>
<tr><td>Author/s:</td><td>Name: Peter Beckwith/Richard Voakes
Title: Director of Finance/Business Intelligence Lead</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td></td><td>To receive & note</td><td>✓</td></tr>
<tr><td>For information</td><td></td><td>To ratify</td><td></td></tr>
</table>
</td></tr>
<tr><td>Purpose of Paper:</td><td>This purpose of this report is to inform the Trust Board on the current levels of performance as at the end of February 2022.

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<tr><td>Governance:
Please indicate which committee or group this paper has previously been presented to:</td><td>
<table>
<tr><td></td><td>Date</td><td></td><td>Date</td></tr>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td></td><td>Workforce & Organisational Development Committee</td><td></td></tr>
<tr><td>Finance & Investment Committee</td><td></td><td>Executive Management Team</td><td></td></tr>
<tr><td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td>☑</td></tr>
<tr><td>Charitable Funds Committee</td><td></td><td>Collaborative Committee</td><td></td></tr>
<tr><td></td><td></td><td>Other (please detail)</td><td></td></tr>
</table>
</td></tr>
<tr><td>Key Issues within the report:

Please ensure you also complete the monitoring and assurance framework summary below:</td><td>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

Information on waiting times has been reported separately in the report to provide more detail and a detail breakdown of over 52 week waits for paediatric Autism Spectrum Disorder (ASD) has been included at appendix 1.

A full review of the performance report to inform 2022/23 reporting is planned by EMT in March.

Commentary for indicators that fall outside of normal variation is included below:

Safer Staffing Dashboard – key headlines from the safer staffing dashboard (as at the end of January) include</td></tr>
</table>

Caring, Learning & Growing Together

	Care Hours Per Patient Day (CHPPD) remains above threshold across all units with the exception of Westlands which has dropped slightly below the target due to high bed occupancy. Bed occupancy has dropped in February and this should be reflected in an improved position in relation to CHPPD. Sickness is a significant issue across the majority of wards, and this was highlighted by the high level of sickness at Trust level in last months performance report. TEC are showing 6 red flags. Three of these relate to their fill rates. Despite the low fill rates, which are due to only having one registered nurse on duty at times, they have good CHPPD levels and although their fill rates remain below target they have improved from December. Supervision has dropped from 81% in December to 41% due to high levels of clinical activity and acuity; vacancies and high sickness. The Modern Matron is ensuring that this is addressed going forward. Clinical Supervision is below target for 3 units which has been impacted on by staffing and clinical pressures, full detailed narrative is included in the body of the report.' **Memory Diagnosis** – this is a new indicator included in the IBR to ensure reporting is in line with the mental health key performance indicators reporting through the Integrated Care System. The Memory Assessment Service have a recovery plan in place for addressing the increased demand into the service. The East Riding team are making good progress against their improvement trajectory and Hull team are in the process of recruiting additional clinical capacity to support the improvement plan. Waiting times for memory assessment and diagnosis has been impeded due to lack of access to diagnostic imaging during the Covid- 19 pandemic. **Waiting Times** – Focussed work has been maintained in the last month on all areas with long waiting times. Some areas such as core CAMHS continue to see higher than usual demand due to the ongoing impact of Covid- 19. All services with long waiting times have detailed recovery plans with improvement trajectories in place. These are monitored weekly and reported to the Operational Delivery Group (ODG). A significant piece of work has been completed between our neurodiversity team and core CAMHS as part of the introduction and launch of the new Hull and East Riding Children's Neurodiversity Service. The Attention Deficit Hyperactivity Disorder (ADHD) cases have been removed from the CAMHS waiting list to a separate list. This has resulted in a significant reduction in long waiting

	times for core CAMHS. Future reports will show Paediatric Attention Deficit Hyperactivity Disorder (ADHD) waiting times along with the Autism Spectrum Disorder long waiters as part of our Neurodiversity provision. Paediatric and Adult ASD long waiting patients continue to improve and plans are in place to maintain this progress against the improvement trajectories. More detail is provided in appendix 1 on the position with CAMHS ASD waiting times for Hull and the East Riding of Yorkshire. **Early Intervention in Psychosis (EIP)** – whilst the service made good progress in January in line with their improvement plan by maximising clinical capacity. Staffing availability was reduced in February due to unplanned absences and the improved clinical capacity could not be maintained. Recruitment is currently underway which will improve the overall capacity to make achievement of the access targets sustainable.

Monitoring and assurance framework summary:

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

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

Financial Year
2021-22

NHS
Humber Teaching
NHS Foundation Trust

INTEGRATED BOARD 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:
Feb-22

Humber Teaching NHS Foundation Trust
Integrated Board Report

For the period ending:	Feb 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	Incidents	Total number of incidents reported on Datix
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

For the period ending:	Feb 2022

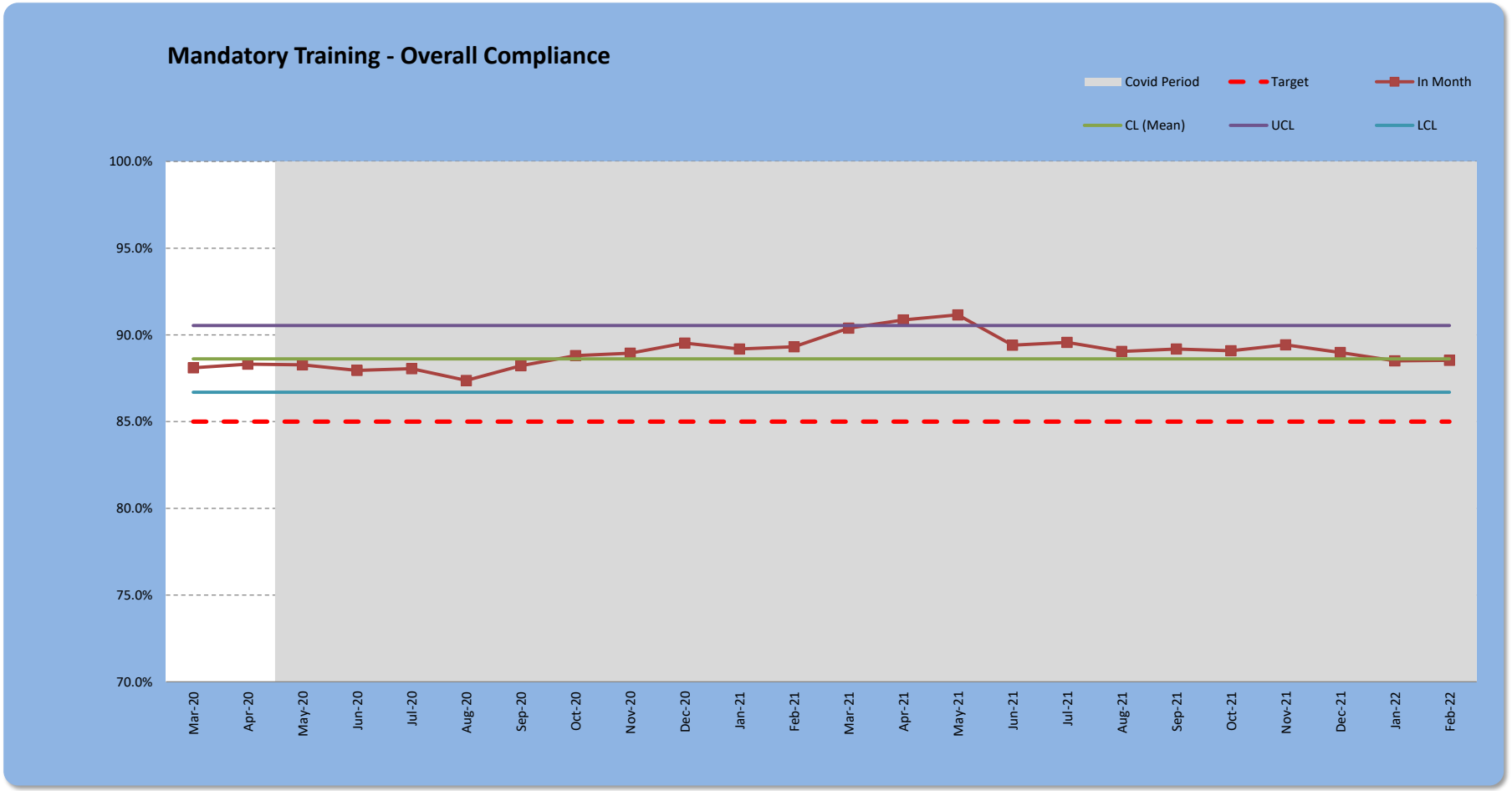
Goal 2	Memory Service - Assessment/Diagnosis Waiting List	Referral to Assessment/Diagnosis Waiting Times (Incomplete Pathways) : The number of patients referred to the Memory Service are awaiting greater than 18 weeks for assessment and/or feedback of diagnosis.
Goal 2	RTT - 52 Week Waits	Number of patients 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	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)
Goal 4	Staff Turnover	Percentage of leavers against staff in post
Goal 5	Finance - Cash in Bank	Review of the cash in the Bank (£000's)
Goal 5	Finance - Income and Expenditure	Review of the Income versus Expenditure (£000's) by month
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 2021-22

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Feb 2022**

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



Target: 85%

Amber: 80%

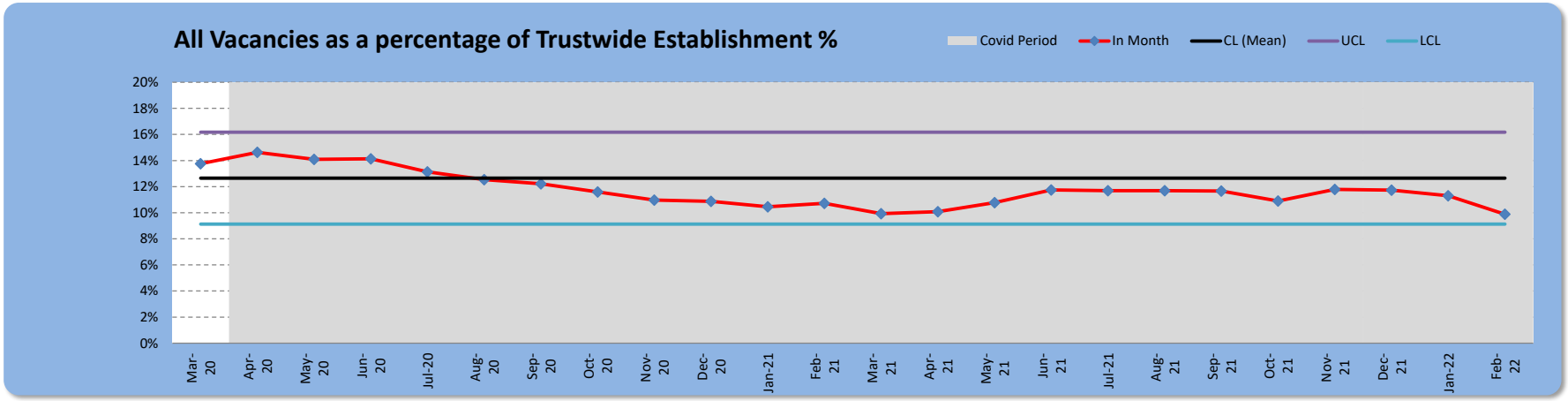
Current month stands at 88.5%

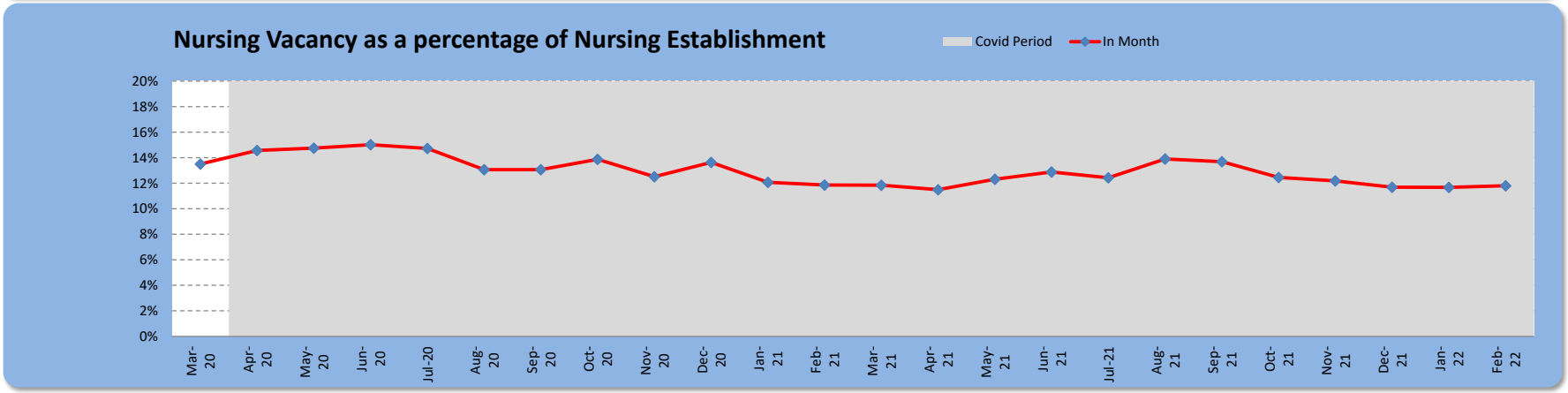
PI RETURN FORM 2021-22

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Feb 2022**

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





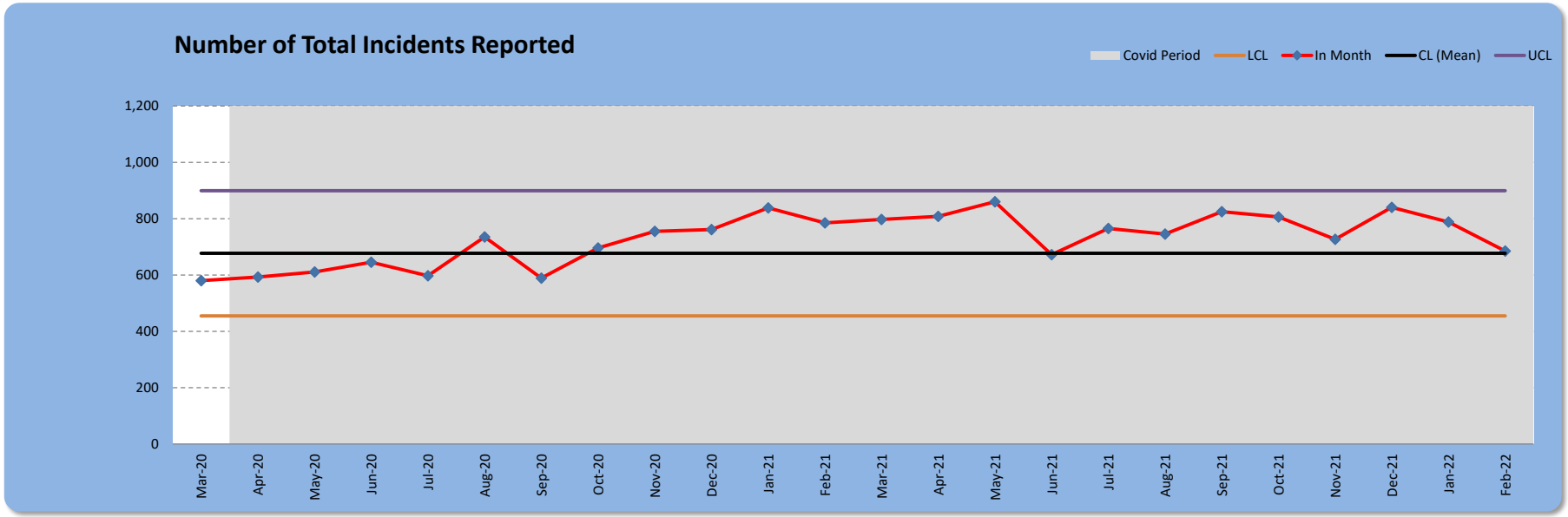
Current month stands at 9.9%

PI RETURN FORM 2021-22

Goal 1 : Innovating Quality and Patient Safety

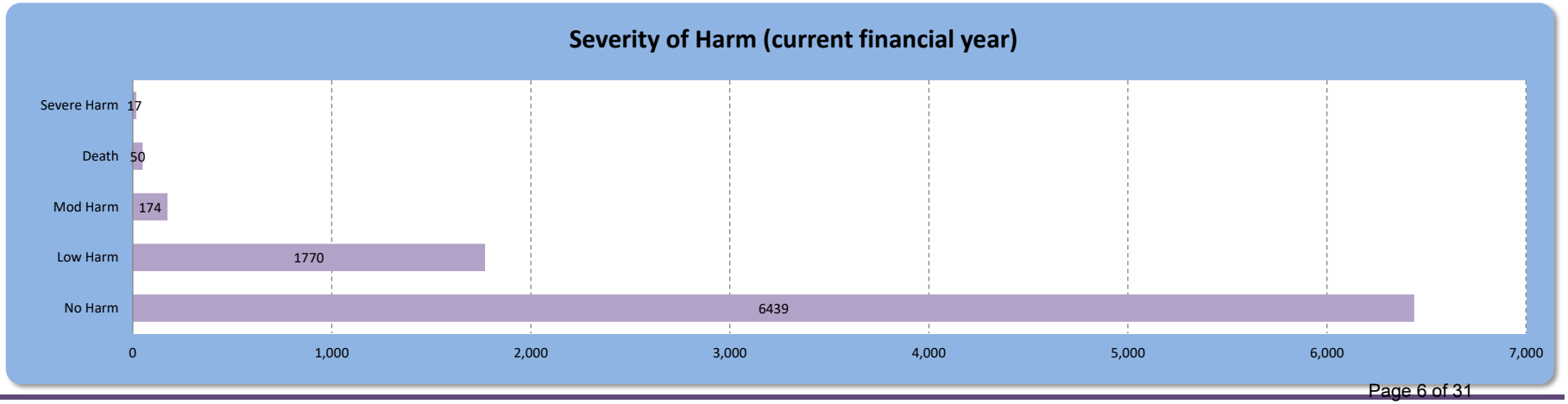
For the period ending: **Feb 2022**

Indicator Title	Description/Rationale		KPI Type
Incidents	Total number of incidents reported on Datix	Executive Lead Hilary Gledhill	IQ 6



UCL: 899
LCL: 455

Current month stands at 685



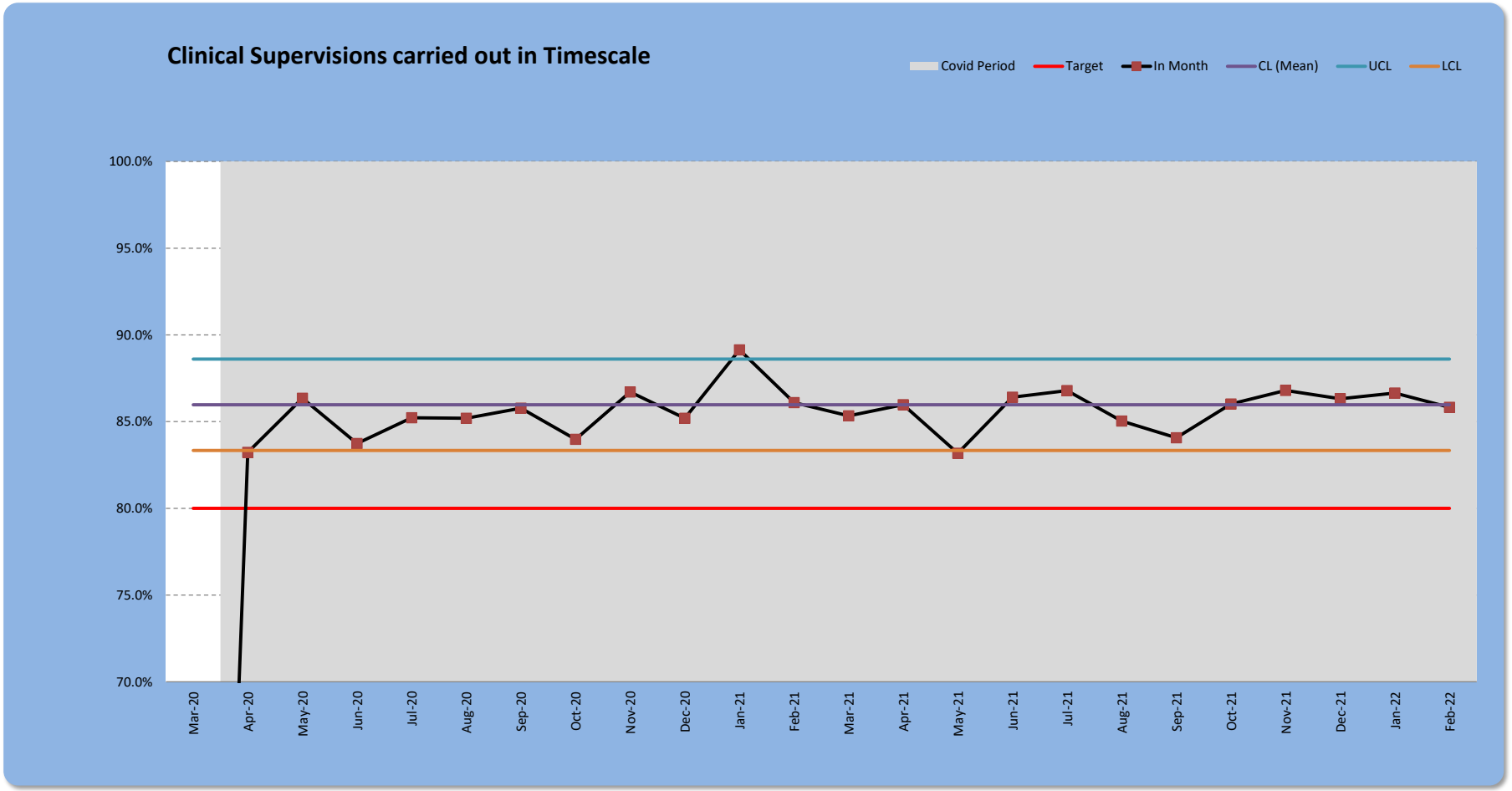
Severity of incidents reported in the current financial year (YTD)

PI RETURN FORM 2021-22

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Feb 2022**

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



Target: 80%

Amber: 75%

Current month stands at 85.8%

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

Staffing and Quality Indicators

Contract Period: 2021-22

Reporting Month: Jan-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)	Dec-21	Jan-22
Adult MH	Avondale	Adult MH Assessment	31.8	79%	11.4	21.5%	↑	9.1%	↑	79%	77%	96%	98%	2	22	8	0	84.0%	88.9%	54.5%	83.3%	12.2%	2.0	2	2
Adult MH	New Bridges	Adult MH Treatment (M)	41.2	92%	9.55	8.7%	↑	14.1%	↓	82%	101%	99%	130%	0	39	0	0	78.9%	96.3%	100.0%	85.2%	3.4%	-0.2	1	1
Adult MH	Westlands	Adult MH Treatment (F)	36.4	99%	7.91	14.7%	↓	17.3%	↑	87%	83%	105%	110%	2	118	8	0	91.7%	84.6%	68.8%	66.7%	6.3%	1.4	1	3
Adult MH	Mill View Court	Adult MH Treatment	28.9	121%	9.12	28.7%	↓	11.5%	↓	85%	82%	84%	100%	0	13	2	0	78.3%	86.9%	62.5%	80.0%	0.4%	5.8	2	2
Adult MH	STARS	Adult MH Rehabilitation	36.2	100%	24.26	10.3%	↓	1.4%	↓	62%	50%	100%	98%	1	15	0	0	94.9%	95.2%	91.7%	84.0%	2.1%	0.5	4	3
Adult MH	PICU	Adult MH Acute Intensive	31.9	56%	26.89	24.5%	↓	14.7%	↑	83%	88%	89%	106%	1	71	0	0	100.0%	89.3%	84.6%	94.1%	9.2%	3.0	0	1
OP MH	Maister Lodge	Older People Dementia Treatment	29.4	63%	22.55	18.8%	↓	10.9%	↓	96%	99%	104%	110%	0	43	0	0	94.6%	88.2%	61.5%	63.2%	1.4%	2.0	0	2
OP MH	Mill View Lodge	Older People Treatment	21.5	85%	13.92	22.5%	↓	15.5%	↑	48%	99%	101%	102%	8	25	0	0	45.0%	86.7%	63.6%	53.8%	8.2%	1.8	4	5
	Pine View	Forensic Low Secure	24.8	88%	9.89	37.4%	↓	0.0%	→	96%	106%	48%	123%	8	11	1	39	65.4%	92.5%	90.0%	75.0%	0.0%	2.2	4	2
	Derwent	Forensic Medium Secure	28.7	92%	11.62	24.1%	↓	0.0%	→	89%	73%	96%	104%	0	10	2	0	100.0%	94.8%	100.0%	83.3%	20.3%	-0.2	2	3
	Ouse	Forensic Medium Secure	24.5	93%	6.75	6.6%	↓	0.0%	→	47%	92%	96%	92%	2	5	1	16	87.5%	91.9%	75.0%	75.0%	14.8%	2.6	3	3
	Swale	Personality Disorder Medium Secure	25.4	91%	8.96	29.7%	↑	0.0%	→	104%	93%	106%	93%	1	20	8	27	76.0%	94.0%	81.8%	75.0%	11.2%	2.0	3	1
	Ullswater	Learning Disability Medium Secure	33.8	50%	15.39	20.4%	↓	0.0%	→	91%	84%	101%	84%	0	32	6	4	76.2%	90.3%	62.5%	66.7%	22.6%	1.4	3	2
Child & LD	Townend Court	Learning Disability	39.6	74%	48.08	35.5%	↓	0.2%	↓	71%	68%	60%	124%	9	83	1	0	41.4%	88.9%	61.5%	83.3%	16.8%	3.1	5	6
Child & LD	Inspire	CAMHS	50.0	78%	19.24	25.3%	↓	12.4%	↓	44%	83%	63%	94%	8	75	2	0	92.3%	80.0%	66.7%	74.2%	8.6%	0.0	2	1
Child & LD	Granville Court	Learning Disability Nursing Treatment	50.7	n/a	n/a	28.7%	↓	12.3%	↓	122%	75%	119%	94%	1	4	0	0	83.3%	82.0%	45.5%	85.7%	9.3%	0.0	3	3
CH	Whitby Hospital	Physical Health Community Hospital	39.7	93%	7.68	2.0%	↑	3.4%	↓	85%	76%	96%	97%	4	0	1	0	82.8%	78.2%	56.3%	47.4%	13.7%	3.8	3	4
CH	Malton Hospital	Physical Health Community Hospital	34.4	80%	9.31	Not on eRoster	→	Not on eRoster	→	123%	80%	110%	95%	2	2	1	0	No Ret	71.6%	75.0%	58.8%	0.0%	0.0	3	2

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

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

Humber Teaching NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : January

4 wards have below target levels of fill rates on days which is a slight improvement from 5 wards in Dec. The registered fill rates on nights are all above the threshold apart from Pine view and Townend court which are both showing fallrates of 48% and 60% respectively. In most instance the lower fill rates indicate that the shifts are being run with 1 registered nurse and on TEC one registered nurse is covering both units on nights. However, all CHPPD levels remain above the threshold apart from Westlands which has dropped slightly below the target due to high bed occupancy. Bed occupancy has dropped in February, and this should be reflected in an improved position in relation to CHPPD

The high bed occupancy on MVC reflected the fact that 5 beds were stood down to enable the Covid pod to be opened. These beds have now been brought back into general use.

The low fill rates on STARS are because there is often 1 OT on shift during the day, but this is not reflected in the demand template. This will be addressed in the next safer staffing review.

The registered fill rates on days for MVL is 48%. The B6s and Nursing associates are not currently counted in the planned hours but this is being addressed and their CHPPD are above target.

TEC are showing 6 red flags. Three of these relate to their fill rates. Despite the low fill rates, which are due to only having one registered nurse on duty at times, they have good CHPPD levels and although their fill rates remain below target, they have improved from December. Supervision has dropped from 81% in December to 41% due to high levels of clinical activity and acuity, vacancies, and high sickness. The Modern Matron is ensuring that this is addressed locally. One patient who has been in long term seclusion and then care away from others has now been moved to seclusion in the Humber Centre which will alleviate some of the immediate clinical pressures.

Supervision is below target for MVL; Pine view and TEC. MVL compliance has dropped further to 45% in January due to the absence of the B7 and the 2 B6s and this has been picked up with the modern matron. TEC compliance has dropped from 81% in December to 41.4% and reflects the significant clinical pressures, sickness, and vacancies on the unit currently.

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
A full review of ILS and BLS compliance has been undertaken and was reported to the workforce and OD committee in November including reasons for low compliance and a recovery plan to achieve compliance which is currently under further review. Additional capacity has been bought in and the recovery trajectories are being monitored closely.

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)

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

Slips/Trips and Falls (Rolling 3 months)

	Dec-21	Jan-22	Feb-22
Maister Lodge	3	6	4
Mill View Lodge	5	5	6
Malton IPU	4	3	7
Whitby IPU	0	0	1

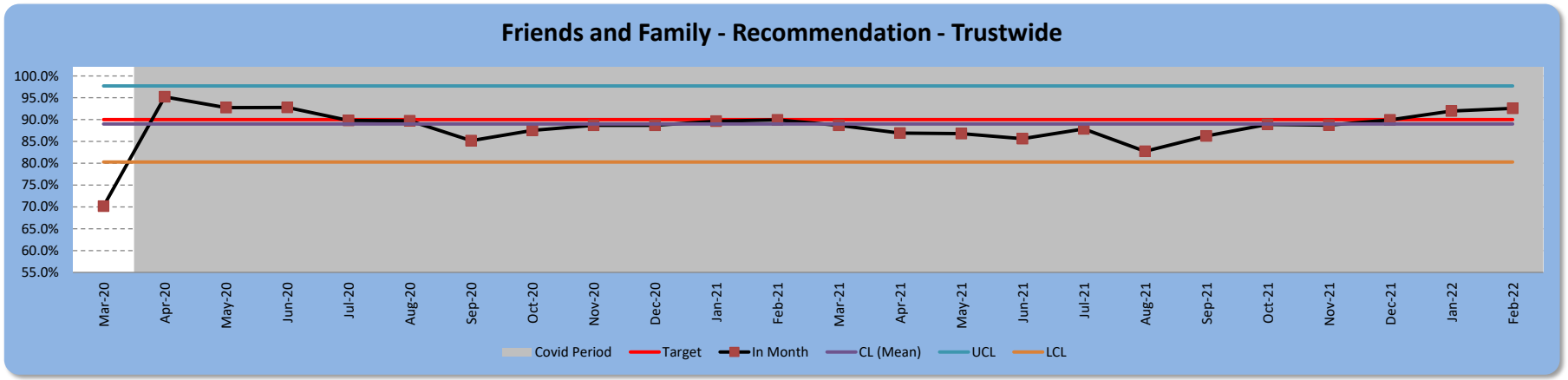
Malton Sickness % is provided from ESR as they are not on Health Roster

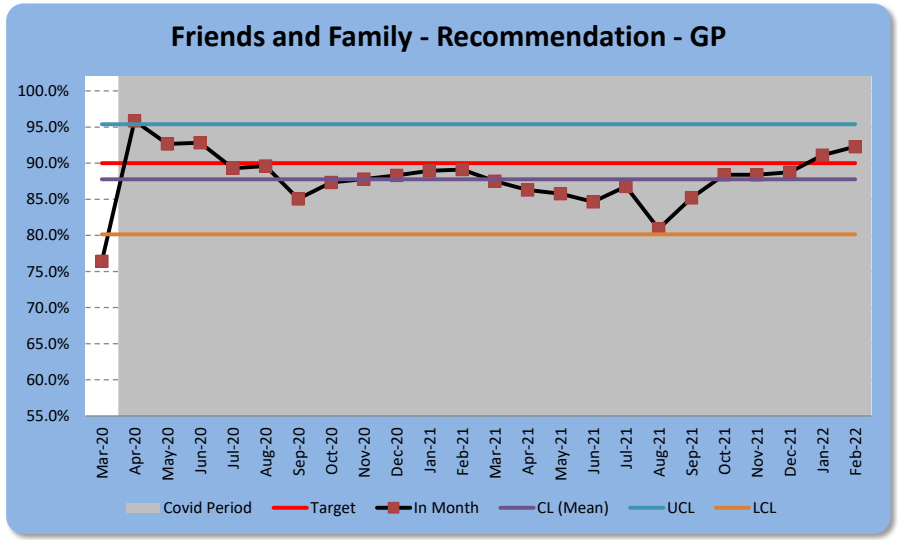
PI RETURN FORM 2021-22

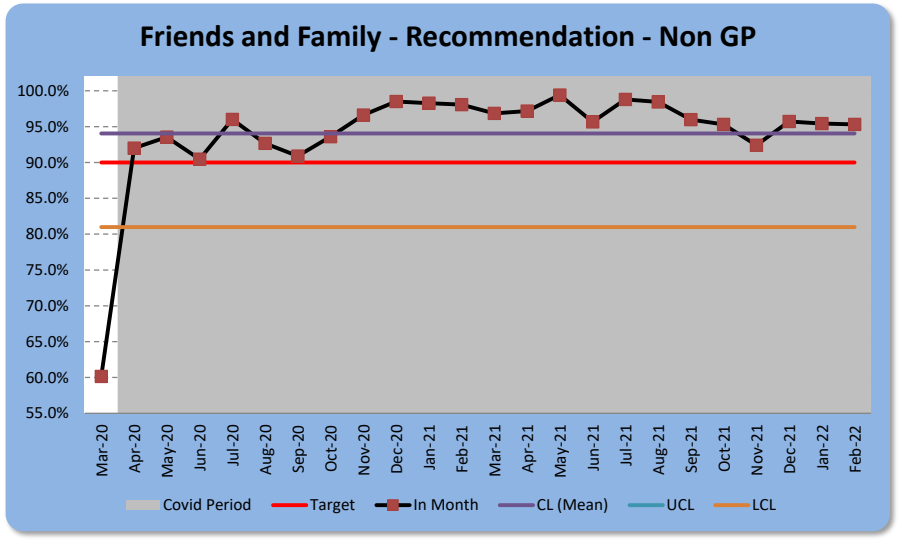
Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Feb 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 %







Target: 90%

Amber: 80%

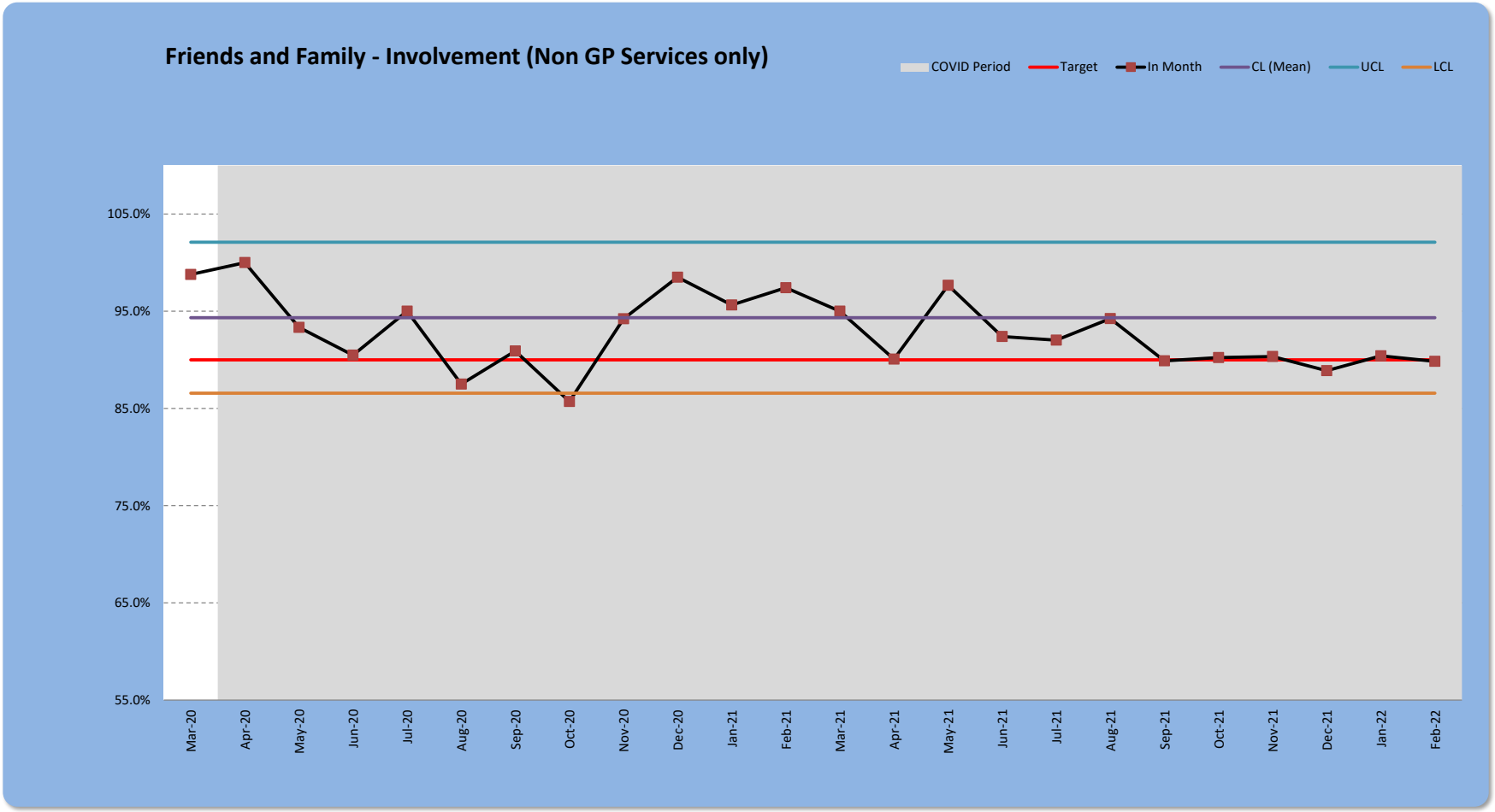
Current month stands at 92.6%

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 2022**

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



Target: 90%
Amber: 80%

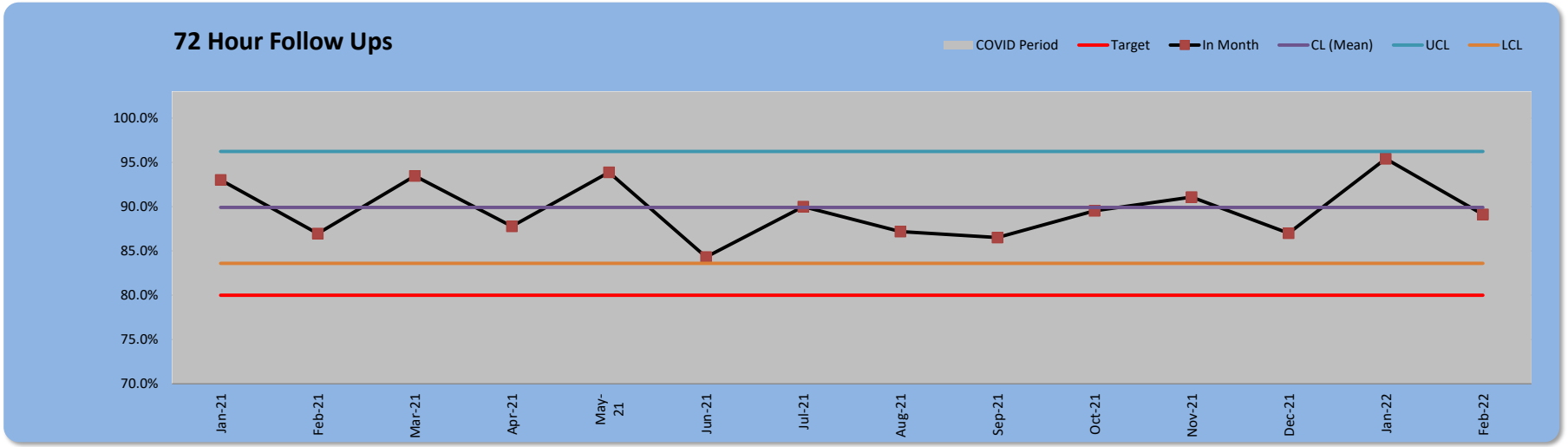
Current month stands at 89.8%

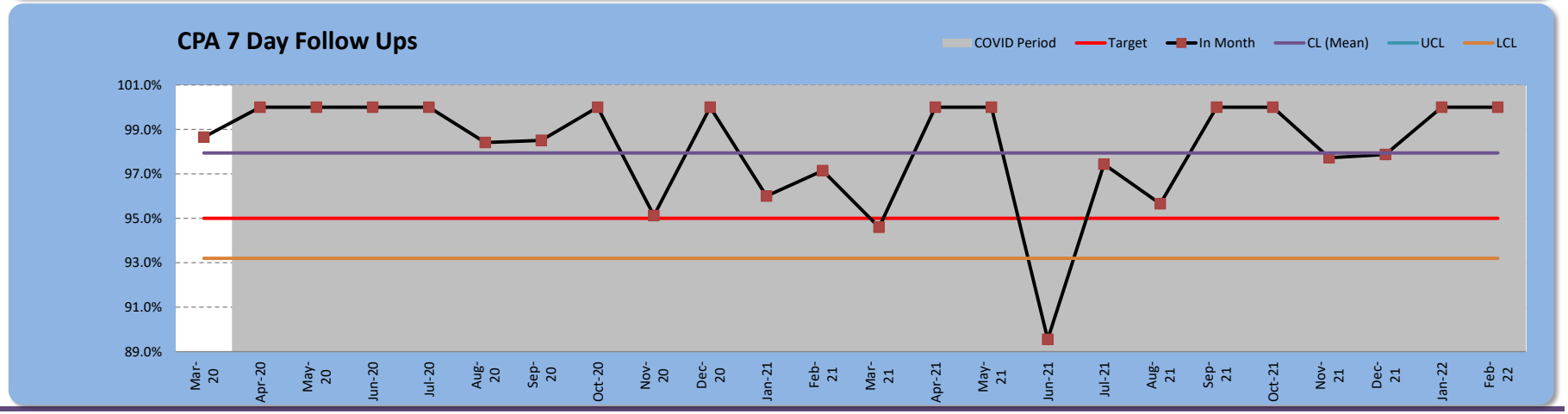
PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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





Target: 80%
Amber: 60%

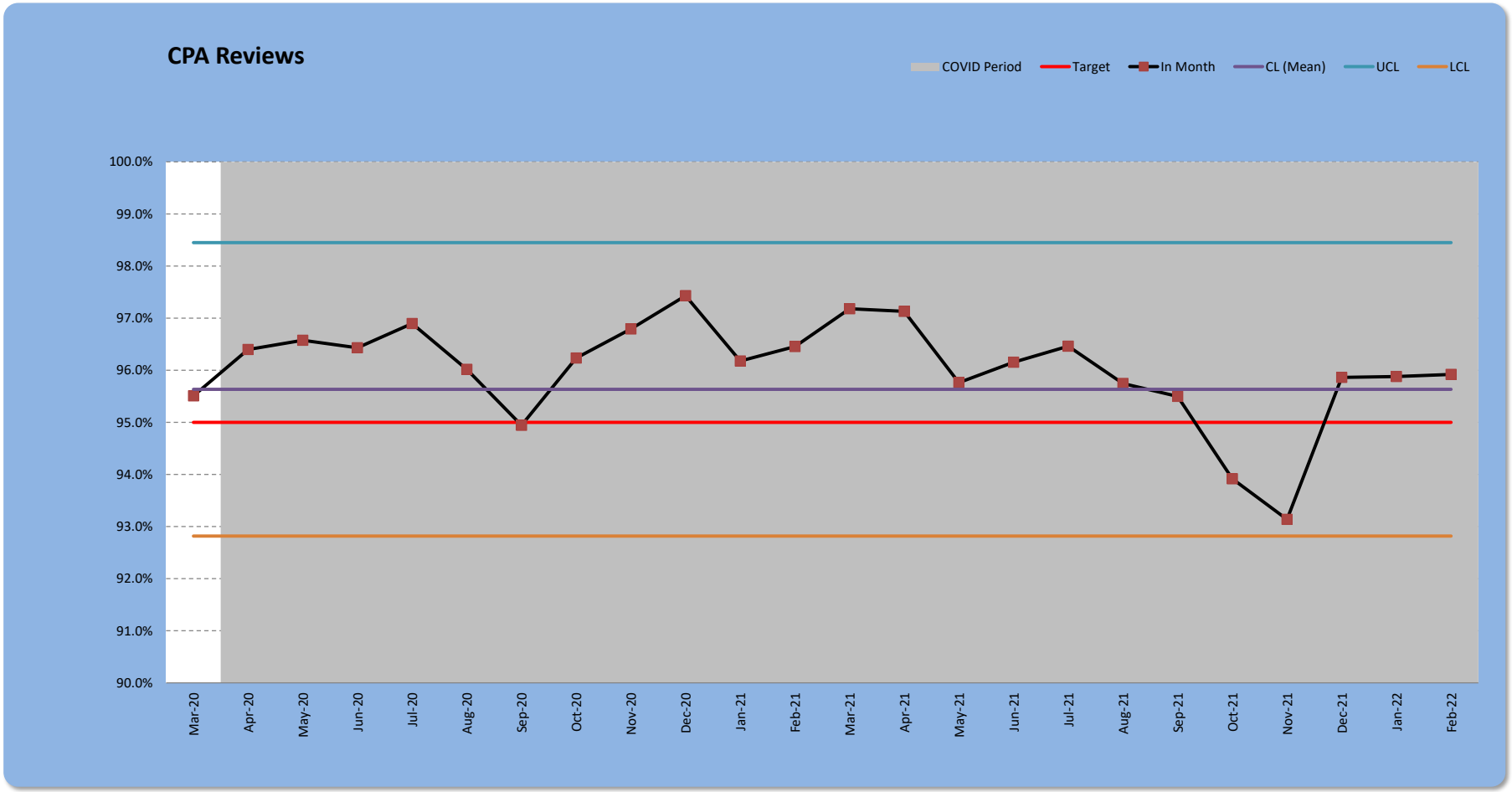
Current month 72 hr stands at 89.1%

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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



Target: 95%

Amber: 85%

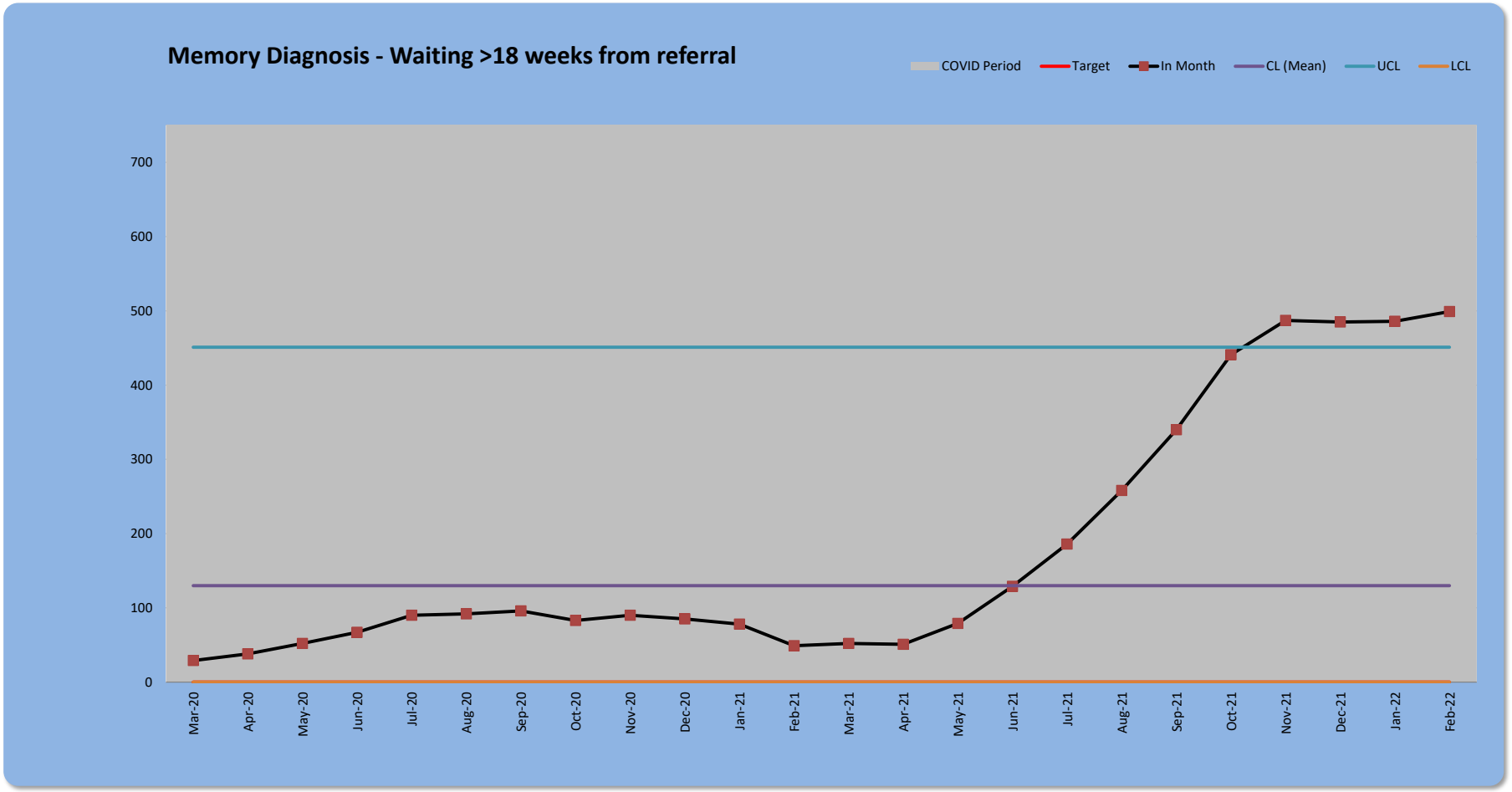
Current month stands at 95.9%

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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



Target: N/A

Amber: N/A

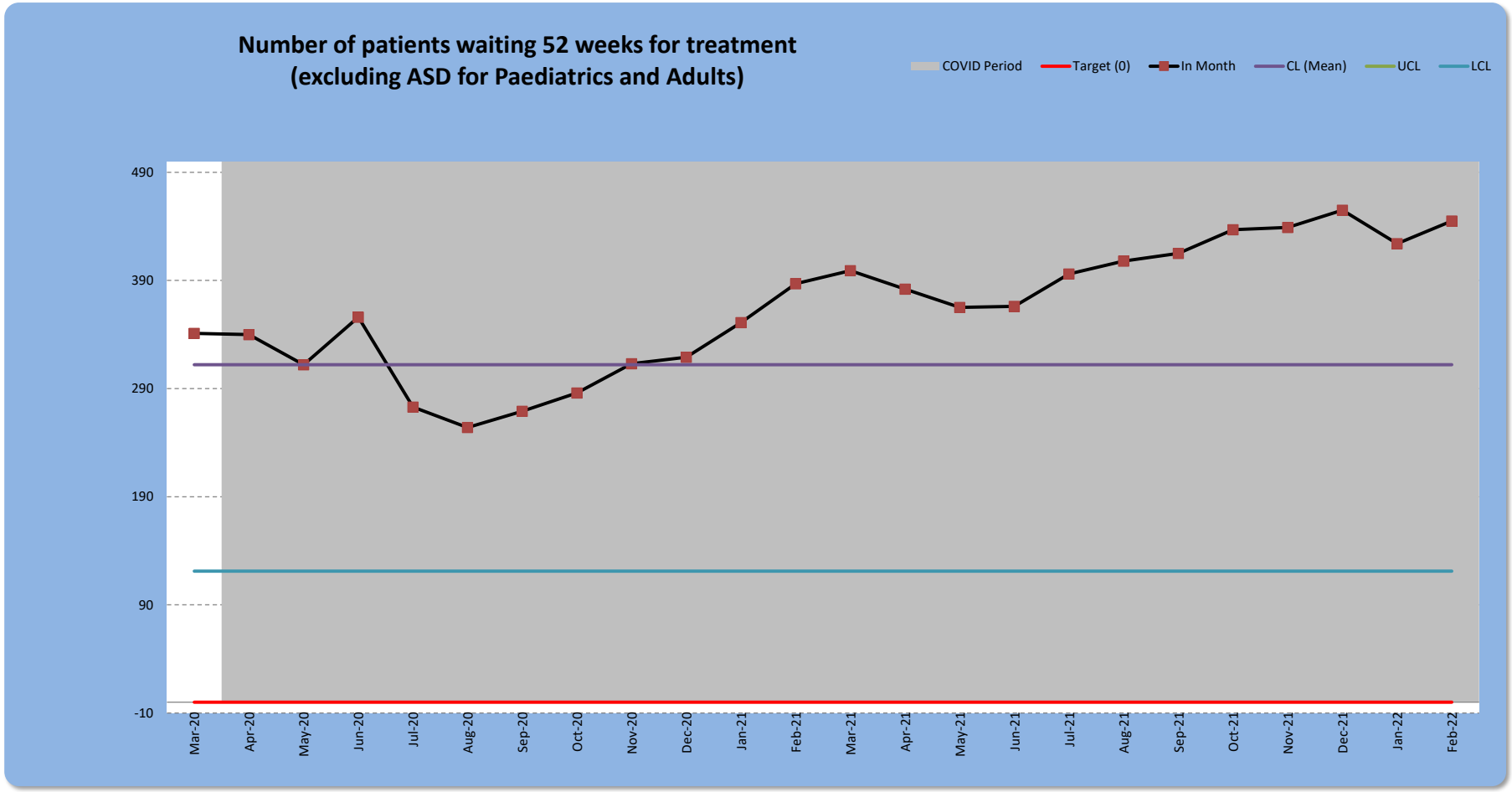
Current month stands at 499

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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



Target: 0

Amber: 0

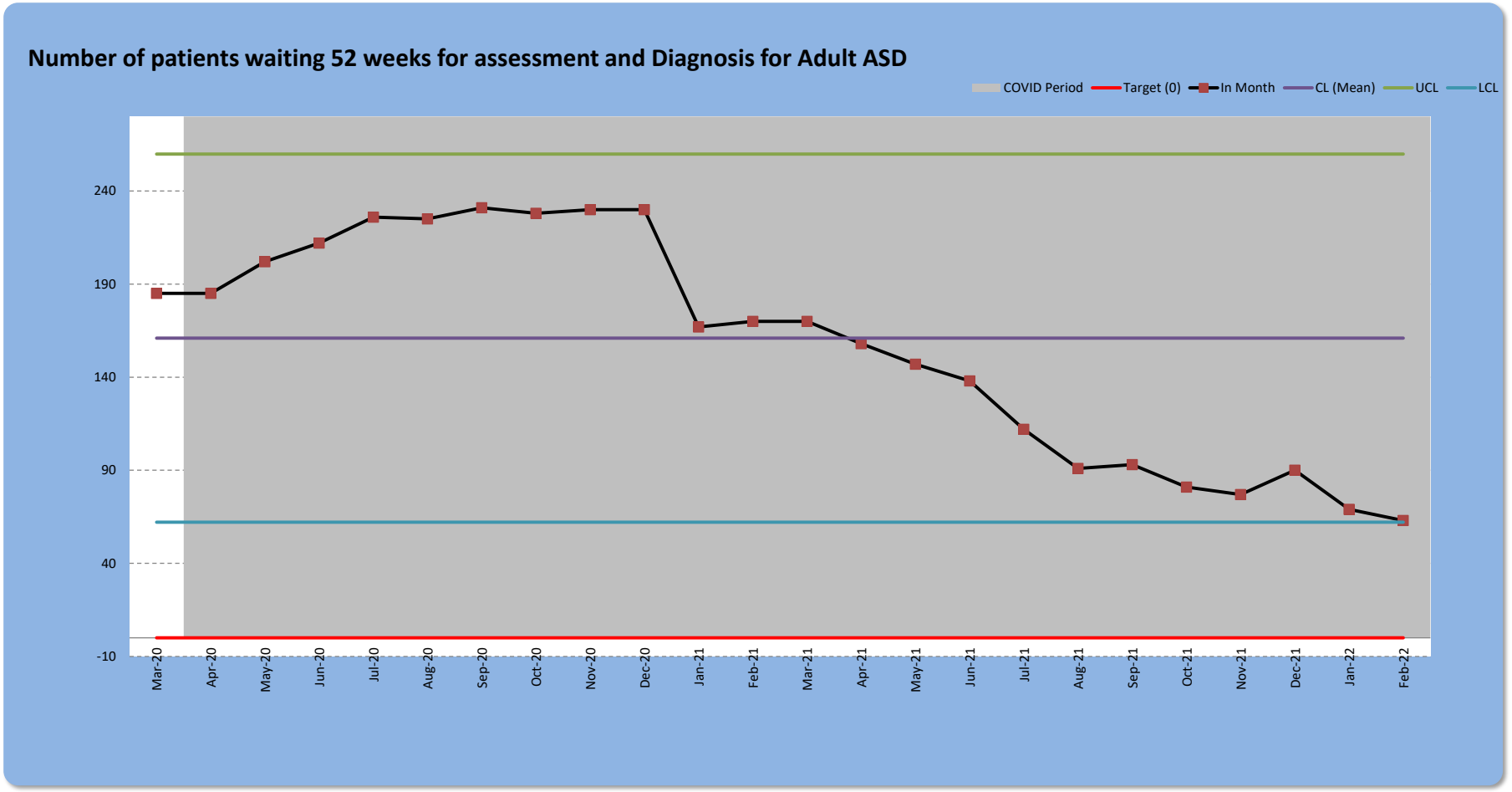
Current month stands at 445

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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



Target: 0

Amber: 0

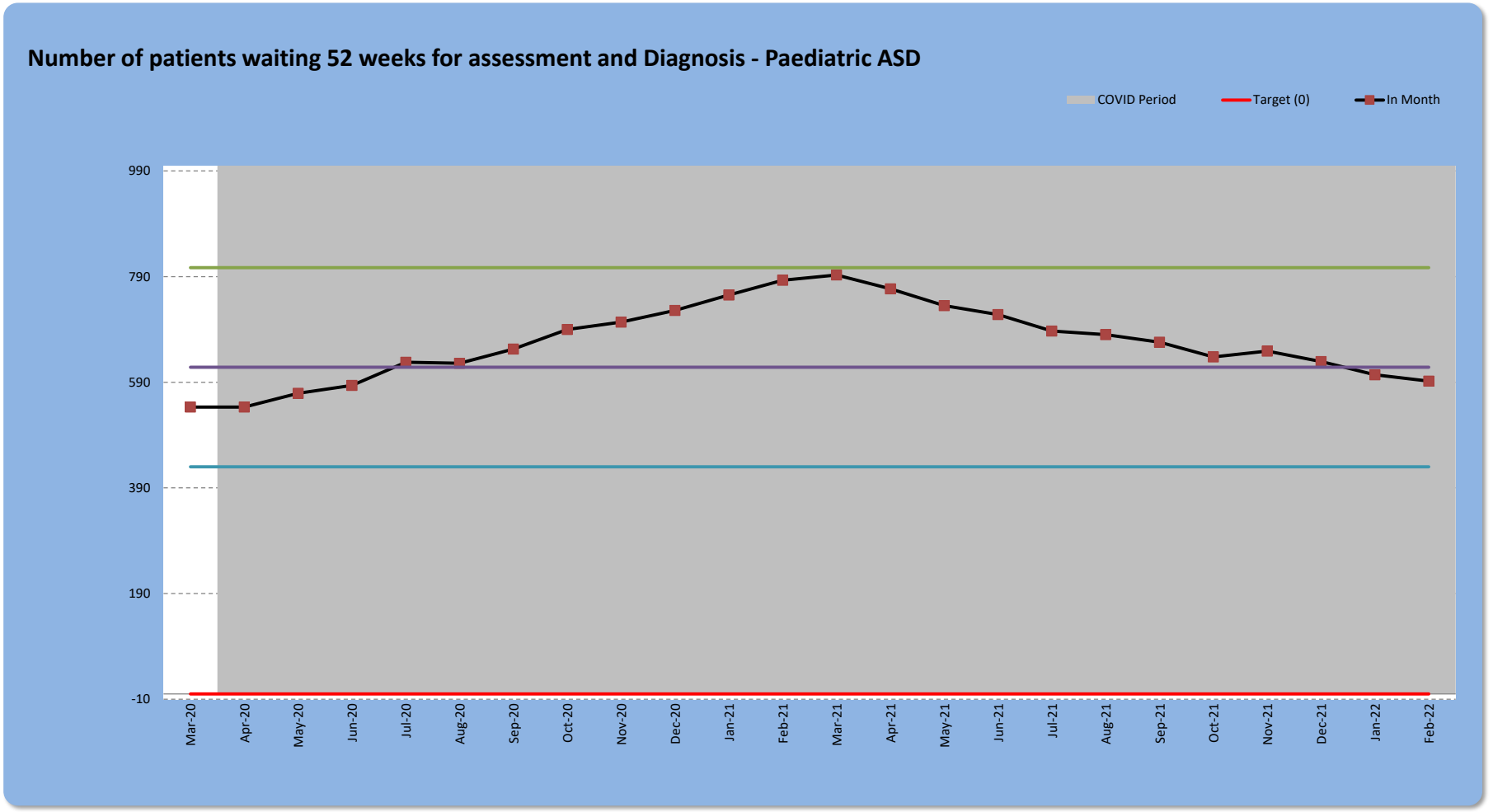
Current month stands at 63

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 2022**

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



Target: 0

Amber: 0

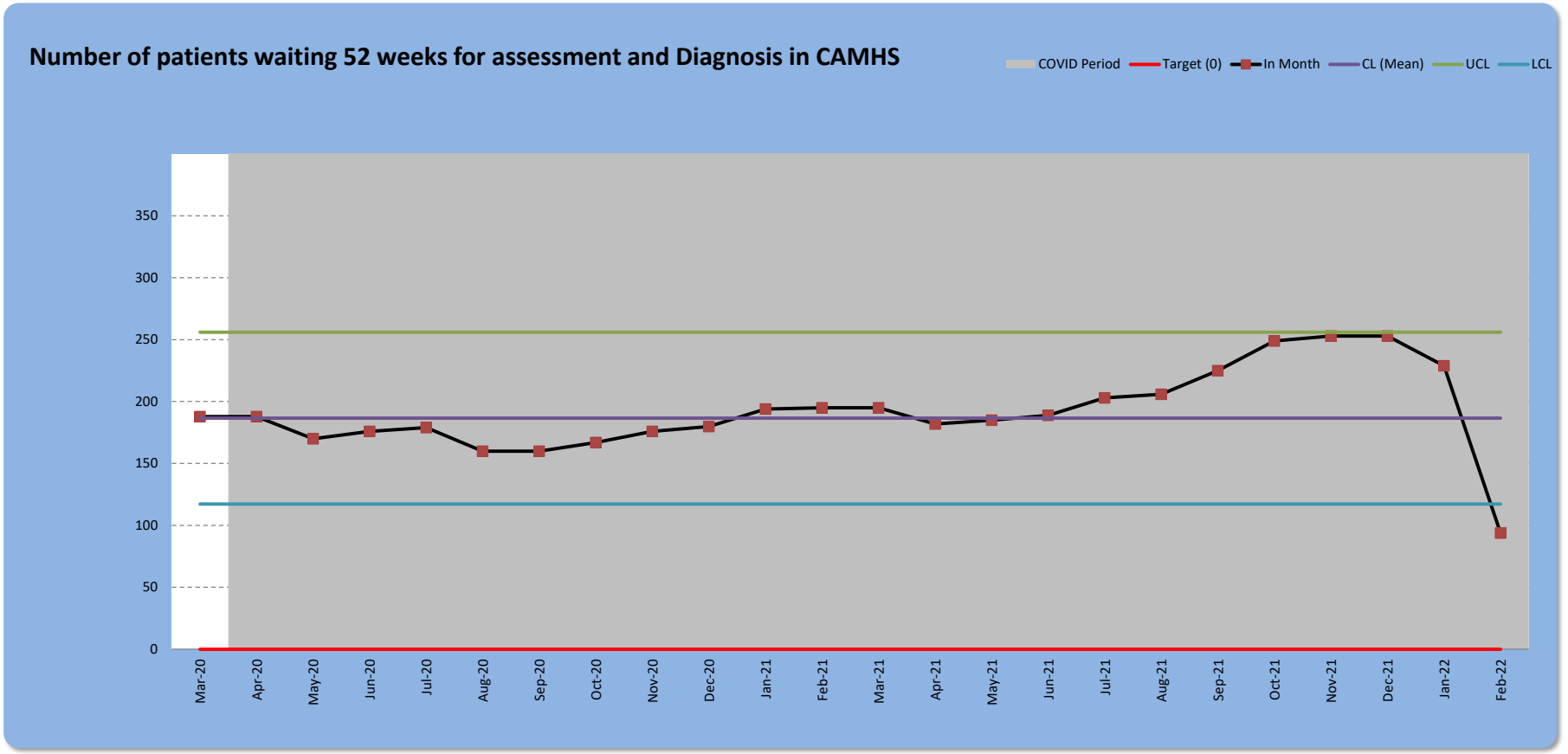
Current month stands at 592

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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



Target: 0

Amber: 0

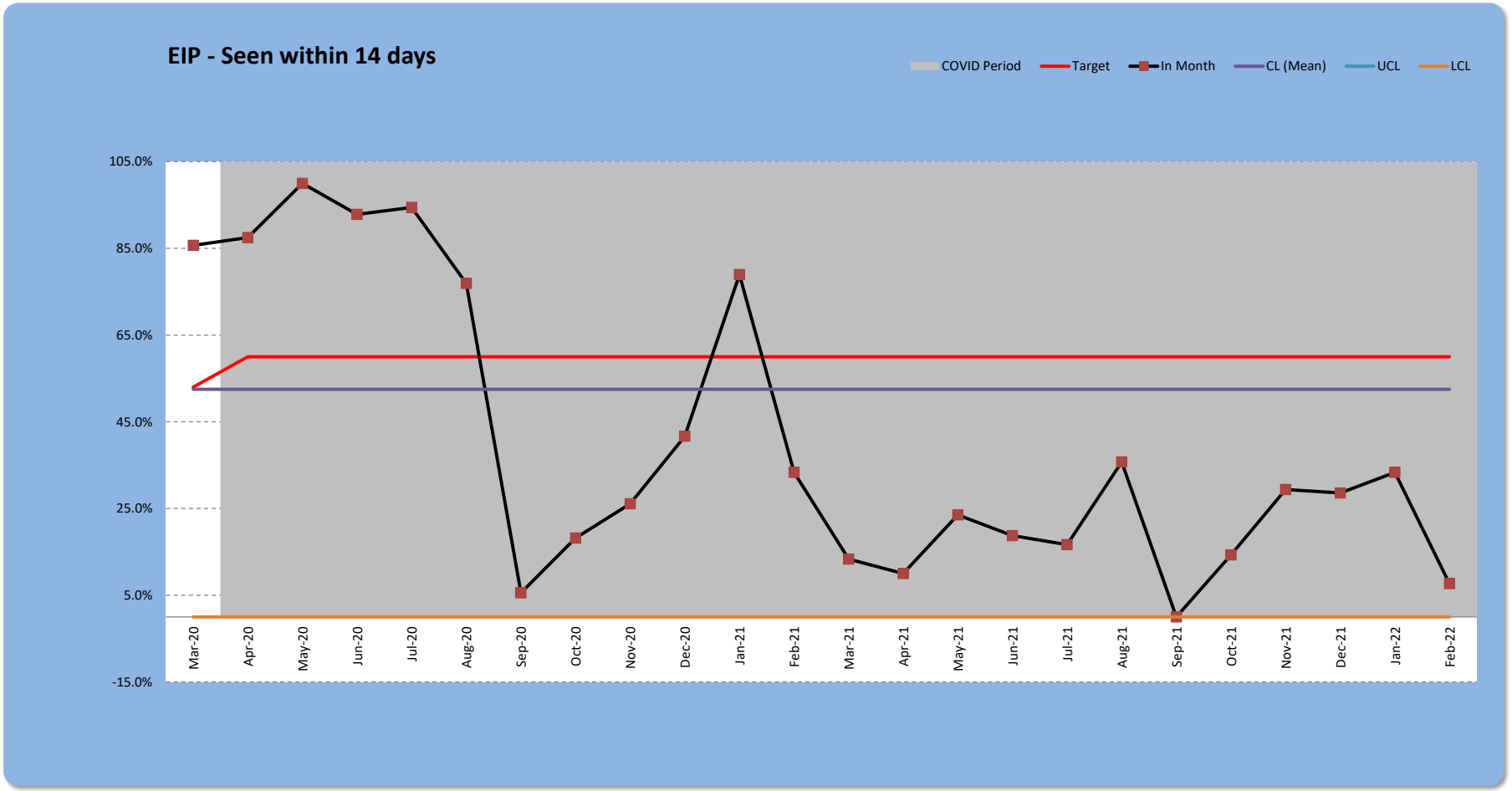
Current month stands at 94

PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 2022**

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



Target: 60%
Amber: 55%

Current month stands at 7.7%

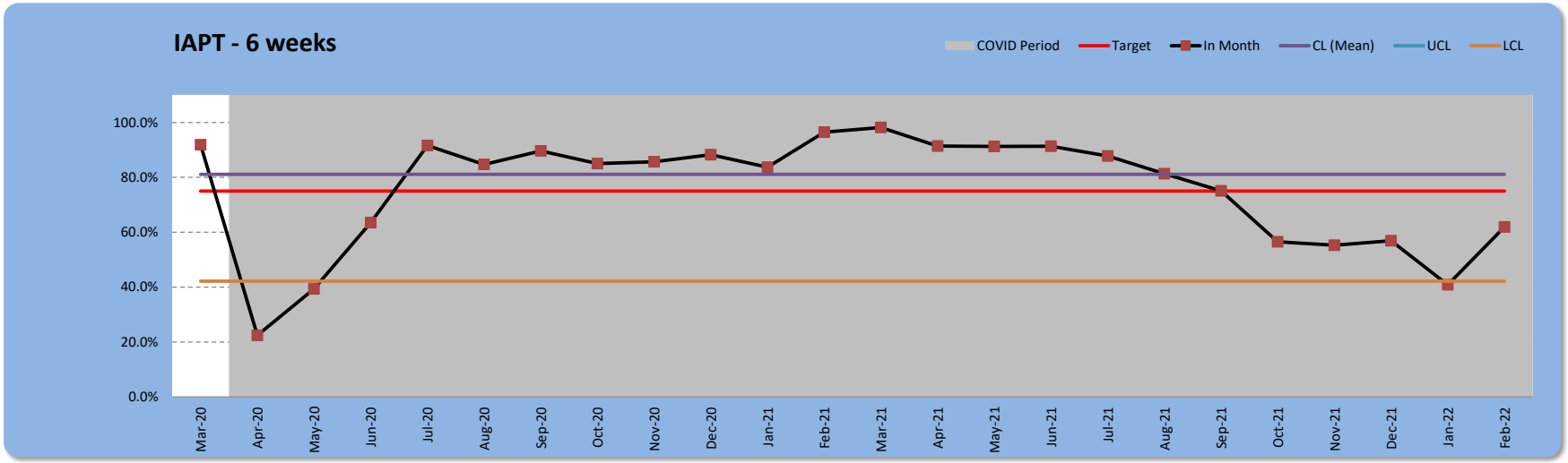
PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

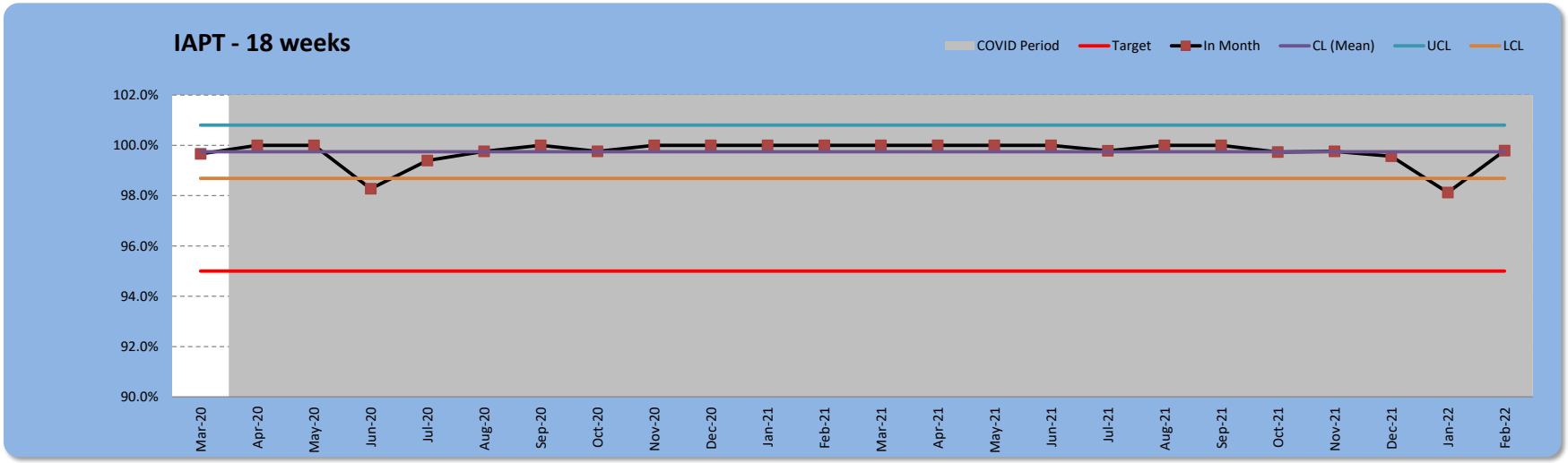
For the period ending: **Feb 2022**

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	Executive Lead Lynn Parkinson	OP 10a

Target: 75%
Amber: 70%
Current month 61.9%



Target: 95%
Amber: 85%
Current month 99.8%

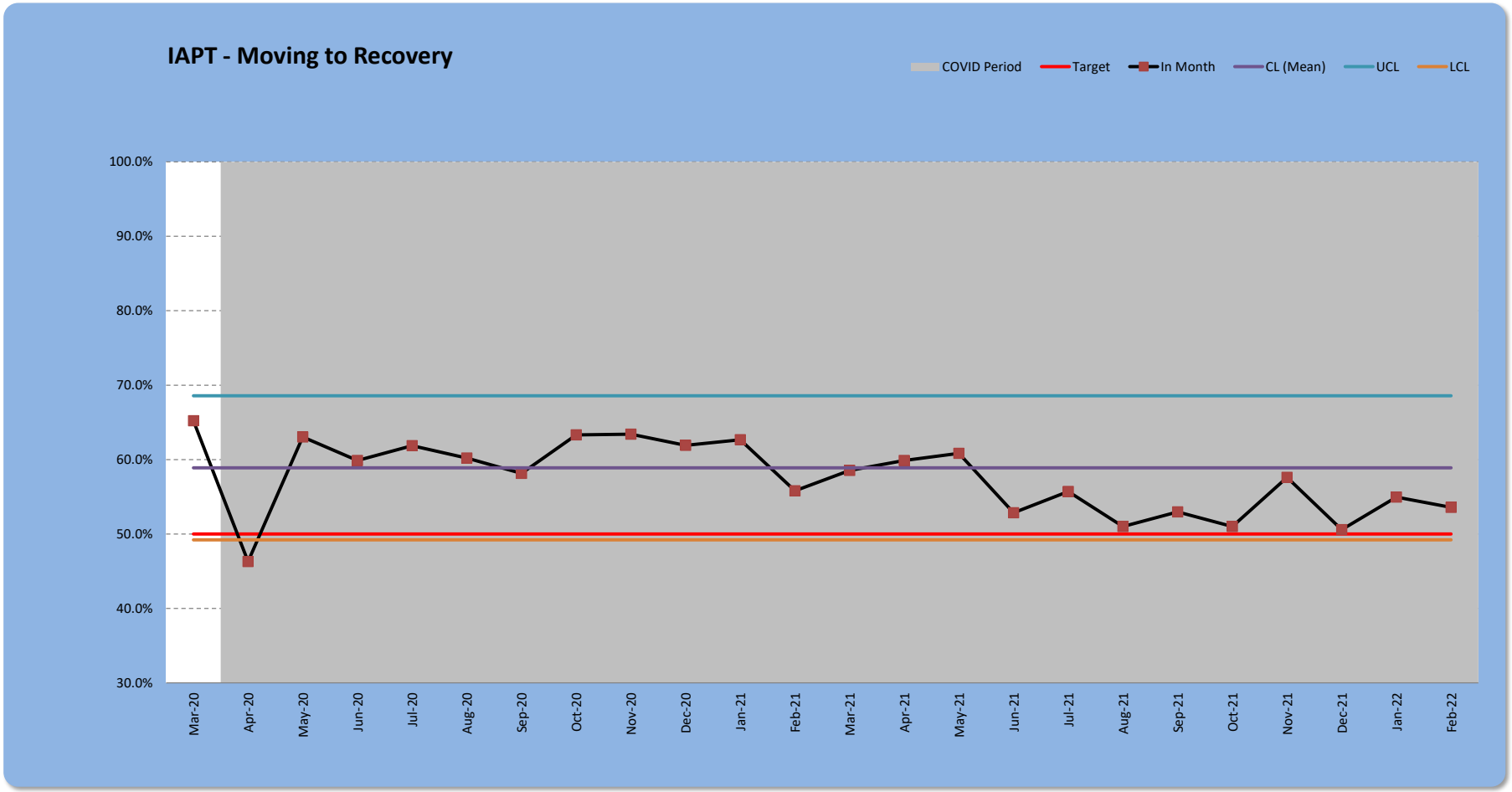


PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Feb 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	Executive Lead Lynn Parkinson	OP 11



Target: 50%
Amber: 45%

Current month stands at 53.6%

PI RETURN FORM 2021-22

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Feb 2022**

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

Total number of patients out of area within month **14**

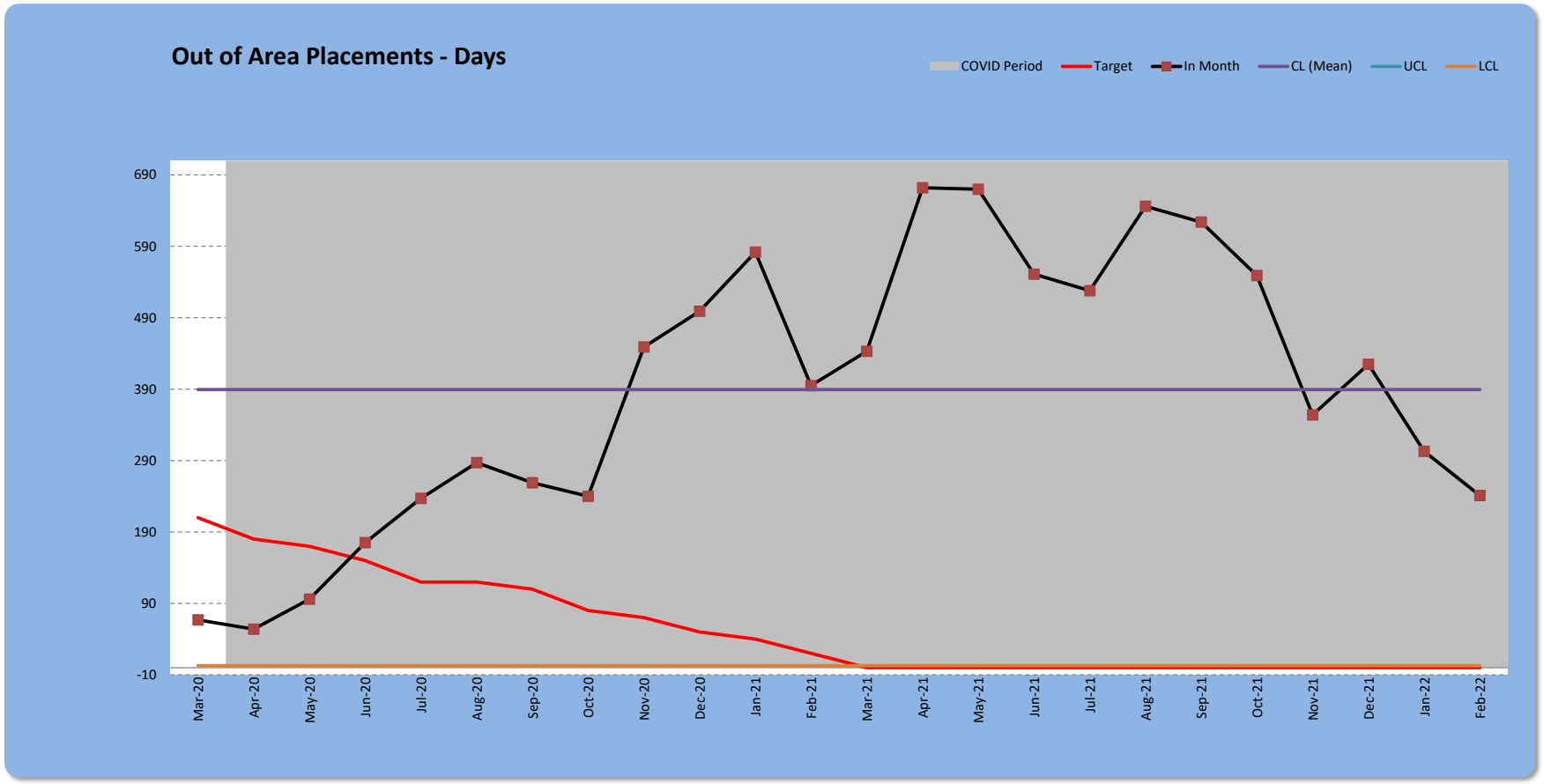
Patients OoA - Split

	# days	# patients
Adult	137	8
OP	104	6
PICU	0	0

Target: 0

Amber:

Current month stands at 241

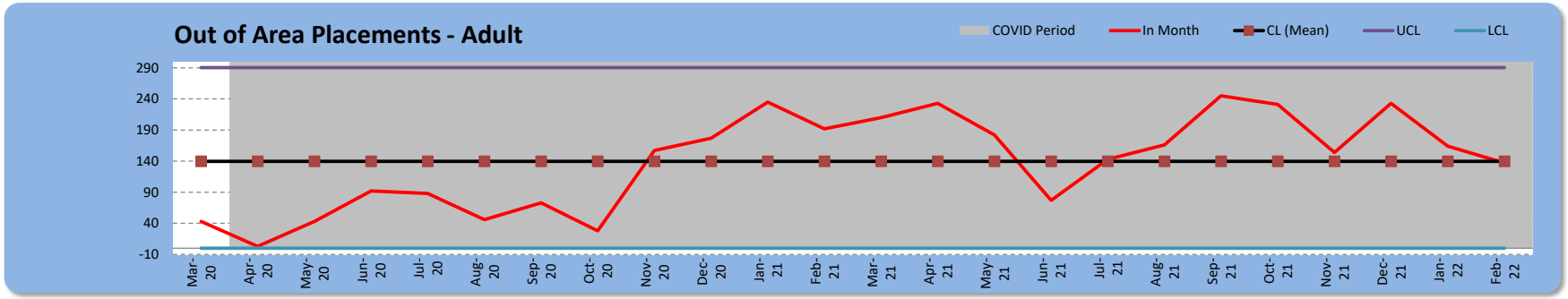


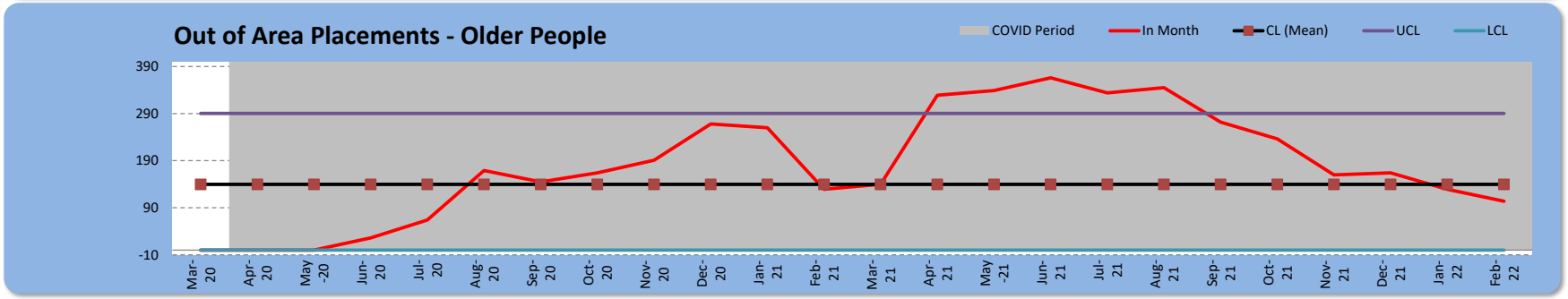
PI RETURN FORM 2021-22

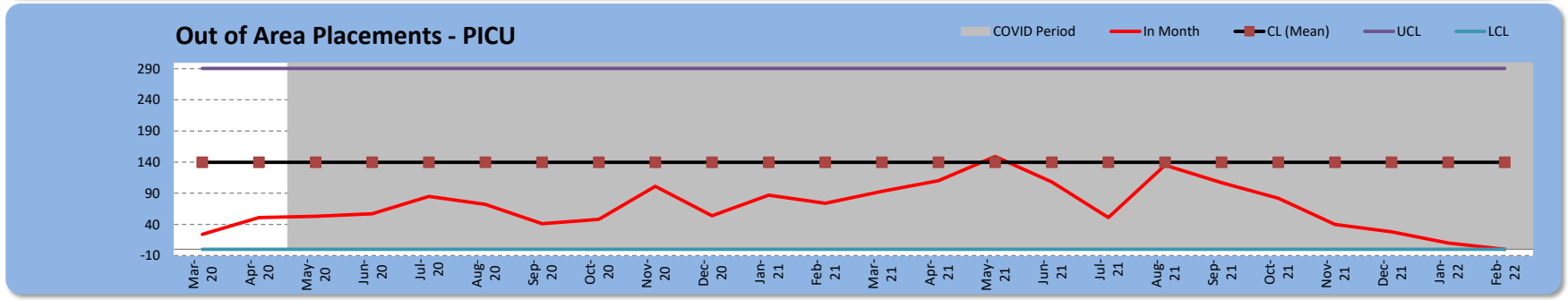
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Feb 2022**

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







The split for the current month is as follows:

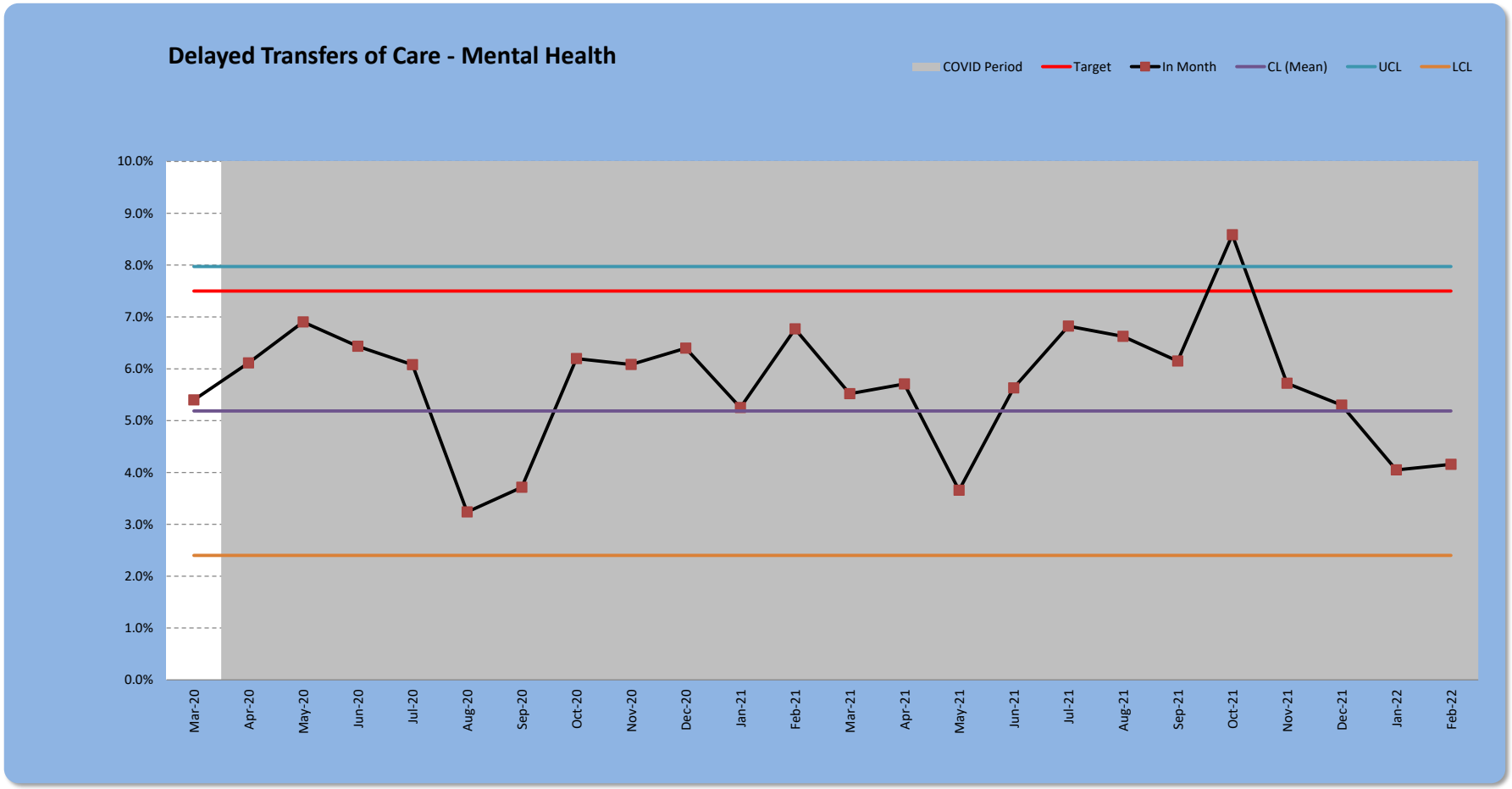
Feb-22	
137	Adult
104	OP
0	PICU
241	Total

PI RETURN FORM 2021-22

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Feb 2022**

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



Target: 7.5%

Amber: 7.0%

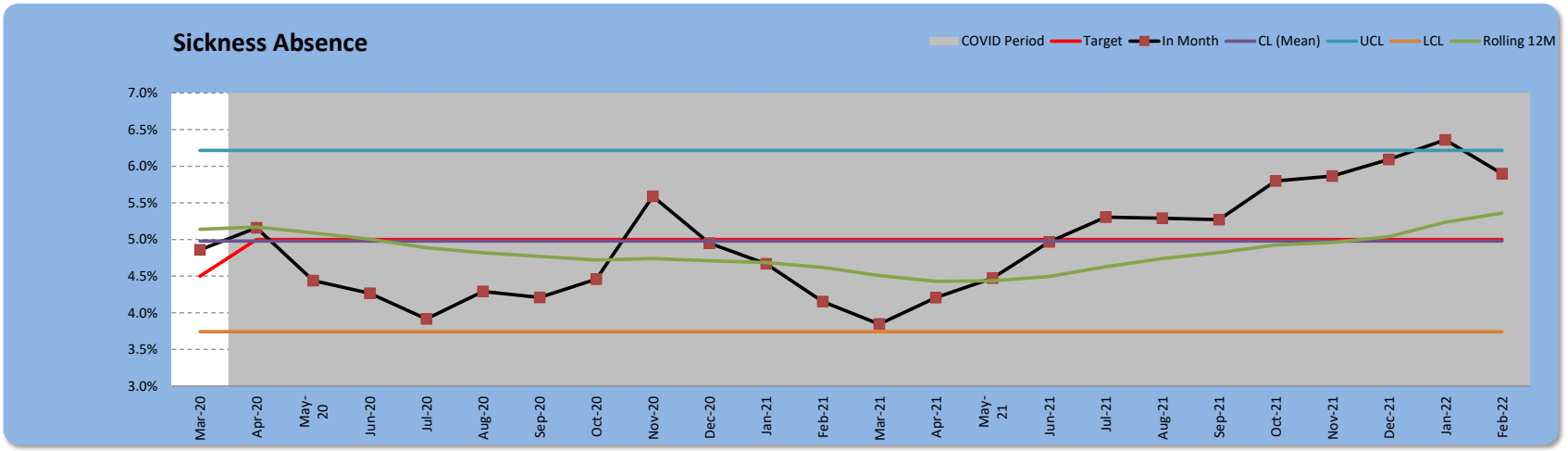
Current month stands at 4.2%

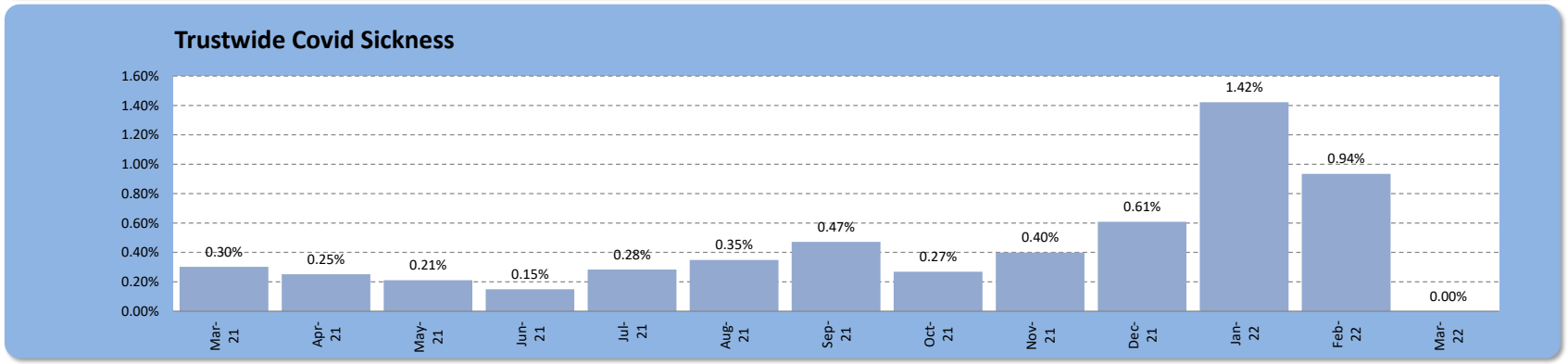
PI RETURN FORM 2021-22

Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Feb 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	WL 1





Target: 5.0%
Amber: 5.2%

Current month
6.23%

PI RETURN FORM 2021-22

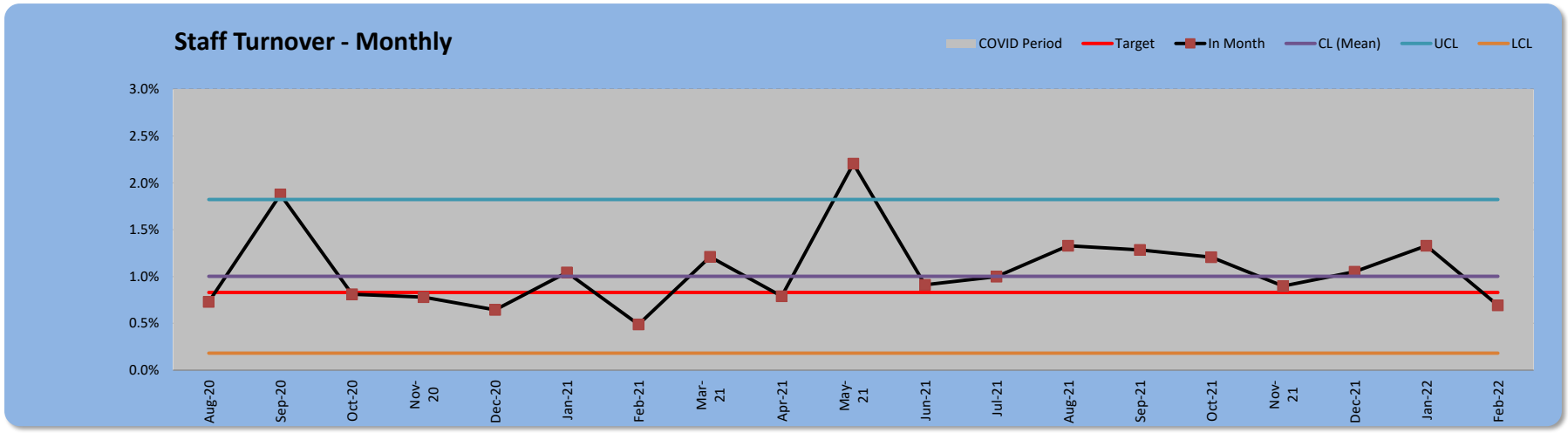
Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Feb 2022**

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, retirements, TUPE transfers out and staff coming to the end of temporary contracts. It doesn't include junior doctors on rotation	Executive Lead Steve McGowan	WL 3 TOM

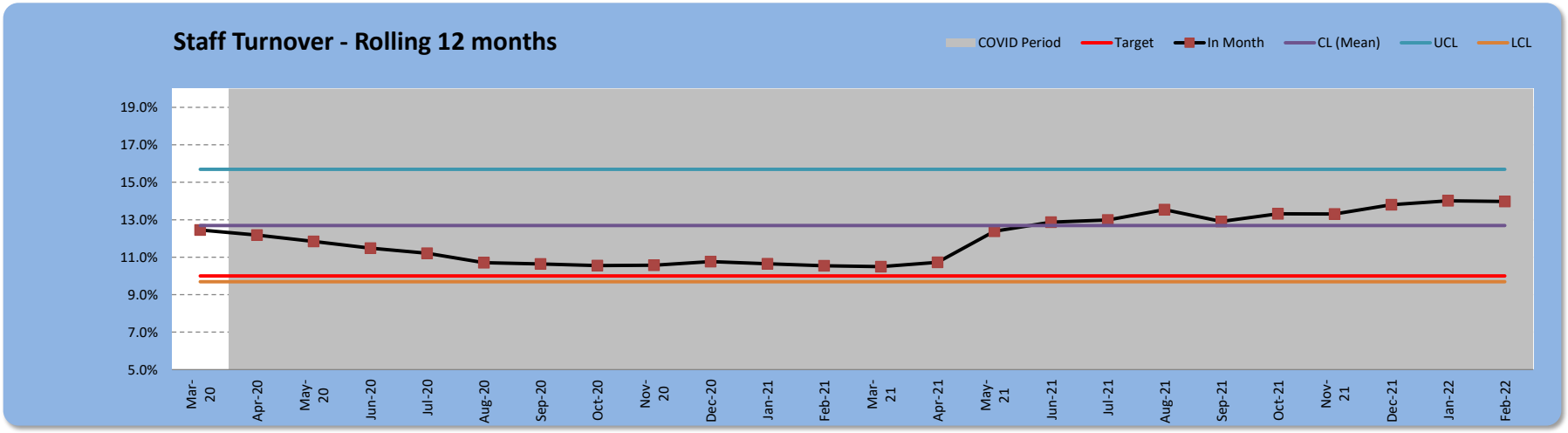
Target: 0.83%
Amber: 0.70%

Current month stands at 0.7%



Target: 10%
Amber: 9%

Current month stands at 14.0%

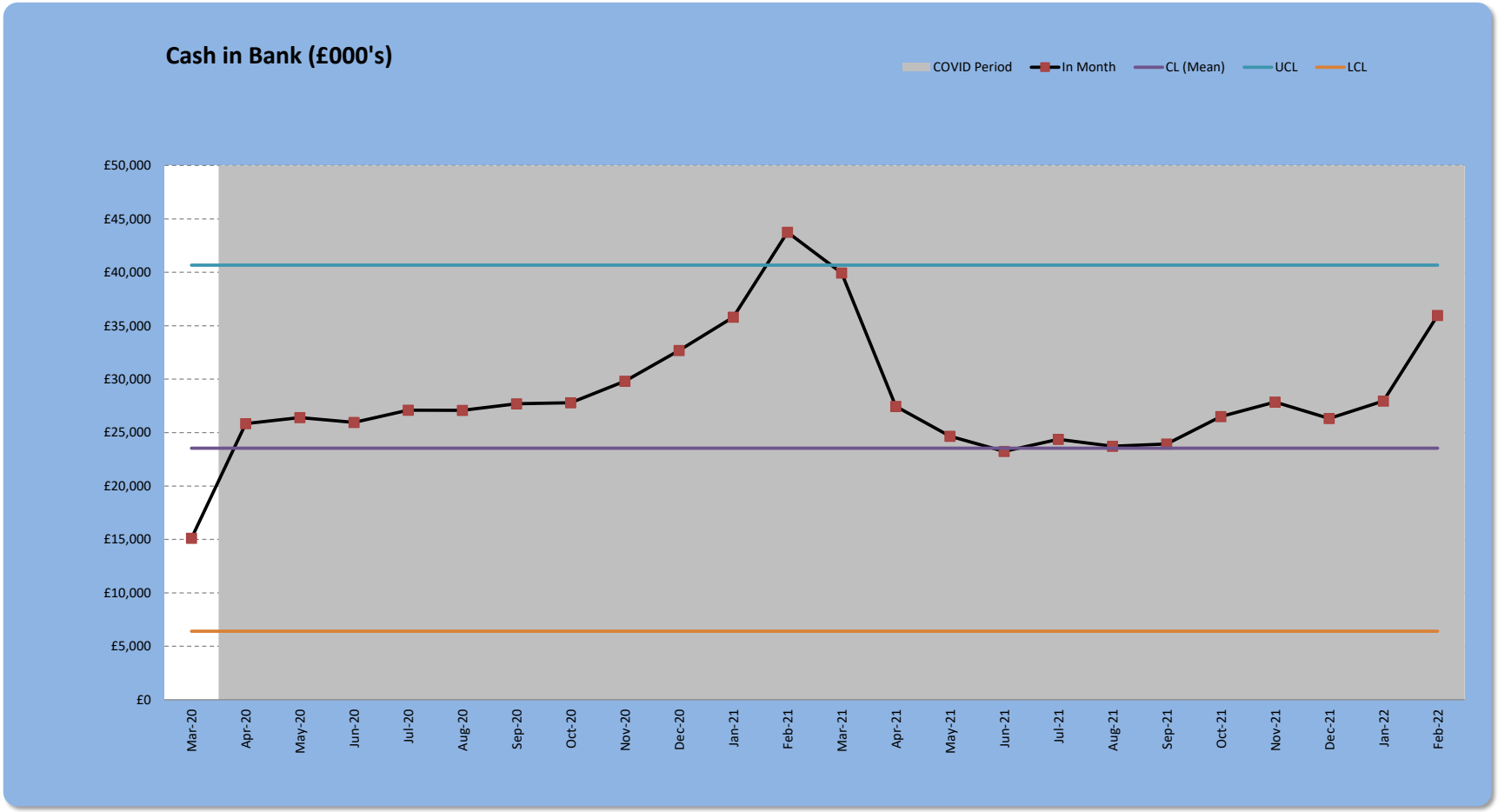


PI RETURN FORM 2021-22

Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Feb 2022**

Indicator Title	Description/Rationale		KPI Type
Cash in Bank (£000's)	Review of the cash in the Bank (£000's)	Executive Lead Peter Beckwith	F 2a



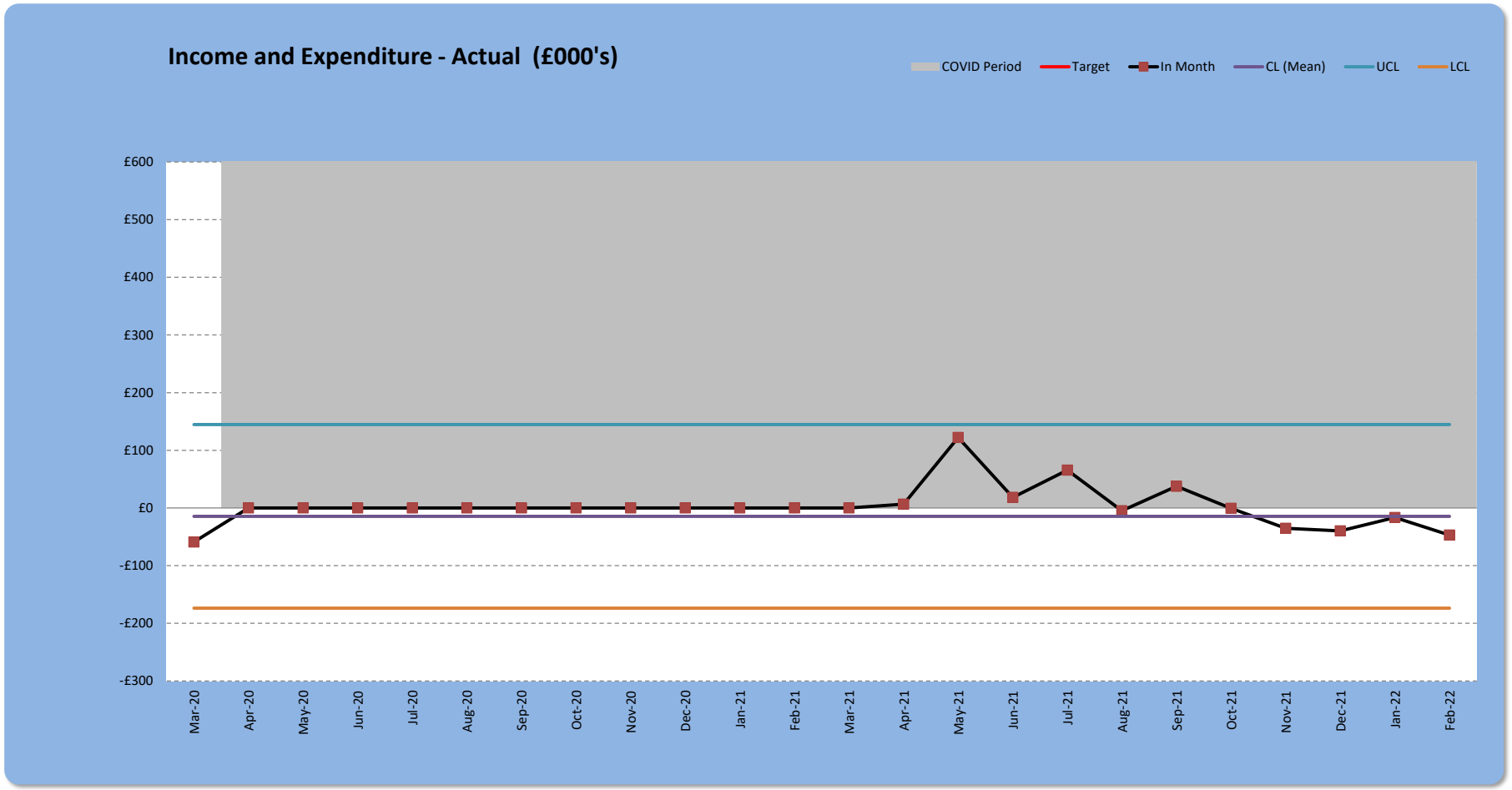
Current month stands at £35,967 ,000

PI RETURN FORM 2021-22

Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Feb 2022**

Indicator Title	Description/Rationale		KPI Type
Income and Expenditure (£000's)	Review of the Income versus Expenditure (£000's) by month	Executive Lead Peter Beckwith	F 4b



Target:

Amber:

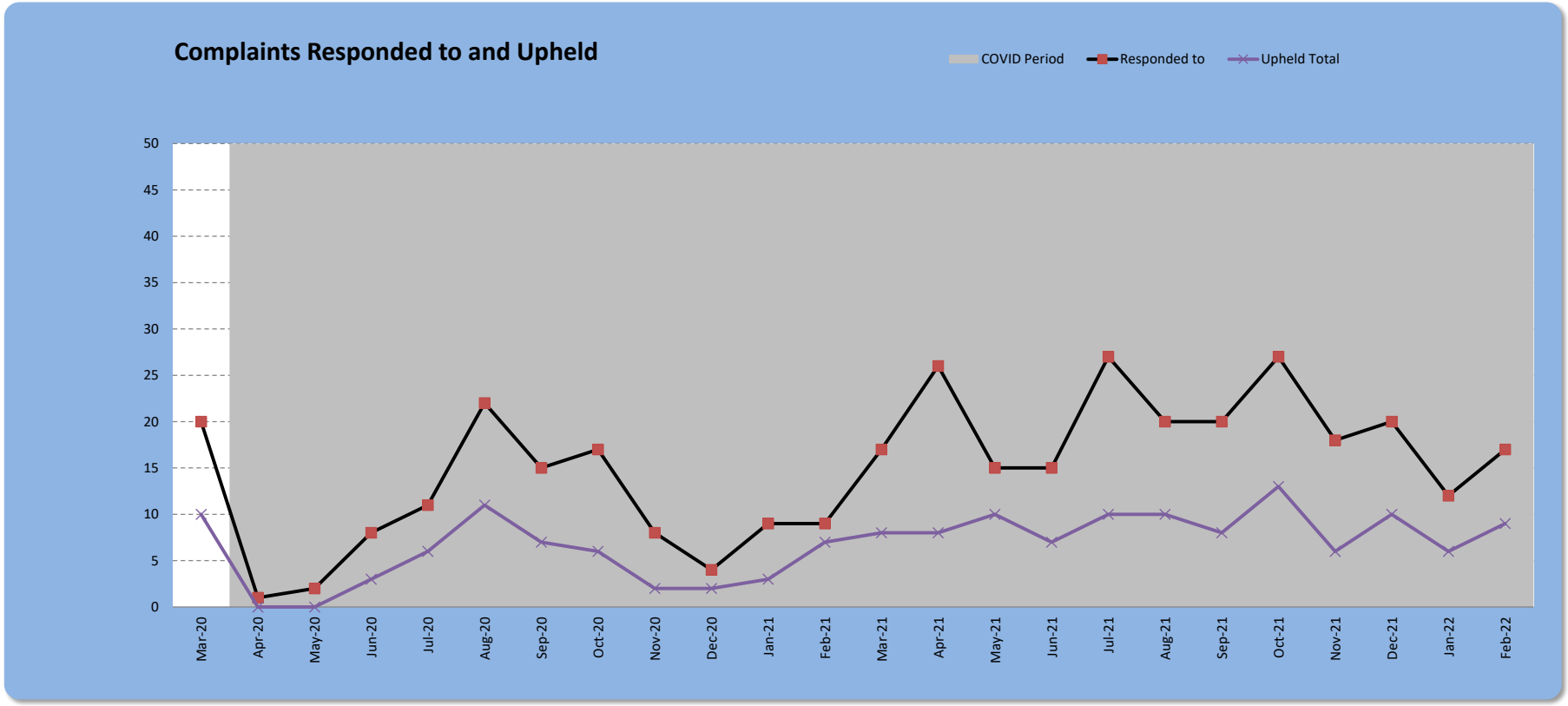
Current month stands at -£47 ,000

PI RETURN FORM 2021-22

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Feb 2022**

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



Of the number of complaints responded to in the month
9
were upheld which equates to

52.9%

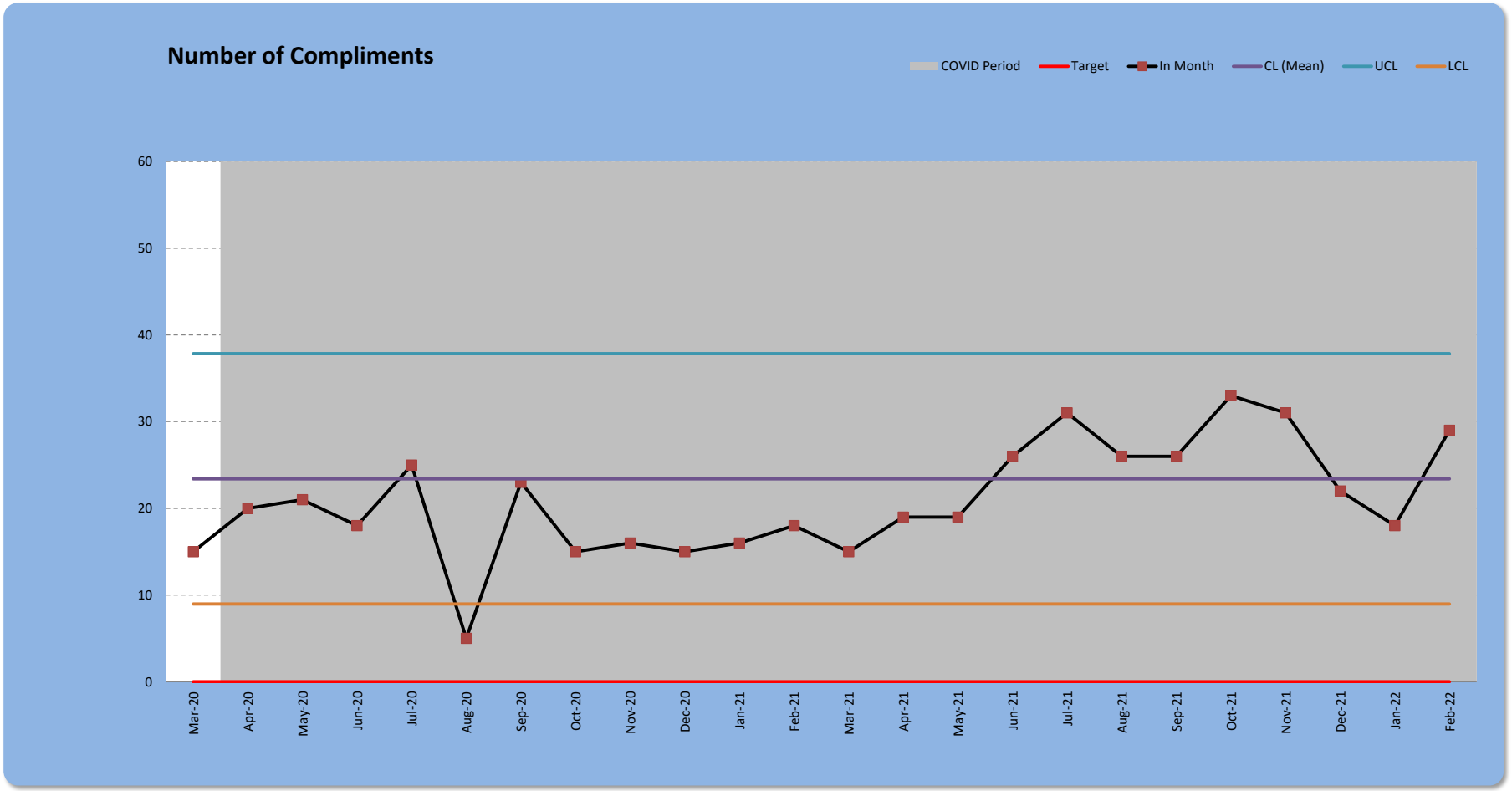
YTD Upheld
50.0%

PI RETURN FORM 2021-22

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Feb 2022**

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



Target: 0

Amber: 0

Current month stands at 29

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: 22/03/2022

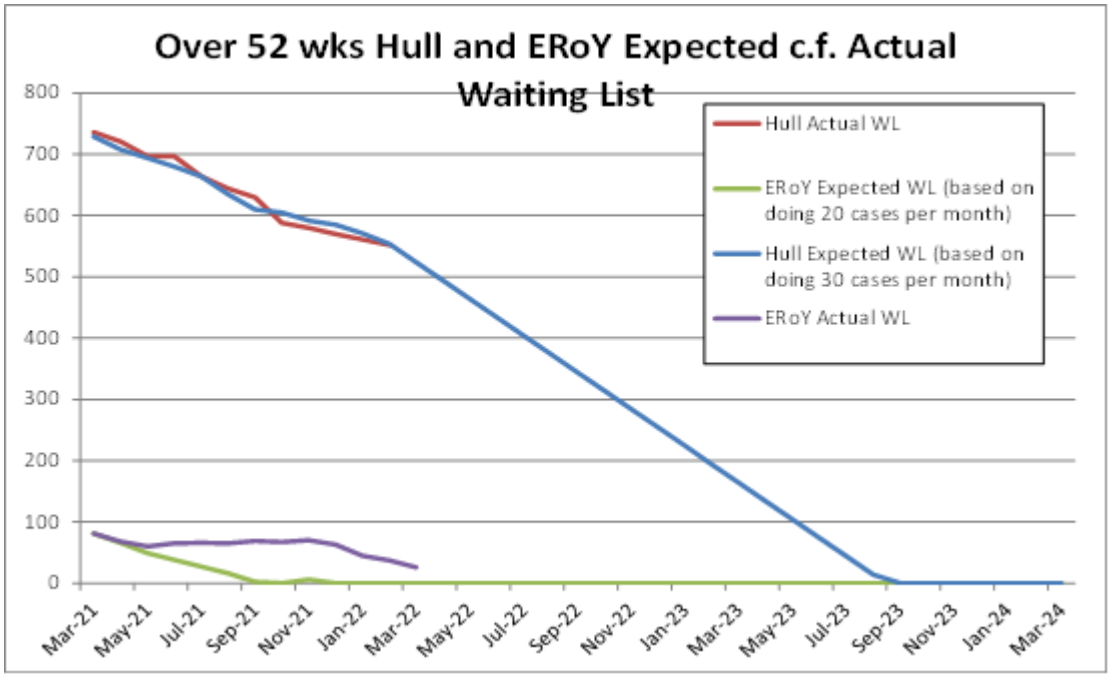
Appendix 1

Hull and East Riding of Yorkshire (ERY) Paediatric Autism Spectrum Disorder Waiting Time Update

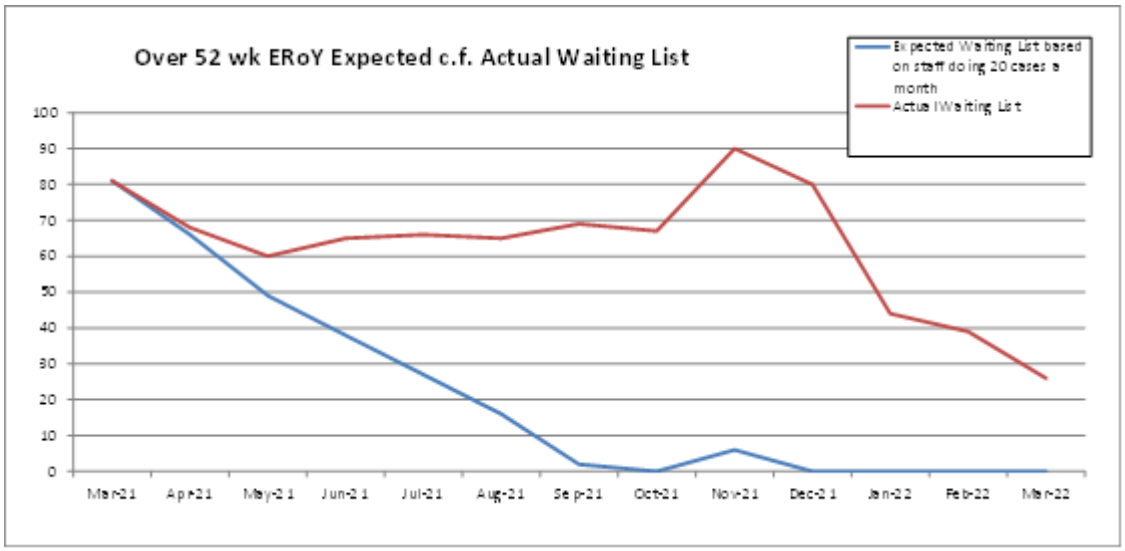
This summary provides an update on the over 52 week waiting time position for the Hull and ERY paediatric ASD service. The new Hull and East Riding Children's Neurodiversity Service was officially launched in March following a "soft launch" in January 2022. It will be the new "front door" for all children who require support with ASD and Attention Hyperactivity Disorder (ADHD).

This service is a true partnership working together with parents and their child/young person and family to understand what support is needed and how help, advice and support can improve outcomes for their child/young person and their family. The service is being operationally led and implemented by the Trust. By offering early support the new service will transform the previous provision which was commissioned to provide a diagnosis only and will support the reduction in current waiting times. Ongoing work and additional measures to reduce the current long wating times are continuing alongside the launch of the new service. The data below sets out the current position against the improvement trajectories in place.

<u>Over 52 week waits for Hull and ERY against the expected trajectory</u>



Over 52 week waits for ERY against the expected trajectory



As both charts demonstrate the improvement trajectory for those waiting over 52 weeks for Hull is being maintained, the trajectory for ERY is delayed but is now improving. The position in ERY was impacted by staff absence and vacancies, recruitment has taken place and the services are now managed within the new service model. Overall, the approach (as agreed with the commissioners) has been that long waiters will be seen in chronological order irrespective of whether they reside in Hull or ERY and Hull has had the highest number and longest waiters.

To maintain and improve the rate of performance a range of operational measures are in place, and these are summarised below:

- Daily monitoring of waiting time activity.
- Reports for waiting list management purposes have been reviewed and revised to ensure that they provide the data and detail required to monitor progress.
- Data quality reporting is in place for ensuring activity reconciliation is taking place for all provision (including sub-contracted providers).
- Improvement task and finish project group in place to oversee progress.
- Capacity and demand modelling work currently being revised in line with the new service model.
- Continued contract with Healios in place and recent increase in capacity supported by additional Trust investment (minimum of 32 assessments per month increasing to 40).
- Contract with a new provider is now in place (Dr J and Associates) supported by Trust investment.
- Development of a revised pathway provided by speech and language therapists for the under 5's.
- The standard operating procedure has been reviewed to align with the new service model.

The intention of all the measures above is to eradicate the over 52-week wating position and expedite progress.

Agenda Item: 10

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 30 March 2022</td></tr>
<tr><td>Title of Report:</td><td>Finance Report 2021/22: Month 11 (February 2022)</td></tr>
<tr><td>Author/s:</td><td>Name: Peter Beckwith
Title: Director of Finance</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td></td><td>To receive & note</td><td>☑</td></tr>
<tr><td>For information</td><td></td><td>To ratify</td><td></td></tr>
</table>
The Trust Board are asked to note the Finance report for February and comment accordingly.
</td></tr>
<tr><td>Purpose of Paper:</td><td>This report is being brought to Board Members to provide the financial position for the Trust as at the 28 February 2022 (Month 11).

The report provides assurance regarding financial performance, key financial targets and objectives.

The Board are asked to note the financial position for the Trust and raise any queries, concerns or points of clarification.</td></tr>
<tr><td>Governance:
Please indicate which group or committee this paper has previously been presented to:</td><td>
<table>
<tr><th></th><th>Date</th><th></th><th>Date</th></tr>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td></td><td>Workforce & Organisational Development Committee</td><td></td></tr>
<tr><td>Finance & Investment Committee</td><td></td><td>Executive Management Team</td><td></td></tr>
<tr><td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td>22.03</td></tr>
<tr><td>Charitable Funds Committee</td><td></td><td>Collaborative Committee</td><td></td></tr>
<tr><td></td><td></td><td>Other (please detail)</td><td></td></tr>
</table>
</td></tr>
<tr><td>Key Issues within the report:

Please ensure you also complete the monitoring and assurance framework summary below:</td><td>

The Trust recorded an overall operating surplus of £0.106m at Month 11, a position consistent with the Trust’s planning target.
Within the reported position at Month 11 is Covid expenditure of £4.431m and income top up of £2.438m.
Cash balance at the end of Month 11 was £35.967m.
The Year to Date Agency expenditure was £6.939m, this is £0.890m more than the previous year’s equivalent month 11 position.

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

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 – February 2022

1. Introduction

This report is being circulated to The Board to present the financial position for the Trust as at the 28th February 2022 (Month 11). The report provides assurance regarding financial performance, key financial targets and objectives.

The Board are asked to note the financial position for the Trust and raise any queries, concerns or points of clarification.

2. Position as at 28th February 2022

Under the planning guidance the Financial year has been split into two halves, within the first half (referred to as H1) the Trust was required to make a surplus of £0.315m and this was achieved.

Confirmation of the target for the second half of the year (H2) has been received by the Trust and the requirement is for an annual break even position to be delivered, this results in a deficit position £0.315m for H2.

Table 1 shows for the period ended 28 February 2022 the Trust recorded an operating surplus of £0.106m, details of which are summarised in the table on the following page.

There are 3 items which don't count against the Trust's financial control targets, these are

i) The Trust has accrued for the amount of expenditure undertaken which relates to Grant Income including the Yorkshire and Humber Care Record, this totals £3.039m.

ii) Donated Asset Depreciation (totals £0.053m year to date)

iii) Profits on the Sale of Assets of £0.064m

Including the above items, the overall Ledger Position is a £3.156m surplus.

Table 1: 2021/22
Income and Expenditure

	21/22 Net Annual Budget £000s	In Month			Year to Date		
		Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
Income							
Trust Income	**130,796**	**11,028**	**11,494**	**466**	**119,605**	**120,716**	**1,111**
Clinical Income	**16,176**	**1,306**	**1,666**	**360**	**14,855**	**16,292**	**1,437**
Covid 19 Income	7,154	631	792	161	6,933	9,132	2,199
Covid 19 Income	**7,154**	**631**	**792**	**161**	**6,933**	**9,132**	**2,199**
Total Income	**154,126**	**12,964**	**13,951**	**987**	**141,394**	**146,140**	**4,746**
Expenditure							
Clinical Services							
Children's & Learning Disability	30,154	2,486	2,682	(195)	27,548	28,000	(451)
Community & Primary Care	29,376	2,457	2,727	(269)	26,923	28,152	(1,229)
Mental Health	52,376	4,479	4,597	(118)	48,122	47,512	610
Forensic Services	11,905	1,010	904	107	10,854	10,375	480
	123,812	**10,433**	**10,909**	**(476)**	**113,448**	**114,038**	**(590)**
Corporate Services							
	29,829	**2,449**	**2,559**	**(109)**	**27,474**	**25,997**	**1,477**
Total Expenditure	**153,641**	**12,882**	**13,467**	**(585)**	**140,922**	**140,035**	**887**
EBITDA	**485**	**82**	**484**	**402**	**472**	**6,105**	**5,633**
Depreciation	4,031	336	324	12	3,695	3,708	(13)
Interest	148	12	12	(0)	135	135	(0)
PDC Dividends Payable	2,341	195	195	-	2,146	2,146	-
ICS Contribution	-	-	-	-	-	9	(9)
Operating Total	**(6,035)**	**(461)**	**(47)**	**414**	**(5,505)**	**106**	**5,611**
BRS	(6,036)	(416)	-	(416)	(5,613)	-	(5,613)
Operating Total	**1**	**(45)**	**(47)**	**(2)**	**108**	**106**	**(2)**
Excluded from Control Total							
Grant Income	-	-	(81)	81	-	(3,039)	3,039
Profit on Assets Held for Sale	-	-	-	-	-	(64)	64
Donated Depreciation	70	6	5	1	64	53	11
	(69)	**(51)**	**30**	**80**	**44**	**3,157**	**3,113**
Excluded							
Commissioning	1	(3)	3	(6)	5	0	5
Ledger Position	**(70)**	**(47)**	**27**	**74**	**39**	**3,156**	**3,118**
EBITDA %	**0.3%**	**0.6%**	**3.5%**		**0.3%**	**4.2%**	
Surplus %	**-3.9%**	**-3.6%**	**-0.3%**		**-3.9%**	**0.1%**	

2.2 Income

Trust Income is overachieving against budget by £1.111m this is due to the Trust being in receipt of the backdated pay award funding, additional SDF and Spending Review monies which have been transacted by the CCGs.

The additional £1.076m of Clinical Income relates to a number of areas across the Trust and includes:

i) Non recurrent income from commissioners for Out of Area placements provides £0.331m.

ii) Additional income in Community and Primary Care and Addictions of £0.690m

The remaining overachievement relates to a number of minor additional amounts in Children's and LD.

2.3 Divisional Expenditure

The overall Operational Divisional Gross Expenditure is showing an overspend of £0.590m.

2.3.1 Children's and Learning Disability

Children's and LD is reporting a £0.451m overspend year to date.

CAMHS Inpatient Service is reporting a significant pressure this financial year with a year to date overspend of £0.944m. The pressure to open the PICU beds and the acuity of the patients has resulted in increased staffing levels and pay is overspent by £0.891m. The cost of the doctors for the ward is £0.361m over spent year to date due to the difficultly recruiting and the use of agency consultants.

Nursing is £0.604m overspent due to the use of agency, maternity cover and the staffing levels required.

Within LD there are pressures particularly at Granville Court with a year to date overspend of £0.440m. This has been picked up with East Riding CCG who are aware of the pressures at Granville Court and there is an understanding this will be a high priority within the Planning round.

2.3.2 Community and Primary Care

Community and Primary Care is reporting an overspend of £1.229m.

Primary Care is showing an overspend of £0.939m which is primarily due to pressures caused by the required increase of Locum Doctors which are significantly more expensive than substantive staff, this is particularly the case at Market Weighton and Practice 2.

2.3.3 Mental Health

The Division is showing an underspend of £0.610m. There are pressures on medical staffing budgets due to the use of agency locums, but this is offset by underspends across the division due to vacancies within a number of service areas reflecting in part recruitment to new posts/services which have been funded for the full year within the Trusts plan. There are agency staff being employed to fill essential roles and this is being constantly reviewed.

2.3.4 Forensic (Secure) Services

The year to date position of Forensic Services is an underspend of £0.480m which primarily relates to pay within the Community Forensic service due to vacancies.

2.3.5 Corporate Services

Corporate Services are reporting an underspend of £1.477m, this is primarily in Finance Technical and relates to reserves/contingency budgets

3. COVID Expenditure

At the end of February the Trust recorded £4.431m of Covid related expenditure and £2.438m of Income Top Up, details of which are summarised below:

Table 2 Covid Costs

Covid Costs	Total £m
Pay	1.479
Non Pay	2.952
Expenditure	4.431
Income Top Up	2.438
Total	**6.869**

4. Cash

As at the end of Month 11 the Trust held the following cash balances:

Table 3: Cash Balance

Cash Balances	Provider £000s	Provider Collaborative £000s	Total £000s
Cash with GBS	33,315	2,413	35,728
Nat West Commercial Account	192	-	192
Petty cash	47	-	47
Total	**33,554**	**2,413**	**35,967**

Included within this amount is the Provider Collaborative cash amount of £2.413m.

The cash position has increased by £8.416m, the main reason being the receipt of H2 income and some additional non recurrent funding.

5. Agency

Actual agency expenditure for February was £0.746m. The year to date spend is £6.939m, which is £0.890m above the same period in the previous year.

Table 4 Agency Spend v previous year

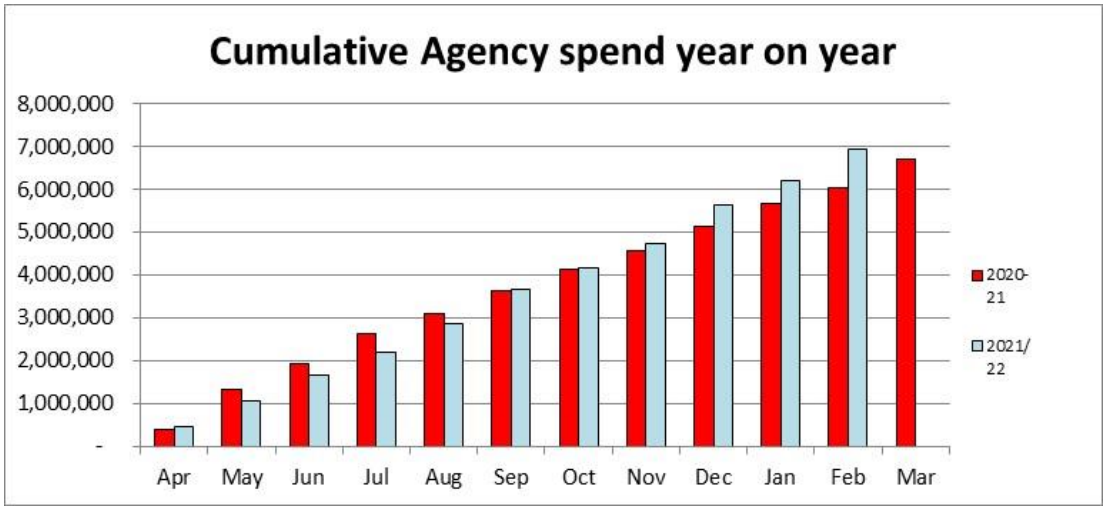


Table 5 Agency spend by staff group

Staff Type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Consultant	390	342	456	432	505	542	327	405	560	233	283	4,475
Nursing	27	152	106	81	58	186	123	132	221	171	191	1,448
AHPs	10	51	(1)	6	16	(11)	(2)	5	43	20	16	154
Clinical Support Staff	13	26	18	22	42	64	32	32	48	145	178	622
Administration & Clerical	17	20	24	17	30	18	43	(16)	5	4	78	241
Grand Total	**457**	**592**	**602**	**558**	**652**	**799**	**522**	**559**	**878**	**573**	**746**	**6,939**

The table above shows the agency spend by staff type by month, the majority of expenditure relates to Consultants.

6. Statement of Financial Position

The Statement of Financial Position in Appendix 1 shows the Trust's assets and liabilities as at 28 February 2022. A comparison has been made against January 22.

At £101.245m total Taxpayer Equity has increased by £0.026m.

7. Recommendations

The Trust Board are asked to note the Finance report for February and comment accordingly.

Appendix 1

Statement of Finance Position – 28 February 2022

	Feb-22 £000	Jan-22 £000	Movement £000	Comments
Non-current assets				
Property, Plant & Equipment	88,167	88,051	116	
Intangible Assets	14,816	13,927	889	Additions less depreciation
Total non-current assets	102,983	101,978	1,006	
Current assets				
Cash	35,967	27,956	8,011	Increase from invoices held relating to Provider Collab due to queries & £6.1m more received from ER CCG & Hull CCG
Receivables	12,724	10,516	2,208	Increase due to ER Council Invoices
Inventory	155	155	0	
Assets held for sale	599	599	0	
Total current assets	49,445	39,226	10,219	
Current liabilities				
Payables	8,446	6,955	1,491	Due to increase in Non PO Invoices accrual (NHS & Non-NHS) - waiting to be approved and paid
Accrued liabilities	19,094	15,414	3,680	Increase in general accruals - NHS & Non-NHS
Other liabilities	16,324	10,296	6,028	Increase relating to ER CCG Deferred Income
Total current liabities	43,864	32,665	11,199	
Net current assets	5,581	6,561	-980	
Long Term Liabilities				
Non-current borrowings	3,420	3,420	0	
Non-current- other liabilities	3,899	3,899	0	
Total Long term Liabilities	7,319	7,319	0	
Total Net Assets	101,245	101,219	26	
Revaluation Reserve	16,250	16,250	0	
PDC	69,652	69,652	0	
Retained earnings reserve	17,417	17,391	26	
Other	(2,073)	(2,073)	0	
Total Taxpayers Equity	101,245	101,219	26	
Total Liabilties	152,429	141,203	11,225	

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Agenda Item 11

Title & Date of Meeting:	Trust Board Public Meeting – 30 March 2022
Title of Report:	Enhancing Board Oversight: A New Approach to Non-Executive Director Champion Roles
Author/s:	Caroline Flint, Chair Michele Moran, Chief Executive
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper:	NHS England published guidance in December 2021 that sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. The report also provides details on the Chairs of the Sub Committee which is presented to the Board annually.
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	✓

Key Issues within the report:

The Board is asked to:

I. To note the agreed leads for each of the required NED Roles
II. To support the Sub- Committee chairs.
III. For NED chairs and executive leads of each committee to ensure the roles that are recommended and those that are to be aligned to committee structures be considered and included in the annual effectiveness review and terms of reference that are scheduled for the end March/April committees for presentation to the May Board for approval.

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	

Enhancing Board Oversight:
A New Approach to Non-Executive Director Champion Roles

1. Introduction

NHS England published guidance in December 2021 that sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some non-executive director champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue. The full guidance can be found here:

https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf

The guidance outlines how this new approach will help enhance board oversight for these issues, by ensuring they are embedded in governance arrangements and assurance process, and through providing an audit trail of discussions and actions identified by committees.

The CQC were involved throughout the development of this approach and "while there is a shared understanding that strong leadership and board oversight is critical for the provision of high-quality care, the governance arrangements that individual trusts use to achieve this is expected to vary according to local circumstances and priorities. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of important issues. Trusts will be expected to demonstrate how they provide this, including with reference to this guidance where appropriate."

The guidance suggests Trusts:

- Review current roles
- Align remaining roles to committee structures
- Outline reporting structures
- Update terms of reference

The guidance states that this new approach is recommended but not mandatory. If trusts consider NED champion roles an effective tool to provide assurance to their board on specific issues, then they have the flexibility to retain or implement that approach.

2. Our Current Position

- Wellbeing Guardian – Dean Royles
- Freedom to Speak Up (FTSU) NED Champion – Peter Baren
- Emergency Planning – Mike Smith
- Health and Safety – Francis Patton
- Cyber Security – Francis Patton
- Flu Champion – Francis Patton

3. Key Elements of the Guidance

The guidance lists five NED champion roles to be retained: -

- Wellbeing Guardian
- Freedom to Speak Up (FTSU) NED champion
- Doctors' Disciplinary NED champion/independent member

- Security Management NED champion
- Maternity Board Safety champion

All other roles should be embedded in governance arrangements and aligned to committee structures where possible i.e.:

- Learning from Deaths - Quality Committee
- Safety and Risk - Quality Committee
- Health and Safety – Audit Committee
- Palliative and End of Life Care – Quality Committee
- Hip, Fracture, Falls and Dementia – Quality Committee
- Children and Young People – Quality Committee
- Resuscitation – Quality Committee
- Cyber Security – Finance and Investment Committee
  Emergency Preparedness – Finance and Investment Committee
- Safeguarding – Quality Committee
- Counter Fraud – Audit Committee
- Procurement – Finance and Investment Committee
- Security Management Violence and Aggression – Audit Committee

The guidance suggests Trusts:

- Review current roles
- Align remaining roles to committee structures
- Outline reporting structures
- Update terms of reference

4. Chairs

Audit Committee – Stuart Mckinnon-Evans
Finance and Investment – Francis Patton
Quality – Mike Smith – To be reviewed when new appointee commences
MHLC – Mike Smith
Workforce – Dean Royles
Charitable Funds Committee – Stuart McKinnon-Evans - To be reviewed when new appointee commences
Collaborative Committee – Stuart McKinnon-Evans

5. Recommendation

i) To note the agreed leads for each of the required NED Roles

- Wellbeing Guardian – Dean Royles*
- FTSU NED champion – Dean Royles*
- Doctors' Disciplinary NED champion/independent member – Dean Royles*
- Security Management NED champion - Francis Patton
- Maternity Board Safety champion – N/A

*to be reviewed when new NED appointed

ii) To support the Sub- Committee chairs.

iii) For NED chairs and executive leads of each committee to ensure the roles that are recommended above, and those that are to be aligned to committee structures at section 3 above, be considered and included in the annual effectiveness review and terms of

reference that are scheduled for the end March/April committees for presentation to the May Board for approval.

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Humber Teaching
NHS Foundation Trust

Agenda Item 12

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 30 March 2022</td></tr>
<tr><td>Title of Report:</td><td>Humber Coast and Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative – Collaborative Committee Report</td></tr>
<tr><td>Author/s:</td><td>Peter Baren
Non-Executive Director and Chair of the Collaborative Committee</td></tr>
<tr><td>Recommendation:</td><td><table>
<tr><td>To approve</td><td></td><td>To receive & note</td><td></td></tr>
<tr><td>For information</td><td>√</td><td>To ratify</td><td></td></tr>
</table></td></tr>
<tr><td>Purpose of Paper:</td><td>The Collaborative Commissioning Committee is one of the sub committees of the Trust Board

This paper provides an executive summary of discussions held at the meeting on Thursday 24 February 2022 and a summary of key points for the Humber Teaching NHS Foundation Trust Board to note.</td></tr>
<tr><td>Governance:
Please indicate which committee or group this paper has previously been presented to:</td><td><table>
<tr><th></th><th>Date</th><th></th><th>Date</th></tr>
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<tr><td>Charitable Funds Committee</td><td></td><td>Collaborative Committee</td><td>24.2.2022</td></tr>
<tr><td></td><td></td><td>Other (please detail)</td><td></td></tr>
</table></td></tr>
<tr><td>Key Issues within the report:</td><td>
Continued pressure on CAMHS beds regionally and nationally
Schoen Clinic temporarily closed to admission following CQC inspection on 25 and 26 January 2022
Mill Lodge Day Care proposal reviewed and supported in principle
CAMHS and AED Clinical Lead – proposal to advertise a substantive post supported in principle
Continued positive financial position for 2021/22
Quality Assurance and Quality Improvement ToRs approved
Collaborative Committee updated ToR approved – the new ToR reflect the committee role as Lead Provider assurance
</td></tr>
</table>

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:

The aim of this report is to provide assurance to the Board about the Collaborative Commissioning Committee which has been established by Humber Teaching NHS FT (HTFT) as the Lead Provider within the Humber Coast and Vale (HCV) Specialised Mental Health, Learning Disability and Autism Provider Collaborative.

To demonstrate robust governance in its role as Lead Provider and avoid conflicts of interest with its provision arm, HTFT as Lead Provider has delegated some of its responsibilities to a new Commissioning Team which is accountable to the Commissioning Committee.

The purpose of the Team's role will be to undertake much of the work previously carried out by NHS England Specialised Commissioning in terms of commissioning, contractual management and quality assurance of the provision, Specialised Mental Health, Learning Disability and Autism services in the HCV region, and for patient placements outside of natural clinical flow for people who are receiving specialist care for:

1. Child and Adolescent Mental Health In-Patient services
2. Adult Low and Medium Secure services
3. Adult Eating Disorder In-Patient services.

Key Issues:

Key areas for noting from the meeting on **24 February 2022:**

Quality Assurance and Improvement

- Schoen Clinic
  - Temporarily closed to admission following CQC inspection on 25 and 25 January 2022. Action plan due 2nd March . Contingency planning in place should we have any new referrals
  - Quality Assurance and Improvement lead at the CPaQT has worked closely with CQC and NHS E Regional Leads following the CQC inspection and have regularly visited the Schoen Clinic to support and understand the pressures
  - Agreed an imperative to work with NHS E and CQC to ensure the beds are opened safely as soon as possible due to pressures across the system
  - Agree need to learn and use this a case example for any future similar issues as the provider collaborative is maturing

- Safe and Well-being Reviews completed and are with HCV ICS for Safe and Wellbeing Panel – it is understood the ICS will meet the 28 February 2022 deadline and lessons learned are being collated by the HCV ICS LD & Autism Lead
- Two outstanding reviews due to be completed by beginning of March – delayed due to COVID, staffing and bereavement of a service user
- CAMHS and AED Clinical Lead – proposal for substantive post following being unable to recruit to fixed term contract post supported in principle pending approval from PCOG
- Quality Assurance and Improvement Group has commenced meeting and Terms of Reference were shared and ratified at the Collaborative Committee

Work Streams

3 work stream visioning and planning events in diaries for February and March 2022 – involving all provider partners, CCGs, Local Authority, and service users; all 3 workshops will be independently Chaired and facilitated.

Key issues to note from each workstream -

<u>CAMHS</u>

- Local and National pressure on CAMHS in-patient beds and young people in paediatric wards
- At present 9 young people from HCV awaiting CAMHS beds – predominantly with eating disorder and require NG tube feeding
- Weekly SITREP is shared with MM as SRO for HCV ICS and with NHS E Regional Team who are collating all waiting list information
- CAMHS eating disorder task and finish group to be established – first meeting 28 February 2022 – will feedback to CAMHS workstream and HCV ICS CAMHS Executive Group
- New CAMHS and AED Case Manager commences in post on 7 March 2022
- CAMHS workstream supported the Mill Lodge Day Care proposal – supported in principle by the Collaborative Committee but acknowledged the timings of PCOG and CC and so should PCOG approve then will return to CC for any contractual process to be undertaken

<u>Adult Eating Disorder</u>

- 1 new ONCF placements – healthcare professional who it was agreed not appropriate to admit to HCV services
- Continued high level of referrals from other provider collaborative areas
- Schoen Clinic currently closed to admissions following CQC visit

- Rharian Fields have undertaken relevant checks and process to be able to admit under 18 years olds – to support the HCV CAMHS waiting lists

Adult Secure

- Focus on specific areas starting with Learning Disability and Autism, Women's, and Personality Disorder
- Visioning workshop held in February for adult secure – facilitated by the Yorkshire and Humber involvement network. Further meetings to be held to progress actions and form plans for the future
- Delayed Transfers of Care – this is predominantly due to limited community provision and suitable accommodation. Noted that definition of DTOC differs within services and so consequently a common definition is being developed
- 2 discharges in January and 1 admission

Contracting Update

H2 2021/22 Contracts -

- Sub-Contracts (Direct Agreements) have been developed and have been shared with HCV PC partners and the Pricing Activity Matrix (PAM) shared with NHS E/I regional team as per national guidance
- Stockton Hall Partnerships in Care (PiC) have negotiated a separate national agreement with NHS E and so considerable work has been undertaken to mirror the national agreement but also ensure it meets the requirements in HCV PC. Contract with PiC currently with them for signature
- Lead Provider to Lead Provider – for outside natural clinical flow placements – will be developed and shared end of January 2022 – however concern has been raised with NHS E regarding the lack of LP to LP from other Provider Collaborative who place patients in the HCV area e.g., at Stockton Hall Hospital who have over 120 beds
- Sub-contact meetings have commenced with partners in the collaborative and feedback to the new approach of a collaboration rather than historic commissioning v provider approach has been positive

Finance

- Planning Guidance has been shared by NHS E for 2022/2023
- Funding confirmation received mid-February 2022 from NHS E
- Current HCV Specialised PC financial position demonstrates a favourable position for year end of £1.1 million
- Discussions with auditors re reserve and 2021/22 underspend are ongoing
- NHS E have advised that from 1 April 2022 all provider bed occupancy within the Provider Collaborative should be funded by the Lead Provider Collaborative and then 'claimed' from other placing provider collaborative areas. The big 5 independent sector providers (ISP) have challenged this position and are requesting we continue as we have in H2 2021/22 and ISP invoice placing Provider Collaborative directly

Humber Teaching NHS Foundation Trust

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting – Wednesday 30 March 2022
Title of Report:	Charitable Funds Committee Assurance Report
Author/s:	Name: Peter Baren Title: Non-Executive Director and Chair of Charitable Funds Committee
Recommendation:	To approve: ; To receive & note: √ For information: ; To ratify:
Purpose of Paper:	The Charitable Funds Committee (CFC) is one of the sub committees of the Trust Board. This report is provided to the Trust Board as Corporate Trustee of the Charity. This paper includes details of the meeting held on 15 March 2022 and provides a summary of key points for the Board to note. The minutes of the meeting held on 16 November 2021 are also attached for information.
Governance: *Please indicate which committee or group this paper has previously been presented to:*	See table below
Any Issues for Escalation to the Board:	No items were highlighted for escalation to the Board.

	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	15.03.22	Collaborative Committee	
		Other (please detail) Assurance Report	✓

Monitoring and assurance framework summary:

Links to Strategic Goals *(please indicate which strategic goal/s this paper relates to)*
√ *Tick those that apply*

Caring, Learning & Growing Together

	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:

Introduction

This summary Assurance Report provides feedback from Charitable Funds Committee (CFC) Meeting on 15 March 2022 and encloses the agreed minutes from 16 November 2021.

CFC Summary Points from Chair

1. The minutes of 16 November 2021 were agreed as a true record.

2. The November CFC Board Assurance Report was accepted by the November Board.

3. The actions list was discussed an updated. 73/21 (a) Insight Report - The Committee discussed this action and agreed it relates to raising the profile of Health Stars now that we are coming out of the pandemic. Mr Baren emphasised the importance to get some momentum behind some of the fundraising activities. It was noted that going forward and will be covered within the Fundraising Plan. Mr Beckwith advised that a paper was discussed at the Executive Management meeting (EMT) on Fund Zone Managers in terms of re-aligning staff to fund zones. It was noted that plans are in place for looking at an away day on what the expectations are of the Fund Zone Managers and how they can promote the Charity more. Mr Baren asked Ms Winterton to include an update on Fund Zone Managers within the CFC March Board Assurance Report.

4. Insight Report. The Committee acknowledged the report.

10 Charitable Funds Request Over £5k for Bridlington. The request was for £17,229 for Carer's Plus. The Committee agreed to hold on to this until we get views from others including Ms Moran about whether this is charitable or non charitable. Mr Beckwith agreed to go back to Claire Jenkinson and Lynn Parkinson and get some further information.

11 Finance: The Committee acknowledged the finance report. It was noted that it was unlikely the fundraising target will be achieved this year. Ms Winterton shared that Health Stars were anticipating a grant from NHS Charities Together for £66,000 that was due in the

2022/23 financial year.

12 Agree KPIs for 2022. The committee agreed they wanted the existing KPIs to continue into the following year. A key focused was stressed on income generation KPIs.

13 2022/2023 Fundraising Plan. The draft fundraising plan was proposed. It was agreed an appeal needs to be identified to enable the fundraising plan to be more ambitious. The Health Stars team are going to enhance the plan based on feedback in the meeting.

14 12-18 Month Priorities for the Charity (particularly fundraising initiatives) Mr Beckwith made suggestions based on buildings projects such as Granville Court and the Humber Centre. Mr Royles also proposed a themed approach to an appeal focusing on a patient demographic such as children with eating disorders.

Minutes of Previous Meeting - The minutes of 16 November 2021 are attached.

Peter Baren
Chair, Charitable Funds Committee”

Charitable Funds Committee

Minutes of the Charitable Funds Committee Meeting

Held on 16 November 2021 1.00pm via Microsoft Teams

Present:	Peter Baren, Non-Executive Director (Chair) Hanif Malik, Associate Non-Executive Director Dean Royles, Non-Executive Director Peter Beckwith, Director of Finance Steve McGowan, Director of Workforce and Organisational Development
In Attendance:	Michele Moran, Chief Executive Andy Barber, Hey Smile Foundation Chief Executive Kristina Poxon, Fundraising Manager Kerrie Neilson, PA (minutes)
Apologies:	Victoria Winterton, Head of Smile Health

69/21	**Declarations of Interest** None declared.
70/21	**Minutes of the Meeting held on 22 September 2021** The minutes of the meeting held on 22 September 2021 were agreed as a correct record.
71/21	**Action List, Matters Arising and Work Plan** The Committee discussed the actions list, and the following was noted: **59/21 (a) Insight Report** This item was closed as it was covered within item 6 (Insight Report). **ACTION KN** **59/21 (b) Insight Report** This item was closed as it was covered within item 6 (Insight Report). **ACTION KN** **62/21 CFC Finance Report** It was agreed that a reserve account needs to be reviewed and considered for the charity in time for the next meeting in March. **ACTION PBe, SM, VM** **53/21 Any Other Business (b)** The Committee agreed to discuss the Whitby Appeal and what it should look like for 2021/2022 and 2022/2023, as a separate item later in the meeting. Mr Baren discussed the revised work plan and the new quarterly Committee dates for 2022 with the Committee. He asked the Committee to discuss and agree the budget for 2022/23 at the March 2022 meeting, as it is not specifically on the work plan. Mr Barber provided assurance and stated that it will be discussed as part of fundraising costs. Mr Baren suggested bringing forward the 2021/2022 Fundraising Plan from June to March, to tie in with the budget. The Committee agreed with his suggestion. **ACTION KN**

	Mr Baren also suggested bringing forward the Annual Accounts from December to September for those to be presented to the November Trust Board. **ACTION KN**
72/21	**CFC September Board Assurance Report** Mr Baren confirmed the Board accepted the report. **Resolved:** The report was noted.
73/21	**Insight Report** Ms Poxon provided an overview of the Insight report. The report provided updates on Fundraising Activity, Campaigns/Appeals, Performance against KPI's and Summary of Wishes. It was noted that since publishing the report unfortunately the 'Starlight Seekers' event which was planned for 13 November has been rearranged to 8 January. This was because the forecast for the star correlation had dropped to well below to 50% meaning that visibility for what they were wanting to deliver at the event would not have been possible. The Orion's belt should also be visible on the new date. The Committee were updated on the fundraising within the period. It was noted that a further £1k donation has been received to support Christmas parties for all the inpatient units which breaks down to £50 for each area. The Committee were informed of an additional £2k that had been pledged from the Jack Brunton Charitable Trust Fund in support of the Whitby Hospital Appeal. The team continue to be proactive with grant applications. Ms Poxon noted that everything is going well with the Whitby Hospital Appeal, and she is really pleased to be supporting the community at the Art exhibitions. She said that it should hopefully give that extra push around the appeal and the fundraising bricks. Ms Poxon provided a further update on the wishes and noted that additional support has been provided from Smile to help Ms Poxon with the Christmas wishes. Ms Poxon agreed to bring more of those good news stories forward. It was noted that a further 7 wishes have also been approved this morning. Ms Poxon agreed to circulate an updated document outside of the meeting. Mr Barber talked through the KPIs and noted that we are still in a very positive position. He confirmed there is still £210,000 surplus position in the last 5 years alone, and we are still ahead on benchmarking compared to other Mental Health Provider Trusts. The Committee provided constructive challenge regarding the future fundraising and communications plans. Praising the ongoing efforts but requesting further insight into how we can mitigate recurring challenges. Mr Baren welcomed question or comments. Mr Beckwith referred to those wishes where it states that 10 was declined to duplication of requests. He asked Mr Barber to review those outside of the meeting, as that will bring the percentage down. Mr Beckwith stated that items such as weighing scales and microphones should come from core spend. Ms Poxon agreed to edit how she reports this going forward. Ms Moran emphasised that there are some wishes that should not have been granted so be mindful about what the Trust should be paying for. Ms Moran talked about fundraising in more detail and noted that she would like to see our own staff raising funds for our own charity. She suggested competitions on who has raised the most

	money. She wants to see something more innovative, and she wants to see an increase in income verses investment. She suggested re grouping and discussing that challenge about engaging with staff to raise for the charity. Mr Barber agreed and said it is constructive challenge and it is about utilising resources in the best possible way. The Committee agreed that there is a need to build the momentum in the organisation about Health Stars with the health stars expertise. Ms Moran highlighted that branding needs to be reviewed to raise the profile of Health Stars and look at the possibility of having champions in each area. She said it is important that we continue to raise the profile, with help from Comms. Ms Moran requested that going forward all progress made is listed in the Insight Report. Ms Poxon provided assurance in terms of on innovation and communication whilst noting that there are some constructive things that could be improved. It was agreed that Mr Barber, Ms Poxon and Ms Winterton would progress more with innovation and communication with the help from the Comms and Ops Teams. Mr Beckwith referred to fund zone managers and noted that it might be useful to have a fund zone network, to help move this forward. Mr Baren commended the efforts of the sponsored walk, in support of the Whitby Hospital Appeal which raised £7,198.00. Ms Poxon confirmed that a letter of thanks has been sent to the organisers. The Committee noted that they would like to hear about the smaller achievements that go on behind the scenes, and that charity achievements should be celebrated more. The Committee agreed that there are some things to improve on. There is a need to engage more with staff and work on the branding, and move fundraising forward proactively, with help from the Comms team. Mr Baren referred to gift aid and income tax relief. Mr Barber provided assurance and noted it is on the individual sponsor forms. **Resolved:** The report was noted by the Committee. The Committee requested an interim update via email in 8 weeks' time on the branding position. **ACTION AB/KP/VW** Ms Poxon agreed to circulate an update in relation to wishes outside of the meeting. **ACTION KP**
74/21	**Updates from Sub Group – Whitby** Mr Beckwith presented the Whitby Project Group Assurance Report, highlighting the following areas to the Committee- • The building is now operational • The garden work is finished and now looking at recruiting volunteers for the ongoing maintenance • Artwork is progressing He asked the Committee if the Assurance Report could be included within the Insight Report, rather than have a separate item on the agenda. The Committee agreed. Mr Baren asked for clarity on what the current target is on the current Whitby Appeal. Mr Beckwith confirmed it is £85k. Ms Poxon highlighted that this could change. Mr Baren emphasised the need to be clear about this in future Board Assurance Reports.

	Mr Baren also asked if the Trust would have to fund the difference, if the £85k could not be raised for whatever reason. Mr Beckwith said there are certain elements we would not be able to progress because we cannot afford to do it. Meaning we would have to raise the resources to get the remaining funds. Ms Poxon provided assurance and confirmed that just over £45k has been raised in terms of the elements that we fundraise solely for the appeal, and within the fund zone there is just over £58k. It was noted that the televisions and furniture have been purchased by the Trust. The garden has been underwritten and the Dementia friendly plots have been purchased by Health Stars. Mr Barber said he is confident that they will continue to raise the funds required. He asked that for the next meeting we think about whether we continue to call it an appeal, or whether it moves into that longevity of supporting Whitby Hospital. Mr Malik referred to the transition of Whitby and said prior to that transition we need to ensure that we know what that is going to look like further down the line. **Resolved:** The Committee noted the report. The Committee agreed that going forward the Whitby Project Group Assurance Report would be included within the Insight Report going forward. **ACTION PBec/AB/VW/KP**
75/21	**Charitable Funds Requests that Require Committee Approval** No items to approve at this meeting.
76/21	**CFC Finance Report** Mr Barber provided an overview of the CFC Finance report. The report provided the Committee with an update on finances and fund zone balances. Income in October and September includes fundraising from the Whitby Zumba event and the Whitby 10k event. Also included in this period is £812.35 from the charity lottery. It was noted expenditure includes various low-level wishes and in September £4,160 for St Pauls Boxing Club. A breakdown of the fund zone balances (500k) is attached at appendix B, as requested by the Committee this splits funds between restricted and unrestricted. Mr Barber added that there is still a strong performance in the fund balance. He pointed out that there we are in a strong surplus position. There are some areas within Bridlington and Driffield that need to be looked at. He said we are in a strong position from a fund perspective. Ms Poxon added to this and referred to previous conversations about engaging more with fund zone managers and reviewing fund zone managers. Mr McGowan indicated that this needs to be discussed at EMT in the first instance. Following discussion at EMT, the charitable funds committee will look at how take it forward. Mr Hanif asked where the digital FR strategy sits within our wider FR strategy. He asked about contactless donation points and emphasised the importance to retain this. Ms Poxon advised that she has started a piece of research on contactless donation points in terms of gathering prices and how that could work for us. She said she is happy to draw up a paper and pinpoint some sort of trial areas where those could be rolled out. Mr Barber added to this and said they have been looking at this, as well as working with other Trusts. He noted that it comes down to the Comms plan, and there is a need to have a conversation about working in partnership with other Trusts in the local area. Mr Malik spoke about digital fundraising, especially in those high footfall areas and sharing his experiences. He agreed to speak to Mr Barber and Ms Winterton outside of the meeting. Mr Baren asked if we are still in contact with CHCP about their various funds in their area, and whether they still put wishes and requests forward. Mr Barber confirmed that sporadic wishes

	do come in from the finance team at CHCP, specifically around Bridlington. Mr Baren suggested reviewing the relationship there. **Resolved:** The report and verbal updates were noted. Mr Malik, Mr Barber and Ms Poxon agreed to meet to discuss digital fundraising and share their experiences. **ACTION HM, AB, VW**
77/21	**Fund Raising Costs** It was noted that this item was action from the previous meeting. This item was covered in item 78/12.
78/21	**Future Fundraising Campaigns** It was noted that this item was an action from the previous meeting. Mr Barber verbally reported that Ms Poxon has been doing a lot of work with the Humber Centre and the Humber Centre gym. Mr Barber provided a brief update on other future fundraising campaigns that he is working on. An update was provided on the project in Bridlington a Health and Social Centre at Crown Building looking at opening an empty space and unlocking the resource that is there which will have a wide range of voluntary sector organisations utilising that space for 18 months. The building has been donated by ER Council. We will look at bringing Health and Social providers into that area to stimulate new activity, particularly for elderly residents and young people in that area. Mr Royles commented on future campaigns and said strategically as we go forward, the main aim is to get that long-term strategic focus. He asked that we think about services to get that long term focus. Mr Barber agreed with Mr Royles comments and agreed to think about this going forward. **Resolved:** The verbal update was noted.
79/21	**Review of the Meeting and Agree Content for Assurance Report** Members of the Committee felt the meeting had covered the items appropriately. The content for the Assurance Report was discussed and agreed. Ms Poxon will prepare the report for the Chair/Executive Directors to review. **ACTION KP**
80/21	**Any Other Business** Mr Hanif referred to the recent Board discussion about the potential impact of another outbreak of the pandemic on the overall operations. He asked whether there are contingency measures and a contingency plan in place. Mr Barber provided assurance by saying that we are in a really good position. It was noted that additional resource will be put in to help with circle of wishes, and that will be monitored on a regular basis. In terms of resource, it was noted there is more resource coming to us from NHS Charities Together. He noted that we are one of the only Trusts to maximise resources that are already there. It was noted that this is Mr Baren's last Charitable Funds Committee meeting before he leaves the Trust at the end of January 2022. The Committee formally thanked Mr Baren for all his contributions and wished him all the very best for the future. The Committee will miss Mr Baren's valuable input. **Resolved:** The verbal update was noted.
81/21	**Items for Escalation or Inclusion on the Risk Register** There were no items which required escalation.

82/21	**Date and Time of Next Meeting** Tuesday 15 March 2022, 1.00pm – 3.00pm, via Microsoft Teams.
83/21	**Exclusion of Attendees from the Part II Meeting** It was resolved that Mr Barber and Ms Poxon would be excluded from the Part II meeting due to the confidential nature of the business to be transacted.

Signed: …… Chair: Peter Baren

Date: ……

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 14

Title & Date of Meeting:	Trust Board Public Meeting – 30 March 2022
Title of Report:	Staff Survey
Author/s:	Steve McGowan Director of Workforce & Organisational Development
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper:	A presentation will be given by Quality Health on the results of the staff survey which are embargoed until 30 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		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	✓

Key Issues within the report:	Any issues will be identified during the presentation

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
Legal	√			
Compliance	√			

Caring, Learning
& Growing Together

Communication	√			as and when required by the author
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Humber Teaching NHS Foundation Trust

Agenda Item 15

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 30th March 2022</td></tr>
<tr><td>Title of Report:</td><td>Q4 2021/22 Board Assurance Framework</td></tr>
<tr><td>Author/s:</td><td>Oliver Sims
Corporate Risk and Compliance Manager</td></tr>
<tr><td>Recommendation:</td><td><table>
<tr><td>To approve</td><td></td><td>To receive & note</td><td>√</td></tr>
<tr><td>For information</td><td></td><td>To ratify</td><td></td></tr>
</table></td></tr>
<tr><td>Purpose of Paper:</td><td>The report provides the Trust Board with the Q4 2021/22 version of the Board Assurance Framework (BAF) allowing for the monitoring of progress against the Trust's six strategic goals.</td></tr>
<tr><td>Governance:</td><td><table>
<tr><td></td><td>Date</td><td></td><td>Date</td></tr>
<tr><td>Audit Committee</td><td>02/ 2022</td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>02/ 2022</td><td>Workforce & Organisational Development Committee</td><td>01/ 2022</td></tr>
<tr><td>Finance & Investment Committee</td><td>01/ 2022</td><td>Executive Management Team</td><td>03/ 2022</td></tr>
<tr><td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td></td></tr>
<tr><td>Charitable Funds Committee</td><td></td><td>Collaborative Committee</td><td></td></tr>
<tr><td></td><td></td><td>Other (please detail)</td><td></td></tr>
</table></td></tr>
<tr><td>Key Issues within the report:</td><td>

Progress against the aligned risks is reflected within the framework to highlight the movement of current risk ratings from the previous position at Quarter 3 2021/22. The format allows for consideration to be given to the risks, controls and assurances which enables focused review and discussion of the challenges to the delivery of the organisational objectives.
Each of the Board Assurance Framework sections continue to be reviewed by the assigned assuring committee alongside the recorded risks, to provide further assurance around the management of risks to achievement of the Trust's strategic goals.
Overall assurance rating for each of the strategic goals is applied based on the review of the positive assurance, negative assurance and gaps in assurance identified against the individual goal, as well as with consideration of the current risk scores of all identified risks aligned to that strategic goal. The overall rating is not applied solely based on the highest rated risk aligned to that section of the framework and instead represents the overall assurance available to the Executive Lead at the time of review.

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</table>

	Overview of Board Assurance Framework from Quarter 3 2021-22 to Quarter 4 2021-22. **Strategic Goal 1 – Innovating Quality and Patient Safety** - Overall rating maintained at Yellow for Quarter 4 2021/22 **Strategic Goal 2 – Enhancing prevention, wellbeing and recovery** - Overall rating maintained at Amber for Quarter 4 2021/22. **Strategic Goal 3 – Fostering integration, partnerships, and alliances** - Overall rating maintained at Green for Quarter 4 2021/22. **Strategic Goal 4 – Developing an effective and empowered workforce** - Overall rating maintained at Yellow for Quarter 4 2021/22. **Strategic Goal 5 – Maximising an efficient and sustainable organisation** - Overall rating maintained at Yellow for Quarter 4 2021/22. **Strategic Goal 6 – Promoting people, communities, and social values** - Overall rating maintained at Green for Quarter 4 2021/22.

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		Yes	If any action	N/A	Comment

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

BOARD ASSURANCE FRAMEWORK				Trust Board							
ASSURANCE OVERVIEW				30th March 2022							
Strategic Goal	Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Risk Appetite	Assurance Rating					Highest current risk
						Q 4	Q 1	Q 2	Q 3	Q 4	
Innovating Quality and Patient Safety	Y	Overall rating of 'good' from 2019 CQC Inspection Report. 'Requires Improvement' rating for Safe domain in CQC report. 'Must do' actions completed within Trust including safer staffing and supervision. Positive internal audit of Trust significant event investigation process and duty of candour.	Director of Nursing	Quality Committee	OPEN	Y	Y	Y	Y	Y	12
Enhancing prevention, wellbeing, and recovery	A	Robust monitoring arrangements developed through monthly operational delivery group to monitor waiting times. Areas of long waits reviewed and monitored through ODG and Quality Committee. Impact to Trust services and waiting list targets impacted because of COVID-19 national situation. Patient Access and Performance manager appointed focussing on clinical systems, information capture and reporting. To review reporting and monitoring processes to make sure we maximise our performance reporting and Trust overall performance.	Chief Operating Officer	Quality Committee	SEEK	A	A	A	A	A	12
Fostering integration, partnership, and alliances	G	Place plans and Patient Engagement Strategy implemented, and positive service user surveys received. Social Values Report launched, and a section has been incorporated into the annual report. More work is to be undertaken to promote service users/ care groups. NHSI videos launched. Co-production work continues with regular meetings. Involvement with local groups.	Chief Executive	Audit Committee	SEEK	G	G	G	G	G	6
Developing an effective and empowered workforce	Y	Overall Staff Turnover at 0.7% in February 2022 against Trust target of 0.83%, but rate has increased from 0.5% in February 2021.Trust headcount has increased compared to 12 months ago (2792.8 in February 2022 compared to 2660.4 in February 2021). Overall statutory and mandatory training performance remains above target (89.1% at February 2022 against target of 85%). 101.5 (FTE) Nursing vacancies February 2022 compared with 100.4 (FTE) in February 2021. Qualified Nursing vacancy rate 11.81%. 10.8 (FTE) Consultant vacancies in February 2022 compared with 14.9 (FTE) in February 2021. Consultant vacancy rate 23.89%.	Director of Workforce and OD	Workforce and OD Committee	MATURE	Y	Y	Y	Y	Y	16
Maximising an efficient and sustainable organisation	Y	Trust financial position at Month 11 2021/22 reported a surplus of £0.106m which is in line with the ICS control total of a break-even position for the full Financial Year. Cash position remains stable with bank balance at £35.967m of which £2.413m relates to the Provider Collaborative. Better Payment Practice Code is cumulatively 83% for 21/22 for non-NHS suppliers and plan is in place to improve both NHS and non-NHS performance during 21/22. The Trust has continued to monitor progress against the budget reduction strategy. The Trust has disposed of £1m of surplus estates during the 21/22 financial year.	Director of Finance	Finance and Investment Committee	SEEK	Y	Y	Y	Y	Y	15
Promoting people, communities and social values	G	Place plans and Patient Engagement Strategy implemented, and positive service user surveys received. Social Values Report launched, and a section has been incorporated into the annual report. More work is to be undertaken to promote service users/ care groups. NHSI videos launched. Co-production work continues with regular meetings. Involvement with local groups.	Chief Executive	Quality Committee	SEEK	G	G	G	G	G	9

ASSURANCE LEVEL KEY			
Green	Significant Assurance	- System working effectively / limited further recommendations. - Effective controls in place. - Satisfied that appropriate assurance is available.	**OR** >= 50% of aligned risks scored at **LOW / MODERATE** (RATING SCORE 1-6)
Yellow	Partial Assurance	- System well-designed but requires monitoring/ low priority recommendations. - Some effective controls in place. - Some appropriate assurances are available.	**OR** >= 50% of aligned risks scored at **HIGH** (RATING SCORE 8-10)
Amber	Limited Assurance	- System management needs to be addressed/ numerous actions outstanding. - Controls thought to be in place. - Assurances are uncertain and/or possibly insufficient.	**OR** >= 50% of aligned risks scored at **HIGH** (RATING SCORE 12)
Red	No Assurance	- System not working / actions not addressed. - Effective controls not in place. - Appropriate assurances are not available.	**OR** >= 50% of aligned risks scored at **SIGNIFICANT** (RATING SCORE 15+)

BOARD ASSURANCE FRAMEWORK

STRATEGIC GOAL 1	INNOVATING QUALITY AND PATIENT SAFETY	Lead Director: Dir. Nursing	Lead Committee: Quality Committee	Assurance Level	Q4	Q1	Q2	Q3	Q4
					Y	Y	Y	Y	Y

Positive Assurance	
Assurance	**Source**
- Audit and Effectiveness Group which oversees work in relation to all aspects of CQC compliance. - CQC Engagement Meetings. - Quality Dashboard in place and items escalated as required. - Overall rating of 'good' in 2019 CQC inspection report. - Patient Safety Strategy 2019-22 implementation. - CQC 'must do' actions completed. - Internal audit of SEA (significant event analysis) process and Duty of Candour. - Six-monthly safer staffing report / DATIX Reporting / Weekly Ops meeting to discuss staffing - Safeguarding Annual Report - CQC TMA January 2020 – positive outcome.	Quality Committee assurance report to Board. CQC Engagement meeting CQC Inspection Report / TMA Feedback

Negative Assurance	
Assurance	**Source**
- 'Requires Improvement' rating for Safe domain in CQC report. - Clinical governance arrangements for Secure and LD services.	Trust Board CQC Report Internal Audit

Gaps in Assurance
What do we not have
Good rating in 'safe' domain for CQC rating.

Objective	Key Risk(s)	Q3 21-22 Rating	Q4 21-22 Rating	Target	Movement from prev. Quarter
Embed the characteristics needed to be recognised as a High Reliability Organisation	**NQ37 – Inability to meet Regulation 18 HSCA (RA) Regulations 2014 regarding Safer Staffing.**	6	6	3	⇔
	NQ38 – Inability to achieve a future rating of 'good' in the safe domain at CQC inspection.	9	9	6	⇔
	NQ48 – Currently the quality of staff supervision is unknown by the Trust which may impact on effective delivery of Trust services	9	9	3	⇔
	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.	16	12	8	⇓
Understanding of our local population's health needs to inform service planning, design and transformation	**No risks identified.**				
Provide evidence based, innovative models of care that function as part of the integrated care system, developed in collaboration with patients, carers and commissioners that is clearly understood by the teams and improves the safety of patients within the local and wider system					
Our research approach will be maximised through education and teaching initiatives and will support local priorities and influence our service user priorities					

Key Controls	Sources of Assurance – Reporting Mechanisms
(NQ37) Routine monitoring of staffing establishments and daily staffing levels.	6-month safer staffing report.
Research strategy Implementation	Quality Committee Trust Board
(NQ37) Consideration of nursing apprenticeships and nursing associate roles and greater use of the wider multi-disciplinary team in providing clinical leadership to units	Quality Committee Trust Board
(NQ38) Trust self-assessment against CQC standards.	Quality Committee Trust Board
(NQ38) Review undertaken of safety across Trust services.	
(NQ38) Development of regular audit arrangements to assess, monitor and improve the quality and safety of Trust service in 'MyAssurance' system. Quarterly monitoring reports established and implemented audit as part of standing agenda across Trust clinical network and divisional meeting to monitor divisional compliance with required standard.	Quality Committee QPAS Clinical Networks

Gaps in Control	Actions
(OPS11) Process for mitigating risks to individual patients based on length of waits.	Implementation of method for robust oversight of waiting list and patient risks for all Trust service areas (31/03/2022)
(OPS11) Issues around monitoring arrangements / governance in terms of performance.	Increase governance arrangements to ensure that there is rigour and governance in place to ensure patients are treated in chronological order and according to level of risk based on use of risk stratification tool (30/06/2022)
(NQ38) Outstanding actions from Safe KLOE self-assessment.	Embedding of actions identified through of Safe KLOE review. (31/12/2022).

BOARD ASSURANCE FRAMEWORK

STRATEGIC GOAL 2	ENHANCING PREVENTION, WELLBEING AND RECOVERY	Lead Director: Chief Operating Officer	Lead Committee: Quality Committee	Assurance Level	Q4	Q1	Q2	Q3	Q4
					A	A	A	A	A

Positive Assurance	
Assurance	**Source**
- Waiting times continue to be an area of focus as and are reviewed monthly by the Operational Delivery Group. Waiting list update reported into Quality Committee for oversight and consideration of quality impact.	Trust Board ODG
- Proactive contact with patients on waiting list within challenging services.	Quality Ctte
- Collaborative working between Trust and CCGs supportive of additional interventions to reduce waiting times	ODG / CLD Delivery Group
- Patient Access and Performance manager appointed focussing on clinical systems, information capture and reporting. To review reporting and monitoring processes to make sure we maximise our performance reporting and Trust overall performance.	

Negative Assurance	
Assurance	**Source**
- Increase in demand in community health services and primary care. Community health services have seen increase in patients having been discharged from hospital who require ongoing health support. - National increase in demand for CAMHs in patient and mental health inpatient beds.	Trust Board Quality Ctte

Gaps in Assurance
What do we not have
Data capture and performance reporting for some patient pathways.

Objective	Key Risk(s)	Q3 21-22 Rating	Q4 21-22 Rating	Target	Movement from prev. Quarter
Work in partnership with our service users, carers and families to optimise their health and wellbeing **Optimise people's recovery and build resilience for those affected by Long Term Conditions**	**OPS08 – Failure to equip patients and carers with skills and knowledge need via the wider recovery model.**	6	6	3	⇔
Prevention and Making Every Contact Count will be at the core of our strategy to optimise expertise for physical and mental health across our teams and the people they care for	**OPS04 – Patients don't have the right level of physical healthcare support and there is not a cohesive alignment of mental health and physical health services to get parity of esteem.**	9	9	6	⇔
	LDC32 – As a result of increased demand for ADHD assessment and limited capacity within the service, there is a significant waiting list which may lead to increased safety risk for patients and others, impacting on the wellbeing of staff as well as reputational harm to the Trust.	12	12	4	⇔
	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.	16	12	8	↓
	OPS13 – Due to the increasing complexity of CAMHs inpatients nationally, an increasing demand for CAMHs inpatient beds far exceeding capacity and increased breakdown of residential care placements for looked after children, there is increased use of out of area and inappropriate hospital beds (e.g. adult mental health beds and acute hospital beds) for young people which may lead to delayed discharges, insufficient management of patients in line with complexity and clinical risk and less good outcomes.	16	16	8	⇔
	LDC49 – Ongoing pressures within Hull and ERY CAMHS with high acuity of patients and high volumes of referrals resulting in long waiting times.	16	12	4	↓
	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.	16	12	4	↓
	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.	12	12	6	⇔
Bridlington Health Town to be used as an exemplar to demonstrate model, associated benefits and opportunity for a community-based model of care **Enhance prevention of illness and improve health and wellbeing of our staff, both physically and emotionally**	**No risks identified**				

Key Controls	Sources of Assurance – Reporting Mechanisms
(OPS11) Work underway with Divisions to address three areas of challenges currently (Children's ADHD / ASD, Memory Assessment Service, Department of Psychological Medicine)	Reports to demonstrate waiting list performance to Trust Board, Quality Committee and Operational Delivery Group. Quality impact on key identified areas monitored via Quality Committee. Weekly divisional meetings with Deputy COO around waiting list performance.
(OPS11) Local Targets and KPIs.	

Gaps in Control	Actions
(OPS11) Process for mitigating risks to individual patients based on length of waits.	Implementation of method for robust oversight of waiting list and patient risks for all Trust service (31/03/2022)
(OPS13) National deficit in CAMHS PICU / general adolescent beds.	Ongoing communication and escalation to Specialist Commissioning and CCGs (30/06/2022)

BOARD ASSURANCE FRAMEWORK

STRATEGIC GOAL 3	FOSTERING INTEGRATION, PARTNERSHIPS AND ALLIANCES	Lead Director: Chief Executive	Lead Committee: Audit Committee	Assurance Level	Q4	Q1	Q2	Q3	Q4
					G	G	G	G	G

Positive Assurance	
Assurance	**Source**
- STP/ ICS partnership events. - Mental Health Partnership Board and MOUs in place. - Health Expo event and Planned Members meeting. - High profile visits to Trust. - Visioning event across Humber Coast and Vale - Lead provider role within STP - Refreshed Operational and Strategic plans shared with stakeholders. - Hull Health and Wellbeing Board.	Board of Directors
- ICS Accredited Programme - HCV has been successful in the application to become an Integrated Care System (ICS) which indicates confidence in the area and its leaders.	HCV Exec Committee

Negative Assurance	
Assurance	**Source**
- Further work needed to take place in engaging with patient, carers and local communities to develop plans. - Continued development of relationships with communities and development of membership and Governors. - Clear Governor links to constitutions.	Board of Directors

Gaps in Assurance
What do we not have
- No gaps identified against overall assurance rating of this strategic goal. - Full ICS system in place – but still developing long-term plans.

Objective	Key Risk(s)	Q3 21-22 Rating	Q4 21-22 Rating	Target	Movement from prev. Quarter
Be a leader in delivering Sustainability and Transformation Partnership plans **We will be clear about what we offer, who we offer it to and how we work with others**	**FII174 - Lack of Trust involvement or influence in work-stream activity associated with Sustainability and Transformation Programmes (STPs), will in turn impact on our ability to influence and shape local commissioning plans. This may result in a failure to deliver strategic priorities, with an associated risk of developing a poor reputation and reduced business/income opportunities that may challenge future sustainability.**	6	6	3	⟺
Continue to provide opportunities for all service users, patients, carers, families, staff and communities to influence service planning and design	**FII180 - There is a risk to future sustainability and reputation, arising from a failure to compete effectively because we have not maintained and developed strategic alliances and partnerships and not increased our commercial/market understanding.**	6	6	3	⟺
Demonstrate increased collaboration with system partners to maximise efficiency and effective use of resources available across health and social care services.	**FII185 - Failure to utilise evidence-based practice to inform and influence business decisions, resulting in the delivery of outdated service models, an inability to effectively compete with other providers and a subsequent loss of business/ income and reputation.**	6	6	3	⟺
	FII222 - Failure to utilise evidence-based practice to inform and influence business decisions, resulting in the delivery of outdated service models, an inability to effectively compete with other providers and a subsequent loss of business/ income and reputation.	12	12	4	⟺
Host partner organisations' staff and vice versa, to enable system workforce resilience	**No risks identified**				

Key Controls	Sources of Assurance – Reporting Mechanisms
(FII174) Trust Strategy, values and goals aligned with Humber, Coast and Vale STP	Regular STP updates to Trust Board Formal and informal dialogue with Commissioners
(FII174) Alignment clearly demonstrated within two-year operational plan	Regular STP updates to Trust Board Formal and informal dialogue with Commissioners Assurance systems for Service Plans/ Strategies Internal Clinical Audit programme R&D programme
(FII174) Chief Executive is Senior Responsible Officer for Mental Health Work-stream.	
(FII185) Enhanced staff structure in Business Development team to explore evidence-based practice	
(FII185) Formal programme to review and benchmark Trust position.	Assurance systems for Service Plans/ Strategies Internal Clinical Audit programme R&D programme Monthly reporting to Commissioning Committee, FIC and Trust Board.
(FII222) Commissioning committee now live and governance arrangements in place.	
(FII222) Business case to outline provider collaborative submitted to NHSE.	Monthly reporting to Commissioning Committee, FIC and Trust Board.

Gaps in Control	Actions
(FII222) Lack of movement from NHSE to address gaps identified through due diligence.	Ongoing meetings with NHSE and regional team to seek clarification around funding position - 31/03/2022

BOARD ASSURANCE FRAMEWORK

STRATEGIC GOAL 4	DEVELOPING AN EFFECTIVE AND EMPOWERED WORKFORCE	Lead Director: Dir. of Workforce and OD	Lead Committee: Workforce and OD Committee	Assurance Level	Q3	Q4	Q1	Q3	Q4
					Y	Y	Y	Y	Y

Positive Assurance

Assurance	Source
- Overall Staff Turnover at 0.7% in February 2022 against Trust target of 0.83%, but rate has increased from 0.5% in February 2021. - Trust headcount has increased compared to 12 months ago (2792.8 in February 2022 compared to 2660.4 in February 2021) - Overall statutory and mandatory training performance remains above target (89.1% at February 2022 against target of 85%).	Trust Board Workforce and OD Committee Workforce Insight Report Audit Committee Quality Committee

Negative Assurance

Assurance	Source

- 101.5 (FTE) Nursing vacancies February 2022 compared with 100.4 (FTE) in February 2021. Qualified Nursing vacancy rate 11.81%.
- 10.8 (FTE) Consultant vacancies in February 2022 compared with 14.9 (FTE) in February 2021. Consultant vacancy rate 23.89%.
- 7 job descriptions for consultant posts missing impacting on ability to advertise posts.
- Non-compliance with Job Planning process for Medic roles.
- Some statutory/mandatory training is below trust target, including:
  - Adult and Paediatric Basic Life Support / Immediate Life Support
  - Information Governance
  - DMI
  - Mental Health Act
  - Moving & Handling – Level 2 / Level 3
  - Personal & Team Safety
  - Safeguarding Adults / Children – Level 3
	Trust Board
	
	Workforce and OD Committee
	Workforce Insight Report

Gaps in Assurance

What do we not have
- No gaps identified against overall assurance rating of this strategic goal.

Objective	Key Risk(s)	Q3 21-22 Rating	Q4 21-22 Rating	Target	Movement from prev. Quarter
Development of a healthy and engaged organisational culture, clinical and support services working together as "One Team" to free up time for patient care. **Enable transformation and organisational development through shared leadership.**	**WF07 – The quality of leaders and managers across the Trust is not at the required level which may impact on ability to deliver safe and effective services.**	6	6	3	⟺
Optimise the staffing profile to ensure delivery of high-quality care. **Demonstrate that we are a diverse and inclusive organisation.**	**WF03 – 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**	15	15	10	⟺
	WF04 – 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.	15	15	10	⟺
	WF10 – With current national shortages, the inability to retain GPs may impact on the Trust's ability to deliver safe services.	15	15	10	⟺
	WF33 – Lack of oversight, accountability, and responsibility on the activity of medics due to non-compliance with Job Planning process for Medic roles	N/A	12	4	New Risk
	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.	10	10	5	⟺
Increase our service offer to support work in partnerships with the STP/ICS and PCNs to optimise the workforce within the system. **Ensure a well-trained digital ready workforce.**	**No risks identified**				

Key Controls	Sources of Assurance
(WF03) Detailed Recruitment plan in place (progress against which reported to EMT and Workforce and OD Committee).	Trust Board Workforce and OD Committee ODG Task and Finish Group (hard to recruit posts)
(WF04) Trust Retention Plan.	
(WF05) Trust-wide workforce plan.	

Gaps in Control	Actions
(WF03) Qualified Nurses and Nurse Managers hard to recruit vacancies.	Ongoing review of recommendations implementation from establishment review as part of workforce plan review ('Hard to Recruit' Task and Finish Group) (30/06/2022)
(WF10) Divisional use of exit interview data to shape actions to support retention	Programme of 6 monthly deep dives into Leaver data to be undertaken and reported into WFOD Committee (30/06/2022)
(WF04) Lack of career development opportunities indicated through employee exit interviews/questionnaires.	Trust divisions to develop bespoke plans supported by deep dive analysis (30/06/2022)

BOARD ASSURANCE FRAMEWORK

STRATEGIC GOAL 5	MAXIMISING AN EFFICIENT AND SUSTAINABLE ORGANISATION	Lead Director: Dir. Finance	Lead Committee: Finance and Investment Committee	Assurance Level	Q4	Q1	Q2	Q3	Q4
					Y	Y	Y	Y	Y

Positive Assurance

Assurance	Source
- Financial position Month 11 2021/22 – Trust reported an operational surplus of 0.106m which is in line with the ICS target of Break even. - Trust cash position has stabilised – bank balance of £35.967m (£2.413m) Provider Collaborative - BPPC is cumulatively 83% for 21/22 for non-NHS suppliers and plan is in place to improve both NHS and non-NHS performance during 21/22. - Budget Reduction Strategy to deliver £1.867m of savings from Divisional and Corporate Services. - The Trust has disposed of 1M surplus estates during the 21/22 financial year, work to identify further surplus estate for disposal continues to be progressed. - Benefits of using digital technology introduced as a result of COVID-19 now embedded.	Trust Board Finance and Investment Committee

Negative Assurance

Assurance	Source
- Recurrent pick of non-recurrent resource is not know at this time	Trust Board Finance and Investment Committee

Gaps in Assurance

What do we not have
- Detailed planning guidance for 2022/23 not yet published - Longer term Commissioning Intentions not known.

Objective	Key Risk(s)	Q3 21-22 Rating	Q4 21-22 Rating	Target	Movement from prev. Quarter
Optimise business opportunities to develop integrated services **Effective marketing plan that ensures clear and effective communication pathways and celebrates our successes jointly with our partners**	**FII180 – There is a risk to future sustainability and reputation, arising from a failure to compete effectively because we have not maintained and developed strategic alliances and partnerships and not increased our commercial/market understanding.**	6	6	3	⟷
Embrace new technologies to enhance patient care across the health and social care system	**FII177– Adverse impact of inadequate IT systems, failing to effectively support management decisions, performance management or contract compliance**	8	8	4	⟷
Optimise our IT system to improve access for staff and free up time for patient care	**FII186 – Trust IT systems are compromised due to a Cyber Security attack/incident - this could be a malicious attack from an external third party or an accidental attack from inside the trust network due to inappropriate actions taken by staff, patients or visitors that comprise the IT systems security.**	12	12	8	⟷
Reduce our reliance on sustainability funding to achieve long term financial balance	**FII205 – 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.**	15	15	10	⟷
	FII216 – Risk of fraud, bribery and corruption.	9	9	3	⟷
	FII221 – If the Trust cannot achieve its Budget Reduction Strategy for 2021-22, it may affect the Trust's ability to achieve its control total which could impact on finances resulting in a loss of funding and reputational harm.	6	6	3	⟷
	FII220 – The financial effect of COVID-19 and the risks that the full costs will not be recovered.	8	8	4	⟷
Have an efficient estate that provides a safe and cost-effective environment that is conducive to operational delivery	**FII58 – Inability to address all risks identified as part of the capital application process due to lack of capital resource.**	8	8	4	⟷
	FII181 – Inability to improve the overall condition and efficiency of our estate.	8	8	4	⟷

Key Controls	Sources of Assurance
(FII205) Budget Reduction Strategy established with MTFP.	Finance & Investment Committee Reports - Cash - Financial Position - BRS - Debtors/ Creditors
(FII205) Monthly reporting, monitoring and discussion with budget holders.	
(FII205) Financial plan agreed.	
(FII205) BRS reporting to FIC	Trust Board Reports - Financial Position - Cash
(FII205) Trust Control Total agreed for months 1-6 2021/22.	
(FII220) Recovering the costs of COVID-19 through the ICS.	
(FII220) Accurately recording the costs of COVID-19.	

Gaps in Control	Actions
(FII205) Budget Reduction Strategy 2021/22 implementation.	Budget Reduction Strategy implementation 2021-22 (31/03/2022).
(FII205) Budget reduction strategy plans for 2022/23.	Detailed budget reduction strategy plans for 2022/23 to be developed (31/03/2022).
(FII220) Major Schemes have not been agreed at this stage as funding is from Covid Blocks and Major schemes rely on normal commissioning process returning	Continue to bid for national resource as and when it becomes available (ie Winter monies) (31/03/2022)
(FII220) The effect of COVID-19 in terms of the effect on Operational and Corporate Services which hinders services from making efficiency savings.	Ongoing Accountability review process (31/03/2022)
(FII220) The effect of COVID-19 on Commissioners in terms of the Block Funding arrangements and not being able to fund MHIS and STP Transformation funding.	Continue to work with Commissioners to highlight the requirement for funding through MHIS (31/03/2022).

BOARD ASSURANCE FRAMEWORK

STRATEGIC GOAL 6	PROMOTING PEOPLE, COMMUNITIES AND SOCIAL VALUES	Lead Director: Chief Executive	Lead Committee: Quality Committee	Assurance Level	Q4	Q1	Q2	Q3	Q4
					G	G	G	G	G

Positive Assurance	
Assurance	**Source**
- Continual development of the Recovery College. - Health Stars developing - Wider community engagement developing through changes to constitution and more work with Governors. - More internal Trust focus on promoting wellness and recovery. - Positive service user survey results. - Trust developed in year social values reporting arrangements - Hull Health and Wellbeing Board - Project Group established to develop wider wellbeing and recovery approach bringing in a focus on both mental and physical elements of recovery. - 'Making Every Contact Count' being led by Trust across ERY - Launch of Social Values Report - NHSI scheme launched	Board of Directors

Negative Assurance	
Assurance	**Source**
- Negative media outweighs positive media regarding promotion of communities. - Trust membership base is not fully operational and negative assurance around membership involvement. - Limited feedback on how local communities are influencing our Trust Strategy.	Board of Directors

Gaps in Assurance
What do we not have
Patient outcome measures. Detailed Community engagement strategy or Relationship strategy.

Objective	Key Risk(s)	Q3 21-22 Rating	Q4 21-22 Rating	Target	Movement from prev. Quarter
We will work with our partners to develop voluntary sector led, multi-specialty community hubs that focus on prevention, wellbeing and recovery	**OPS08 – Failure to equip patients and carers with skills and knowledge needed via the wider recovery model.**	6	6	3	⟺
	MD05 - Inability to implement the Trust's Equality and Diversity strategy may impact on the Trust's ability to have a workforce trained and engaged with the equality and diversity agenda, limit accessibility to services and prevent achievement of the Trust's E&D aims.	6	6	3	⟺
	MD06 - Reduction in patients likely to recommend Trust services to friends and family may impact on Trust's reputation and stakeholder confidence in services provided.	8	8	4	⟺
Increase the utilisation and spread of our charity, Health Stars	**HS5 - The loss of key Trust staff and changes in leadership which may impact delivery of Health Stars charity.**	N/A	6	3	New Risk
Embrace and expand our use of volunteers	**None identified.**				

Key Controls	Sources of Assurance
(OPS08) Trust Recovery Strategy	Trust Board
(OPS08) CMHT transformation work underway which will impact Recovery College due to its status as a discharge pathway.	
(OPS08) Recovery college offer moved to online provision and broadened.	
(MD05) Supporting forums established for development of equality and diversity work within the Trust.	Quarterly reporting to Quality Committee and Clinical Quality Forum
(MD05) Equality and Diversity Leads identified for 'patient and carers and 'staff' respectively.	
(MD06) Task and finish group identified	Reports to QPaS and Quality Committee
(MD06) All clinical teams give out FFT forms and results are fed into services through level 3 reporting system.	

Gaps in Control	Actions
(OPS08) Secured funding for Recovery College with Commissioners	Ongoing communication with commissioners regarding funding - awaiting planning guidance around funding (30/04//2022)
(OPS08) Recovery focussed practice still to be fully embedded across the Trust	Delivery of Recovery Strategy implementation plan (30/04//2022)

BOARD ASSURANCE FRAMEWORK

RISK SCORING MATRIX

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

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

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

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 16

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 30 March 2022</td></tr>
<tr><td>Title of Report:</td><td>Risk Register Update</td></tr>
<tr><td>Author/s:</td><td>Executive Lead: Hilary Gledhill, Director of Nursing, Allied Health & Social Care Professionals.

Oliver Sims
Corporate Risk and Compliance Manager</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td></td><td>To receive & note</td><td>√</td></tr>
<tr><td>For information</td><td></td><td>To ratify</td><td></td></tr>
</table>
</td></tr>
<tr><td>Purpose of Paper:</td><td>The report provides the Board with an update on the Trust-wide risk register (15+ risks) including the detail of any additional or closed risks since last reported to Trust Board in November 2021.</td></tr>
<tr><td>Governance:</td><td>
<table>
<tr><td></td><td>Date</td><td></td><td>Date</td></tr>
<tr><td>Audit Committee</td><td>02/ 2022</td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>02/ 2022</td><td>Workforce & Organisational Development Committee</td><td>01/ 2022</td></tr>
<tr><td>Finance & Investment Committee</td><td>01/ 2022</td><td>Executive Management Team</td><td>03/ 2022</td></tr>
<tr><td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td>03/ 2022</td></tr>
<tr><td>Charitable Funds Committee</td><td></td><td>Collaborative Committee</td><td></td></tr>
<tr><td></td><td></td><td>Other (please detail)</td><td></td></tr>
</table>
</td></tr>
<tr><td>Key Issues within the report:</td><td>

The Trust-wide risk register details the risks facing the organisation scored at a current rating of 15 or higher (significant risks) and agreed by Executive Management Team.
There are currently 5 risks held on the Trust-wide Risk Register. The current risks held on the Trust-wide risk register are summarised below:

<table>
<tr><th>Risk Description</th><th>Initial Rating</th><th>Current Rating</th></tr>
<tr><td>WF03 – 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.</td><td>20</td><td>15</td></tr>
<tr><td>WF04 – 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.</td><td>20</td><td>15</td></tr>
</table>
</td></tr>
</table>

Caring, Learning
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	WF10 – With current national shortages, the inability to retain GPs may impact on the Trust's ability to deliver safe services.	**20**	**15**
	FII205 – 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**
	OPS13 – 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**

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	

Risk Register Update

1. Trust-wide Risk Register

There are currently **5** risks reflected on the Trust-wide risk register which records all risks currently scored at a rating of 15 or above and is reflected in ***Table 1*** below:

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

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
WF03	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	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	With current national shortages, the inability to retain GPs may impact on the Trust's ability to deliver safe services.	**20**	**15**	**10**
FII205	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**
OPS13	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**

2. Closed/ De-escalated Trust-wide Risks

There are **3** risks previously held on the Trust-wide risk register which has been closed / de-escalated since last reported to Trust Board in November 2021.

Risk ID	Description of Risk	Current Status
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.**

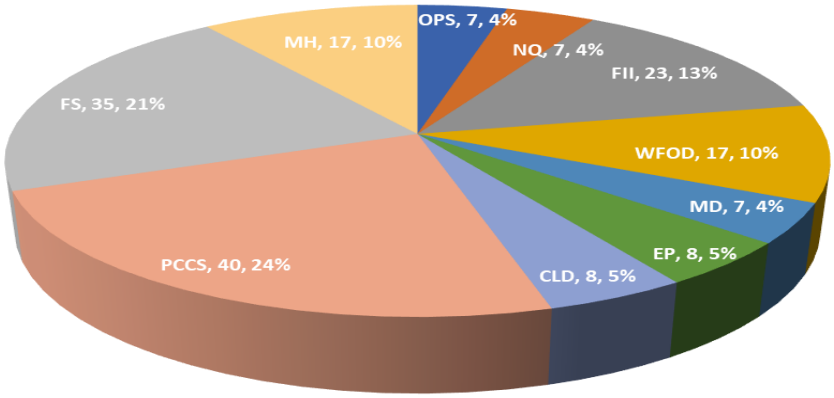
3. Wider Risk Register

There are currently **169** risks held across the Trust's risk registers. The current position represents an overall decrease of **31** risks from the **200** reported to Trust Board in November 2021. The table below shows the current number of risks at each risk rating:

Table 4 - Total Risks by Current Risk level

Current Risk Level	Number of Risks – November 2021	Number of Risks – March 2022
20	0	0
16	4	1
15	4	4
12	62	43
10	9	11
9	52	34
8	19	27
6	43	40
5	2	2
4	2	4
3	1	3
2	0	0
Total Risks	**200**	**169**

Chart 1 – Total Risks by Division/ Directorate



Key:

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

Trust-wide Risk Register 15+

Row	Risk ID	Date Added	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
PROVIDER RISKS 15+ (Identified through Trust Divisional / Directorate Risk Registers)																									
1	**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.	Objectives	Likely	Catastrophic	**20**	**Significant**	1. Detailed Recruitment plan in place (progress against which reported to EMT and Workforce and OD Committee). 2. Recruitment task and finish group in place. 3. Launch of 'Humbelievable.' 4. International recruitment programme (20 new nurses per annum) 5. Availability of Nurse Degree Apprenticeship Programme. Workforce planning process and overarching plan to be discussed at WFOD Committee 6. Workforce planning process and overarching plan reviewed by WFOD Committee 7. Successful recruitment of 7 international nurses to the Trust and further international recruitment continues. 8. Plan in place for further attendance at overseas recruitment fairs further expanding the reach of recruitment activities.	1. Workforce and OD Committee. 2. Divisional ODG Meetings. 3. EMT. 4. Trust Board 5. ODG.	1. Expansion of new clinical roles needed. 2. Qualified Nurses and Nurse Managers hard to recruit vacancies.	1. 101.5 (FTE) Nursing vacancies as at February 2022 compared with 100.0 (FTE) in January 2022. 2. 11.81% Registered Nursing vacancy rate.	Possible	Catastrophic	**15**	**Significant**	1. Ongoing review of recommendations implementation from establishment review as part of workforce plan review ('Hard to Recruit' Task and Finish Group) 2. Development and expansion of new roles such as Associate Practitioners and Advanced Clinical Practitioner roles	Julie Taylor	Hilary Gledhill	WFOD / EMT	Trust Board	Rare	Catastrophic	**10**	**High**
2	**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.	Objectives	Likely	Catastrophic	**20**	**Significant**	1. Appraisal process. 2. Leadership and management development programmes. 3. Staff Health & Wellbeing Group and action plan. 4. PROUD programme. 5. Health and Social Care Professional Strategy. 6. Trust Retention Plan. 7. Review completed for new year staff survey results and development of departmental / divisional action plans monitored through accountability reviews.	1. Trust Board monthly performance report. 2. Staff surveys. 3. Insight report to Workforce and OD Committee. 4. Workforce and OD Scorecard. 5. Accountability Reviews.	1. Trust-wide workforce plan delivery. 2. Formalised Band 5 Nurse Career development provision.	1. Current turnover 10.98% as at February 2022 (10.791% January 2022) 2. Lack of career development opportunities indicated through employee exit interviews/questionnaires.	Possible	Catastrophic	**15**	**Significant**	1. Programme of 6 monthly deep-dives into Leaver data to be undertaken and reported into WFOD Committee 2. Business Partners to develop bespoke action plans at divisional level based on 6 monthly deep-dive programme analysis	Divisional General Managers	Lynn Parkinson	WFOD / EMT	Trust Board	Rare	Catastrophic	**10**	**High**
3	**WF10**	**10/06/2019**	With current national shortages, the inability to retain GPs may impact on the Trust's ability to deliver safe services.	Objectives	Likely	Catastrophic	**20**	**Significant**	1. Staff engagement though TCNC (Trust Consultation and Negotiation Committee). 2. Staff Health & Wellbeing Group and action plan. 3. Trust retention plan as agreed with NHSI. 4. PROUD programme. 5. Recruitment and retention incentives 6. LNC - Positive staff engagement with medical workforce. 7. HRBPs support divisions with WOD scorecard. 8. Transfer of medical workforce team to HR and appointment of new Team Leader and Manager	1. Workforce and OD Insight Report. 2. Staff surveys. 3. Staff Friends and Family Test. 4. Workforce and OD committee. 5. EMT. 6. Workforce scorecard.	1. Lack of career development opportunities indicated through employee exit interviews/questionnaires.	1. Current medical staff turnover 11.44% as at February 2022 (10.30% January 2022). 2. Increase of 1.1 WTE vacancy since August 2021.	Possible	Catastrophic	**15**	**Significant**	1. HR Business Partners ongoing review of exit questionnaire results to identify any hot spots 2. Ongoing PROUD programme implementation plan - ongoing 3 year programme 3. Programme of 6 monthly deep-dives into Leaver data to be undertaken and reported into WFOD Committee 4. Business Partners to develop bespoke action plans at divisional level based on 6 monthly deep-dive programme analysis	Karen Phillips	Steve McGowan	WFOD / EMT	Trust Board	Rare	Catastrophic	**10**	**High**

Trust-wide Risk Register 15+

Row	Risk ID	Date Added	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls	Gaps in Assurance	Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk	What additional actions need to be completed?	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk
4	FI1205	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.	Objectives	Almost Certain	Catastrophic	25	Significant	1. Budgets agreed. 2. Monthly reporting, monitoring and discussion with budget holders. 3. Small contingency / risk cover provided in plan. 5. MTFP developed to inform plans. 6. Service plans. 7. Regular reviews with NHSE/I and relevant Commissioners 8. Budget Reduction Strategy established with MTFP. 9. Non-recurrent savings. 10. BRS reporting to FIC 11. Trust Control Total agreed for 2021-22 12. Financial plan agreed	1. Monthly reporting to Board and Bi monthly to FIC. 2. Monthly & Quarterly reporting to NHS I and NHS I feedback 3. ODG monitoring progress of BRS plans. 5. Budget Reduction Strategy policy and procedure agreed by Finance and Investment Committee and Trust Board. 6. External / Internal Audit position. 7. Regular input through Humber Coast and Vale ICS	1. Budget Reduction Strategy 2021/22 implementation 2.Budget reduction strategy plans for 2022/23.	1. Longer-term plan guidance is awaited.	Possible	Catastrophic	15	Significant	1. Budget Reduction Strategy implementation 2021-22 2. Detailed budget reduction strategy plans for 2022/23 to be developed	Iain Omand	Peter Beckwith	FIC / EMT	Trust Board	Unlikely	Catastrophic	10	High
5	OPS13	08/11/2021	Due to the increasing complexity of CAMHs inpatients nationally, an increasing demand for CAMHs inpatient beds far exceeding capacity and increased breakdown of residential care placements for looked after children, there is increased use of out of area and inappropriate hospital beds (e.g. adult mental health beds and acute hospital beds) for young people which may lead to delayed discharges, insufficient management of patients in line with complexity and clinical risk and less good outcomes.	Objectives	Almost Certain	Severe	20	Significant	1. Staffing levels adjusted to take into account the acuity of patients. 2. Trust beds reduced as appropriate in response to acuity levels and the staffing levels required to support. 3. Recruitment/training plan in place to open PICU capacity in Inspire. 4. System work at ICS level to address the pressures with appropriate partners.	1. Weekly updates received regarding staffing/capacity 2. Implementation plan in place to demonstrate timeframe for staff recruitment/training to open the CAMHs PICU 3. Local system escalation taking place through OPEL reporting and other system arrangements.	1. Instances of Under-18 patient being admitted to adult beds due to complexity of patient mix on Inspire. 2. National deficit in CAMHS PICU / general adolescent beds. 3. Children who would meet the threshold for PICU admission nursed in general adolescent beds impacting on staffing and ward safety arrangements. 4. Breakdown of residential care placements leading to admission to hospital beds for young people for whom this could be avoided if alternative community packages of care could be found.	None identified	Likely	Severe	16	Significant	1. Ongoing communication and escalation to Specialist Commissioning and CCGs.	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High

Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting – 30th March 2022
Title of Report:	Peer Support Worker Roles - Service Update
Author/s:	Natalie Belt, Service Manager
Recommendation:	To approve: ; To receive & note: x ; For information: ; To ratify:
Purpose of Paper:	To provide an update on the development of peer support worker roles within mental health services.

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	✓

Key Issues within the report:
Please ensure you also complete the monitoring and assurance framework summary below:

Key issues within the report are:

- The current position with roles in place and the plan to expand further as part of the Trusts clear intention to embed lived experience as the heart of service delivery.
- Progress made in developing a clear and robust approach to supporting and embedding the roles
- Access to provision for training and further development
- The important connection to the Recovery College
- Plans to evaluate the roles

Monitoring and assurance framework summary:

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

Peer Support Worker Roles - Service Update

1. Introduction

The Trust has now developed the Peer Support Worker (PSW) role as part of our wider approach to embed lived experience and coproduction at the heart of our services. Introduced in 2020, peer support workers are now working across a number mental health inpatient and community services. Commencing with twelve Peer Support Workers (PSW's) recruited in 2020 as part of the Community Mental Health Team (CMHT) Transformation, there are now seventeen in post with plans in place to recruit to a further nine whole time equivalent (wte) posts.

Peer Support Workers (PSWs) are individuals with personal lived experience of mental health challenges, by building on shared experiences and empathy, they can support individuals, staff, and services to work within the principles of a recovery approach focussed on personalised support.

2. Current Service Overview

A robust induction and development plan is in place to support the introduction of the new roles. Ongoing personal development for each PSW is continuous and ongoing and it is clear that their skill and confidence in their roles is growing. Additionally, a co-designed service operating procedure in line with Trust policies and values, has been developed to support these roles and is available to all existing PSW team members, supporting/supported team members and new starters. All Humber PSWs are managed and supervised (both clinically and managerially) by a senior member of the team they work within. They are actively involved in the routine service activities e.g., they participate in multidisciplinary team (MDT) meetings, daily and weekly safety huddles etc. The table below sets out the current position with PSW roles:

Service/ Team	**No. of PSW posts in place**
East Riding (ERY) Primary Care Mental Health Networks	7.0 wte
Hull Primary Care Mental Health Networks	5.0 wte (employed by Hull and ERY MIND)
STARS (rehabilitation service)	2.0 wte
Westlands	1.0 wte
Home Based Treatment Service	1.0 wte
Forensic Service	1.0 wte

To ensure that consistent support and access to development is in place, the peer support worker roles across all services are overseen by our Prevention, Recovery and Wellbeing Service (PRWS). This service has now brought together our Individual Placement Support and Positive Assets (employment services) with our recovery college, social prescribing, health trainers and Trust

volunteer service. This has created a distinct and robust pathway by which our recovery focussed services have been integrated to optimise access and outcomes for our service users. The PSW's come together monthly to ensure that their development needs are being met and progressed, for group peer support and to participate in and support plans to expand the number of roles further. PSWs have a strong connection with the Recovery College and are involved in both the co-production and delivery of curriculum activities. They are actively involved in the Trust Lived Experience group, and many represent their teams in the Patient and Carer Experience (PACE) forum.

An integral part of the Trusts ongoing support and development of the PSW role is to create a supported and clear pathway for individuals with lived experience to be successfully recruited into these posts, for example an individual can be signposted and supported by any of our services and our partners to become a volunteer, they might also be supported by our employment services and at the same time they can access a wide range of support from our recovery college including our Peer Support Training modules. Launched in 2021 this course is specifically designed to prepare people to apply for these roles. This course includes the following elements:

- Ethos and values of PSW
- History of PSW
- Benefits of PSW
- Why PSW in Mental Health and Recovery?
- PS within Humber
- Supervision for PSW
- Our PSWs – their experience.
- Peer support champions and mentor scheme

This new co-designed peer support course is available on our Recovery College platform. A PSW champion network is available for people who have completed the course to join and receive ongoing support to continue to volunteer or access paid roles. This approach has been developed in partnership with colleagues in the voluntary sector to widen the scope of opportunities available for people with lived experience to achieve paid employment. Our intention is to build further on these pathways to support access to other paid roles in the Trust and with our other partners.

3. Service development plans

Learning from other Trusts who have successfully embedded these roles it is critical that the support and developmental structure for these roles is effective and robust. Now that this architecture is in place and developing, our mental health and learning disability services have plans to expand the number of PSW roles into new service areas. These include nine new posts based in:

- Complex Emotional Needs Team
- Homeless Mental Health Team
- Improving Access to Psychological Therapy (IAPT)
- Early Intervention in Psychosis (Psypher)
- Perinatal Community Service

4. Peer Support Worker Roles within Primary Mental Health Networks

The Trust first established the peer support worker roles as a key element of the community mental health team transformation and placed them within the Hull and ERY primary mental health networks. The ERY team are directly employed via the Trust and the Hull team are sub-contracted

via our partners at Hull and East Yorkshire (HEY) Mind. The East Riding team has been fully embedded since December 2020 and Hey Mind since March 2021. A key element of their role within the networks is to work directly with service users. Referrals for the PSW's are being received by all team members via both primary and secondary mental health services, feedback from all teams and service users has been extremely positive. Referrals are discussed by the MDT and clinical responsibility remains with clinical leads throughout. Services users are assessed as suitable for peer support as part of a personalised discharge plan from Primary Mental Health Services back to General Practice and the Community.

PCMHN Peer Support Referrals to date - *Jan 2021 – Jan 2022*	
Area	**Total**
ER	147
Hull	132
Total	**279**

All service users receiving peer support have an active referral within the electronic patient record for the duration of that support. Referrals are allocated to individual PSWs, and all contacts are being recorded against these referrals.

5. National Training and Development Programmes

Supporting these roles with effective training and development is critical to ensuring that they succeed, thrive, and develop within our services. The Trust applied for and was successful in accessing a fully funded 12-week PSW training course (accredited to Level 4/30 UCAS Points) provided by Teesside University. Twelve peer support workers accessed this programme and eleven completed it, further cohorts are planned. Teesside University also provide a PSW Supervisor 8-week course – this has been completed by one staff member with plans in place for further uptake. All PSW's have received Royal Society for Public Health (RSPH) Training for Making Every Contact Count (MECC) mental health and most have completed the RSPH level 4 training for behavioural change.

The Trust have participated in a Trailblazer group working with Health Education England (HEE) as part of the development and coproduction of a PSW Apprenticeship. We registered our interest for five PSWs to commence this programme in January 2022 and ten additional PSWs to commence January 2023. Unfortunately, the programme has been delayed due to HEE difficulty in sourcing apprenticeship deliverers.

The Trust is also working in partnership with ImROC (Implementing Recovery through Organisational Change) to access a package (supported by HEE funding) that includes:

- **Organisational Preparation –** To support the overall organisational understanding of Peer Support and their commitment to supporting all staff with lived experience including peer workers
- **Team Preparation Training and Support –** Support for teams to understand the rationale for peer workers, their role, their status (as a colleague, not as a 'patient') and their employment conditions.
- **Training for Trainers** to co-deliver ImROC Peer Support Training within Trust to all existing / new PSW Team Members.

This commenced with a series of 'Team Preparation' workshops which were attended by over one hundred staff from all areas of the Trust focussed on utilisation of peer support within mental health

recovery and effective support and integration of this lived experience role within our services. Within this partnership agreement ImRoc will continue to support the Trust to develop our lived experience workforce whilst effectively utilising, and maintaining, the integrity of this vital role. They are providing some external, group supervision to the Peer Support Team and are working with the Recovery College to complete an in-depth review.

6. Peer Support Workers – feedback

Supporting these roles well is crucial and feedback both from our staff in these roles, services, and service users that they work with is sought through a variety of mechanisms and below is a selection of what they say:

"Work with clients feels valuable and impactful; ability to offer validation, time and person-centred support has led to excellent results as seen in some of our case studies and 100% feedback on Friends and Family Tests."

"A gap in mental health services is being filled and peer support is helping to transform the way we deliver mental health support."

"Remit of role not always clear"

"Band 2 does not reflect the work PSWs do"

"I wanted to be in the role because I know from personal experience how powerful validation can be. I did not realise I would be involved in so many clinical meetings it is inclusive and is a good thing. Initially I didn't expect this but makes me feel treated as an equal and listened to and I feel valued."

"PSW was there to listen to me, encourage me in my small successes and provide validation when I found things hard. I am now in recovery and receiving counselling and I honestly believe I would not have come this far without PSW help." – Anonymous service user – Beverley PCMHN

"Being able to talk to PSW as someone who truly understands what it is like to feel that way has actually made the most difference in my current situation." – Anonymous service user – Cygnet PCMHN

"One thing I like is that there's more of a connection because it's fortnightly instead of once every 6 months, it's really nice to have a second opinion and other input on top of my own, it helps for things to not be one sided in my head and for providing a different outlook, and it's less 'professional' and more human compared to some other people which also helps with the connection." – anonymous service user Harthill PCMHN

7. Next Steps

The plan over the coming year is to:

- Ensure that the training and development opportunities available to support both the PSW roles directly and the services and wider staff teams they are based within are fully optimised and the outcomes evaluated.
- Increase the number of PSW roles in our services
- Evaluate the impact of these roles on service user and carer experience working with our PACE (patient and carer experience team).
- Evaluate the Peer Support worker course provider by the recovery college and its impact on supporting people to apply and be appointed to paid roles

- Build on the partnership working with wider stakeholders to support and expand the opportunities for people with lived experience in services.
- Develop a Peer Support Worker competency and career framework – utilising PSW apprenticeship accredited learning and ongoing personal development to ensure a pathway for progression.

8. Conclusion

The board are asked to note the content of this update, the progress made to embed and develop the Peer Support Worker roles and the plans in place to both expand but also to evaluate the impact they are having.

Humber Teaching NHS Foundation Trust

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting - 30 March 2022
Title of Report:	Infection Prevention and Control Board Assurance Framework
Author/s:	Executive Lead: Hilary Gledhill, Executive Director of Nursing, Allied Health and Social Care Professionals Report Author: Deborah Davies, Lead Nurse, Infection Prevention and Control
Recommendation:	To approve ( ) To receive & note (x) For information ( ) To ratify ( )
Purpose of Paper:	The purpose of the report is to provide an update of the ongoing work and progress made to achieve full compliance and assurance against the key lines of enquiry outlined in the recently refreshed National Infection Prevention and Control Board Assurance Document (1.8 released in December 2021).
Governance:	Audit Committee – Date Quality Committee – Date Finance & Investment Committee – Date Mental Health Legislation Committee – Date Charitable Funds Committee – Date Remuneration & Nominations Committee – Date Workforce & Organisational Development Committee – Date Executive Management Team – 14/03/22 Operational Delivery Group – Date Collaborative Committee – Date Other (please detail) – Date
Key Issues within the report:	This report provides an assessment of compliance against the updated Infection Prevention and Control Board Assurance Framework Document published December 2021 version 1.8 and highlights the actions to be taken to address areas where full assurance cannot yet be provided. The key changes in version 1.8 are highlighted within the body of the 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

Caring, Learning & Growing Together

√	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	

BACKGROUND

The Infection Prevention and Control (IPC) BAF has been developed to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19-related infection prevention and control guidance and to identify risks and mitigating actions. The first version was published on 4 May 2020 and included 60 key lines of enquiry (KLOE). The BAF continues to evolve and additional lines of enquiry have been added additions since the last update (highlighted in yellow). Although using the framework is not compulsory NHSE/I recognises its use as a source of internal assurance to support all organisation's in the maintenance of quality standards.

The information below provides an assessment of the processes and IPC measures in place to demonstrate compliance against the additional lines of enquiry as a consequence of the updated document (v1.8)

Infection prevention and control board assurance framework

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
□ a respiratory season/winter plan in place: o that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on the pathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units aspart of the Trusts winter plan.	Standard Operating Procedures in place for all Divisions within the Trust which reflect the recommendations outlined within national guidance document 'Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 (www.gov.uk) The current isolation and screening requirements are included within each of the SOPS and are updated as the national and local picture changes. The Trust has stood down the routine use of COVID designated units within adult mental health to care for positive COVID cases however there are processes are in place to support the isolation of any COVID-19 positive patients within their respective clinical areas. Hot and cold areas within each unit are adopted when feasible to segregate the patients according to category of risk. Evidence; Minutes of incident/outbreak meetings/IPC alert organism call log available A multi-disciplinary is adopted in the creation and improvement of facilities. Multi- disciplinary involvement and attendance noted on The COVID Task Group The Clinical Environmental Risk group (CERG) Examples of collaborative work completed • the setting up of COVID-19 designated areas. • The completion of Workplace Risk Assessments within both clinical and non-	A review of the Trust Influenza Plan for 2022-23 is required to ensure any additional elements required as a consequence of COVID-19 are included. The Trust is not able to provide point of care testing (for any respiratory virus other than COVID-19 testing for seasonal respiratory viruses) Difficulties may occur due to patient presentation. Where patients are not detained movements and exposures are as limited as far as practicably possible	Meeting arranged between the Emergency Planning and IPCN Lead to determine a time frame for completion. Expected to be delivered for the end of April 2022 Lateral flows completed on admission to all admitting areas within mental health to optimize the use of limited en-suite facilities. Mechanisms are in place to access the level of testing required from secondary care.

	clinical settings • The installation of the ventilation system at ECT • The planning and the delivery of health and well- being facilities in all clinical areas. • Involvement in the initial planning stages of the Humber Centre improvement work. • Regular meeting attendance at the COVID CERG Evidence IPCT call logs Incident and outbreak meeting minutes. Minutes of CERG and COVID Task Group meetings Workplace Risk Assessments are in place within each Trust occupied building. Any risks identified have been mitigated against where possible. This has included the use of barrier screens in reception areas, modification to the ventilation in a selection of the primary care settings and the use of maximum occupancy signage displayed within each room/ area.		
□ health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	A detailed ventilation survey of all primary care settings has been undertaken and remedial work is in the final stages of completion within the Humber Estate. Inpatient ventilation survey audit programme in progress across the Trust Estate. Multi- disciplinary Ventilation Group initiated and inaugural meeting held on the 28.2.22 Evidence Survey reports for all audited areas. The installation of a ventilation system within the ECT Department. Contract for newly appointed Authorised Ventilation Engineer in place. Minutes of the inaugural meeting of the Ventilation Group held on the 28.2.22. Terms of reference agreed and available.	A Review of the risk assessments in place undertaken in the non-clinical environment to ensure all changes in the national guidance is reflected e,g changes to the minimum social distancing requirements Improvement work required cannot be progressed in a small majority of the surgeries due to being non-Trust owned building requiring owners approval. The survey of all in-patient areas has not yet been completed in all areas.	Social distancing and PPE in all areas remain in place. Staff advised to open windows where this is practicable.

Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in thelocal area. o applied in order and include elimination; substitution, engineering,administration and PPE/RPE. o communicated to staff.	All risk pertaining to IPC are discussed and reviewed as part of the local Governance processes and placed upon the Trust risk register when required. Evidence. IPC risk register entries. A review of the risks associated with the management of each confirmed COVID-19 positive patient, incident or outbreak is completed in conjunction with the IPCN, Matron, and Unit Lead. The use of RPE is recommended when the risk of transmission is deemed to be high. Notes and evidence of actions taken are available as part of the IPCT notes/ log / incident/ outbreak meeting minutes.	None	Not Required
safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have beenapproved through local governance procedures, for example Integrated Care Systems. if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has beencompleted and it has been approved through local governance procedures, for example Integrated Care Systems.	All IPC current systems of work remain in line with the current national guidance as a minimum standard. Where there has been any deviation from the minimum standards outlined within the national guidance the risk is assessed through the Trust Governance processes and escalated via the Trust Board or command structure and communicated to staff through a variety of means, including EMT briefings and Q&A's with The Trust Executive Management Team. IPCT Link practitioner catch ups	None	Not Required
risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	IPC quality visits, H&S and IPC risk assessments, modern matron audits, inpatient and community setting in place. All workplace risk assessments have been completed by staff who have the skills and knowledge to recognize hazards associated with infectious agents Aide memoire produced to support staff and oversight of all assessments completed will continue to be provided by the Health and Safety, Estates or the Infection Prevention and control Team.	None	Not Required
• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE)for patient	The use of RPE is considered in the management of every individual patient confirmed as COVID positive and any areas of higher than expected	None	Not Required

care in specific situations should be considered.	cases such as in an outbreak in accordance with the IPC hierarchy of controls requirements. Evidence Incident meeting minutes/ Outbreak meeting minutes IPCT alert logs		
• ensure that patients are not transferred unnecessarily between care areasunless, there is a change in their infectious status, clinical need, or availability of services.	All patients identified with a communicable disorder (including COVID 19) are individually assessed in conjunction with the IPCT prior to any movement to ensure they are cared for in an appropriate location. The assessment makes consideration of their clinical needs and the effective use of available facilities ie rooms with en-suite facilities to maintain both patient safety and the protection of others. No moves take place without due consideration. When operational capacity issues are seen to be a challenge within mental health services the IPCT will attend bed planning meetings to support the decision- making process. Daily bed review completed in conjunction with the IPCT to manage beds within Malton Community Hospital Evidence IPCT call logs Incident / outbreak meeting minutes	None	Not Required
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases.	All data produced by the Trust Business Intelligence (BI) Team is scrutinised for accuracy and signed off daily by the Director of Infection and Control (DIPC) or in their absence the Deputy Director of Nursing Evidence includes: • BI report sent to DIPC and Chief Operating Officer • The daily Sitrep Report.	None	Not Required
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	The Executive Nurse, Medical Director and Matrons have maintained visibility in each of the clinical inpatient areas throughout all phases of the pandemic and have challenged IPC practice when required.	A limited programme in place in the initial stages of the pandemic to minimise the potential risks of transmission but visits have	Guidance for Non-Executives undertaking site visits during COVID Pandemic produced and a schedule of visits

	IPC quality visits, H&S and IPC risk assessments, and matron audits, in use across inpatient and community settings. The IPC Assurance Framework (this document) once updated is presented at Trust Board by the DIPC/ Lead Nurse.	increased throughout the latter stages of the pandemic	arranged.
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agencyand external contractors).	The availability of resources has continued to be actively monitored and managed by the Trusts PPE team and review at HAIG. A good level of supply has been maintained in all areas and no issues identified.	None	Not Required
• the application of IPC practices within this guidance is monitored, eg: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination.	An IPC audit monitoring programme is in place which includes the routine monitoring of hand hygiene, PPE donning and doffing within all inpatient settings and has been maintained throughout all phases of the pandemic by the Matrons, the IPCT and the Link Practitioners. All audit results are completed and stored on MyAssurance. The results of the audits are included within the matron reports and are reviewed by the Healthcare Associated Infection Group (HAIG) which is chaired by the Director of Nursing, Allied Health & Social Care Professionals. An additional audit tool has been developed specifically to measure performance around COVID-19. Additional audits have been completed by exception and the findings are included as part of the outbreak meeting reports with action/learning captured. Informal spot checks have been undertaken February/ March 2022 in all clinical inpatient areas by the IPCT and Matrons utilising the 'Every Action Counts' Checklist. Immediate feedback is provided and a subsequent action plan is produced and circulated. Copies of Every Action Counts Audit Reports Every Action Counts Action plans IPC Audit reports (stored on MyAssurance).	None	Not Required
• the IPC Board Assurance Framework is	The IPC BAF has previously been presented at	None	Not Required

reviewed, and evidence ofassessments are made available and discussed at Trust board.	both the Quality Committee and the Trust Board meetings in 2021.This report is due for presentation to the Board on the 30.3.22 Evidence; minutes of Board and QPaS meetings.		
• the Trust Board has oversight of ongoing outbreaks and action plans.	Trust Board members are kept updated of any outbreaks and action plans via the DIPC who is also the Executive Director of Nursing, Allied Health & Social Care Professionals. In addition IPC check and challenge opportunities are available throughout the regular Executive Management Team Meeting and through the Governance framework including HAIG, QPAS and the Quality Committee.	None	Not Required
• the Trust is not reliant on a particular mask type and ensure that a range ofpredominantly UK Make FFP3 masks are available to users as required.	The Trust is currently using 8 different types (5 brands) of disposable FFP3 masks with an active programme to ensure diversification. The Trust PPE team monitor usage across the Trust to ensure there are sufficient supplies in all required areas. No issues identified. Updates of any communication received from the national team are provided at the HAIG meetings – now quarterly. Evidence. Fit testing database / ESR records / HAIG meeting minutes	None	Not Required
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at boardlevel.	The National Standards have been reviewed in conjunction with Hotel Services, the IPCT and the Matrons. A draft implementation plan has been developed to adopt the standards outlined within the national guidance within the nationally agreed time frame.	The plan is currently being finalised.	The Patient Environment Manager, Hotel Services to present to the EMT for consideration and approval in April.
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	The Trust has distinct processes in place to manage changes in the functionality of areas/ rooms For individual rooms A new works request is made via the Estates Helpdesk. The Estates team then work with the users and other stakeholders to ensure that any requests are considered in line with the Building Regulations	None	Not Required

	A Capital investment application is made when the changes are more significant in nature (i.e. new accommodation of reconfiguration of an area to suit a change in service need or refurbishment) then this would be included in a capital investment application, which is monitored via the Estate Strategy and Capital Group. No issues have been identified with either process		
• cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment.	A Trust Cleaning Monitoring Programme is in place the results of which are discussed at local level in the Quality / Business User Group meetings. 95% standard achieved in Q1,2,3 2021-2-2022. A review of the cleaning performance data and any remedial actions required are included as a quarterly agenda item at HAIG. Routine standards of cleaning are also monitored by the Matrons and the IPCT in each of the clinical in-patient areas as part of the IPC audit programme. Reports available and presented at HAIG.	None	Not Required
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	An enhanced level of cleaning is undertaken in any areas where the transmission of infection is deemed to be high. This is monitored by the supervisor for the area. Evidence. Monitoring records /Matron audit reports/ IPC Walk round reports	None	Not Required
• Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solutionat a minimum strength of 1,000ppm available chlorine as per national guidance.	A chlorine releasing agent is utilised throughout he Trust when caring for any patient who is deemed to be infectious due to a respiratory organism in accordance with the national guidance recommendations. Evidence outbreak meeting minutes available	None	Not Required
• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effectiveagainst enveloped viruses.	All cleaning products utilised within the Trust are in accordance with national guidance therefore not applicable	None	Not Required
• manufacturers' guidance and recommended product 'contact time' isfollowed for all	Information re the use and dilution of all products is available on all sites. Information posters displayed in all clinical areas.	None	Not Required

cleaning/disinfectant solutions/products.	All domestic received initial and in house annual refresher training./ Risk and COSHH assessments completed for the products used (copies available**)** Compliance monitored by the area domestic supervisor.		
• a minimum of twice daily cleaning of: ○ patient isolation rooms**.** ○ cohort areas**.** ○ Donning & doffing areas ○ 'Frequently touched' surfaces eg, door/toilet handles, patient callbells, over bed tables and bed rails**.** ○ where there may be higher environmental contamination rates, including: • toilets/commodes particularly if patients have diarrhoea	An enhanced level of cleaning is undertaken in any areas where the transmission of infection is deemed to be high. All staff are reminded of the need to regularly decontaminate frequently touched surfaces. No issues have been identified with the ability to comply Evidence Incident logs / outbreak meeting minutes /outbreak debrief minutes Individual commodes or toilets are allocated for patient use when patient has diarrhoea to reduce the risk of transmission within the community hospital setting. All commodes are cleaned by the nursing staff. I am clean stickers utilised. me	None	Not Required
• A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removaland disposal/or laundering of all curtains and bed screens); ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and airchange within the room).	A process for arranging a terminal/deep cleans is in place in all clinical in-patient areas. A formal sign off for each clean undertaken was introduced in 2021 which included the required completion of a formal sign off sheet. Evidence; Sign off sheets available from the Hotel Services Team.	None	Not Required
• reusable non-invasive care equipment is decontaminated: ○ between each use**.** ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaningprotocol ○ before inspection, servicing, or repair equipment.	The cleaning of all re-usable equipment is undertaken in line with the national and manufacturers guidance. Performance is monitored as part of the IPC and Matron audit programme and results are documented within MyAssurance. All results are included as part of the Matron reports presented at HAIG	Inconsistencies noted in the completion of documentation in some areas on occasion	Reminders and targeted actions provided to the areas identified

• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Evidence; Local cleaning lists, IPC and Matron audits results./ Matron quarterly audit reports HAIG meeting minutes	None	Not required
• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet nationalrecommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estatesteams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	A survey of the ventilation survey has been completed within primary care and completed in a selection of the Trust inpatient areas. Specialist Team contract in place to undertake a complete the surveys within the inpatient units Oversight available from the newly appointed Trust Authorised Ventilation Engineer. A Multi-disciplinary Ventilation Group has been initiated to and an inaugural meeting has been held on the 28.2.22. Evidence Survey reports for all audited areas. The installation of a ventilation system within the ECT Department. . Minutes of the inaugural meeting of the Ventilation Group held on the 28.2.22. Terms of reference agreed and available.	None	Not Required
• where possible air is diluted by natural ventilation by opening windows and doors where appropriate	The opening of doors and windows is encouraged. A review of the ability to open the windows (when safe to do so) completed in all reception and primary care areas and any remedial work required undertaken	None	Not Required
• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates / ventilation group.	The exploration of the use of HEPA filters 'air scrubbers' and carbon monoxide monitors currently underway.	None	Not Required
when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Screens and partitions considered as mitigation and in place in reception areas across the Trust where required.	None	Not Required

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and process are in place to ensure that:
• arrangements for antimicrobial stewardship are maintained
• previous antimicrobial history is considered
• the use of antimicrobials is managed and monitored:
  ○ to reduce inappropriate prescribing.
  ○ to ensure patients with infections are treated promptly with correctantibiotic.
	Electronic prescribing in place in the majority of our inpatient units with prescribing pathways in place.
	
	Access to locally approved antimicrobial formularies available on the intranet. (Guidelines for Treatment of Infections in Primary Care in Hull and East Riding)
	
	All inpatient units and primary care practices have a clinical pharmacist in place to provide daily support and guidance. Additional technician support is available in the majority of units.
	
	Audits of prescribing compliance completed for mental health and learning disability settings. Results discussed and presented at the Drugs and Therapeutic Committee/Clinical network meetings and HAIG.
	
	Audits of prescribing compliance completed for primary care settings. Results discussed and presented at the Drugs and Therapeutic Committee/Clinical network meetings and HAIG.
		No Electronic system in place at Malton Community inpatient unit.
		
		Hull and East Riding Infection Control Antimicrobial Formulary noted to be out of date.
		
		No current audit results in the community in patient unit (Whitby and Malton)
		
		Prescribing performance data shown to be in the 'Red' category for a selection of primary care settings (last audit completed October 2021)
			A request for this work has been made for this work to be prioritized by the Clinical Digital Systems in 2021-2022. Updates to be provided to HAIG by the Chief Pharmacist.
			
			An update on progress of the review has been requested and details of the anticipated completion sought to determine the time frame for completion.
			
			Prescribing audit to be completed in the community in patient unit (Whitby and Malton) In quarter 1 2022
			
			Any patient prescribing queries escalated to the Pharmacist or Microbiologists when required.
			
			Targeted remedial plans are in place for each of the areas shown to be in the red category. A repeat and review of the antibiotic data to be completed at 6 months.
			
			A report of the progress to be presented to Drugs and Therapeutic Group

mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	All required mandatory reporting is in place and managed on a day to day basis by the IPCT. Data is included as part of the monthly Integrated Quality and Performance Tracker with narrative attached when required.		
• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	The Trust prescribing guidance and the regular pharmacy support within each of the inpatient units assists in the minimization of risk of consequences of other pathogens such as Clostridiodes difficile and others. Post infection reviews are completed for any potential Trust apportioned case of a communicable infection which potentially may have been precipitated by the use of antibiotic to identify any themes which are reviewed through the governance processes.	None	Not Required
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing ofpatients, staff and visitors	Compassionate visiting arrangements are in operation within the Trust ensuring that when safe to do so all patients are able to have support in hospital from the people who matter to them.	None	Not Required
national guidance on visiting patients in a care setting is implemented.	The Trust visiting guidance SOP is regularly reviewed to ensure it reflects national guidance. Version 12 is currently in draft and awaiting approval at the Clinical Advisory Group on the 15.3.22	None	Not Required
restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	The restriction on visiting is carefully considered at each outbreak meeting as a standard agenda item to ensure the least restrictive options are put in place and is individually risk assessed. The Mental Health Legislation Team attend the outbreaks within mental health to support decision making. Exceptional visits are minuted within the outbreak minutes or in the individual patients records. Evidence; Trust Visiting Guidance SOP Individual patient records / Outbreak meeting minutes	None	Not Required
there is clearly displayed, written information available to prompt patients'visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	Standardised posters are available throughout the Trust and a selection of national guidance and videos available on the Trust intranet site as a prompt. Posters have been updated at regular intervals throughout the pandemic. Posters reinforcing the importance of the	None	Not Required

	continued wearing of facemasks refreshed. Compliance has been formally monitored utilizing the national COVID-19 Monitoring checklist tool (February 2022). IPC Compliance overall noted to be good. Informal spot checks and impromptu training sessions completed by the matrons and IPC visits to the clinical areas. Immediate feedback is provided. Evidence includes: Posters Back to basics posters Key messages circulated via global email		
if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	All visitors entering any of the Trust premises have been booked in prior to attendance. All are triaged on admission and have completed a lateral flow test prior to the visit unless there are extenuating circumstance which have been agreed prior to the visit. Any PPE requirements required are explained as part of the triage process. Records available at individual unit level	None	Not Required
visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (endof life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	There have been no circumstance up to date where this has been applicable within the Trust. However if this arose in collaboration with the IPCT an individual plan of care would be initiated to maintain patients, staff and visitors safety	None	Not Required
visitors are not present during AGPs on infectious patients unless they areconsidered essential following a risk assessment eg, carer/parent/guardian.	There have been no circumstance up to date where this has been applicable within the Trust. However if this arose an individual plan of care would be initiated to maintain patients, staff and visitors safety.	None	Not Required
Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Elements of the document which are deemed to be appropriate for the Trust have been introduced. This includes the use of the; Every action counts Vulnerability Assessment Tool COVID 19 Check List Assessment in both inpatient and primary care areas IPC Champion role info utilized for the development of the link practitioners The Hierarchy of Controls Video (made available on the Trust Intranet)	None	Not Required

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage is evident at the entrance of all Trust building. Posters available throughout the Trust Estate. Compliance has been formally monitored utilizing the national COVID-19 Monitoring checklist tool (February 2022). IPC Compliance overall noted to be good.	None	Not Required
• Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Infection prevention and control admission, transfer and discharge policy in place. No untoward incidents reported related to IPC due to an absence of communication between the Trust and any receiving organizations	None	Not Required
• staff are aware of agreed template for screening questions to ask.	COVID SOPS in place outlining staff responsibilities. Triage templates are in place and are included within the Systm One and Lorenzo IPC risk assessment documentation. An audit of staff compliance is completed monthly and results are presented as part of the Matrons report	None	Not Required
• screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Not applicable within the Trust	None	Not Required
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection asper national guidance.	All patients admitted in accordance with the SOP appropriate for the respective area. A review of the measures taken reviewed on receipt of any positive COVID result as part of the post infection review (PIR)	None	Not Required
• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	All PCR tests are undertaken only by an individual who is competent in the undertaking of this task. A Training video is on the Trust Intranet to support practice. Individual training may be made available from the IPCT if required. The patient is then isolated until the results are received	None	Not Required
• there is evidence of compliance with routine testing protocols in line with trust approved hierarchies of control risk assessment and approved.	A review of each COIVD-19 positive patient's admission data is completed. Monthly prevalence audits in place which confirm a high level of compliance with screening.	None	Not Required

patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	Clear advice provided to patients suspected or confirmed with a respiratory infection.	Poor compliance noted within the mental health units	Ongoing need to continually reinforce the message
patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.	All patients within the Trust who have commenced with respiratory symptoms have been nursed in a single room. Evidence IPC call logs /incident meeting and outbreak meeting minutes	None	Not Required
patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	All patients within the Trust presenting with COVID-19 symptoms have been placed in a single room. Evidence IPCT call logs	None	Not Required
patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	All patients undergo a clinical assessment as part of their initial admission assessment.	The need for protective measures however may not always be recognized on admission particularly within the mental health units.	A revision of the IPC Triage tool to be completed to support staff identify vulnerable individuals. Amendments made will be incorporated by 1.4.22
where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	All positive COVID-19 patients are reviewed on a daily basis in conjunction with the IPCT. Any clinical interventions planned are assessed according to clinical need. Evidence patients records IPC call logs	None	Not Required
face masks/coverings are worn by staff and patients in all health and care facilities.	Fluid repellant masks available at all entrances of Trust premises Visual reminders available throughout the estate Observational audits completed and compliance noted to be good in the clinical settings. Staff Track and trace data scrutinized for any breaches identified for positive cases	None	Not Required

□ where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	All infectious respiratory patients within the Trust have been cared for in single room facilities in 2021-2022. There has been no occasion up to date when cohorting has occurred. If cohorting required however (Malton and Whitby) 2 metres social distancing can be maintained within the bay areas. Evidence. Discussion notes re inspection of bed space within the bays.	None	Not Required
□ patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	Social distancing measures in place throughout the Trust estate. This includes the implementation of barriers and the use of screens at reception areas and maximum occupancy signage.	Communal space within some of the units pose some difficulties in the achievement of the social distancing requirements.	A continual review of the areas in place. A multi disciplinary walk round of all in-patient units to take place during Q1 2022. Immediate measures taken include the feasibility/ introduction of 2 meal sittings / replacement of settees with single chairs / a review of the tables used for dining.
□ patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. □ isolation, testing and instigation of contact tracing is achieved for all patientswith new-onset symptoms, until proven negative.	Screening protocols in place which includes rescreening / re testing. The patient is isolated in accordance with the respective SOP for the area. A review of each positive case is conducted in conjunction with the IPCT and details of all potential contacts are ascertained. Any potential contacts are cohorted in accordance with national guidance. Evidence IPC call logs Patient records Incident meeting/ outbreak meeting minutes PIR reviews	None	Not Required
□ patients that attend for routine appointments who display symptoms ofCOVID-19 are managed appropriately.	SOP in place to support the management of any individual presenting with symptoms. 'Red areas' set up in all primary care settings to see any patient who requires a face to face appointment	None	Not Required

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that:			
□ appropriate infection prevention education is provided for staff, patients, and visitors.	PHE and Gov.uk information available on Trust website PHE site has link to Easy read versions. Staff encouraged to print out for patients and carers who may not have access to leaflets. On- line training IPC training programme is in place for both clinical and non-clinical staff. The use of Videos demonstrating donning and doffing along with PHE visual guides are available to support staff in the choice and application of PPE is available on the Trust intranet site to access 24/7. Standardised posters available and have been disseminated to wards and departments, demonstrating what PPE is required and when.	None	Not Required
□ training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	The IPCT team and link practitioners continue to provide practical sessions for staff when requested or required. it test and fit test training is provided for any individual who may be required to wear a filtered face piece (FFP3) as part of their clinical duties. Key FFP3 mask fit trainers in place in the majority of clinical areas	None	Not Required
□ all staff providing patient care and working within the clinical environmentare trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;	On line training IPC training programme is in place for both clinical and non-clinical staff. The use of Videos demonstrating donning and doffing along with PHE visual guides to support the appropriate wearing of PPE is available for to both clinical and non-clinical staff at a time to suit them.	None	Not Required
□ adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. □ gloves are worn when exposure to blood and/or other body fluids, non- intact skin or mucous membranes is anticipated or in line with SICP's	PPE compliance audits programme in place includes the use of gloves undertaken within all inpatient units by the IPC link practitioners. Data is entered on to the Myassurance database and presented as part of the matrons quarterly report at HAIG. The actions taken are highlighted within the Matrons performance	None	Not Required

andTBP's.	report as an exception. Impromptu checks also completed by the IPCT. Evidence includes: • Demonstration videos • Posters • Audit reports of IPC practice and clinical environments • HAIG minutes		
the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splashcontamination as per national guidance.	No hand dryers are utilized within the clinical areas within the Trust	None	Not Required
staff maintaining physical and social distancing of 1 metre or greaterwherever possible in the workplace	Every Action Counts COVID 19 Observational Audits completed by the Matrons/ IPCT in February 2022 indicates that staff compliance with the requirement for 2 metres social distancing (when appropriate) within the clinical environments remains good.	None	Not Required
staff understand the requirements for uniform laundering where this is not provided for onsite	Uniform policy in place on the Trust intranet which outlines the uniform laundering requirements due to COVID-19. No issues have been identified with the delivery of this SOP	None	Not Required
all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms(even if experiencing mild symptoms) in line with national guidance.	National and Trust guidance for staff available on the Trust Intranet site and 7 day support and guidance is provided via the Humber Track and Trace Team Additional advice is provided on a daily basis from The IPCT team.	None	Not Required
to monitor compliance and reporting for asymptomatic staff testing	Staff are encouraged to undertake LFD testing twice weekly and to document results on the Trust reporting portal. The compliance data for each division is reported as part of the weekly operational report. Test and trace data obtained from COVID positive staff members is analysed on a daily basis by the IPCT to identify any potential compliance issues	The documentation of results noted to be low	Regular reminders to report both negative and positive results are provided regularly via the Trust briefings.
there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	Regular local and regional colleagues pertaining to IPC are attended by the DIPC or the Lead Nurse with data shared across agencies and meetings. Minutes and dashboards available.	None	Not Required

positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and arereported.	All cases that meet the UKSA criteria for definite or probable hospital acquisition of COVID-19 have been reviewed in conjunction with the respective area manager, matron and the IPCT. A PIR case is completed for each case classified as probable or definite. A preliminary incident meeting is held to determine whether the cases are associated in time place. If this has occurred an outbreak is reported in accordance with guidance. Evidence, Incident meeting minutes Outbreak meeting minutes PIRs	None	Not Required
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	The wearing of masks is actively encouraged within all our in-patient settings. Observational audits completed by matron and the IPCT	Compliance poor particularly within mental health. The advice provided not consistently captured within the patients records.	The number of visual reminders to be increased in communal areas. Reminder sent to all units to capture the discussions that are held with the patient re mask wearing
separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic schedulingto reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Digital appointment system utilized when required Designated 'Hot room' arrangements in place in all of the primary care setting to allow the segregation of potentially infectious individuals.	None	Not Required
patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred,their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. patients are appropriately placed ie, infectious patients in isolation or cohorts. ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care	In place. All patients have been isolated in accordance with the national guidance. Evidence Incident and outbreak meeting minutes Risk assessment reviewed and refreshed as required. PPE worn in accordance with national guidance. Evidence of appropriate use includes Observational audits reports Matron/IPC COVID audits /IPC. Compliance monitored via HAIG	Challenges have been experienced particularly with some patients within mental health	An individualized care pathway initiated to maintain the safety of both the patient and other.

requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased			
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals.	The Trust is reliant on local laboratories to undertake our screens (Hull/York). Both laboratories are fully accredited and have systems and processes are in place with the laboratories. Turnround is usually within 24 hours	None	Not Required
• patient testing for all respiratory viruses testing is undertaken promptly and inline with national guidance;	All patients are tested in accordance with the national requirements COVID-19. Additional testing is completed as required Evidence Incident review data Outbreak meeting minutes.	None	Not Required
• staff testing protocols are in place	All staff are tested in accordance with the national requirements. Evidence Track and Trace data.	None	Not Required
• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	Monthly reports produced via external partners from receipt to reporting produced by Pathology to NHSE/I	The Turn round time continues to remain variable at times due to the reliance on the laboratories as the service is provided.	Any concerns re the exceptional delay of any specimen is fed back directly to the Laboratory Manager via the IPCT team.
• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	In place. Prevalence audit of screening compliance completed monthly and data presented as part of the matron reports and presented at the HAIG meetings.	None	Not Required
• screening for other potential infections takes place	Screening protocols in place for MRSA in line with national guidance.	None	Not Required
• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	In place. Admission compliance data available. A negligible number of patients only admitted within the Trust with any respiratory symptoms suggestive of COVID-19.	Although compliance rates good for admissions screening compliance noted to drop	Reminders and feedback provided to areas where compliance is noted to drop

		in subsequent screening regimes ie day 3 and day 5-7.This has been noted to be due to patient compliance but documentation not always available to support this	
• that those inpatients who go on to develop symptoms of respiratory infection / COVID-19 after admission are retested at the point symptoms arise	Data scrutinised from 1.1.22 for all patients yielding a positive COVID positive result. All patient who had presented with symptoms indicative of COVID 19 had been tested in a timely manner. Prevalence audit of screening compliance completed monthly.	None	Not Required
• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily	Screening protocols in place. All admissions are screened on the day of admission day and day regardless of whether they are displaying symptoms. Compliance data collected monthly Screening programme in place. No incidents of non-conformity notified.	None	Not Required
• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge • those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	No patients identified as COVID have required transfer to a COVID designated setting.	None	Not Required
• there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance	Not applicable to the Trust	None	Not Required

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	A robust IPC audit monitoring programme is in place which includes the routine monitoring of hand hygiene, PPE donning and doffing within all inpatient settings and has been maintained throughout all phases of the pandemic by the Matrons, the IPCT and the Link Practitioners. All audit results are completed and stored on MyAssurance. The results of the audits are included within the matron reports and are reviewed by the Healthcare Associated Infection Group (HAIG) which is chaired by the Director of Nursing, Allied Health & Social Care Professionals. An additional audit tool has also been developed specifically to measure performance around COVID-19. Additional audits have been completed by exception and the findings are included as part of the outbreak meeting reports with action/learning captured. Informal spot checks have been undertaken February/ March 2022 in all clinical inpatient areas by the IPCT and Matrons utilising the 'Every Action Counts' Checklist. Immediate feedback is provided and a subsequent action plan is produced and circulated. Copies of Every Action Counts Audit Reports IPC audit data	None	Not Required
staff are supported in adhering to all IPC policies, including those for otheralert organisms.	Support is provided via the infection prevention and control team during office hours via email or telephone. Out of hours emergency advice is available via the Infection Control Doctor / Clinical Microbiologist on call for York hospital. Additional support is provided from the IPCT Link Practitioners and matrons within each of the clinical areas. All guidance documents are available for access 24/7 either on the COVID Intranet IPC website	None	Not Required
safe spaces for staff break areas/changing facilities are provided.	An extensive programme to improve staff welfare and changing facilities has been undertaken throughout the Trust clinical estate during 2021-2022. Details of work completed available via the Estates Team	None	Not Required

robust policies and procedures are in place for the identification of andmanagement of outbreaks of infection. This includes the documented recording of an outbreak.	All outbreaks declared in accordance with the national definition. Trust Outbreak policy in place which was updated to include the regional reporting arrangements for COVID outbreaks. All outbreaks are reported via the NHS England Outbreak Electronic reporting system.	None	Not Required
all clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored and managed in accordance with current nationalguidance.	All waste and linen managed in accordance with the national guidance. IPC audits completed indicate a high level of compliance.	None	Not Required
PPE stock is appropriately stored and accessible to staff who require it.	In place. Storage checked as part of the IPC audit programme. Any issues identified are actioned on the day of the visit.	None	Not Required
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice aspermanent staff.	Occupational health and IPC colleagues work together to provide advice and guidance in relation to COVID-19 and other infectious organisms. The IPCT are accessible to all staff whether bank or agency when specialist advice is required. Urgent Out of hours advice provided as part of a service level agreement. Bank and agency staff are managed in the same manner in terms of deployment. IPC support and advice is provided supported regardless of their method of employment. A range of guidance documents and policy documents are available on the Trust intranet to ensure staff have access to up to date guidance. Referral to Occupational health is available for Trust staff when deemed to be appropriate to support health and well-being. Staff continue to have access to an alternative range of options for wellbeing support and the Trust continues to enhance its offer of wellbeing resources via the “ShinyMind” app.	None	Not Required

	The Humber Coast and Vale Resilience Hub which continues to support frontline staff remains operational, providing an increased offer of psychological and emotional wellbeing support for our staff		
staff who are fully vaccinated against COVID-19 and are a close contact of acase of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	A protocol for the management of staff who potentially may be suitable to return to work is in place. This includes the manager completing a COVID exemption risk assessment tool to the individuals return to work. This is providing certain criteria can be evidenced, including vaccination status negative PCR test results, being asymptomatic and conducting daily latera flow tests in accordance with the guidance. Evidence. Managers Covid- 19 Risk Assessment Documentation Global communication emails	None	Not Required
staff understand and are adequately trained in safe systems of working,including donning, and doffing of PPE.	Mandatory IPC training programme in place IPCT Training records IPC Compliance audits.	None	Not Required
a fit testing programme is in place for those who may need to wearrespiratory protection.	An ongoing training programme is in place led by the IPCT. 50 fit testers trained across the organisation to support the team.	None	Not Required
where there has been a breach in infection control procedures staff arereviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness andabsence.	The COVID test and trace team provide advice to all staff who test positive. This includes an assessment of clinical activity within the 48 hour period prior to the commencement of symptoms. Any breaches in IPC practice and the potential of any contacts is completed.	None	Not Required
facilitate access of staff to antiviral treatment where necessary andimplement a vaccination programme for the healthcare workforce	Not utilized currently for staff within the Trust.	None	Not Required
lead on the implementation of systems to monitor staff illness, absenceand vaccination against seasonal influenza and COVID-19 encourage staff vaccine uptake.	The Flu and COVID vaccination programme has been led by the Executive Medical Director and the Trust Pharmacy Team with a selection of trained volunteers. The COVID vaccination programme has had an excellent response.	None	Not Required
staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	All staff are expected to comply with all nationally recommended infection prevention compliance in all instances. Evidence; IPC observational audits of compliance in place	None	Not Required

a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illnessfrom COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; ○ that advice is available to all health and social care staff, includingspecific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories shouldfollow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Risk screening process for all staff. Identified 'vulnerable' and 'at risk' groups and a detailed risk assessment process in place Local bespoke interventions and plans developed for each individual involving Occupational Health where appropriate BAME engagement / listening events in place Psycho-social support in place to support staff Individual risk assessments have been and continue to be carried out for staff identified as in the at risk groups. The completion rates for the assessments monitored by the Divisional Leads. All data included within the weekly Operational report.	None	Not Required
vaccination and testing policies are in place as advised by occupationalhealth/public health.	Policies in place	None	Not Required
staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained andheld centrally/ESR records.	All Staff required to wear FFP3 masks have received training that is approved by the HSE ie face fit tested by a Fit 2 Fit accredited trainer. All face fit tests are recorded (pass and fail) utilising approved HSE documentation. A copy of which is given to the wearer, the manager of their local department, and held on a central database and individual's property register on the ESR system.	None	Not Required
staff who carry out fit test training are trained and competent to do so.	All trainers who undertake fit testing within the organisation have received external fit 2 fit accredited training approved by the HSE and have been assessed as competent. Records available	None	Not Required
all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	All staff individual records include the details of the mask that the individual is fit tested against. A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	None	Not Required
all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	The Trust has an active ongoing programme to ensure staff who are required to wear an FFP3 mask have been fitted to at least 2 masks fitted.	None	Not Required

	A database of all fit test training completed is available and passes recorded on the staff members ESR property register		
a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	A record is kept of all fit test whether it is a pass or a fail. A record is given to the employee and also held centrally within the organisation.	None	Not Required
those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	A record is given to the employee of every fit test completed regardless of whether it is a pass or a fail which includes full details of the respirators and hoods used. A record is held via both the employee and on the staff members ESR property register.	None	Not Required
that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained accordingto the manufacturer's instructions.	Powered air purifying units have been purchased and are available across the trust sites for usage if an appropriate fit for an FFP3 mask cannot be found. A Competency training package develop to support the usage of the respirators.	None	Not Required
members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate withthe staff members skills and experience and in line with nationally agreed algorithm. a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employmentrecord including Occupational health.	The staff fit test training records reviewed by the IPCT on a weekly basis and this course of action not required for any member of staff at the time of writing this report	None	Not Required
boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	A SOP for the selection of respiratory protective Equipment and fit testing requirements within a clinical environment developed and approved. Updates are provided of the Trust position as part of the Health and Safety agenda. Updates provided to HAIG. The matrons report now reflect the training position for each of the clinical units. All data is available for viewing centrally.	None	Not Required
consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Not applicable to the Trust	None	Not Required

health and care settings are COVID-19 secure workplaces as far as practical,that is, that any workplace risk(s) are mitigated maximally for everyone.	Covid secure risk assessments completed and any non conformities actioned. Evidence Action Counts Reports and action plans/ IPC COVID observational audits	An update of the COVID assessment tools is required to reflect the changes in social distancing recommendation of 1 metre instead of 2 in non-clinical areas	Not required
staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Staff absences due to COVID are monitored in all divisions. Evidence; Weekly Operational Reports.	None	Not Required
staff who test positive have adequate information and support to aid their recovery and return to work.	Advice provided via the respective manager and Occupational Health. Return to work interviews undertaken. Compliance monitored of the return to work interviews completion rate. Evidence. individual staff records	None	Not Required