NHS
Humber Teaching
NHS Foundation Trust

Trust Board Meeting 29 September 2021
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 29 September 2021, 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 28 July 2021	CF	To receive & approve	√
4.	Action Log and Matters Arising	CF	To receive & discuss	√
5.	Patient Story – Graham's Story - 'If You Get Your Health Right, Everything Else Will Follow'	JB	To receive & note	√
6.	Chair's Report	CF	To note	verbal
7.	Chief Executives Report	MM	To receive & note	√
8.	Publications and Highlights Report	MM	To receive & note	√
	Performance & Finance			
9.	Performance Report	PBec	To receive & note	√
10.	Finance Report	PBec	To receive & note	√
	Assurance Committee Reports			
11.	Finance & Investment Committee Assurance Report	FP	To receive & note	√
12.	Charitable Funds Committee Assurance Report	PB	To receive & note	√
13.	Quality Committee Assurance Report & 2 June 2021 Minutes	MS	To receive & note	√
14.	Workforce & Organisational Development Committee Assurance Report & 21 July 2021 minutes	DR	To receive & note	√
15.	Mental Health Legislation Committee Assurance Report	MS	To receive & note	√
16.	Audit Committee Assurance Report	PB	To receive & note	√
17.	Commissioning Committee Assurance Report	PB	To receive & note	√
	Quality and Clinical Governance			
18.	Patient & Carer Experience (incl Complaints and PALs) Annual Report – Mandy Dawley, Head of Patient and Carer Experience and Engagement attending	JB	To receive & note	√
19.	Quality Improvement Strategy (2021-2026)	JB	To receive & approve	√
	Strategy			
20.	Clinical Review of Issues Arising from the Transfer of	LP	To receive & note	√

	Community Paediatric Medical Services of City Healthcare Partnership (CHCP) to Hull University Teaching Hospitals NHS Trust (HUTH) - Trish Bailey, General Manager attending			
21.	Infection Prevention and Control Strategy Refresh (2021-2022) Debbie Davis, Lead Nurse Infection Prevention Control attending	HG	To receive & approve	√
	Corporate			
22.	Infection Prevention Control Annual Report – Debbie Davis, Lead Nurse Infection Prevention Control attending	HG	To receive & approve	√
23.	Board Assurance Framework - Oliver Sims, Corporate Risk & Compliance Manager attending	MM	To receive & note	√
24.	Risk Register - Oliver Sims, Corporate Risk & Compliance Manager attending	HG	To receive & note	√
25.	Guardian of Safeworking Annual Report – Dr Mohammed M Qadri, Consultant Forensic Psychiatrist & Medical Psychotherapist, Humber Centre - Guardian of Safer Working attending	JB	To receive & note	√
26.	Safeguarding Annual Report – Rachael Sharp, Head of Safeguarding attending	HG	To receive & ratify	√
27.	Review of Standing Order Scheme of Delegation and Standing Financial Instructions	MH	To receive & approve	√
28.	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance	JB	To receive & approve	√
29.	Winter Plan	LP	To receive & note	√
30.	Items for Escalation	All	To note	verbal
31.	**Any Other Business**			
32.	**Exclusion of Members of the Public from the Part II Meeting**			
33.	**Date, Time and Venue of Next Meeting** Wednesday 27 October 2021, 9.30am by Microsoft Teams			

Humber Teaching NHS Foundation Trust

Agenda Item 2

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
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. Declarations for Rt Hon Caroline Flint, Chair have been added and details of the previous Chair, Sharon Mays removed. Declarations for Professor Mike Cooke who left the organisation at the end of August have also been removed Addition to the declarations for Mike Smith for Trustee - The Rotherham Minster Development Trust
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		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	√			

Caring, Learning & Growing Together

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

Directors' Declaration of Interests

Name	Declaration of Interest
Executive / Directors	
Ms Michele Moran Chief Executive (Voting Member)	• Appointed as a Trustee for the RSPCA Leeds and Wakefield branch • Chair of Yorkshire & Humber Clinical Research Network • SRO Mental Health/Learning Disabilities Collaborative Programme. • HCV CEO lead for Provider Collaboratives
Mr Peter Beckwith, Director of Finance (Voting Member)	• Sister is a Social Worker for East Riding of Yorkshire Council • Son is a Student at Hull York Medical School
Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	No interests declared
Dr John Byrne, Medical Director (Voting Member)	• Executive lead for Research and Development in the Trust. No personal involvement in research funding or grants. Funding comes into the Trust and is governed through the Trust's Standing Instructions • Senior Responsible Officer for the Local Health Care Record Exemplar (LHCRE).which is governed through Humber Teaching NHS FT standing orders and procedures
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	No interests declared
Mr Steve McGowan, Director of Workforce and Organisational Development (Non Voting member)	No interests declared
Non Executive Directors	
Rt Hon Caroline Flint – Chair (Voting Member)	• Husband is a member of Doncaster MBC Councillor and Cabinet member • Brother in law is a Consultant Opthalmologist
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 • Director, Fleet Street Communications Limited
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 • Non Executive Director, Yorkshire Cricket • Trustee, Give a Gift (Leeds)

Humber Teaching NHS Foundation Trust

Item 3

Trust Board Meeting
Minutes of the virtual Public Trust Board Meeting held on Wednesday 28 July 2021 (in person for Board members only) and livestreamed for Members of the Public

Present:	Mrs Sharon Mays, Chair Mrs Michele Moran, Chief Executive Mr Peter Baren, Non Executive Director Professor Mike Cooke, Non Executive Director Dr Hanif Malik OBE, Associate Non Executive Director Mr Francis Patton, Non Executive Director Mr Dean Royles, 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 Mr Mike Smith, Non-Executive Director
In Attendance:	Mrs Michelle Hughes, Head of Corporate Affairs Rt Hon Caroline Flint, Chair Designate Mr Adam Ubi, Student Nurse (for item 142/21) Mrs Cathryn Hart, Associate Director of Research & Development (for item 154/21) Mr Adam Dennis, Communications Officer Mrs Jenny Jones, Trust Secretary (minutes)
Apologies:	None

The Board meeting was held in person for Board members only and livestreamed for members of the public. Social distancing was maintained and Board members followed the approved guidance and infection control measured.

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.

140/21 **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 declared an interest as the Chair of the Clinical Research Network for relevant items on the agenda.

The Chief Executive, Mr Baren and Director of Finance declared an interest for items related to the Commissioning Committee.

141/21 **Minutes of the Meeting held 30 June 2021**
The minutes of the meeting held on 30 June 2021 were agreed as a correct record.

141/21 **Matters Arising and Actions Log**
The action log and work plan were noted.

142/21 **Staff Story – A Student Nurse in Practice**
Mr Abam Ubi joined the meeting virtually to share his experiences with the Board. He explained that he had joined the Trust as a Health Care Assistant in 2017 working in various areas of the organisation to help him decide which are he wanted to work in. He found that he liked Mental Health nursing particularly in the Psychiatric Intensive Care Unit (PICU) environment. Through the Nursing Apprenticeship scheme the Trust has supported Mr Ubi to progress to a Qualified Mental Health Nurse which allows him to work and study.

Mr Ubi urged anyone with a dream of becoming a nurse in Mental Health, but did not have the relevant qualifications to consider the apprenticeship scheme. He felt it is never too late to learn and there are opportunities to progress through different roles.

Mr Ubi's enthusiasm and passion for his work was evidence and the Chair thanked him for sharing his story. In response to Mr Smith's question about where he would like to end up working, Mr Ubi said he likes it where he is as he is well supported and benefits from the experience of other staff and is also able to take part in research which will help patients.

Mr Royles said he is proud of the Trust's investment in apprenticeships and asked how his working week is set out. Mr Ubi explained that he is working for most of the week and has time for studying and supports himself by working. Professor Cooke encouraged Mr Ubi to keep going and learning. He noted that the PICU environment is tough and asked what else interested Mr Ubi about working there. Mr Ubi said it is a supportive team and they rely on each other. In the four years he has worked there he has been supported with supervision and when things go right or not so right. He has appraisals and the team help him to identify his goals and the direction he needs to go in to achieve them. He accepted that PICU is a high pressured environment, but the team support and working approach is great.

Mrs Parkinson asked if there is anything more Mr Ubi thought the organisation could do to attract others into the roles and through the apprenticeship route. Mr Ubi felt that many people did not think they have the skills to move forward in their working roles but with the support that is offered he encourages people to push themselves to achieve their goals. The Chief Executive asked if he had any thoughts or ideas on how people in education could be encouraged to come into these roles. Mr Ubi said that some staff due to personal circumstances may not be in a position to progress or may not be an academic, he felt that promoting the apprenticeships is key and something he will continue to do.

The Chair thanked Mr Ubi for attending the Board meeting.

143/21 **Chair's Report**
The Chair provided a verbal update update explaining that today's meeting was the first meeting held in person for some months and was being conducted under appropriate infection control rules.

Going forward the majority of Board meetings will be held virtually as they give more people the opportunity to join the meeting and participate in different ways. Also in attendance at the meeting was the Chair Designate, Caroline Flint who takes over as the Trust Chair in September and Hanif Malik, Associate Non Executive Director who was appointed on 1 July 2021.

This was also the last meeting for Professor Cooke who is retiring at the end of August. The Chair thanked Professor Cooke for everything he has done over the last five years and for his contribution to the Board and the Trust. His ambition for patients and staff has never

waivered and he has championed so many causes during his time with the organisation.

The recruitment process for the replacement of Professor Cooke is being planned with Governors.

Governor elections will shortly be getting underway and there are a number of Governor seats available in various constituencies. Board members were asked to promote the elections to anyone they feel may be interested.

Resolved: The verbal updates were noted

144/21 **Chief Executive's Report**

The report provided updates from each of the Directors along with a summary of activities undertaken by the Chief Executive who drew the Board's attention to the following areas:-

Leadership – the work that staff have been participating in with Lumina will be developed for the Board to help with Board Development going forward

Hull Daily Mail Awards – the Trust was successful in the Hull Daily Mail Awards in two categories. The Volunteer of the Year was awarded to Soraya Hutchinson and the Health Improvement Project Award went to the Smoking in Pregnancy Project. Congratulations to all involved.

Humber Youth Action Group (HYAG) – this is the new name for the group chosen by the young people. Discussions will take place at a future Board development session as to how this group links in with the Board.

External Governance Review – a timeline has been produced for undertaking the review and work is progressing to select the external consultants for the work.

Board Voting - Due to the resignation of Professor Cooke, the arrangements for voting at the Board have been reviewed until a replacement Non Executive Director has been appointed. To comply with the requirement in the Constitution that at all times at least half of the Board of Directors, excluding the Chair, will be Non Executive Directors, it was agreed by the Board that the Chief Operating Officer will abstain from any voting during this period.

Health and Care Bill – the key highlights from the publications were detailed in the report. Developments will be monitored as the Integrated Care Service (ICS) starts to develop its structures.

HSJ Patient Safety Awards 2021 -The Trust has been shortlisted for 4 awards and more detail was included in the report.

Office 365 – the programmed work to move to Office 365 continues led by the Director of Finance.

Market Weighton – A meeting was held yesterday regarding the GP practice where there are pressures in the system. National guidance is being followed and the Chief Executive thanked the team and the operational team for dealing with the pressures and the challenges being faced. Residents of Market Weighton and the GP Practice are being written to about the pressures being seen.

Covid Update

Mrs Parkinson reported that over the last month high pressures continue to be seen across most of the operational services including Primary Care. For a short period of time in June the Operational Escalation Level (OPEL) was raised to 4. Focus continues on the ongoing position around Children and Young People's Mental Health demand and the impact of Covid. One ward was closed to admissions and there was pressure on staffing. More detail

was provided in the appendix to the report.

Despite the pressures staff are supporting services and small numbers were redirected to help in other areas. Work continues on the staff health and wellbeing agenda supporting them through the ongoing pressures and recognising the impact on them. System work continues and some progress is being made around Children and Young People pressures. Additional support is now in place.
Dr Byrne explained that the Government has stated that the vaccination programme is to continue and in October anyone who has received two doses will receive a third dose within a 15 week period. The flu vaccination programme will also be starting in the coming months. It is hoped that the third dose of the Covid vaccine will be delivered over a 4/5 day period depending on supplies. The vaccination group continues to meet and oversee the programme. In thinking about vaccinating our own staff the impact on other services will be considered such as pharmacists and nurses who delivered the vaccination programme. Plans may need to be adjusted when confirmation of supply is received. There was an uptake of 85% for the first dose which increased for the second dose and Dr Byrne was confident the third dose would also be well received.

Testing is moving away from Lateral Flow Tests to LAMP. The Lateral Flow Test is a nasal swab test undertaken twice weekly. LAMP is a saliva test once a week and is more accurate with results. There are some complications with the LAMP testing involves a self test which needs to be analysed within 24 hours. The sample has to be taken when someone has been two hours free from eating, drinking and smoking. If a positive LAMP test is shown, A PCR test is not required which is different from the Lateral Flow Test. The Older Peoples Mental Health Team in East Riding has started a six week pilot. System colleagues are already using this test and there are challenges around the uptake. There have been very few outbreaks in inpatient units demonstrating that the infection control elements are working.

Care Quality Commission (CQC) Update
The Care Quality Commission is working on a new approach to the inspection regime. Details were included in the report. Inspections will focus on four themes and there will be a new way of regulating with some on site visits and some off site work using intelligence and data. Organisations' ratings can change at any time not just following an inspection. Regular meetings are held with the CQC, informally and formally. More detailed information on the work that has been done will be showcased by the organisation.

The Key Lines of Enquiry (KLOE) are being reviewed and regulating of Local Authorities for some of the services they provide are being brought under the CQC's remit. The main changes are to the regulating and inspections and the CQC will be looking at information provided and the organisation will be working in a proactive way to prepare for unannounced inspections and using the meetings in place to explore the detail that has been provided to the CQC.

Communications
The Head of Corporate Affairs, Mrs Hughes, highlighted the work of the Youth Board which is being led by the Head of Patient and Carer Engagement and Experience in conjunction with the Engaging with Members Governor Group. The group have offered the opportunity and hope that in time a young person will observe the group, gain and build confidence so we can start to encourage younger members putting themselves up for membership and governor elections.

The Humberleivable recruitment campaign progresses and Mrs Hughes drew attention to the videos on the website for anyone looking for a role in the Trust where staff promote the Trust as a fantastic place to work.

Mr Patton thanked the Executive Team for an excellent report and congratulated those involved in winning and being shortlisted for awards. He referred to the Heath and Care Bill stating that Integrated Care Service (ICS) will be setting its own pay levels and length of

tenure which he felt did not seem right. More information on training and development and the Whitby Urgent Treatment Centre (UTC) was welcomed. Mr Patton noted that the outline case for the new wave hospitals will be going to the Finance & Investment Committee (FIC) and Board shortly.

Peer Support Workers
Mrs Parkinson was pleased to report the progress made in recent months with the Peer Support Worker roles. A number of services have been integrated including the Mental Health Community teams which links to the Community Mental Health Teams (CMHT) transformation. The key to the success of these roles is to ensure they are well supported in the organisation. Plans are in place to ensure that individuals are supported in teams and that teams are prepared to receive the roles.

The Trust is fortunate to be in the position to access a bespoke academic programme by Teeside University. Work is also taking place with IMROC to support these roles and there is more to come from the partnership. Work is taking place with the national team to design and implement an apprenticeship programme to look at roles in all places in the organisation and to ensure there are career pathways designed for the future. The route into a Peer Support Worker role is via a bespoke training programme delivered by the Recovery College and will be launched this summer.

Mr Patton thought the work that is being done is impressive and suggested that in 6 – 8 months an update could come to the Board on how the programme is doing

Professor Cooke was pleased to see the development with the Peer Support Worker role and the work that is gaining momentum. He too felt the report was informative and acknowledged the pro active work taking pace around the CQC and the testing of evidence and information.

He noted the successful funding to support research across the GP practices, the external governance review and the Trust's recognition for various awards. In relation to access to "front door" for people with mental health problems, Professor Cooke asked if this is being monitored even though it is in the early stages. Mrs Parkinson explained that the changes came into effect on 19 July and close monitoring is being undertaken. It is a positive change and addresses increase in complexities that have been seen in recent months. Links have been made with partners to redesign this element of the service and working with MIND who monitor the general phone number that anyone can call. 250 – 300 calls in a 24 hour period are being received. Calls that are deemed to be more urgent these are directed to the Crisis team. There are separate telephone numbers for professional to refer to these services. Although at an early stage, there has been positive feedback from GPs.

Mr Baren was pleased to see the timelines for the external governance review. He suggested that the Board needed to oversee the action plan and offered the services of the Audit Committee should it be necessary for any of the work to be delegated from the Board. The Chief Executive confirmed there would be Board oversight of the action plan and further discussions around this when the process is progressed.

The refurbishment work at the Whitby Urgent Treatment Centre (UTC) was noted. Mr Baren asked what the difference is between a UTC and a Minor Injuries Unit (MIU). He was informed that there are very clear set standards in relation to UTCs who are assessed against the standards. Work takes place with commissioners around moving from MIUs to UTCs to have a more consistent and public understanding of how to deal with urgent issues. In UTCs there is more focus on minor illnesses rather than minor injuries and patients can be booked into a UTC. Resources and staffing are also assessed through the standards and one other area of change is having direct access to GPs. GPs based in Whitby are aligned with the UTC requirements.

The Chair said it was good to see the changes to the mental health services given the regular discussions at the Board. The update on Peer Support Workers was encouraging given the

difference these roles make to patients.

In relation to the pausing of the LGBT and Disability networks, the Chair asked how the gap is going to be filled. Mr McGowan explained that there is an extensive communications campaign across the Trust to gain interest for a chair. He was pleased to see the investment made by the organisation in this area and the chair post will continue to be promoted. The Chief Executive raised it in her blog and administration support to help with the role has been identified. Dr Byrne confirmed that the work has not stopped and there have been virtual sessions taking place recently. The Chief Executive supported the comments made and suggested that more work is needed around physical disability within this agenda. The Board will be kept updated on progress.

Resolved: The report was noted,
Update on Peer Support Workers to come back to the Board in 6 – 8 Months **Action LP**

145/21 **Publications and Highlights Report**

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

Mr Smith referred to the Care Programme Approach: position statement publication and the new "front door" access noting that some standards are face to face with patients being seen within one hour of referral from A&E. He asked how close the organisation is to the consultation and gearing up for the next steps. The Chief Executive explained that it is not just around urgent referrals but also non urgent referrals. There are significant changes and these are being looked at which link into the Mental Health Investment Standard, the Trust's licence and registration.

The consultation was published last week and the new approach is based on the following five broad principles. These 5 principles outline in the position statement regarding CPA.

i) A shift from generic care co-ordination to meaningful intervention-based care and delivery of high-quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care.

ii) A named key worker for all service users with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.

iii) High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community: a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (eg section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure housing, public health and the voluntary, community and social enterprise (VCSE) sector.

iv) Better support for and involvement of carers as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.

v) A much more accessible, responsive and flexible system in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their

carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time.

Resolved: The report was noted.
A post meeting note will be provided on the approach being taken **Action LP**

Post Meeting Note
A CPA workstream has been established which has a cross representation of teams, services and organisations and also includes service users by experience. A person centred care planning document has been coproduced which has been widely consulted on across divisions , organisations and individuals including service users who have been pivotal in shaping this. The workstream are currently working on guidance on how the person centred care planning process will work across the services.

One hundred places for training on person centred care planning have been commissioned to support the shift in culture that is needed in order to achieve the 5 principles within position statement

146/21 **Performance Report**
Mr Beckwith presented the report relating to the current levels of performance as at the end of June 2021. Updates were provided for indicators which had fallen outside the normal variation range including Waiting Times, Out of Area Placements, CPA 7 Day Follow Up, IAPT – Moving to Recovery, Sickness, Statutory and Mandatory training and the Safer Staffing dashboard.

Mrs Parkinson reported that focus continues in this area especially with over 52 week waits and work has been ongoing for some months around Autistic Spectrum Disorder. Some in month improvement is being seen and pathway changes are being embedded into clinical practice and monitored to ensure they are working effectively by the Deputy Chief Operating Officer. The East Riding and Hull position is showing improvement and updates will be included quarterly in future reports.

The out of area position has seen some improvement in month. Reviews of the Infection Prevention Control requirements have allowed some reopening of some of the beds closed at the beginning of the pandemic which will off set some of the pressures. Works are on track to complete at Maister Lodge which will reopen beds and open the additional beds. There is a national requirement to be able to reduce the out of area placements and achieve a zero trajectory and an operational plan has been developed to achieve this.

Some 7 day follow up breached have been identified. Mrs Parkinson explained that when these occur they are reviewed quickly within the clinical team and there is contact made with the service user.

Recovery rates for Improving Access to Psychological Therapies (IAPT) have recovered and as of 20 July were within normal variation. The Chair suggested that for the September meeting, a refresh of the trajectories should be included in the report.

Mr Smith appreciated the update on out of area placements. He was informed that the position has started to recover which is positive. Mr Baren referred to the Safer Staffing Dashboard and appreciated the highlights provided on the front page of the report. He noted that Whitby sickness is at 11% and the return for clinical supervision was an issue. He commented that occupancy was at 95% and sickness at 11%, but the backfill rate was zero. Mrs Gledhill said that supervision rates were still reasonable and occupied bed days was high. Mrs Parkinson explained that in terms of sickness there did not appear to be any underlying issues although there has been increased pressure at Whitby. Staff have also been supporting Malton recently which Mrs Parkinson thanked staff for doing. Pressure and complexities are high and continue to be monitored closely.

Mr Baren commented on the use of agency at Granville Court which was unusual. Mrs Parkinson explained that this was usually a stable position but due to long term absence agency staff have been used.

Mr Patton commended the excellent work in workforce, but noted that turnover, sickness and vacancies were increasing. He was informed this is being monitored closely. Mr Beckwith explained that in relation to turnover a possible impact could be due to Hotel Services staff TUPE to Whitby which has been discussed at the Workforce & Organisational Development Committee. Mr McGowan added that a report has been received showing that of 31 trusts, the organisation is second best for workforce. There are pressures in the system but assurance can be taken that other trusts are facing the same issues.

Mr Royles wanted to draw attention to some of the positive areas of the report including Friends and Family Test which is stable and with high levels of response and 18 week waits which sometimes are overlooked. In terms of sickness and turnover, a number of areas have come down and it may be possible to predict some people that may want to leave and to monitor this to see what can be done to help prevent it.

The Chief Executive referred to Improving Access to Psychological Therapies (IAPT) where most areas apart from the Trust are outliers. This is a good achievement for Trust and important that staff support continues. We continue to change and develop the different areas using an array of services as what may work in one area may not in another.

The Chair asked about delayed discharges asking if this is due to pressures in the Local Authority. Mrs Parkinson confirmed that locally and around the Integrated Care Service (ICS) there are pressures. Local Authorities use the same OPEL levels as the NHS and most of the time they operate at levels 3 or 4 due to difficulties around the provider market and residential care.

Resolved: The report and verbal updates were noted
Updated trajectories table to be included in the September report **Action LP**

147/21 **Finance Report**

Mr Beckwith presented the highlights from the finance paper including:

- The Trust recorded an overall operating surplus of £0.147m which is in line with the ICS Months 1-6 expectation of a £0.315m surplus
- Within the reported position at Month 3 was Covid expenditure of £1.293m and income top up of £0.615m.
- Cash balance at the end of June 2021 was £23.242m
- The Year to Date Agency expenditure was £1.651m this is £0.284m less than the previous year's equivalent month 3 position.

He explained that the organisation continues to operate under a block contract funding regime until September. He drew the Board's attention to the agency spend which is currently £1.6m for the first quarter. The agency ceiling target remains suspended but if this were in operation the Trust would have been ahead of the previous £2.9 million annual target.

Mr Royles asked if there was any update on H2 and national settlements. Mr Beckwith reported there was no guidance yet for H2 and the expectation is for a block system for the second half of the year, It is thought there will be efficient requirement of 1.5%. NHS Providers has written to NHS England around the proposed 3% pay award asking for it to be funded.

The Chair noted a dip in the income which Mr Beckwith will review and include a post meeting note for. Mr Beckwith explained about the mental health underspend which is the net positions. The Trust was fully funded for the Community Mental Health Team (CMHT)

transformation programme from 1 April 2021 however there has been a delay in recruiting to all of the posts and a high number of posts were filled using bank and agency staff. Recruitment to the posts is now nearing completion.

Resolved: The report was noted.
Post meeting to be included in the minutes regarding the change in income **Action PBec**

Post Meeting Note
The dip in income is affected by current income mechanism and classification of Trust Income compared to covid income (including Top UP) and the Treatment of Income budget for Non Contract Activity.

148/21 **Charitable Funds Committee Assurance Report & 18 May 2021 Minutes**
Details of the meeting held on 20 July 2021 were provided for the Board to note. The minutes of the meeting held on 18 May 2021 were presented for information.

Professor Cooke was pleased to note that Mr Malik, Associate Non Executive Director will be joining the Committee. Mr Baren will take over as interim chair of the Committee and Mr Royles will be temporarily joining the Committee.

The Committee reviewed the Impact Appeal to support Inspire Unit which raised £336,176. Professor Cooke was keen to ensure the funding was used in the right areas. It was noted that £176k had been allocated for the Inspire gardens and for the Children's Centre for the outdoor area and for trips and travel for young people who used the unit.

The effectiveness of the Committee during Covid 19 was discussed and also the Whitby Hospital appeal. £33k has already been raised of which some will be used for tangible assets for patients, the community and staff particularly around gardens. Trust funds stand at around £500k.

Resolved: The report was noted.

149/21 **Workforce & Organisational Development Committee Assurance Report & 12 May 2021 Minutes**
Mr Royles presented the assurance report from the last meeting and the minutes of 12 May meeting for information. He thanked those involved for producing the report immediately after the meeting.

The Committee received a presentation from Dr Byrne looking at his Directorate's approach to the staff survey and hot improvements could be made. The Workforce Insight report was received and the consequences of Covid 19 were discussed. This included looking at overtime, agency usage and working pressures.

A number of reports were received that are on today's agenda including, Equality & Diversity Annual Report, Workforce Disability Equality Standard and Gender Pay Gap Report. The committee recognised the amount of work put into producing the reports and extended its thanks to all involved which was well received.

Resolved: The report and minutes were noted

150/21 **Humber Coast & Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative Commissioning Committee Assurance Report**
The report provided information on the areas discussed at the meeting held on 21 July 2021.

Mr Baren reported that the team that is undertaking the Provider Collaborative work have been excellent and it is clear that everything being done is for the benefit of patients. There is confidence that the go live will go ahead on 1 October subject to approval.

Mr Smith commented that there were a number of initiatives around improvement, but not many around Autism which is an area he thought the Integrated Care Service (ICS) could have a big impact. The figures in the performance report showed a 52 week wait for assessment and diagnosis which was not where it needed to be. The Chief Executive acknowledged the comment and that this is an area discussed at the Committee. The Autism Strategy was recently published which aligns with the organisation's strategy. The Chief Executive of Care Plus, Ms Jane Miller has been asked to lead a piece of work on Autism to look at how services and develop them across the system with the multiple partners and services.

Resolved: The update was noted.

151/21 **Six Month Review of Safer Staffing – Inpatient Units (Oct 2020 – March 2021)**
The six monthly report was presented to the Board and presented the outcomes of the review of safer staffing requirements across our in-patient units using the National Quality Board (NQB) guidance and NHS Improvement 'Developing Workforce Safeguards'.

It has been reviewed by the Executive Management Team (EMT) and the Workforce & Organisational Development Committee. It was recognised that this period was a difficult time for staffing and for the units. Two new Covid 19 wards were also included at the time. The flexibility of staff working in inpatient units and community teams put the Trust in a good position. It was noted that Care Hours per Patient Day (CHPPD) perform well and continues to be above the national average.

Professor Cooke commented that over the last few years this has become more systematic and he thanked Mrs Gledhill, the Deputy Director of Nursing and the team for this achievement. The Quality Committee reviewed the process and the report provides answers to questions that may be asked.

The Chair recognised that it was a comprehensive assurance report. She congratulated everyone involved on the remarkable achievement over the six month period. The Chief Executive agreed that it was impressive during a pandemic especially the Care Hours Per Patient per Day.

Resolved: The report was noted.

152/21 **Mortality Review Update April 2019 – April 2021**
Dr Byrne explained that the World Health Organisation declaration on 30 January 2020 of the outbreak of COVID-19 to be a Public Health Emergency of International concern. Impacts of the pandemic have been seen worldwide in relation to morbidity and mortality, in addition to much wider indirect consequences relating to both the pandemic, and different national responses to COVID-19. The report had been produced in conjunction with Alex Macnamara Public Health Registrar.

Sadly in the United Kingdom, there have been a total of 152,289 deaths due to COVID-19. Further work has demonstrated that several population groups have a higher risk of dying from COVID-19, including older adults, men, those with pre-existing medical conditions, those living in more deprived areas, people from some ethnic minority groups, those who are obese, those in certain public-facing occupations and those with a disability (including learning disabilities).

The Board took a few moments to reflect and think about the families affected by these deaths.

The report drew attention to the following areas:-

- The COVID-19 pandemic has had significant impacts on mortality nationally, with tens of thousands of excess deaths attributed to the pandemic.

- Established risk factors for adverse outcomes in COVID-19 infection include male sex, older age, some ethnic minority groups and deprivation, with evidence suggesting there are inequalities in COVID-19 mortality.
- Humber Teaching NHS FT has seen a rise in mortality in periods consistent with the peaks in mortality from COVID-19 nationally, aligning with the first and third "waves" of the pandemic (April 2020 and December 2020/January 2021).
- The highest numbers of deaths were seen in older adults, males and users of community services within Humber NHS FT, which is in keeping with known risk factors.

The presentation provided with the report gave more detail of what the data had identified.

Professor Cooke thanked Dr Byrne for the report. He commented that it is key to learn from the pandemic to reduce any further impact of communicable diseases. The diagram in the report identified a fourth wave, Professor Cooke asked if there is a 5th wave due to long Covid and future long term conditions. He thanked Dr Byrne for taking the report to the Quality Committee and for the use of Public Health skills to produce the excellent report. Dr Byrne thought a 4th wave will happen base don the data. He compared this to the number of male suicides in 2020 that were thought to have been as a consequence of the economic crash in the 80's. In terms of long Covid he explained that most senior clinicians across the system are worried of the concept of people getting infected rather than having the vaccination. There will be a cohort of people exposed to the disease that will have long term consequences for them. There is a fear that the burden of long Covid will get lost and a few years there will have to be an understanding that the decisions made at this time will have an impact. He emphasised that the way forward is for social distancing, face coverings and getting the vaccination.

The Chair expressed her thanks to Ms Mcnamara for the report and to Dr Byrne for the thoughtful way that this had been presented to respect the families who have been affected.

Resolved: The report was noted by the Board

153/21 **Quality Accounts 2020/21**

The report was presented at the Quality Committee on 2 June 2021, with amendments made following suggestions from the Committee mainly in relation to layout. It was also presented to EMT on 12 July 2021 for comments.

The Quality Accounts have been out to partners as part of the required consultation period. Statements on the quality accounts were also requested and statements received from Hull & East Riding Clinical Commissioning Group (CCG), Hull City Council Health and Wellbeing Overview and Scrutiny Commission and North Yorkshire CCG. No other responses have been received despite reminders being sent. The Quality Accounts have been circulated to Governors as part of the consultation process no comments have been received to date.

The Chair congratulated all involved for the production of the report. Mr Baren noted that more visuals and graphs have been included which is helpful to the reader. He also noted that next year's report will form part of the Annual Report and Accounts and whether the timescales that are tight for completing the Annual Report and Accounts will be need to be met.

Mr Patton felt this was an excellent document and felt it would be a pity to lose some of the content when it merges into the annual report. He asked whether it would be possible to use some of the information as a way of celebrating the work that has been done. Mrs Gledhill explained that there is repetition in the report for some areas and will consider if there is a way of producing a document without additional work.

Professor Cooke has been involved in the report's production during his time with the organisation and felt they get better each year. He congratulated Mrs Gledhill and the team

for their work on this report.

Resolved: The report was ratified by the Board.

154/21 **Research & Development Six Month Report**

Ms Hart, Assistant Director Research & Development attended to present the report. She thanked Professor Cooke for his support with research and wished him well in the future.

The Trust's recruitment target of 660 for NIHR Portfolio studies in 2020-21 was exceeded by over 100%. The recruitment target for NIHR Portfolio studies in 2021-22 is yet to be confirmed, but expected to increase from previous years due to a change in the way this is being calculated across Yorkshire and Humber. There are currently 28 Portfolio studies active in the Trust.

As one of the CRN high level objectives in 2021-22, is for 45% of GP practices to be recruiting into Portfolio studies, this is something that becomes a Trust challenge with having GP practices in the Trust.

CRN funding for 2021-22 to support delivery of NIHR Portfolio studies has recently been confirmed, following a delay due to last minute additional DHSC funding being allocated to CRNs across England. An increase from that of 2020-21 has been received, mainly as a result of changes in the funding model to reflect Trust performance. In 2020-21 the opening allocation was £314k and this has increased to £364k for 2021-22.

The report covered areas including Covid 19 and opportunities and alliances. Details were also provided with the Research Conference taking place in November 2021. Speakers include:-

- Prof Calum Semple (OBE), Professor of Child Health and Outbreak Medicine, University of Liverpool and member of NERVTAG and SAGE
- Prof Partha Kar (OBE), Consultant in Diabetes & Endocrinology, Portsmouth Hospitals NHS & National Specialty Advisor for Diabetes with NHS England.
- Prof Kieran Walshe, Professor of Health Policy and Management at Alliance Manchester Business School.
- Prof Tim Kendall, NHS National Clinical Director for Mental Health.

Professor Cooke commented that without the support and interest of the Chief Executive, Dr Byrne and the enthusiasm of Ms Hart, it was an achievement to secure these speakers.

The Chair congratulated Ms Hart on the team on the report and achievements.

Resolved: The report was noted by the Board

155/21 **Council of Governors 15 April 2021 Minutes**

The minutes were presented for information

Resolved: The minutes were noted.

156/21 **Trust Position on the Community Mental Health Framework for Adults and Older Adults (2019)**

The Community Mental Health Framework for Adults and Older Adults (2019) outlines the redesign and reorganisation of core community mental health teams in a move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks.

The Trust was one of 12 Early Implementer Sites (EIS) chosen in England for the Community Mental Health Team (CMHT) Transformation programme, established to test new models of

place based community mental health provision. The EIS concluded on the 31 of March 2021 and is now superseded by the national roll out which will continue until the end of 2023/24.

Mrs Parkinson explained that recruitment was difficult during the pandemic, but it has now improved. As a consequence requests have been received from other national teams wanting to know how this has been achieved.

The report outlined the governance arrangements in place and provided an update on the work completed and the plans for 2021/22. CMHT services are aligned with Primary Care Networks (PCNs) across Hull and East Riding with all teams being in place in 12 PCNs. This has supported the change to the mental health "front door" as PCN services are in place which has streamlined the relationship between the CMHT and Primary Care. There is dedicated mental health support in the PCNs.

Work has commenced on the Care Programme Approach (CPA) review as part of the EIS within the Social Work work stream. This has been ahead of the proposed national time frame and is well progressed. The work is multi agency and is being coproduced with service users, new draft guidance has now been developed and will completed and implemented by the end of 2021.

The Chair thanked Mrs Parkinson for the update commenting that this work will improve things for patients and their families.

Resolved: The update was noted

157/21 **Equality Diversity & Inclusion Annual Report 2021**

Mr McGowan presented the report informing the Board that the majority of the work had been completed by Mr Duncan, Equality, Diversity Inclusion lead and Mrs Dawley, Head of Patient and Carer Engagement and Experience. The report provided an overview of workforce, equality diversity inclusions and patient and service user experience. For the staff survey the Trust is the sixth best mental health trust in the country out of 53 which is an achievement.

The report has been reviewed by the Executive Management Team and Workforce and Organisational Development Committee.

Dr Byrne commented that an advantage taken from the pandemic is holding remote meetings which has allowed more people to participate in the online sessions. The Chair agreed noting that there is a mix of people joining in as they now have a different opportunity to participate.

The Chief Executive asked that the report be updated to explain that the pictures were taken before the pandemic.

Resolved; The report was approved subject to inclusion of wording to explain that pictures were taken before the pandemic.

158/21 **Workforce Race Equality Standard (WRES) Report**

The report provided an update on data and progress for the Workforce Race Equality Standard (WRES) submission 2021. The report has been reviewed by the Executive Management Team and Workforce and Organisational Development Committee. Key areas of focus included:-

- Improving BAME representation in AfC bands 6 and upwards in non-clinical roles
- The gap between BAME colleagues who believe that they experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months (24%) compared with 22.4% for white colleagues.
- The gap between BAME colleagues who believe the organisation provides equal opportunities for career progression or promotion (80%) compared to 89.8% of white colleagues.

- The gap between BAME colleagues who believe they have experience discrimination at work from a manager, team leader or other colleague over the past 12 months (18.4%) compared to 3.8% of white colleagues.
- Improving BAME representation on the Board.

Resolved: The report was approved by the Board

159/21 **Gender Pay Gap Report**

This report outlines the approach taken by the Trust in assessing its gender pay gap and the agreed actions to reduce these gaps moving forward. The report has been reviewed by the Executive Management Team and Workforce and Organisational Development Committee.

Areas of highlight included:-

- The Trust has a Gender Pay Gap of 12.91%, just 0.32% up on the previous year, which is significantly lower than the national average of 15. 9%;
- The Trust workforce comprised 78.29% Female and 21.71% Male and whilst the Trust has a high proportion of Female staff overall this is generally in line with National NHS Figures (77%);
- Women occupy 75.06% of the highest paid jobs and 80.84% of the lowest paid jobs;
- There are proportionately more female staff than male staff working at lower bands and therefore, adversely proportionately more male staff working at higher bands;
- The Trust has a median bonus gender pay gap of 60%;

The Trust's PROUD Leadership/Senior Leadership Development programmes and the High Potential Development Scheme will support gender equality across the Trust.

The Chair commented that reference to the previous year's figures in future reports would be helpful

Resolved: The report was approved

160/21 **Workforce Disability Equality Standard (WDES) Report**

The report has been reviewed by the Executive Management Team and Workforce and Organisational Development Committee. The data shows that there is more work to do and an action plan is in place to progress it.

It was noted that this report was in a different template to the previous reports. Mr McGowan explained that this was an NHSI template which had to be used for this report.

The Board expressed its thanks to Mr Duncan and the team for their work on the reports.

Resolved: The Board approved the report.

161/21 **Items for Escalation**

No items were raised.

162/21 **Any Other Business**

Thank You and Goodbye

Mr Baren thanked the Chair for her leadership and support over the last ten years that the Chair has been involved in the Trust as a Governor, Non Executive Director and Chair. He commended the Chair for always having a focus on service delivery for patients and carers and compassion for staff.

Mrs Flint commented that the Chair would be a hard act to follow. She thanked the Chair for her support and time as she was getting to know the role.

The Chair thanked the Board for their kind words and said she has enjoyed her time with the Trust. Staff are amazing putting the patients at the centre of everything we do.

163/21 **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.

164/21 **Date and Time of Next Meeting**
Wednesday 29 September 2021 9.30am by Microsoft Teams

Signed …… Date ……
Chair

Agenda Item 4

Action Log:
Actions Arising from Public Trust Board Meetings

Summary of actions from July 2021 Board meeting and update report on earlier actions due for delivery in September 2021 *Rows greyed out indicate action closed and update provided here*						
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 2022	Item not yet due
27.8.21	145/21	Publications and Highlights Report	A post meeting note to be included in the minutes on the approach being taken	Chief Operating Officer	August 2021	Completed
27.8.21	146/21	Performance Report	Updated trajectories table to be included in the September report	Chief Operating Officer	September 2021	Included in this month's report
27.8.21	147/21	Finance Report	Post meeting to be included in the minutes regarding the change in income	Director of Finance	August 2021	Included in the minutes
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**
31.3.21	62/21	Strategy Refresh	Dates for discussion at a Board Time Out and for Governor updates to be identified	Director of Finance/ Chief Operating Officer	June 2021	Governor meeting held in September, item now closed.
30.6.21	127/21	Finance & Investment	Ratification of the PSDS SALIX tender will be provided to the	Director of Finance	September 2021	Update reported to FIC and included in Chief Executive

		Committee (FIC) Assurance Report	Board in September			Update
30.6.21	132/21	Risk Register Update	Timing of actions updates to be reviewed to see if they can be tightened up	Corporate Risk & Compliance Manager	September 2021	Timescales have been reviewed and updated
30.6.21	133/21	Annual Non Clinical Safety Report 2020-2021 Report	Picture on the front cover to be reviewed and replaced with a more suitable one.	Director of Finance	July 2021	Updated photo is being replaced in the report which will be recirculated.
30.6.21	133/21	Annual Non Clinical Safety Report 2020-2021 Report	It was agreed that the report should also go to the Quality Committee	Director of Finance	October 2021	Paul Dent is contacting the Quality Committee administrator to arrange for it to be presented at the next Committee meeting

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) (v8)*

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	SM	x	x	x	x	x	x	x	x	x	x
Actions Log	Corporate	SM	x	x	x	x	x	x	x	x	x	x
Chair's Report	Corporate	SM	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
Bi Monthly Items												
Finance & Investment Committee Assurance Report	Committees	FP	x		X		x	x		x	x	
Charitable Funds Committee Assurance Report	Committees	MC		x		x	x		x	x		x
Workforce & Organisational Development Committee	Committees	DR		x		x	x		x	x		x
Quarterly Items												
Quality Committee Assurance Report	Committees	MC	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
6 Monthly items												
Trust Strategy Refresh/Update	Strategy	MM						X update				x
Freedom to Speak Up Report	Quality & ClinGov	MM	x						x			
MAPPA Strategic Management Board Report inc in CE report	Strategy	LP					x					x
Safer Staffing 6 Monthly Report	Quality & ClinGov	HG				x				x		
Research & Development Report	Quality & ClinGov	JB				x				x		
Annual Agenda Items												
Review of Strategic Suicide Prevention Strategy	Strategy	JB										**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
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	Reg.Comp	HG		x							x	
Risk Management Strategy	Strategy	HG							x			
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	Perf & Delivery	MM										x
Annual Operating Plan	Strategy	MM									xdraft	x
Report on the use of the Trust Seal	Corporate	MM	x									
Review of Standing Order Scheme of Delegation and Standing Financial Instructions	Corporate	MH							x			
Annual Non Clinical Safety Report (moved to June – Apr 21)	Corporate	PBec		X def	X							
Annual Declarations Report	Corporate	PBec		x								
Charitable Funds Annual Accounts	Corporate	PB/ MC							x			
Equality Delivery Scheme Self Assessment	Corporate	SMcG							x			
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						
Equality Diversity and Inclusion Annual Report moved to July	Corporate	SMcG			X	x						
Board Terms of Reference Review	Corporate	SM		x								
Committee Chair Report	Corporate	SM										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	
Disciplinary Case Review (added March 21)	Corporate	SMcG										x
Workplan for 2021/22: To agree	Corporate	SM/ MM		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
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 - Wednesday 29th September 2021
Title of Report:	Graham's Story - 'If You Get Your Health Right, Everything Else Will Follow'
Author/s:	Graham – Service User Tom Nicklin – Engagement Lead (Learning Disabilities and Autism)
Recommendation:	To approve: ; To receive & note: ; For information: √ ; To ratify:
Purpose of Paper:	To inform the Trust Board of Graham's journey through Learning Disability Services and the value of service user involvement.

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		Other (please detail) Patient/Carer Story	√

Key Issues within the report:

Please ensure you also complete the monitoring and assurance framework summary below:

The key messages from Graham's story are:

- The value of service user involvement in Trust activities.

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	√			

Caring, Learning & Growing Together

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

Agenda Item 7

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
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:

	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		Other (please detail) Monthly report to Board	✓

Key Issues within the report:

- Identified 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 as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			

Caring, Learning & Growing Together

Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Chief Executive's Report

1 Around the Trust

1.1 Visits
It has been a pleasure this month to undertake more face to face visits (within infection control guidelines) alongside my virtual team meetings. Staff outstanding work continues to put patients and their care at the centre of all they do, from estates to our frontline staff.

1.2 Staff Celebration Week
Our staff celebration week was a great success. Throughout the week we have shone a spotlight on each of our locations to celebrate staff, their successes and the amazing work that has taken place at the Trust over the last 18 months.

As well as sharing stories of good practice, and dedicated Thank You messages to colleagues, we also reflected on the activities that have been completed in individual teams and the events held as part of the You're a Star celebrations this summer.

The Board has presented a special gift to all staff to convey their gratitude for your hard work and dedication during these challenging times. Every member of staff will be gifted with £10 in their October 2021 pay cheque. It's hoped that this small token of appreciation goes some way to showing staff how much they are appreciated.

1.3 Humber Youth Board
The work of this groups is progressing well, they have now decided to call themselves the Humber Youth Action Group. We are discussing how this important work influences our ways of working, more over the coming months.

1.4 Inspire Award
Inspire wins again, this time at the design in Mental Health Conference where Inspire won two design awards. Going against a number of high profile new builds Inspire was named "Project of the year New Build 2021" and "Clinical Team 2021". Given the competition it is amazing that the hard work undertaken in the development of the new service has been recognised on a national platform.

1.5 Whitby Hospital
Whitby Hospital development has been successfully handed over. They was a short and informal ribbon cutting event due to the pandemic which was undertaken by our past chairman Sharon Mays. Since the there has been the successful move of 10 patients safely over to the new ward. The careful and diligent planning meant all patients moved following their breakfast and in and settled before lunch time. All patients well, staff excited and happy and adjusting to their new environment, the ward has also taken their first new admission.. Due to staffing pressure due to covid sickness we will increase beds to 16 as safe.

The team have also moved the Urgent Treatment Centre (UTC) equipment and set up the GP out of hour service service, so are now "live". The Outpatient department has moved. Later the move of the community teams will commence.

What great news for the patients and population of Whitby. I sincerely thank all for making this possible and the staff for their work on the successful moves.

1.6 Awareness Weeks
Each month the communications team manage a range of awareness days working with operational and clinical leads. Action plans and original content is created and shared internally

and externally. October is an important month with a number of focus days and weeks. An update on three upcoming awareness days are provided below:

1.7 Freedom to Speak Up Month – October

Speak Up Month is hosted every October by The National Guardian and is a chance to raise awareness of Freedom to Speak Up and the work which is going on in organisations to make speaking up business as usual.

As a Trust, our internal campaign includes creating and sharing supportive content that contributes to Freedom to Speak Up awareness. The aim is to spread important Trust Speak Up strategy messages, as well as to boost staff moral and public confidence in our overall approach to staff support and patient wellbeing. To do this, we will use our internal channels to reinforce important key messages, including who our FTSU guardians are, what they can do to support staff members and to reinforce our culture which promotes speaking up in all teams. Staff will also be invited to several drop in sessions, where they can have an opportunity to meet our guardians 'face to face' and discuss their role in more depth.

1.8 World Mental Health Day – 10 October

World Mental Health Day is a global campaign which aims to raise awareness of mental health issues around the world and to mobilize efforts in support of mental health.
The Day provides an opportunity for all stakeholders working on mental health issues to talk about their work, and what more needs to be done to make mental health care a reality for people worldwide.

As a Trust, we hope to raise awareness of routes into services and signpost self-referral options to help people get the right help, at the right time. Our internal campaign asks staff to 'do one thing' for their mental health, with links to videos for meditation, recipes and more top tips around mindfulness activities they can do. In addition, we're also working to tackle stigma around mental health in the workplace, by sharing videos of members of our staff speaking about their lived experience with mental health, and signposting to our staff mental health community group, Thrive.

1.9 International Infection Prevention Week – 17 October

International Infection Prevention Week (IIPW), established in 1986, aims to shine a light on infection prevention each and every year. This year's theme is Make Your Intention Infection Prevention, which aims to highlight the science behind infection prevention and inspire the next generation of IPs to join the fight.

We will be working with our Infection Prevention Control (IPC) team to reinforce key messages to staff around our Back to Basics campaign, the importance of good hand hygiene, and more, in our internal communications campaign. Each day of the week will have a theme, so that staff can access new information each day. On the Monday, the IPC team will introduce themselves as part of our wider Hello Humber campaign. The hope is that this will help staff recognise their IPC colleagues, whom they can turn to when they need advice and support. In addition to this, the Tuesday will aim to introduce our IPC Link Practitioners, the Wednesday will speak about cleanliness, Thursday shares useful resources around standard precautions, and Friday we will focus on the importance of immunisations.

Bringing together this information in an easy and accessible way is hoped to reinforce our key IPC messages to staff in new and refreshing ways.

1.10 Vaccinations and Care Homes

Board will be aware that new Government regulations come into force on 11 November 2021, requiring car home staff to refuse entry to anybody who cannot evidence that they have had two doses of a Medicines and Healthcare products Regulatory Agency (MHRA) approved COVID-19 vaccine, or that they come within a specified exemption. Given some of our staff need to work in care homes, a review has taken place of those staff and their vaccine status. The trust's general managers have confirmed that due to the high levels of vaccination across the trust and by taking a pragmatic approach to assigning care home duties, the current position stands that the trust will

not need to enter into formal consultation on redeploying or dismissing staff that haven't had the vaccine in these areas. This is obviously a fluid situation and if this changes we will update Board accordingly.

1.11. Black History Month

October is Black History month and an opening session will be held in October to mark this occasion

2 Around the Region

2.1 Prevention Concordat Signatory

Hull has become a Prevention Concordat signatory, which is a testament to all of the fantastic work that happens locally in relation to public mental health and the prevention agenda.

2.2 Director of Adult Social Services

Alison Barker our Director of Adult Social Services (DASS) is moving on to a new Corporate Director role in another authority. Alison will take up her new post in early October. Tracy Meyerhoff who has been Deputy DASS for a number of years has agreed to be Interim DASS for Hull City Council. Tracy took on the role from the beginning of September and will be supported by Anita Brigham one of our current heads of service as Interim Deputy DASS . These interim arrangements will remain in place until the permanent post holder is able to take up the role.

2.3 East Riding of Yorkshire Council

John Skidmore has retired from East Riding Council, where he was Director of Adults and Customer Services .

2.4 Director of Nursing, Leadership and Quality role in NEY NHS England / Improvement

The Director of Nursing, Leadership and Quality role in NEY NHS England / Improvement is now being undertaken by Alison Smith and David Purdue as a job share.

2.5 Winter Planning Update 2021

Strategic Approach to Winter Plans in North East & Yorkshire:

- The 4 ICS Leadership Teams and the NEY Regional Team are committed to planning for winter collaboratively.
- At a regional level, NHSE/I Regional Team + the 4 ICS Leadership Teams will work together to provide a joined up interface with national teams; to co-ordinate our strategic approach to winter planning, and our strategic response to winter.
- To support this, an Operations Hub (Formerly the JROC (Joint Regional Operations Centre)) has been established across NE&Y aligned to EPRR and UEC teams to co-ordinate all operational pressures across the footprint as a Single Point of Contact for NHSE/I.
- As far as possible we want to use this approach to co-ordinate the right support to systems asking for help and to minimise communications “traffic” to systems and providers, and keep things as streamlined and co-ordinated as possible.

Provider, Place & ICS Plans

- Providers & ICPs/ Places will already be progressing their organisational and place level winter plans and if there are any exceptions to this, please let us know.
- Each ICS team is also leading an event to look at winter planning and scenarios this month, and each ICS will be producing a winter plan by the end of September.

Next Steps

- Towards the end of Sep, NE&Y and each UEC ICS team to work through draft winter plans. There may also be a further “check and challenge” event with the national team.
- As a summary if helpful the key topics of discussion and concern for the bilateral are likely to be:

- Particular focus on implementation of mutual aid plans – how do they work in practice?
- Clarity on governance and accountability – who escalates to who and at what point in the incident?
- Interoperability with ODNs for critical care mutual aid and escalation – how does this work?
- 111 and 999 capacity for telephone response – resilience and risks.
- Clinical Advice Services & Primary care urgent care F2F capacity and phone answering risks – resilience and risks.
- Social care capacity – resilience and risks.
- Ambulance handover – Top risks
- Elective cancellations – monitoring and prevention.
- Protected elective capacity – detailed discussion around sites without protected elective activity.

National Initiatives:

- In addition to the above, you may hear more on the national proposal to develop a UEC Recovery Unit with the purpose of providing a national resource to support the most challenged systems across the country, and tied into the wider SOF framework across the country.
- In October 6 – 7 systems nationally will be identified (with the help of regional colleagues) to participate in a more detailed review and action planning approach with ECIST.
- More information to follow.

Our winter plan is completed.

3 National News

3.1 Provider Collaborative

The Provider Collaborative guidance was published on 20 August.

The national provider development team is now working up proposals for the next phase of work on Provider Collaboratives. This may include:

1. Work with NHSEI regions, System Support, and NHS Providers to ensure there are robust local support offers and peer learning networks in place to help systems and providers develop effective provider collaborative arrangements by April 2022.
2. Work with some advanced provider collaboratives to explore how they are tackling Covid-19 recovery and Long Term Plan delivery, and use these priorities to draw out and share best practice on key issues that stakeholders have identified as challenging.
3. Develop principles and recommendations regarding delegating commissioning functions and budgets from NHSE or an ICB to providers, identifying the conditions required for this to work well.
4. Continue to promote trust governance approaches that support trusts to work collaboratively and effectively within systems, consulting on proposed changes in governance guidance and exploring the relationship between ICBs and trust boards and the role of foundation trust councils of governors within systems.

3.2 National Director for Learning Disabilities

Tom Cahill has been appointed as the National Director for Learning Disabilities and Autism since his retirement from Hertfordshire Partnership University NHS Trust where he was Chief Executive.

3.3 People Directorate

Professor Partha Kar has joined the People Directorate - and specifically the Workforce Race Equality Standard (WRES) team. Alongside Professor Anton Emmanuel, Head of Workforce Race Equality Standard, Partha will lead the delivery of actions set out in the medical WRES plan.

He will oversee the next phase of the medical WRES (MWRES); to take action to overhaul progression and recruitment practices, improve representation, further close the ethnicity disciplinary gap and consider regulatory routes to improving accountability.

4 Covid-19 Summary Update – September 2021

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. The NHS national incident level was downgraded to Level 3 on 25th March 2021 due to hospital admissions and the number of deaths reducing.

As of the 14 September 2021 the confirmed cases of Covid-19 for Yorkshire and the Humber are:

Positive Test and Trace Update – Case increase and latest 7-day rate per 100,000.		
Area	**Actual increase in positive tests in latest 7 days (1-7 September)**	**7 day rate per 100,000 for 7 days previous* (1-7 September)**
East Riding of Yorkshire	1547	450.8
Hull	1522	587
North East Lincolnshire	554	347.6
North Lincolnshire	644	372.8
Yorkshire and Humber	21,531	389.6
England	192,257	340
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 380, for Ryedale is 285 and Hambleton is 251.

As of 13 September 2021, there have been 1427 hospital deaths due to COVID-19 across the Humber area. This includes 911 deaths registered by HUTH, 487 deaths registered by NLAG, 27 deaths registered by CHCP (East Riding Community Hospital) and 2 death registered by HTFT.
Due to the rise in infection rates in the population the Trust has recorded 11 new cases of a Covid-19 positive inpatient during the last month. Staff sickness absence related to Covid has remained stable at between 26 and 19 cases daily (see appendix 1). The Covid- 19 Task Group continues to coordinate and oversee our response to any ongoing requirements. The group meets fortnightly, is chaired by the Deputy Chief Operating Officer and reports to the Executive Management Team (EMT).Twice weekly Sitrep reporting remains in place to monitor the ongoing impact of the pandemic on our services. The command arrangements will be quickly stood up again if required, this remains under close monitoring particularly as the infection rates have now risen further in some areas due to the delta variant.

Operational service pressures remained very high in some areas in August and September with the highest pressures seen in our community services in Scarborough and Ryedale due to high demand from the acute hospitals for discharges to be supported along with increased demand for primary care This led to the Trust experiencing overall operational pressures escalation levels (OPEL) varying between 2 (moderate) and 3 (severe pressure) predominantly throughout August

and September. Acute partners in Hull have been reporting Opel 3 and 4 throughout the same period.

CAMH's 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 plateaued during August and early September, however this is not an untypical pattern during school holidays. Break down of placements for young people in residential care continues to lead to urgent and crisis admissions to the acute hospital and mental health beds. System and ICS work is ongoing to enhance provision to support out of hospital care and investment has been approved to:

- Reinstate a CAMHS crisis place of safety which will be fully integrated with the crisis and home-based treatment team
- Provide additional experienced CAMHS staff that will be located in the acute hospital to support children and young people presenting and being treated there.

Further work is taking placed to develop a proposal for a short stay assessment facility to be based at Inspire alongside ongoing work with children's social care to provide additional emergency placements.

Focus continues on reducing waiting times in these services, particularly in relation to autism diagnosis. Our CAMH's PICU ward (Nova) remains open with two of its four beds available, and this has supported the clinical management of the very high complexity of patients within our general adolescent ward (Orion). We will open the remaining two PICU beds as soon as our newly recruited staff team are in a position to safely do that.

We continue to have a contingency plan through a mutual aid arrangement with Navigo to access additional mental health beds when required. The new capital scheme at Maister Lodge has progressed well and the unit has now been handed over to the operational service. This will provide up to five new functional older peoples beds and will be open as soon as recruitment to the new posts required has been completed. The new day treatment service continues to be effective at avoiding admission for some older people. Our overall bed occupancy has remained above its usual level in July and August with the pressures especially high for mental health, learning disability beds and our community beds at Malton and Whitby Hospitals, it has been between 72.8 - 81.2%. 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, however some beds have been reinstated as 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 independent sector beds and the position is continuing to be monitored very closely. Nationally requirements are in place to eradicate the use of out of area beds and our services are implementing plans to achieve this, this remains a challenge however as covid safe working practice guidelines remains in place across the NHS.

Our primary care practices are also continuing to experience a rise in pressure and activity due to undertaking Covid vaccinations alongside higher than usual demand. System pressures continue to be high in North Yorkshire and York in August for both health and social care leading to the system command arrangements being reinstated.

During July and early August, the position relating to sickness absence was impacted by staff having to isolate due to contact tracing requirements. Revised guidance for NHS staff came into effect later in August which allowed staff to return to work if they had been "pinged" by the covid app if conditions set out in the guidance were met. Work has been taking place by our recruitment team to increase the number of staff available to us on our bank, whilst this has had success in attracting new unregistered and administrative, disappointingly there was little interest from registered staff. Staff availability remains an area of operational priority as we finalise our winter surge plans. Elements of business continuity plans for learning disability services were enacted to

support escalating pressures and high acuity in July and August with community staff redirected to support inpatient areas.

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.

Lateral Flow (asymptomatic staff testing)

The Trust continues to encourage all staff to undertake twice weekly Lateral Flow Antigen Testing. Over 69,800 tests have been reported since December with 87 positive results which have been followed up by PCR tests and infection control procedures.
LAMP **(**loop-mediated isothermal amplification) tests are increasingly being utilised by NHS Trusts to replace lateral flow testing, this test is considered to be more effective in detecting coronavirus in asymptomatic staff. It has the benefit of requiring staff to undertake it once per week and is less invasive than a swab test, however the test needs to be undertaken by a lab with the result being returned within 24 hours. The Trust is currently working with a local programme supported by NHS England and commenced deployment of this test in a pilot service area in July, with roll out across further clinical areas late September.

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.

Covid-19 Vaccine

The Trust vaccination centre at Willerby Hill has continued to operate as a Primary Care Network Site for Harthill PCN since the second dose programme for delivering vaccine to our staff was completed. A key area of focus however has remained on bank colleagues where uptake has been lower. Planning has now begun to deliver the booster covid- 19 vaccine with the programme expected to start nationally for health and social care staff in the autumn. Dr John Byrne, Medical Director remains our senior responsible officer (SRO) for our covid vaccination programme and a task group has been established to deliver our plan.

Operational guidance has been issued by the government regarding the requirement for people working or deployed in care homes to have been fully vaccinated against Covid-19, unless exempt. In accordance with the new regulations which aim to ensure some of the most vulnerable in society are protected from Covid- 19, from 11th November 2021 all care home workers and anyone entering a care home will need to be fully vaccinated, unless they are exempt under the regulations. The timeline for implementation outlines that the last date for care home workers/visiting professionals to get their first dose of the vaccine, so that they are fully vaccinated by the time the regulations come into force, is 16th September 2021. This guidance therefore applies to our staff who access care homes. Operational managers are ensuring that unvaccinated staff are fully aware of this requirement and are supporting uptake where that is applicable, a full SitRep has been completed.

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 are at good levels and we have not had any shortages of equipment. Whilst the government moved England to its final step (step 4) out of lockdown from 19th July. 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. This means NHS visitor guidance stays in place across all health services including hospitals, GP

practices, dental practices, optometrists and pharmacies to ensure patients and staff are protected. Staff, patients and visitors are expected to continue to follow social distancing rules when visiting any care setting as well as using face coverings, masks and other personal protection equipment.

Safe Working in our Environments

In accordance with the Government published guidance 'Working safely during coronavirus (COVID-19)" Covid safe working measures remain in place across the Trust. 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 16 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. Frequent "Ask the Exec" sessions continue and these continue to be positively received.

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

Support remains in place for our staff who are experiencing long covid and this has been developed further. The "Reset and Recovery" plan that was developed through wide engagement with staff is now final and implementation has commenced, it is being monitored by the Executive Management Team (EMT).

Covid-19 Clinical Advisory Group

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

- Continuing to ensure that our covid related changes and interventions do not increase restrictive practices.
- Reviewed the updated position on the use of FFP3 Masks when caring for Covid positive patients
- Continuing to review clinical pathways to ensure that use of digital technologies promotes inclusion and maintains recovery rates.

Operational Planning - Recovery and Restore

The NHS Priorities and Operational Planning Guidance 2021/2022 published on 25th March 2021 set out the following priorities:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention.
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19.
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services.
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay.
- Working collaboratively across systems to deliver on these priorities.

The Trust has focused its work on these areas utilising a range of forums with partners to contribute to place and Integrated Care System (ICS) plans. Several submissions were made by the Trust to set out the workforce, financial and activity projections for 2021/2022 to demonstrate how the requirements in the guidance would be met. These priorities need to be supported through the use of data and digital technologies and we continue to make progress and enhance our use of technology.

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. Planning is now being finalised for winter, 2021/2022 which incorporates the learning from the pandemic to date. Nationally a surge is anticipated in prevalence of RSV (respiratory syncytial virus) in children which has a seasonal presentation this winter, local areas are already seeing increased presentations and pressures in primary care and acute hospitals.

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. Data supporting specific areas of our covid response is attached (Appendix 1).

5 Director's Updates

5.1 Chief Operating Officer Update

5.1.1 Community Services

Scarborough Community services have had a complete refresh of their accommodation over the past 12 months, including staff bases and patient clinic venues. This has included:

- Improvements to IT connections within staff satellite bases
- Creation of a clinical hub within Eastfield GP Practice, where some staff are based and 3 patient clinics each day are able to be held
- Moving into a fully re-furbished site on Prospect Road, consisting of 4 terraced houses converted into one base. This provides a main staff base at Scarborough now, with indoor and outside break areas, and also has 3 fully equipped patient clinic rooms. A pilot clinic was held in August to ensure we are compliant with all Health and Safety and Infection control regulations. Very positive feedback was received from a family attending our paediatric continence clinic.

- Health Star funds have been accessed to provide canvas prints of local scenes in patient waiting areas, as well as use of the 'You're a Star' staff recovery funds to create a staff wellbeing and quiet space area.
- Continued use of the local community Rugby and social club venue, to deliver 4 of our services and patient rehabilitation classes.

These refurbishments will provide a valuable boost for staff morale whilst providing a professional and welcoming setting for patients.

5.1.2 Secure Services Medical Staffing

Despite ongoing challenges in recruiting medical staff, Secure Services have been successful in recruiting three new Responsible Clinicians (RC's) who started post in August. This will provide a valuable boost to the service and the medical staffing structure is operating with no vacancies in this Division.

5.1.3 Secure Services Matron up for Awards

Helen Courtney, the Modern Matron in Secure Services has been shortlisted for two national awards which include the Nursing Times Infection Prevention & Control category and HSJ Learning Disability initiative. These nominations relate to the development of a pocket pack of PPE equipment that staff could carry around with them should they be required to undertake an aerosol generating procedure (such as DMI/ILS) this meant that staff didn't have to wear full PPE all of the time. We wish Helen the best of luck with her nominations.

5.1.4 South West Lodge Reopening

South West Lodge opened 1st August, this facility is for low secure patients who are working towards being placed in a community setting. So far, only 1 patient has moved in but others are planned over the coming weeks.

5.1.5 Whitby Hospital

The patients of Whitby Hospital were successfully transferred into the new build on 15 September. The transfer went well with careful and diligent planning, it meant all patients moved following breakfast and were in and settled before lunch time. The staff and patients alike were excited and in ore of their new facilities with many struggling to imagine how the old ward looked as it now feels lighter, brighter and more spacious. On the same afternoon the UTC and the GP Out of Hours were being moved across to its new accommodation enabling the GP service to go live at 5.30pm and as the UTC closed at 8pm, their move was finished enabling the service to receive patients at 8am the following morning.

5.1.6 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. All aspects of the work have been recently affected by the COVID 19 pandemic so this update is presented in that context.

Recent Work

The Trust Protocol related to MAPPA is currently under review to ensure all the forms and links

contained within it are the latest ones. This will now be a joint protocol with Probation to ensure close working, timely updates and continuity of advice for all staff.

The new Trust MAPPA single points of contact for the secure and learning disability services have completed their inductions and awareness training. They are now able to assist colleagues in their areas in all issues MAPPA related and ensure that new processes are disseminated and explained. They can also ensure that colleagues are signposted to the correct MAPPA referral pathway and alternatives for offenders or potential offenders who do not fully meet MAPPA eligibility. We also have new link persons in the Police who host the Potentially Dangerous Persons system and these links have been widely communicated. This system is a good alternative when staff are concerned that someone may offend but has not yet done so.

There has been a national review of Level One MAPPA management and reporting. We submitted our comments for this and there is now fresh guidance which we are shortly to communicate. This year the MAPPA Annual report will include a submission from the Trust regarding the work of the FoLS team which is an excellent opportunity to showcase the work of this team to professionals in the wider Criminal Justice System.

In a recent joint meeting between key MAPPA personnel at probation and the Trust, Probation leads explained that the reunification of services is now almost complete. Offenders of all risk levels will be back under 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 return.

Risk Issues

COVID has introduced a wealth of risks in all public service work but we have mitigated our specific risks by keeping the communication high via MSTeams meetings and more regular telephone and e mail check ins. Face to Face meetings will now be gradually reinstated where appropriate.

5.2 Director of Nursing, Allied Health and Social Care Professionals

5.2.1 Zero Events 2021-22

The annual zero events report was submitted to EMT in June detailing quality improvements and performance against the agreed zero events.

EMT agreed the following zero events to continue for 2021-22:

- No Category 3 (or above) pressure ulcers acquired in our care (quarterly reporting). Despite an overall increase in reporting of pressure ulcers during 2020/21 the number of pressure ulcer zero events has reduced slightly from 30 in 2019/20 to 27 in 2020/21.
- No failure to recognise and escalate the deteriorating patient in line with Trust policy (quarterly reporting). Reduced from 11 to 9 for 2020/21. During 2020/21 our staff has been

caring for more vulnerable patients and patients with Covid-19 and therefore at significant risk of deteriorating physical health. There has been a significant rise in the number of inappropriate discharges from the acute hospitals due to pressures in acute hospitals. In this context a reduction in the number of zero events in this category gives a high level of assurance that our staff are becoming more proficient in the recognition and escalation of a deteriorating patient.

- No avoidable incidents of harm associated with falls/no failure to recognise and manage the risk of falls as per Trust policy (quarterly reporting). Reduced from 7 to 6 for 2020/21

- No under reporting of the level of harm in relation to sexual safety, BAME, or LGBTQ+ incidents relating to staff or patients. (Monthly reporting). There have been 31 zero events reported from Jan- March 21. As this zero event was only introduced in Q4 more work is needed to gather data and analyse the emerging themes.

These zero events will be monitored through datix, IIRs, SEAs and SIs.

It was agreed that the following zero event which commenced in January 2021 is revised for 2021/22 in order to focus on areas where there are reoccurring incidents or themes:

- No failure to complete an initial risk assessment at the first planned visit within the community nursing teams and CMHTs without clear documented rationale. (Monthly reporting). CMHT evidenced high compliance through record keeping audits, therefore for 2021/22 the zero event will focus on the community teams in North Yorkshire.

It was agreed that the following zero events are stepped down for 2021/22:

- No patient in our community inpatient setting should have an inappropriate catheter in place due to positive performance.

- No patient in our MH and LD inpatient services will come to moderate harm (or above) as a result of a self-harm incident where there is an absence of a documented MDT discussion and plan in relation to risk. This zero event to be stepped down as there is a high level of assurance from a large number of incidents. Self-harm and attempted suicide incidents are robustly reviewed at the corporate huddle ensuring appropriate review and action as necessary.

Zero events for 2021-22 were presented to the Quality Committee in August.

5.2.2 Patient Safety Partners: Trust Update

NHSE/I have published a draft framework for involving patients in patient safety in line with the strategic intentions outlined in the national patient safety strategy published in 2019.

Supporting patients to be involved in their own safety and creating the patient safety partner (PSP) role are two important ways to make real what Don Berwick called for when he said that “patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts”.

Patient safety partners (PSPs) are patients, carers, family members or other lay people who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation. As such, they perform a very different role from that of the traditional NHS volunteer who acts as, for example, a hospital guide or befriends and supports patients.

The framework is in two sections. The first describes how organisations should support patients, their families and carers to be directly involved in their own or their loved one’s safety; and the

second how organisations should support PSPs to be involved in wider governance of safety activities.

In line with the National and Trust patient safety strategies the organisation had made a commitment to involving PSPs in patient safety. Over the last two months the Assistant Director of Nursing has attended a combination of staff, patient and carer forums and meetings to promote the role throughout the organisation and also to ensure the development and direction of the role is done through co-production. The response has been overwhelmingly in favour of this role.
The next stage will be to create a framework to support PSP involvement ensuring an inclusive approach which reflects the diversity of the local communities. This will need to ensure that, as far as possible, PSPs are protected from any emotional harm and are appropriately compensated for their involvement. There is some detailed guidance coming out around this from NHS E which should be available by the end of September.

Using a fair, efficient and consistent approach to recruitment of PSPs we will aim to initially recruit two posts ensuring they are trained in line with the national training requirements. The goal is to have our first PSP's in post by April 2022.

5.2.3 International Recruitment- Trust Update

HTFT are working with NHSEI and in collaboration with 5 other Trusts (Tees Esk and Wear Valley, South West Yorkshire Foundation Trust, Leeds and York Partnership Foundation Trust, Rotherham Doncaster and South Humber and Bradford District Care Trust) on our first International Nurse Recruitment Project.

HTFT are aiming to recruit 20 nurses through the project. The nurses will arrive over three separate cohorts in groups of 7 nurses per cohort. Our first nurses are due to arrive in the UK on Monday 20th September. The first cohort of nurses will be coming from Kenya, India, Zimbabwe, and Kingdom of Eswatini (Previously Swaziland). These remain on the red list countries in terms of COVID and therefore the nurses will quarantine in a government approved hotel for an 11-day period prior to arriving at their temporary accommodation in Hull where they will be met by nurses from the Nursing and Quality Directorate.

The first cohort of nurses are Registered General Nurses. Six of the nurses will join the team on the ward at Malton and 1 will join the team at Granville Court. Following the quarantine period and prior to on-boarding to the clinical areas the nurses will complete a dedicated Objective Structured Clinical Examination (OSCE) training plan, in preparation for their NMC OSCE exam. The first cohort OSCE exam is booked for the 26th October in Swindon. Following the examination, the nurse will be on-boarding to their clinical area. They will work as a band 4 until they receive their NMC pin.

The second cohort of nurses are due to arrive in the UK on 8th November, we are seeking 7 Mental Health Nurses for this cohort. We currently have one nurse for this cohort secured. We are working hard to recruit to our remaining 6 places for cohort 2.

We are working with two agencies to recruit nurses into our Trust. They continue to seek ethical applications for mental health nurses however this area of international nurse recruitment is much more challenging then registered general nursing due to differences in nurse training and recognition of mental health overseas. As the UK has a drive on INR with specific interest in recruiting to mental health nurses the already limited international mental health nurse pool is depleting.

The third cohort of nurses are due to arrive the 10th January 2022. We currently have one mental health nurse and one general nurse for this cohort. The aim is again 7 nurses. The international nurse recruitment programme will be evaluated to determine its success and whether we should continue a programme of recruiting international nurses.

5.2.4 Nursing Times Awards- Shortlisted

The Practice Education Team have been shortlisted in the Student Nursing Times Awards 2021 under the category of community placement for the virtual placements we provided during the pandemic for Mental Health and Learning Disabilities students earlier this year. This approach allowed every nurse in training to complete the requirements of their placement.

The judges have commended the high-quality of this year's entries. To be shortlisted is a fantastic achievement. We have been invited to attend the awards on the 4th November 2021 at the Grosvenor House Hotel London when the winner will be announced.

5.3 Medical Director Updates

5.3.1 Research Conference

The final agenda and line up of speakers have been confirmed for the annual research conference and has been shared across the Trust and externally with our partners. We are confident that our blended model will not only increase participation in the event but hopefully improve participants enjoyment of the event. The final agenda has been shared with board and will be available publicly.

5.3.2 Wellbeing and Engagement Sessions

The Director of Medical Education Dr Soraya Moyet and the medical education department is supporting the doctors in the Trust with a suite of wellbeing and engagement sessions following a successful bid for funding form Health Education England in addition to funding available from our own internal recovery funding. As we move forward into the new academic year the bulk of education and training will still remain remote in nature, however once we have completed our Hub vaccine program the intent will be to introduce an element of 'in person' teaching subject to prevailing public health conditions.

5.4 Director of Workforce & Organisational Development

5.4.1 Flu Vaccinations

The Trust took its first delivery of flu vaccinations w/c 13/9/21. 70 peer vaccinators are at various stages of their annual update training and once completed will commence vaccinating. In addition to peer vaccinators, 20 clinics have been set up across the trust during October and November for staff to book into for a vaccination. Peer vaccinators can now enter information directly in the NIVs reporting system which will improve the speed with which we can get current vaccine status information. As with previous years, a flu vaccine, completed statutory and mandatory training and an Appraisal will see staff receive an additional day's annual leave in 2022/23.

5.4.2 Staff Survey

The 2021 NHS national staff survey goes live on 27th September for nine weeks. Communications have gone across the trust encouraging take up and reminding people they will be given the time to complete this in work. Regular communications will take place during the nine weeks, which will include you said we did, reminders, and current data on completion rates.

5.4.3 Health and Wellbeing Coordinator

The Trust's new role of health and wellbeing coordinator started on 13th September. Tasked with putting together a programme of activities to support our staff, the role is for 12 months and is funded from the ICS wellbeing project. This forms part of the trust's COVID recovery plan.

5.4.4 Organisational Health & Wellbeing Checklist

NHSI have released an organisational Health and wellbeing checklist. It is based on the best evidence in the NHS. The checklist will be used in the Trust's Health and Wellbeing Group.

5.4.5 Delivering an NHS COVID-19 Vaccination Programme

NHS colleagues in the North West region have produced videos in a variety of languages highlighting the importance of getting the second dose of the Covid-19 vaccination. We have shared these with all our staff. Languages includes Gujarati, Kannada, Telugu, Malayalam, Arabic, Punjabi, Urdu, Tamil and Polish.

5.4.6 Implementation of new Contractual Flexible Working Provisions

Amendments to the flexible working provisions in NHS Terms and Conditions of Service handbook took effect on 13th of September 2021. As of this date, staff will be able to request flexible working from day one of their employment.

5.5 Director of Finance Update

5.5.1 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 2021 are summarised in the table below:

	Issued	Deployed or no Action required	Awaiting deployment, action or testing	Not Applicable (do not use the system the Care Cert relates to)
High Priority	4	3	0	1
CareCert Bulletins	44	44	0	0

There were no Distributed Denial of Service (DDoS) attacks against the Trusts internet connections during August 2021.

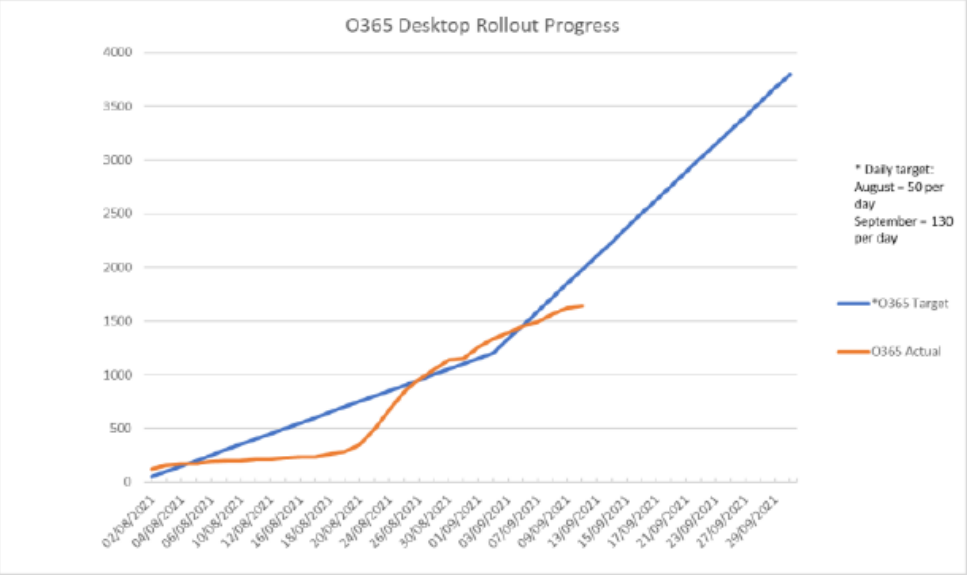
The Trust IT Servicedesk responded to 100 calls for Out of Hours support during June 2021.

5.5.2 Electronic Patient Survey Record Usability Survey

The Trusts operational staff have made 162 submissions to the national Electronic Patient Record usability survey. This places or Trust in the top five returns national and will provide us information to help improve Lorenzo and SystmOne.

5.5.3 Office 365 Update

Good progress continues to be made with 1,650 devices migrating from Office 2010 onto Office 365. All remaining devices are planned to be migrated during September.
Progress is monitored and tracked via the Office 365 Project Board, which reports into EMT



5.5.4 NHSX Documents Published

On the 31st August NHS X issued three online documents to support organisations and ICS improve, sustain, and to continually develop the use of digital technologies to support the delivery of high-quality patient care. The documents have also been developed from the learning gained on the use of digital technologies during the COVID pandemic.

The three online documents are;

- What Good Looks Like
- Who Pays for What
- Unified Tech Fund

Attached as an appendix to this report is a brief summary for each paper

5.5.5 Redesigning Adult Inpatient Mental Health Services

The Trust submitted an expression of interest to the Government's New Hospitals programme on 9th September. The expression of interest is the first stage of a 2 stage process that will result in funding being allocated to 8 projects in the Spring. A National panel will review over 300 applications and develop a long list for Ministerial consideration taking into account available datasets and system priorities. Long listed schemes will be asked to produce further information in the new year the results of which will inform the announcement in the Spring.

5.5.6 SALIX Decarbonisation Update

The decarbonisation programme continues to progress positively against a revised programme and approach.

A full review of the professional team and how the proposed works may integrate with the wider refurbishment project at the Humber Centre has been undertaken. This resulted in some changes to the professional team in the interest of focusing on delivery experience and combining the Humber Centre element into the overall Humber Centre programme.

The East Riding Community Hospital project will progress as an independent project and anticipates to have tender returns ready for entering into contract by December with works completed this financial year.

The Humber Centre programme is on the same timescale however installation works will be phased to align with the wider refurbishment, works that can be undertaken outside of the wards will be completed this financial year, internal ward works such as BMS and lighting replacement will be completed as part of the ward works progressing throughout 2022.

5.5.7 Estates

Services moved into the newly refurbished tower block at Whitby on 15 September, with the ward and UTC successfully moving across from day 1.

Refurbishment at Maister Lodge to increase bed capacity by five has completed. Further works are continuing to enhance the patient garden to be dementia friendly and provide additional staff accommodation and welfare facilities.

Refurbishment of the Humber Centre remains in development, with the appointment of a cost consultant. Design team have developed scheme designs in line with service requests.

Ward refurbishment schemes are continuing and will include Miranda House, Newbridges, Millview and Westands in this financial year.

Trust Headquarters closure. In the process of relocating the last of the corporate services that have indicated a requirement for physical accommodation at Willerby Hill.

Staff wellbeing facilities are continuing to be rolled out across the Trust.

Review of accommodation being undertaken in conjunction with IPC to establish potential increases of space occupancy across the estate. This is to alleviate accommodation pressures and assist operational services to continue as planned.

5.5.8 NHS Resolution Scorecard 2021

The 2021 claims scorecards are now available. The scorecard is accessible on NHS Resolutions extranet page and we have registered to gain access. We are awaiting registration confirmation, upon which updates will be taken to the Finance and Investment Committee and then to Trust Board

The scorecard will assist the Trust with an analysis of our clinical and non-clinical claims. The scorecard allows us to view both clinical and non-clinical claims by type and cost, and, specifically for clinical claims to review the associated specialty/cause. Additionally, as an update for 2021 the scorecard now makes it easier to isolate individual specialities to view their trends and claims. This also makes it easier to share relevant information with clinicians within specific specialities.

The data shows the value and volume of all claims by specialty and cause and will allow us to interrogate claims and the costs of these within each division. We can also use the scorecard to consider areas for a targeted quality improvement focus for the reduction of clinical and non-clinical claims.

It is thought that the Care Quality Commission (CQC) may ask for our claims scorecards as part of data gathering in preparation for an inspection visit and they may also ask for information and examples of learning from our claim's scorecard as part of their regulatory inspections. It is therefore important that, once we have obtained access to the scorecard, it is reviewed in detail by executive management.

5.5.9 NHS System Oversight Framework

The NHS system oversight framework for 2021/22 sets out how NHS England and NHS Improvement (NHSEI) will approach the oversight of integrated care systems, Clinical Commissioning Groups (CCGs) and trusts, with a focus on system led delivery of care.

The framework identifies how the ICS performance will be measured and the level of support and oversight required within the current statutory framework.

The framework has been built around 5 themes with a 6th theme for local strategic priorities, the framework is summarised below:

Regional teams will allocate the ICS, Trust and CCG's into one of four segments (see table below)

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective, self-standing ICS Plans that have the support of system partners in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

The new oversight framework is similar to current arrangements but will focus on wider system metrics as opposed to individual trust performance. The framework has been discussed at Executive Management Team, and further analysis will be undertaken as further guidance is published, with updates brought to the board when appropriate

6 Trust Policies

No policies have been presented to sub committees of the Board for approval since the last report to Board that require ratification by Board.

7 Communications Update

Key Projects

- **New Intranet Launch**

We launched our new intranet, Humbernet, to staff on Thursday, 12 August 2021.

Supporting our staff to do their job is more important than ever before. Our intranet is a key resource to help keep everyone connected to the information they need. It's also an important communications tool to ensure staff can access news and updates.

Humbernet has been developed by the Communications team in collaboration with staff across the Trust to bring them a fresh, updated site that provides them with the best possible online experience.

- **Brand Centre**

The Trust Brand Centre has seen another increase in the number of users over the last month. 295 of the 480 users are first time users. This data demonstrates that the communications around the Trust brand and the templates we have available are receiving engagement from our staff and increasing the activity of the website. Regular updates and improvements to the websites has provided purpose for staff revisiting the site and ensures that teams use the website as a first point of contact for all things relating to the Trust branding.

Brand Centre analytics	Users	Page views	Avg Session Duration	Most viewed page	Most used Templates
February	130	635	1:19 mins	/home/ (327 *views*)	Corporate
March	223	1,246	1:14 mins	/home/ (632 *views*)	Corporate
April	181	889	1:12 mins	/home/ (464 views)	Corporate
May	278	1,540	1:15 mins	/home/ (756 views)	Corporate
June	285	1,320	1:09 mins	/home/ (679 views)	Corporate
July	263	1,133	1:04 mins	/home/ (513 views)	Corporate
August	480	2,312	1:09 mins	/home/ (1,100 views)	Corporate

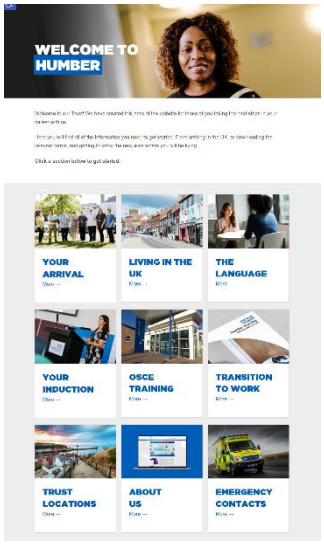
External Communications

- **Service Support**

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

- Youth Action Group

The team are working closely with the Patient and Carer Experience team to develop communication pieces for members of the group. A meeting is due to take place at the end of September, where co-production ideas will be shared and a plan devised to take this work forward to help to promote the group itself to young people. The team will work closely with the new Engagement Lead for the group once they have been appointed.



- International Recruitment Hub:

The team have worked closely with the International Recruitment team to finalise the development of the online international recruitment hub. The hub is now live and provides important information for international recruits who arrive in the country for the first time. The hub provides information that ranges from the language and areas they may live, all the way up to information to support them in their professional role. The hub itself has been shared with NHS England and NHS Improvement and has received very positive feedback.

- Online Recruitment Fair

Working with the Recruitment Team, we have developed an area on the Trust recruitment website that will act as an online fair that is available 24/7, to provide the opportunity for potential applicants to watch videos from our staff and learn more about the roles in order to encourage them to apply. This section of the site is currently under development and is planned for completion by the end of September.

- **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 the new mental health front door and updates around our Whitby Hospital renovation.

Positive new stories published		**Negative new stories**	
Local media	27	Local media	4
Humber website	21		
TOTAL	**48**		**4**

- **Awareness Days**

This period has seen us mark a number of important dates including International Day of Charity, for which we built an external and internal campaign to introduce our Health Stars and Hey Smile teams and how they can support our services.

- **Trust Website Update**

	Target	**Performance over period**
Bounce Rate	50%	62%
Social Referrals	12% (a 10% increase in 2019 position)	5%

- **Social media**

	Target	**Performance over period**
Engagement Rate	4%	6%
Reach	+50,000 p/m	82,025
Link Clicks	1500 p/m	372

Internal Communications

Covid-19

The team continue to support the communications of Covid-19 information and advice to staff including the roll-out of LAMP testing to a small test group and continuation of current IPC guidelines.

We focused our communications on reiterating IPC messaging during w/c 6th September to tie in with schools returning after the summer holidays. Communications regarding IPC was included in Wednesday and Friday's Global e-comms.

Flu Vaccinations

We are working closely with the action group for the flu campaign. As well as working on communications to staff internally, the team have developed two web forms that will be located on the Trust intranet. The first of which is a form where staff can inform the Trust if they have received their vaccine elsewhere. The second is an opt-out form so that the Trust can gain insight into the number of staff declining the vaccine and gain an understanding of the reasons behind this. The Flu campaign is set to launch at the end of September. A full report on activity and objectives will be incorporated in next month's board report.

Staff Thank You & Celebration Week

We launched our first ever virtual Staff Thank You & Celebration Week on Monday, 6 September, to thank our #Humbelievable team, for everything they've done throughout the pandemic to support our patients, their families and carers and importantly - each other.

As a special thank you, during the launch communications on Monday 6, each member of staff was gifted £10 which will be received in their October pay.

Throughout the week we shone a spotlight on a different location every day to celebrate our staff, their successes and the amazing work that has taken place over the last 18 months.

From Extraordinary East Riding, to Super Scarborough, Heroic Hull and Wonderful Whitby – the good news stories and achievements were collated and shared across the patch. The week culminated with an EMT Virtual Lunch and a general knowledge quiz, which was well received and well attended.

We also used the communications to reflect on the 'You're a Star' celebration events that staff organised throughout summer.

Chair Welcome & Farewell Comms

A series of communications to say farewell to current chair Sharon Mays, and welcome to new Chair, Rt Hon Caroline Flint have been delivered. The comms plan involves internal and external communications methods – including e-shots, a press release and website articles about the appointment.

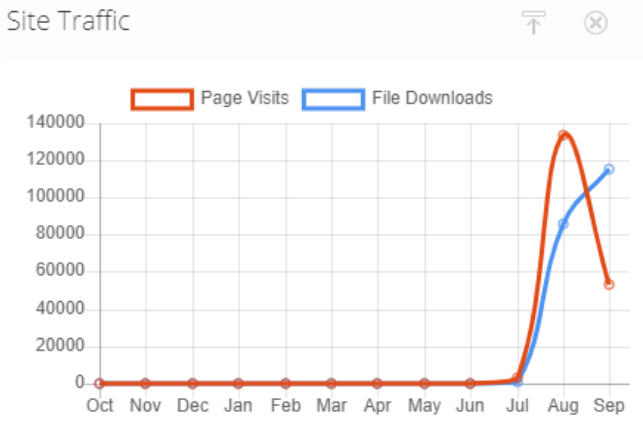
Poppulo – Internal Emails

Between 15 July and 08 September we issued 55 internal communications to staff. Our engagement rates are lower than the last period which is likely due to the summer holidays. Also a number of emails sent during this period didn't include links for staff to click on which could also attribute to the drop in our click through rates.

	Trust average engagement rates	**National Average**
Open Rate	64.2%	65%
Click Through Rates	7.6%	10%

Intranet

Our new intranet platform has been visited 189,444 times since it was launched on 12 August and staff have downloaded 202,244 files.



8 Health Stars

Whitby Appeal

With the cutting of the ribbon taking place on the 12th September 2021 and the transition of services commencing on the 15th September Health Stars were delighted to be a part of this journey seeing first-hand the incredible enhancements of which Whitby Hospital has undergone over the past nine months since the 'Whitby Hospital Appeal' was launched in January 2021.

The team continues to engage with the local community, voluntary sector and local schools around fundraising opportunities and involvement with the enhancements for the Hospital rebuild, continuing to support the ongoing 'Task & Finish' groups and the Extraordinary Whitby Forum.

As work on site continues to progress and we near the next chapter of the appeal the team continue to be diverse and reactive with their fundraising strategies and abilities.

Work between the Charity and the Trust operational team continues. Health Stars are fundraising to 'add sparkle' to the rebuild and the enhancements identified to date total £130,359.48. Whilst there is still room for adjustment and the charity team remain ambitious in supporting all aspects which go over and above what the core NHS can provide. This is the target we are currently fundraising against.

I am delighted to update that the team have raised £32,871.30 through community events and donations. I would like to say a special thank you to all who have supported to date.

The team continue to work hard behind the scenes in making grant applications and identifying potential funders to support the larger areas of the appeal such as the dementia friendly garden which totals £37,000.

As we continue to transition through the COVID19 restrictions the team continue to plan in person events with support of the Trust infection control team and Smiles Event Lead.

Future Events include:

· Community Zumba Walk (Community led event) – September 2021

· Dr Kranks Ghost Walks – Date to be confirmed

· Miniature teddy bears workshop – October 2021

· Rugby Club Fundraiser - Date to be confirmed

· Whitby to Willerby Cycle – Date to be confirmed

We are delighted to confirm the Fundraising Bricks have now been launched with thanks to the Trust communications team. The Health Stars team will continue to work with staff and the local community to promote the sale of the bricks, which will generate further charitable income in support of the appeal.

Further details can be found here: WHITBY HOSPITAL APPEAL – FUNDRAISING BRICKS — Health Stars

Events

As a team Health Stars continue working hard behind the scenes on fundraising events remaining agile and responsive. They have several in person events in planning for 2022 and plans continue for the event in partnership with Burton Constable which will be going ahead on the 13th November. The formerly 'Starlight Ramble' event shining a light on children's mental health post pandemic will now be named "The Health Stars Night Walk." The name is changing for this event due to the Dove House Hospice event "Starlight Stride" which is very similar, and Health Stars felt the need to distinguish the event from theirs.

We are incredibly grateful for the support shown for this event from the guest speakers and the Hull and East Riding Astronomical Society. The team look forward to tickets going on sale later this month.

Community Events Fundraising for Health Stars this period includes:

• Jason Dean Charity Boxing Evening – 10th September
• Namaste Hull Family Fun Day- 19th September

It is great to see strong relationships continuing to be built both internally and externally with new supporters for the charity coming forward including the Trusts 'Thrive' Staff Lived Experience Group who are keen to build a strong working partnership and support with events in the future.

Wishes

The Health Stars team are continuously working hard granting wish requests which span the breadth of Humber Teaching NHS Foundation Trust. The team are currently processing an enormous 109 wish requests.

The highlights of wishes of which have been granted this month include:

- Resources to support the delivery of perinatal DBT groups.
- Burt's Bees Balms to support our EOL Patients at Whitby Hospital
- Printing of Heart Failure Support Leaflets
- Artwork for the Patient Waiting room at Prospect Road Hub Scarborough
- 52 Dementia Clocks for Whitby Hospital (Whitby Hospital Appeal)
- Recovering of 4 Pool Tables at the Humber Centre
- Funding for Patient PT Classes at St Pauls Boxing Gym

The team continue to work closely with the Patient and Carer Experience Team ,Staff wellbeing forums and Service Managers. They are also in attendance at the Patient Council Meetings to ensure they hear first hand from our Patients the enhancements they would like to be supported.

The Health Stars team continue to 'add sparkle' across the Trust and Trust teams are encouraged to build strong working relationships with our Trust charity. It is important we support our Trust charity to ensure they can continue granting wishes which go over and above what the core NHS can provide.

Please continue to showcase the difference they continue to make across our Trust and continue to access our Charitable funds through the Health Stars 'circle of wish' process - Submit Your Wish — Health Stars

Together we can make a lasting impact across our Trust.

Michele Moran
Chief Executive
September 2021

Appendix 1

NHSX Documents summary

Document 1 What Good Looks like (WGLL)

The What Good Looks Like (WGLL) programme draws on local learning. It builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. This will improve the outcomes, experience and safety of our citizens. The WGLL framework has seven success measures:

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

The different criteria are applied to each of the seven success measures as at an Integrated Care System and to an organisation. NHS X will support WGLL by providing tools. These will include an assessment framework to measure your level of digital maturity. The assessments will be repeatable so you can track progress year-on-year. NHS X will also provide an online knowledge base as an easy way for you to access information to support your digital transformation journey. It will include blueprints, standards, templates, real-life examples and best practice. Their goal is to ensure that you have the right information, tools and support to digitally transform services and provide better care.

Our next steps are to assess the local organisation measures and to carry out a self-assessment in readiness for the NHS X assessment framework. Our digital plan will be amended to reflect any areas of improvement highlighted by our self-assessment. The delivery of the updated plan will be lead by the Trust Digital Delivery Group.

Online document available at the following link What Good Looks Like framework - NHS

Who Pays for What

This document is a proposal for consultation.

The current method of providing digital capital and revenue funding has been complicated and generally provided late in the financial year. This has created a situation of poor short term investment decision making to use the digital funding. The position for 2021/22 has been changed and a majority of the different digital initiatives are merged into a unified tech fund which has a clear schedule for making bids, ICS/NHS E approval and when funding will be received.
The position for 2022/23 onwards is expected to be based upon ICS providing digital capital and revenue funding for local initiatives. Examples are;

- applications such as EPRs - procurement, development and management
- cloud services and data centres
- core kit and supplies including laptops, printers, telecoms and networks
- local cybersecurity measures
- IT programme management
- training
- IT service management

- system transformation, for example shared care records

NHS England will provide funding for national products such as the NHS App, national infrastructure, pilots linked to the NHS Long Term Plan commitments in advance of national scaling and things that need to be done across multiple ICS areas - such as Office 365. All future bids must comply to national standards to allow funding to be provided.

Our next steps are to review the proposal and feedback to NHS England as part of the consultation.

Online document available at the following link Who Pays for What proposals - NHSX

Unified Tech Fund (UTF)
The UTF now covers following different run funding initiatives;

- level up the digital maturity of NHS trusts and consortia
- ensure a basic shared care record is in place within all ICSs
- level up cyber security capabilities, address key infrastructure and other specific weaknesses, with continued provision of back-up reviews
- scale what we know works to improve productivity throughout health and care
- support the digitisation of the pharmacy, optometry, dentistry, ambulance and community services sectors, and improve interoperability
- increase system capacity and resilience of diagnostic services. Improve safety and experience for patients and staff through digital capability and reduce manual processes
- improve outcomes for women and their children and also to improve safety of clinical care

The UTF has a clear schedule for making bids, ICS/NHS E approval and having clarified when funding will be received. This is a clear improvement on the historic processes which was very messy and paper driven.

Our next steps are to use the new UTF process to bid for funding for digital initiative.
Online document available at the following link Unified Tech Fund prospectus - NHSX

COVID Patients: Inpatient

14/09/2021

	Trust Wide Total	Community TOTAL	Mental Health TOTAL	Childrens and LD TOTAL	Secure Services TOTAL
Number of occupied beds with confirmed COVID-19 patients	7	0	7	0	0
Number of occupied beds with suspected COVID-19 patients (e.g Isolating with symptoms)	0	0	0	0	0
Number of occupied beds with non COVID-19 patients	156	21	63	14	58
Of which have a learning disability and/or autism	18	0	0	8	10
Number of unoccupied beds	64	1	30	14	19
Number of closed beds	17	12	3	2	0
Number of patients that have had diagnostic swabbing for COVID-19 and are awaiting results at 0800?	0	0	0	0	0
Number of patients on end of life pathways as at 0800?	0	0	0	0	0
Number of patients awaiting transfer to general acute hospital as a result of suspected or diagnosed COVID-19 at 0800	0	0	0	0	0
How many of the confirmed COVID-19 patients identified in questions 18-40 above are NHS staff?	0	0	0	0	0

Risk Assessments

Last Updated:	07/09/2021

	Division	No of Staff	Risk Assessment Completed	Percentage
What % of risk assessments have been completed for staff who are known to be 'at-risk', with mitigating steps agreed where necessary.	Childrens and Learning Disability (Division)	160	158	98.8%
	Community and Primary Care (Division)	164	157	95.7%
	Corporate (Division)	362	329	90.9%
	Mental Health Planned Care (Division)	161	159	98.8%
	Mental Health Unplanned Care (Division)	186	184	98.9%
	Secure Services (Division)	126	122	96.8%
	Mental Health Services Central (Division)	6	6	100.0%
	Trustwide	**1165**	**1115**	**95.7%**
What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary.	Childrens and Learning Disability (Division)	23	23	100.0%
	Community and Primary Care (Division)	18	18	100.0%
	Corporate (Division)	64	57	89.1%
	Mental Health Planned Care (Division)	18	18	100.0%
	Mental Health Unplanned Care (Division)	30	28	93.3%
	Secure Services (Division)	19	17	89.5%
	Mental Health Services Central (Division)	1	1	100.0%
	Trustwide	**173**	**162**	**93.6%**

COVID Vaccinations by Division

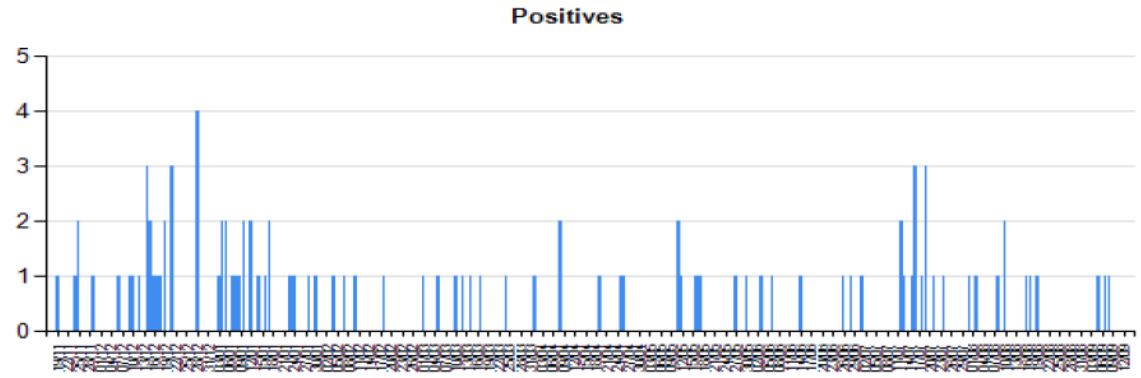
Data up to date **14/09/2021 @ 8am**

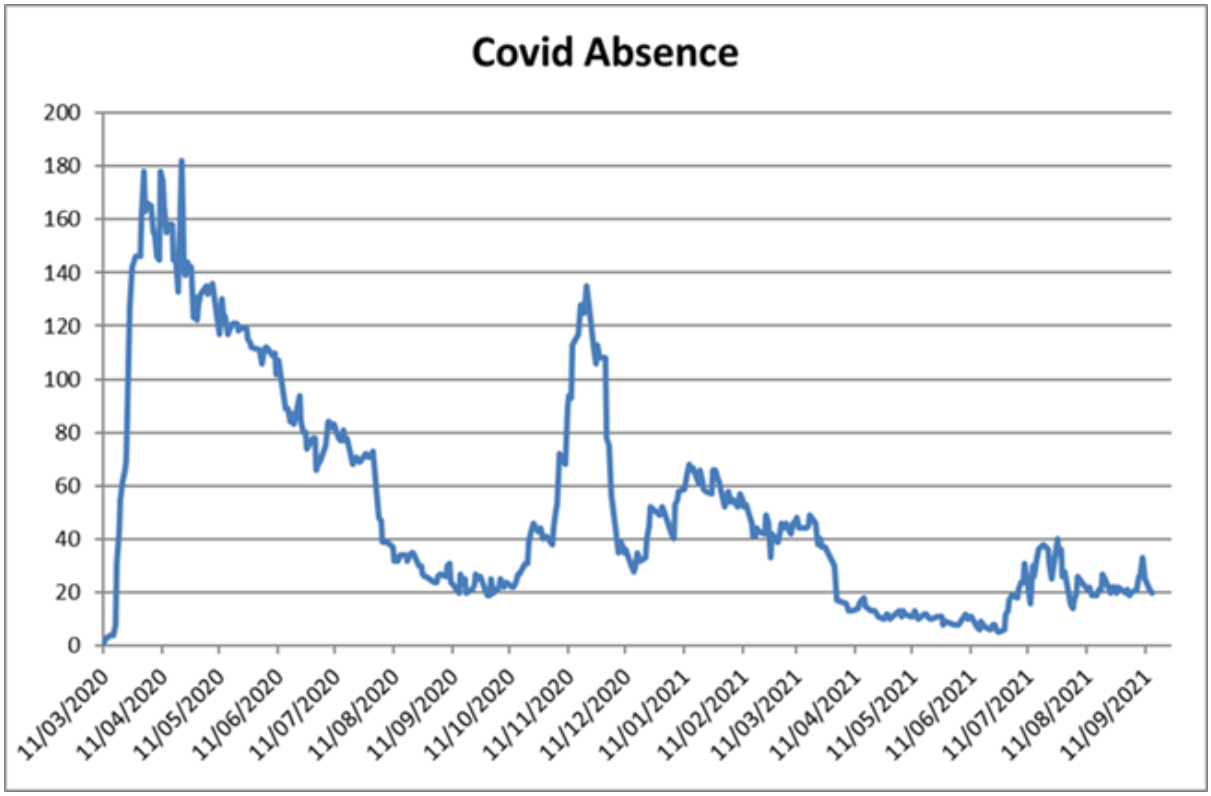
First Dose Compliance	Number of Staff	Number of staff - Opted Out	1st Dose Received	1st Dose Staff Remaining	1st Dose Uptake %
Active Bank	295	3	180	112	61.6%
Childrens and Learning Disability (Division)	673	12	573	88	86.7%
Community and Primary Care (Division)	561	9	466	86	84.4%
Corporate (Division)	568	8	518	42	92.5%
Mental Health (Division)	985	28	834	123	87.1%
Secure Services (Division)	226	10	194	22	89.8%
Total (With Active Bank)	**3308**	**70**	**2765**	**473**	**85.4%**
Total (Without Active Bank)	**3013**	**67**	**2585**	**361**	**87.7%**

Second Dose Compliance	Number of Staff received First Dose	Both Does Received	2nd Dose Staff Remaining	Both Dose Uptake %
Active Bank	180	167	13	92.8%
Childrens and Learning Disability (Division)	573	556	17	97.0%
Community and Primary Care (Division)	466	418	48	89.7%
Corporate (Division)	518	491	27	94.8%
Mental Health (Division)	834	785	49	94.1%
Secure Services (Division)	194	186	8	95.9%
Total (With Active Bank)	**2765**	**2603**	**162**	**94.1%**
Total (Without Active Bank)	**2585**	**2436**	**149**	**94.2%**

Staff Lateral Flow Testing

NHS Staff Asymptomatic LFT data collection		
Last Updated : 10/09/2021	Total number of Lateral Flow Tests submitted to date	69876
	Number of staff who have submitted a Lateral Flow Test so far	3047
	Number of staff who have tested negative	2826
	Number of staff who have tested positive	87
	Number of staff who have submitted a Lateral Flow Test result in the past 7 days	429
	Number of staff who have submitted 2 test results in the last 7 days	184
	Proportion of staff who have submitted 2 test results in the last 7 days	5.6%




Covid Absence
200
180
160
140
120
100
80
60
40
20
0
11/03/2020
11/04/2020
11/05/2020
11/06/2020
11/07/2020
11/08/2020
11/09/2020
11/10/2020
11/11/2020
11/12/2020
11/01/2021
11/02/2021
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11/04/2021
11/05/2021
11/06/2021
11/07/2021
11/08/2021
11/09/2021

Humber Teaching NHS Foundation Trust

Agenda Item 8

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
Title of Report:	Publications and Policy Highlights
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	To approve: ; To receive & note: ; For information: x ; 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:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	5/5
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Other (please detail)	

Key Issues within the report:

I. NHS appoints national director of learning disability and autism
II. Clinical leadership – a framework for action
III. NHS workforce more diverse than any point in its history, as health service commits to more action on representation
IV. Making vaccination a condition of deployment in the health and wider social care sector consultation
V. Understanding integration: how to listen to and learn from people and communities

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

Caring, Learning & Growing Together

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. **NHS appoints national director of learning disability and autism** NHS England 9 September 2021

NHS England has announced the appointment of Tom Cahill as the national director for learning disability and autism. He will join NHS England to build on progress already made in providing people with a learning disability or autism with care in the community, rather than in inpatient settings. He will also lead work set out in the NHS Long Term Plan to drive up standards across the health service and independent sector which provide inpatient care for people with a learning disability and/or autism.

The NHS expects all care providers to deliver high quality and safe care for patients that meets the national standards. The number of inpatients with a learning disability has fallen by around a third since 2015, and with the establishment of integrated care systems, local NHS groups are now working with councils to drive this number down further.

NHS England and NHS Improvement will be undertaking a review, working with commissioners, of every single inpatient with a learning disability, autism or both in a mental health inpatient care setting to ensure that each person has a clear care and treatment plan and discharge date in place. If these are not in place, the review will explore why not.

Lead: Chief Operating Officer

Townend Court LD inpatient services continue to work with families, local commissioners, and providers from the day of admission on the development of safe and robust plans to ensure our patients return to their community-based services. The service is currently supporting one complex patient that they have enlisted NHSE involvement, to help in the identification of an appropriate community-based placement and discharge plan.

The Inspire services support all young people with robust discharge planning this includes Young People with a diagnosis of Autism.

2. **Clinical leadership – a framework for action** NHS England 12 August 2021

The NHS Long Term Plan highlights the importance of visible senior clinical leadership in enabling and assuring the delivery of high quality care both within organisations and in the new system architecture.

This framework, and accompanying case studies, looks at how existing structures and expectations may stand in the way of allied health professionals, doctors, midwives, nurses, pharmacists, psychologists, healthcare scientists and social

workers contributing to strategic leadership. https://www.england.nhs.uk/wp-content/uploads/2021/08/clinical-leadership-framework.pdf

Lead: Director of Workforce & Organisational Development

The Trust supports and encourages clinical leaders to develop their careers, and programmes such as the Nye Bevan Programme are funded by the Trust.

3. **NHS workforce more diverse than any point in its history, as health service commits to more action on representation** NHS England 20 July 2021

A first of its kind report looking into race equality among England's doctors has found that the number from black and ethnic minority backgrounds working for the NHS is the highest on record.

New data published as part of the inaugural Medical Workforce Race Equality Standard (MWRES) commissioned by NHS Chief Executive, Simon Stevens shows that last year more than 53,000 doctors working in the NHS were from a black and minority ethnic (BME) background, up by more than 9,000, a rise of around one-fifth, since 2017. The change confirms the ever-increasing diversity of NHS staff – with 42% of medical staff working in the NHS now from a BME background.

Lead: Director of Workforce & Organisational Development

An interesting report and shows the value of initiatives such as the BAME staff network and our continued focus on workforce diversity.

4. **Making vaccination a condition of deployment in the health and wider social care sector consultation** Department of Health and Social Care 9 September 2021

The government is seeking views on whether or not to extend vaccination requirements to other health and care settings for COVID-19 and also for flu. Vaccines are the best way to protect people from COVID-19 and latest estimates suggest that 105,900 deaths and 24,088,000 infections have been prevented as a result of the COVID-19 vaccination programme (up to 20 August). Vaccinated people are less likely to get seriously ill, be admitted to hospital, or die from COVID-19 and there is evidence that they are less likely to pass the virus on to others.

Following a public consultation on making COVID-19 vaccination a condition of deployment for those working in adult care homes, the government recently announced COVID-19 vaccination would be required of people entering a CQC registered adult care home, unless exempt, to protect vulnerable residents.

While residents in care homes are some of the most at risk from COVID-19, the responses to this initial consultation made a clear case for extending this policy beyond care homes to other settings where vulnerable people receive care and treatment. The government, therefore, is now seeking views on whether or not to extend vaccination requirements to other health and care settings for COVID-19 and also for flu. Recent research has shown people infected with both flu and COVID-19 are more than twice as likely to die as someone with COVID-19 alone

and nearly six times more likely than those with neither flu nor COVID-19, so it is right that both are considered within the consultation.

The consultation proposes that, if introduced, requirements would apply to frontline health and care workers– those with face-to face contact with patients and clients though the delivery of services as part of a CQC regulated activity. It would mean only those workers that are vaccinated could be deployed (or those with a legitimate medical exemption) to deliver those services.

These are complex and important issues and the consultation seeks to gather a wide range of perspectives from the public and across the health and care sectors about whether such requirements should be introduced and how they could be implemented. The consultation ends on 22 October 2021. consultation

Lead: Director of Workforce & Organisational Development

The CEO confirmed to the Trust's staff side representatives that the Trust will be making a submission as part of this consultation.

5. **Understanding integration: how to listen to and learn from people and communities** Kings Fund 21 July 2021

This guide has been produced on behalf of NHS England and NHS Improvement.

The move towards integrated care has been the defining policy in health and care over the past decade and will continue to gather pace with the development of integrated care systems (ICSs). The aim of integrated care is to improve people's outcomes and experiences of care by bringing services together around people and communities. This means addressing the fragmentation of services and lack of co-ordination that people often experience by providing person-centred, joined-up care.

One key question for ICSs and the partners working in them is how they will know whether they are meeting the needs of the people they serve. Those best placed to understand what they need, what is working and what could be improved are the people and communities using services. Their lived experience is a powerful tool to improve existing services and identify new and better ways to meet people's needs. Guide

Lead: Chief Executive

This links to the Trust's strategic work taking place at the moment and for future working into the development of the ICS

Humber Teaching NHS Foundation Trust

Agenda Item 9

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 29th September 2021</td></tr>
<tr><td>Title of Report:</td><td>Performance Report - Month 5 (August)</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 August 2021.

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.</td></tr>
<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>
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<tr><td>Charitable Funds Committee</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>Commentary is included below:

Safer Staffing Dashboard - The safer staffing dashboard is for the month of July which was a particular difficult month for our in-patient services in terms of staffing due to significant clinical pressures in some areas combined with annual leave and the NHS App alerting staff they had been in close contact with someone with COVID and needed to isolate. The pressures have resulted in 5 areas not meeting compliance for clinical supervision. These areas have been discussed with senior managers in the recent accountability reviews to ensure the services get back on track.

Position for clinical supervision for August for units that were non-compliant in July is as follows; Millview Lodge increased to 64%, Townend Court increased to 44%, Whitby compliant at 88% and Granville Court compliant at 90%.</td></tr>
</table>

	Statutory and Mandatory Training – Whilst performance is in normal variation Executive leads for areas of low training compliance have been asked to produce recovery plans, details of which will be discussed at the November Workforce and OD Committee. **Waiting Times -** The Trust continues to focus efforts on the reduction of the ASD waiting times which has been a priority in order to reduce the number of long waiting patients. A detailed Appendix is included that details the progress being made against the original trajectory for Paediatric ASD which is good for Hull patients, where the number waiting is greater, however, for ER the progress has slowed due to absence in the small team and as a result of additional long waiting patients being added to the waiting list Additional digital assessments will take place to help bring the trajectory back on plan. . The service are working closely with the clinical systems and business intelligence teams to review pathway management monitoring. The long waiting patients for Adult ASD continue to reduce significantly, though focussed work is to take place to address some smaller increases in long waiting patients in Mental Health Specialist Services, Scarborough & Ryedale and Learning Disabilities. **IAPT Recovery** - Historically, performance for IAPT Recovery has exceeded national expectations and is still being maintained above this level of 50%. A further deterioration is not expected and the current position maintained. This is being achieved by working closely with our third party virtual therapy provider to agree and monitor an improvement trajectory set for them to achieve rates of recovery for our IAPT patients. The service is actively recruiting staff to enable a review of future third party contract requirements to support improved outcomes. **Out of Area Placements –** There has been an increase in Out of Area Placements for August in comparison to an improved position in July. This change has been impacted estates work on the AMH PICU and Avondale ward which resulted in reduced bed levels, whilst demand has remained increased. As a result of reduced capacity, increased demand and challenging levels of staffing, the AMH service reported OPEL 4 and moved to Busines Continuity during a period in August. The completion of the estate works with Avondale and PICU has resulted in increased bed capacity which will support a reduced reliance on Out of Area Placements. **Statutory and Mandatory Training –** Whilst performance is in normal variation Executive leads for areas of low training

	compliance have been asked to produce recovery plans, details of which will be discussed at the November Workforce and OD Committee.

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:
Aug-21

Humber Teaching NHS Foundation Trust
Integrated Board Report

For the period ending:	Aug 2021

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

Humber Teaching NHS Foundation Trust
Integrated Board Report

For the period ending:	Aug 2021

Goal 2	RTT - Completed Pathways	Based on patients who have commenced treatment during the reporting period and seen within 18 weeks of their referral
Goal 2	RTT - Incomplete Pathways	Based on patients who are waiting for assessment and/or treatment and are waiting less than 18 weeks since referral.
Goal 2	RTT - 52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - Adult ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Adult and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - Paediatric ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Children and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks
Goal 2	RTT - Early Interventions	Percentage of patients who were seen within two weeks of referral
Goal 2	RTT - IAPT 6 Weeks and 18 weeks	Percentage of patients who were seen within 6 weeks and 18 weeks of referral
Goal 3	Recovery Rates - IAPT	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: **Aug 2021**

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

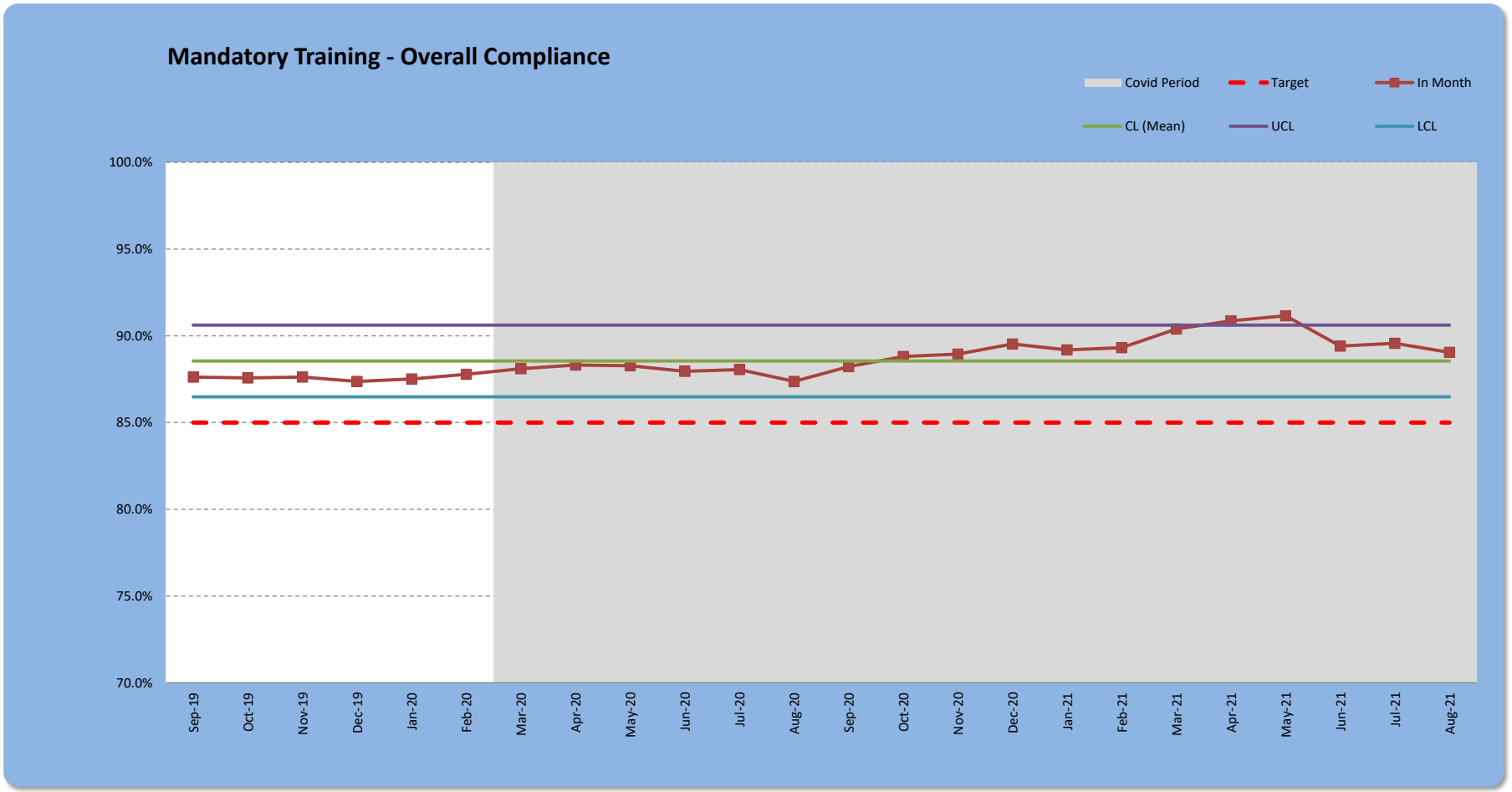
Narrative

Above target, no real change in performance when compared to the previous reporting period.

Target: 85%

Amber: 80%

Current month stands at 89.0%



PI RETURN FORM 2021-22

Goal 1 : Innovating Quality and Patient Safety

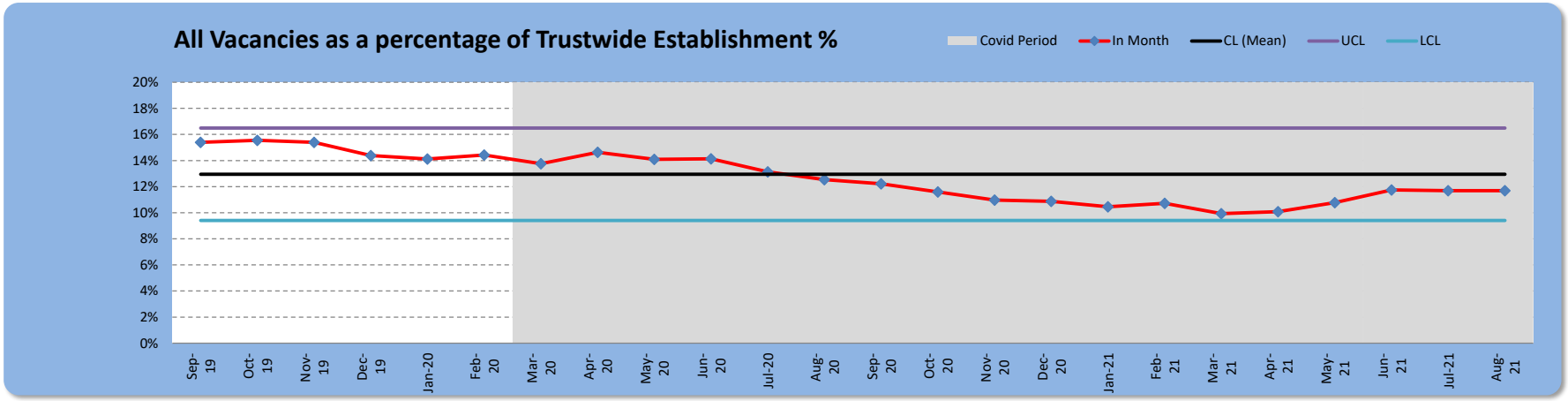
For the period ending: **Aug 2021**

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

Narrative

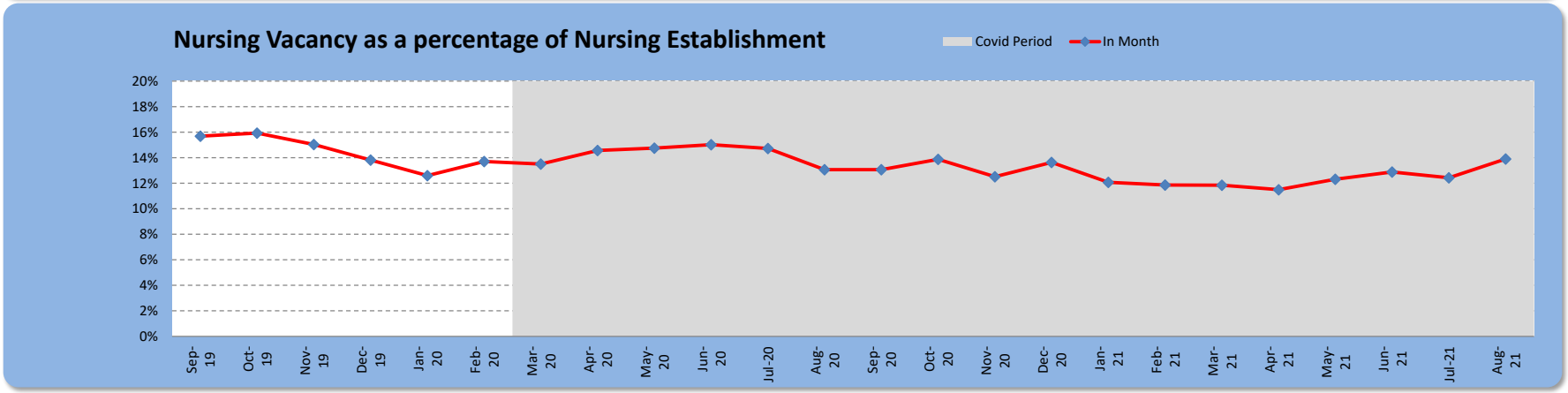
Vacancies remain the same when compared to the previous reporting period.

Nursing Vacancy rate has increased by 1.5% when compared to on the previous month.



Breakdown for Month

	Trustwide	Nursing
Est	3031.4	850.1
Vac	354.4	118.1
	11.7%	13.9%



Current month stands at 11.7%

PI RETURN FORM 2021-22

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Aug 2021**

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

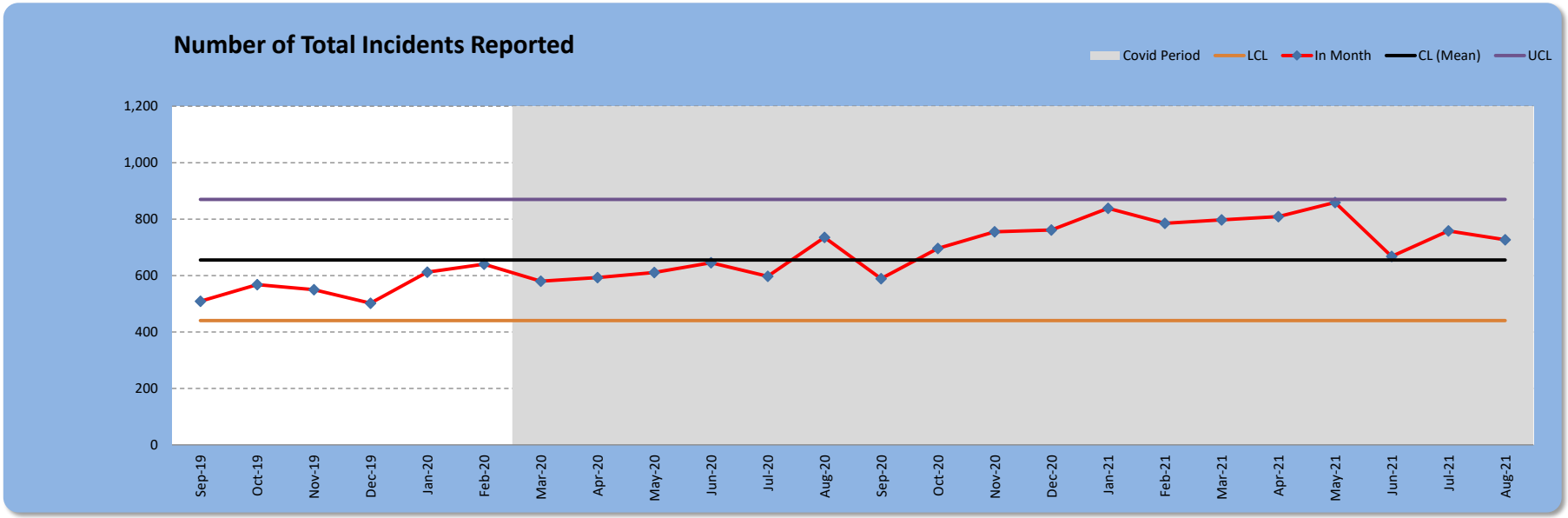
Narrative

Decrease of -31 when compared to the previous month

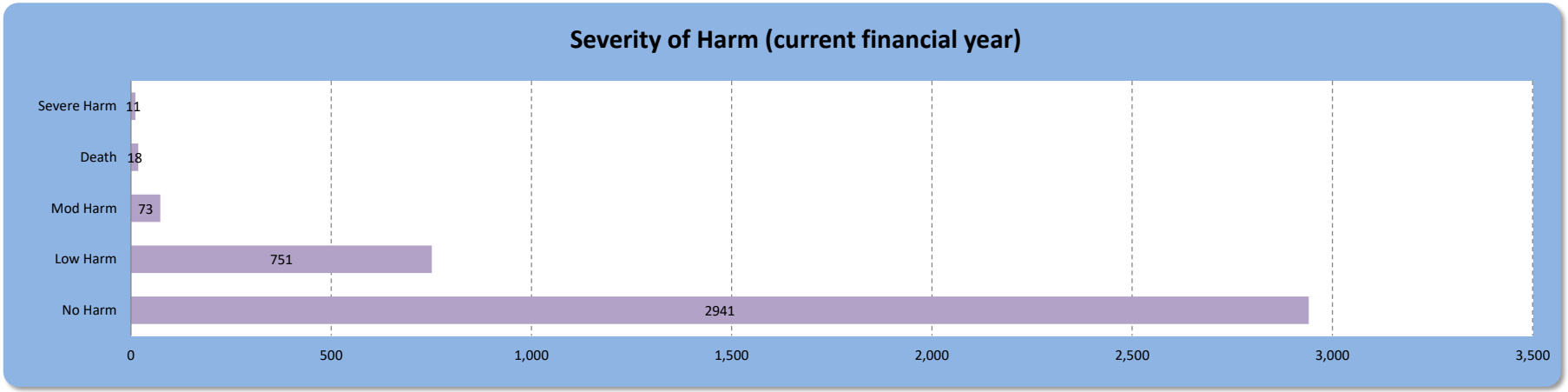
UCL: 870

LCL: 440

Current month stands at 727



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: **Aug 2021**

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

Narrative

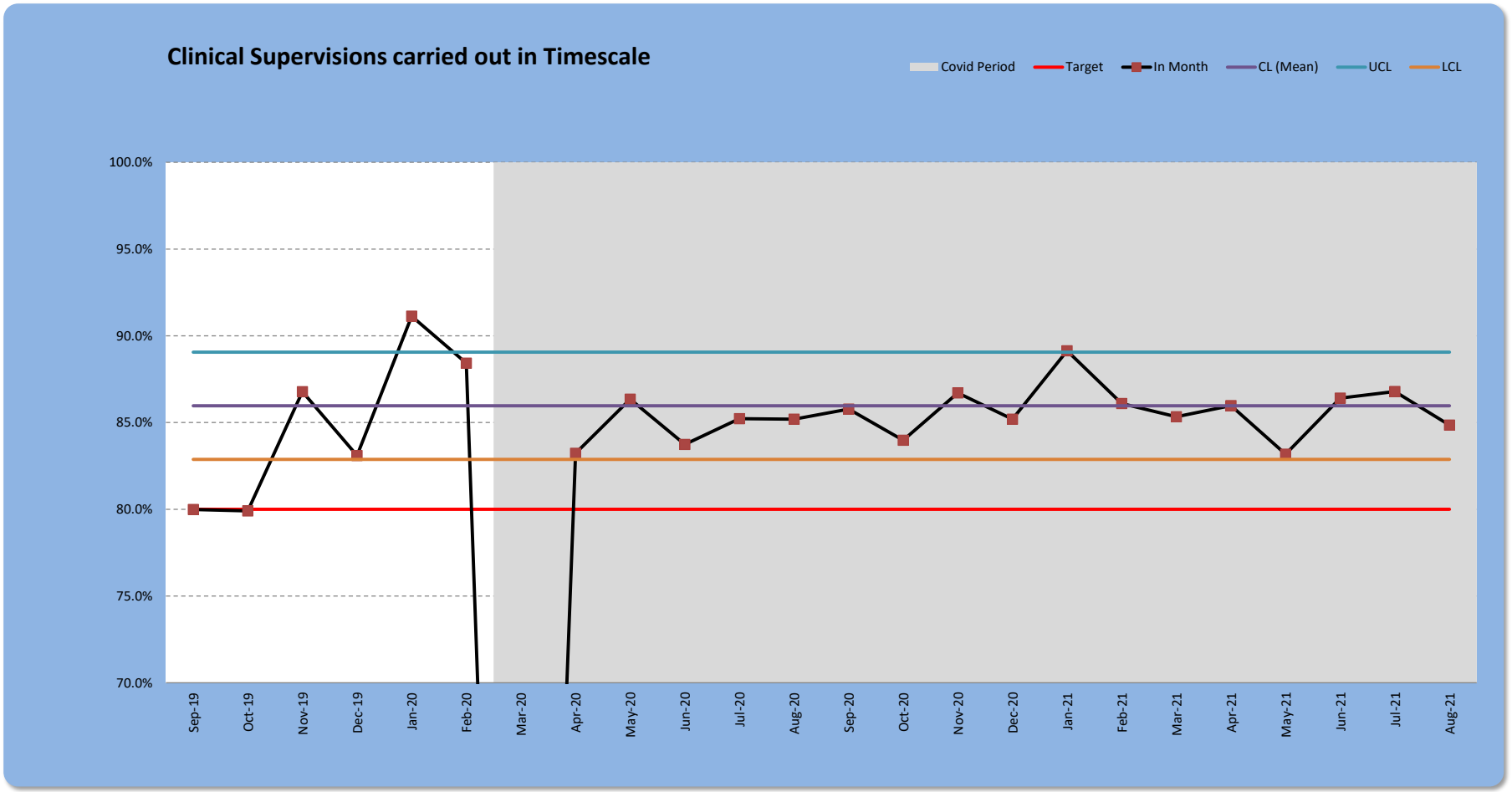
Performance has decreased by 1.9%

No data for Mar-20 for any teams as the data collection was suspended due to COVID-19 planning.

Target: 80%

Amber: 75%

Current month stands at 84.8%



HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

Staffing and Quality Indicators	
Contract Period:	2021-22
Reporting Month:	Jul-21

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)				STAFF QUALITY INDICATORS						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)	Jun-21	Jul-21
Adult MH	Avondale	Adult MH Assessment	34.6	48%		24.32		26.0%	↓	5.7%	↓	59%	83%	91%	102%	1	10	0	0	100.0%	93.5%	90.0%	94.1%	0.5%	0.2	1	1
	New Bridges	Adult MH Treatment (M)	41.5	89%		10.95		22.3%	↓	8.2%	↓	77%	117%	95%	148%	0	18	0	0	94.7%	96.1%	75.0%	86.2%	8.8%	1.5	2	1
	Westlands	Adult MH Treatment (F)	36.9	92%		8.91		20.7%	↑	14.3%	↓	74%	96%	92%	126%	0	23	1	0	75.0%	88.2%	69.2%	76.0%	4.2%	2.0	2	2
	Mill View Court	Adult MH Treatment	36.5	96%		10.57		24.6%	↓	11.8%	↓	60%	76%	68%	110%	0	4	0	0	100.0%	96.4%	66.7%	88.9%	4.2%	5.8	3	3
	PICU	Adult MH Acute Intensive	35.9	65%		22.28		30.4%	↑	13.1%	↓	85%	102%	94%	127%	0	21	0	0	100.0%	88.8%	61.5%	78.9%	0.0%	2.0	2	1
OP MH	Maister Lodge	Older People Dementia	33.3	68%		30.78		15.1%	↑	0.0%	→	71%	86%	100%	82%	0	15	0	0	100.0%	93.3%	90.0%	92.0%	9.8%	3.0	2	2
	Mill View Lodge	Older People Treatment	24.5	95%		13.53		18.8%	↓	11.7%	↓	80%	198%	100%	153%	2	7	0	0	58.3%	96.0%	85.7%	92.3%	12.1%	0.0	3	3
Specialist	Pine View	Forensic Low Secure	28.7	93%		7.38		15.2%	↓	0.0%	→	84%	75%	52%	96%	2	2	0	2	92.6%	93.0%	70.0%	80.0%	3.4%	2.8	5	1
	Derwent	Forensic Medium Secure	23.8	91%		11.20		26.0%	↓	0.0%	→	84%	78%	98%	98%	0	5	1	0	87.0%	95.9%	75.0%	87.5%	4.5%	1.4	0	0
	Ouse	Forensic Medium Secure	23.9	97%		6.11		13.8%	↓	0.0%	→	95%	74%	97%	95%	1	4	0	0	91.7%	97.9%	100.0%	94.4%	18.1%	0.8	3	3
	Swale	Personality Disorder Medium Secure	23.4	87%		10.06		40.8%	↓	0.0%	→	65%	70%	101%	134%	1	3	1	0	87.0%	95.3%	100.0%	88.2%	3.8%	3.0	2	2
	Ullswater	Learning Disability Medium Secure	31.9	67%		12.37		33.3%	↑	0.0%	→	84%	88%	100%	94%	0	23	0	0	82.6%	93.6%	100.0%	87.5%	2.3%	1.4	1	0
Child & LD	Townend Court	Learning Disability	36.9	56%		24.59		21.9%	↑	0.0%	→	44%	88%	88%	112%	2	47	0	0	27.3%	95.2%	90.9%	96.0%	14.7%	4.6	3	3
	Inspire	CAMHS	64.5		64%	35.05		16.7%	↑	6.6%	↓		66%		84%		86%		97%	6	52	0	0	89.8%	75.8%	60.9%	80.0%	1.7%	-1.3	2	1
	Granville Court	Learning Disability Nursing Treatment	51.0		Not Avail	n/a		26.3%	↑	13.9%	↓	101%	92%	100%	100%	0	2	0	0	No Ret	80.5%	75.0%	83.3%	0.0%	2.0	2	1
CH	Whitby Hospital	Physical Health Community Hospital	44.6	39%		9.57		1.2%	↑	0.0%	→	100%	86%	100%	94%	1	0	0	n/a	73.3%	84.5%	84.2%	83.3%	0.0%	1.2	2	1
	Malton Hospital	Physical Health Community Hospital	23.5	39%		12.50		Not on eRoster	→	Not on eRoster	→	82%	103%	100%	105%	0	0	0	n/a	100.0%	71.5%	75.0%	50.0%	10.0%	6.0	2	2

Exception Reporting and Operational Commentary

RAG ratings for Inspire have been removed until all beds are available. Planned establishment has been set at both Orion and Nova wards being fully operational. Until both units are open and functioning, the RAG rating has been stepped down.

Only 3 wards have RN fill rates on days above the upper threshold and 6 wards are below the lower threshold. In most instances this means that shifts are being run with only 1 qualified staff. However CHPPD levels remain above the threshold with the exception of Ouse and Pine view. The low CHPPD for these wards reflects the low levels of dependency of the patient population and a lower national benchmark. The clinical supervision on MVL has risen slightly in August to 64%; supervision on TEC has risen to 44% with local plans in place to improve further. PICU ILS compliance has risen to 69.3% and Inspire has risen slightly to 63.7%. Both teams have been offered tailored session to improve compliance further. 2 further sessions of BLS have taken place at Malton since July so an improvement in their compliance should be seen in the next report.

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.
In respect to the low CHPPD position for Pineview and Ouse wards, this is due to the patients on these wards being low acuity and therefore need less staffing that a normal ward/unit.

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)

Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
9.10%	11.20%	10.60%	10.60%	11.16%	11.90%	10.30%	8.40%	8.80%	10.10%	8.92%	8.70%

Slips Trips and Falls

Rolling 3 mth	Jun-21	Jul-21	Aug-21
Maister Lodge	7	4	8
Millview Lodge	3	5	2
Malton IPU	3	2	2
Whitby IPU	1	0	0

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: Aug 2021

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 %

Narrative

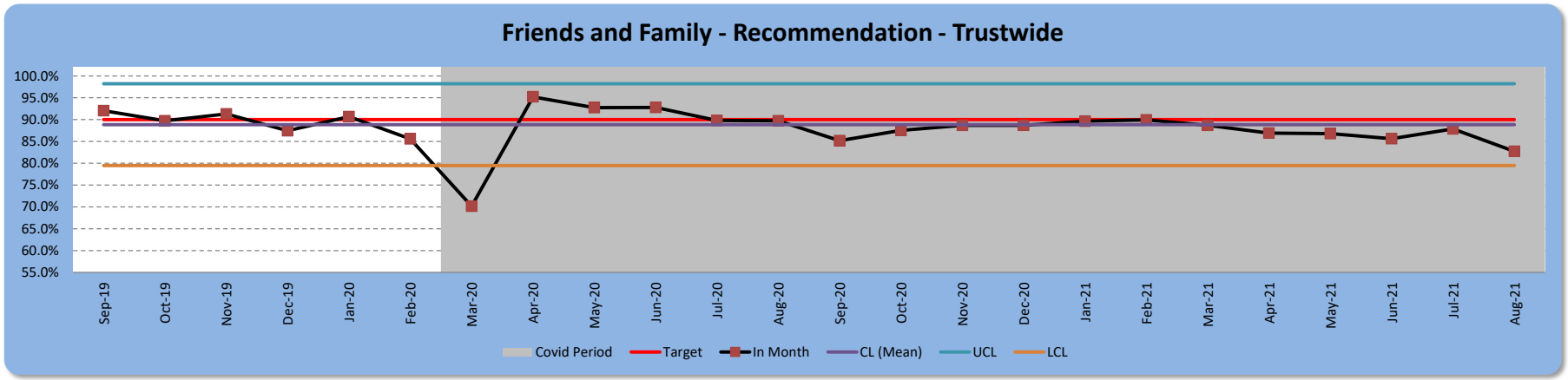
GP Recommendation remains below target and and performance has dropped in August by 5.9%

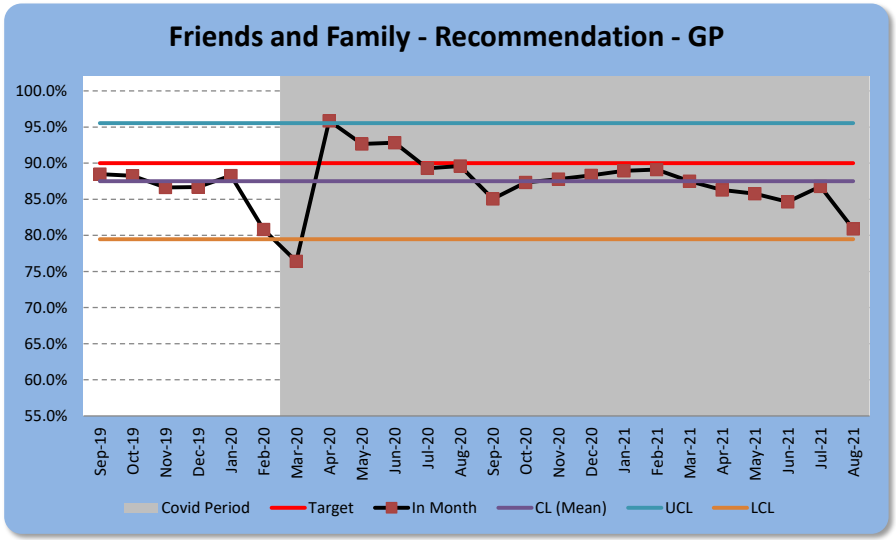
Non GP has fallen just 0.4% from 98.8% to 98.4%

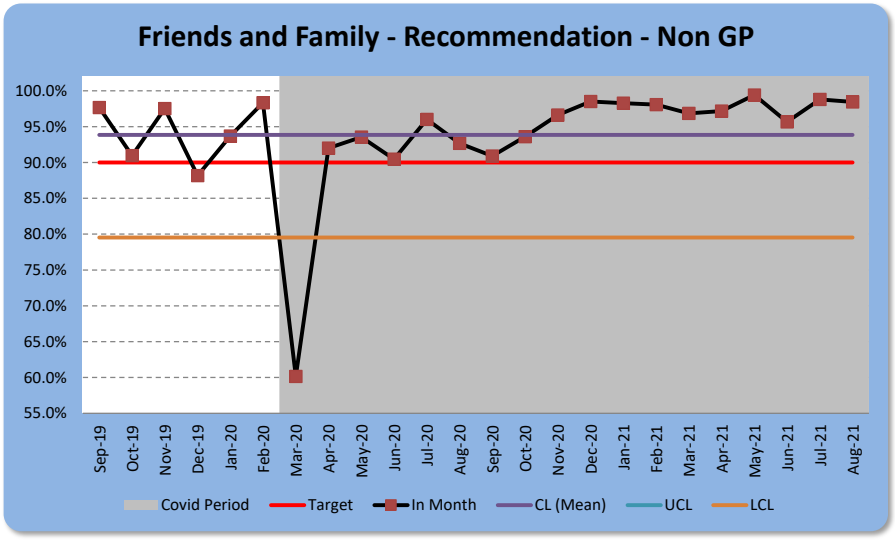
Target: 90%

Amber: 80%

Current month stands at 82.7%







PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

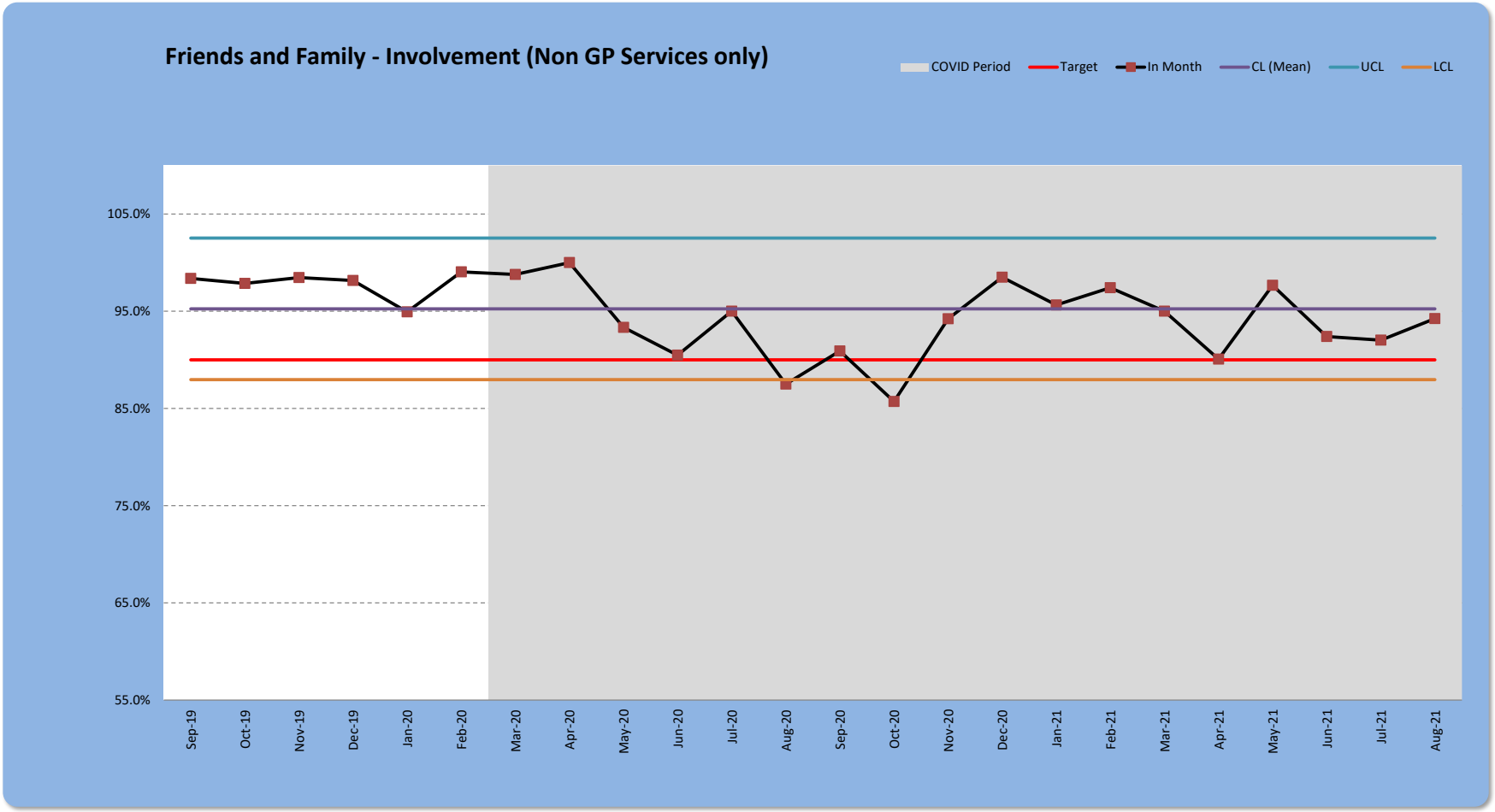
Indicator Title	Description/Rationale		KPI Type
Friends and Family Test	Results of the overall surveys completed where patients felt they were involved in their care	Executive Lead John Byrne	CA 3c %

Narrative

Performance has increased by 2.2% when compared to the previous month

Target: 90%
Amber: 80%

Current month stands at 94.2%



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

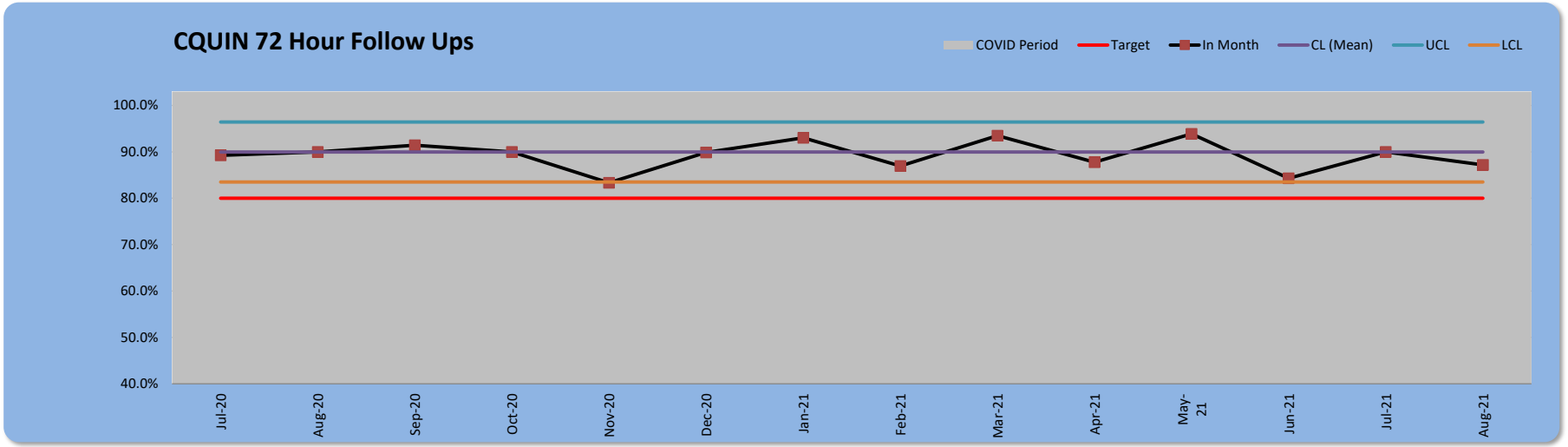
Narrative

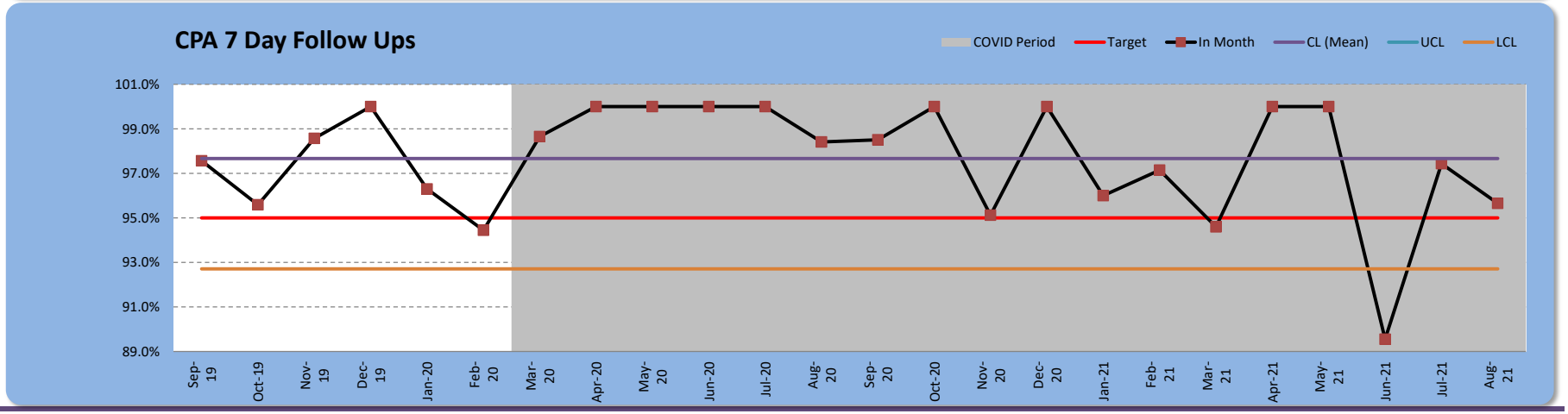
The 72 hours remains above target and performance against the 7 day target has also been achieved in the reporting period.

Target: 80%

Amber: 60%

Current month 72 hr stands at 87.2%





PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

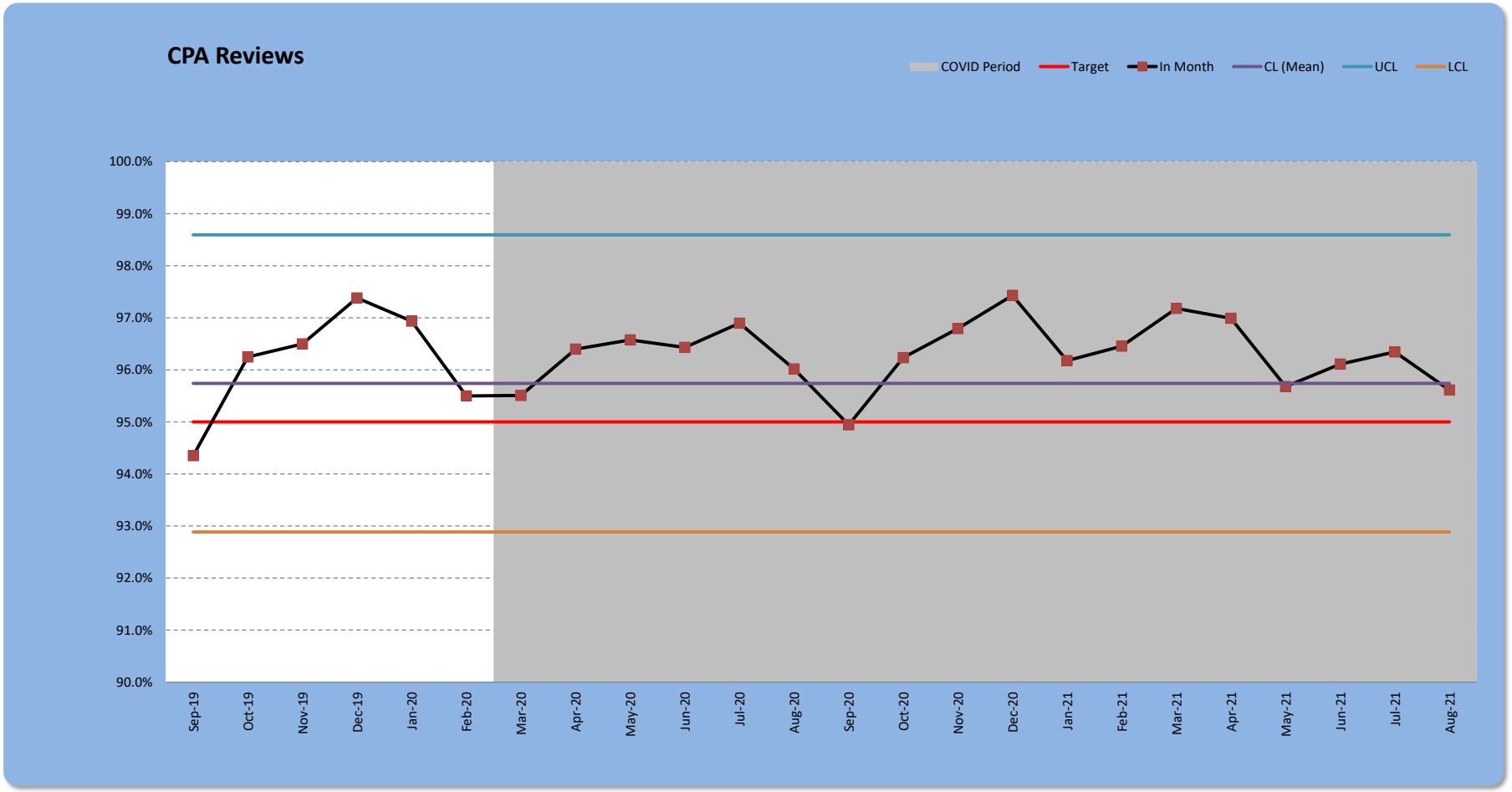
Narrative

Performance has decreased by 0.7% when compared to the previous month.

Target: 95%

Amber: 85%

Current month stands at 95.6%



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

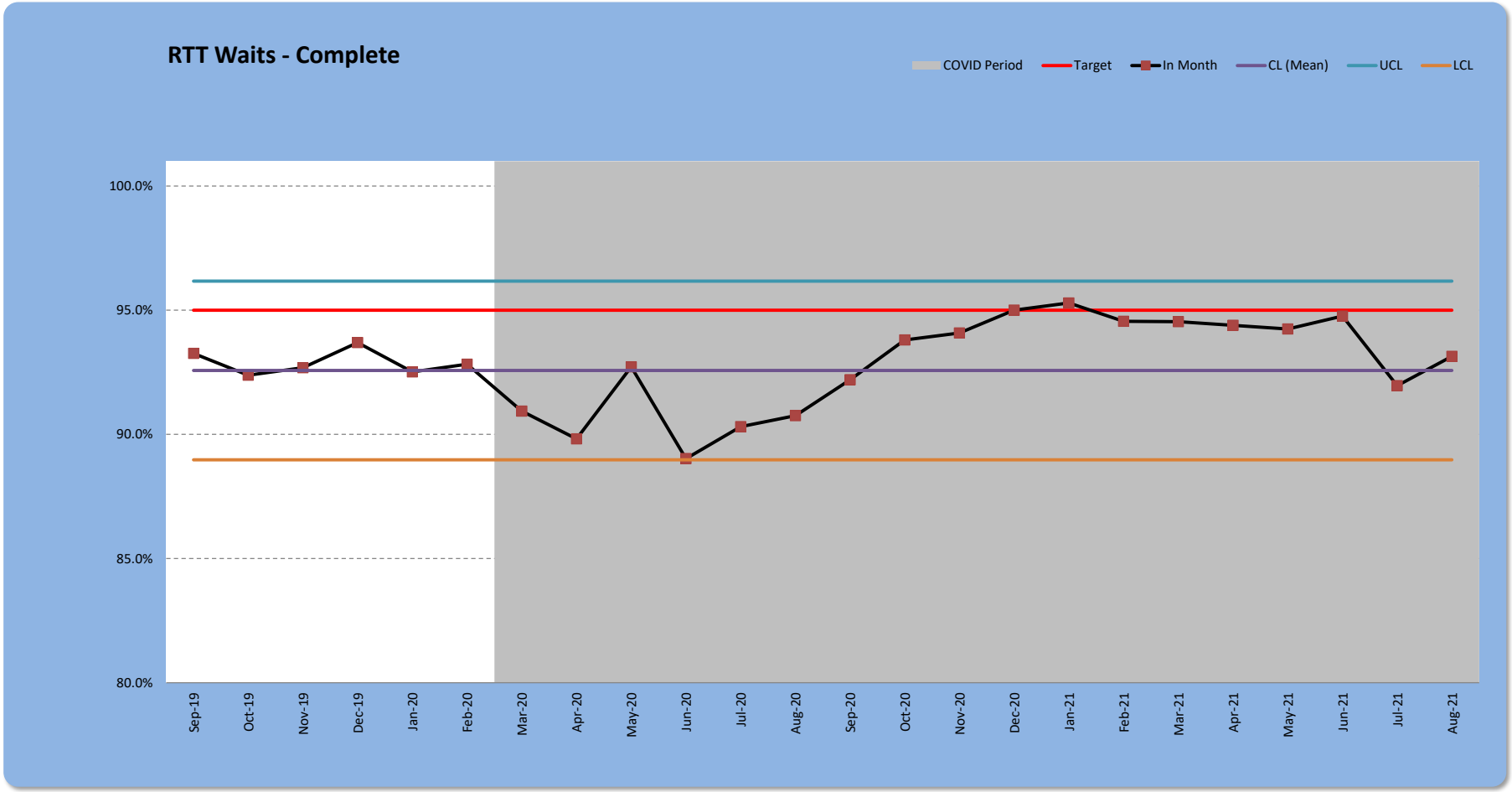
Narrative

Increase of 1.2% when compared to the previous month.

Target: 95%

Amber: 85%

Current month stands at 93.1%



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

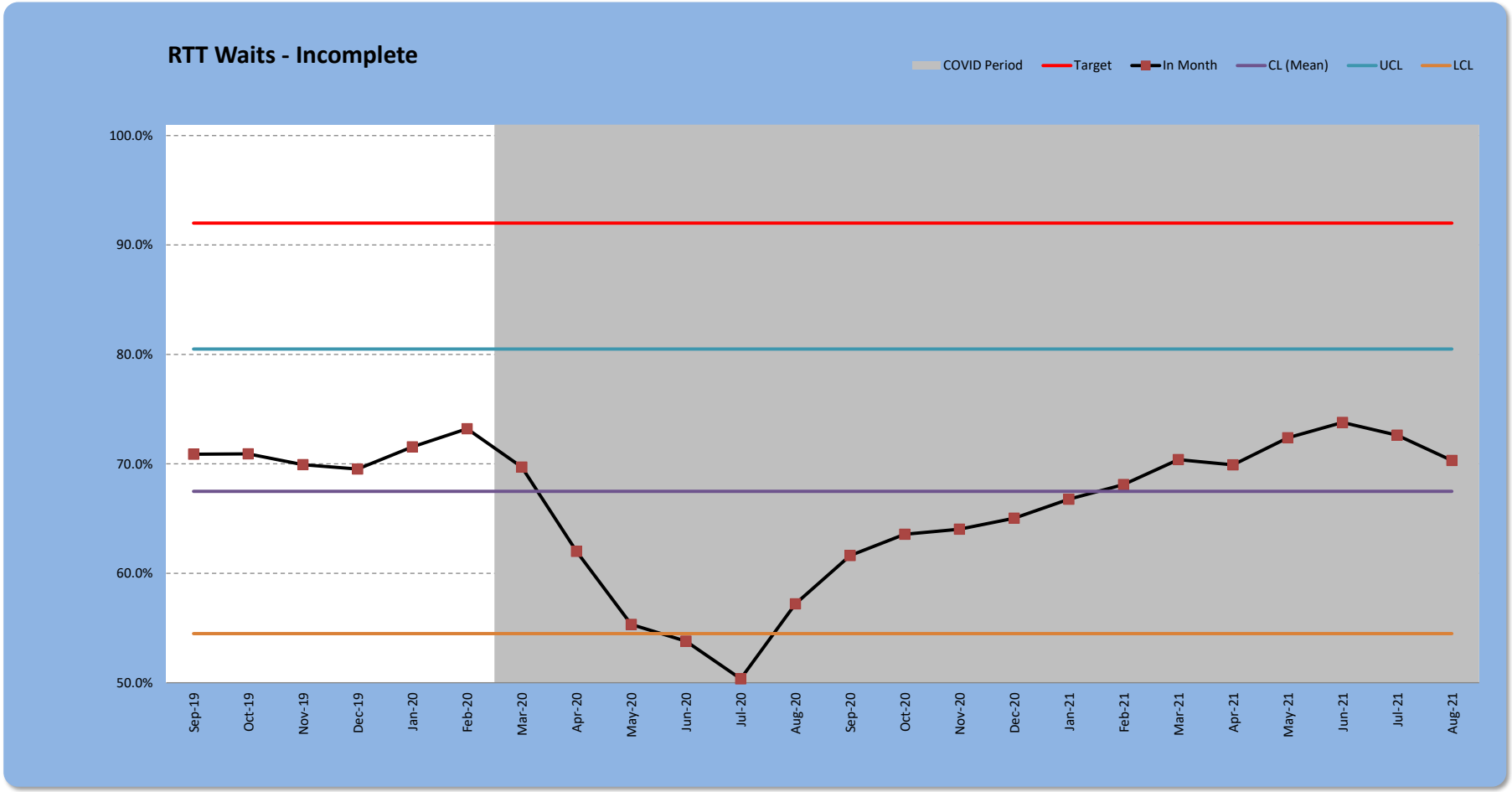
Narrative

Performance has decreased by 2.3% when compared to the previous month.

Target: 92%

Amber: 85%

Current month stands at 70.3%



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

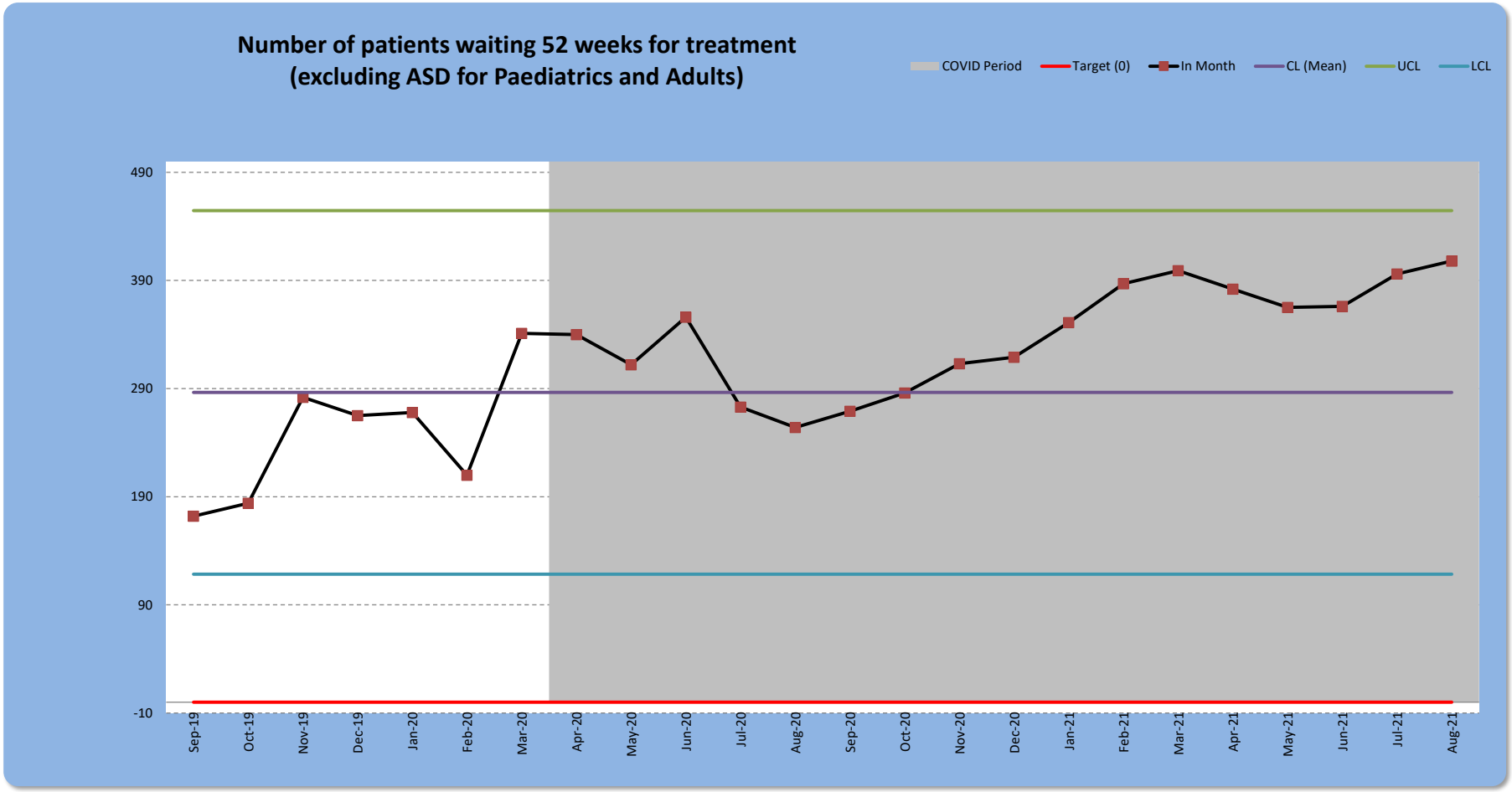
Narrative

A further 12 patients added to the waiting list when compared to the previous month.

Target: 0

Amber: 0

Current month stands at 408



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

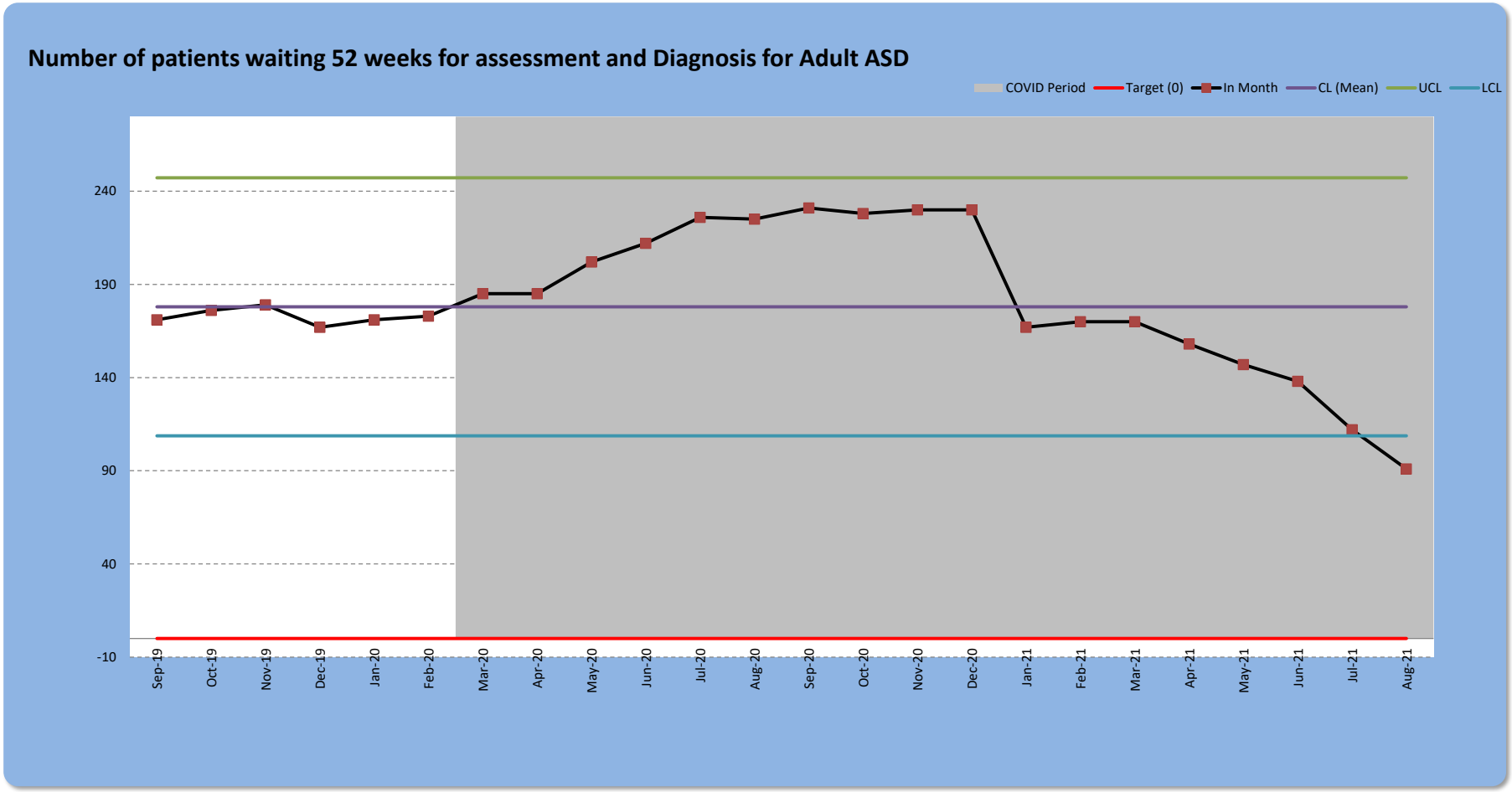
Narrative

Decrease of 21 when compared to the previous month.

Target: 0

Amber: 0

Current month stands at 91



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

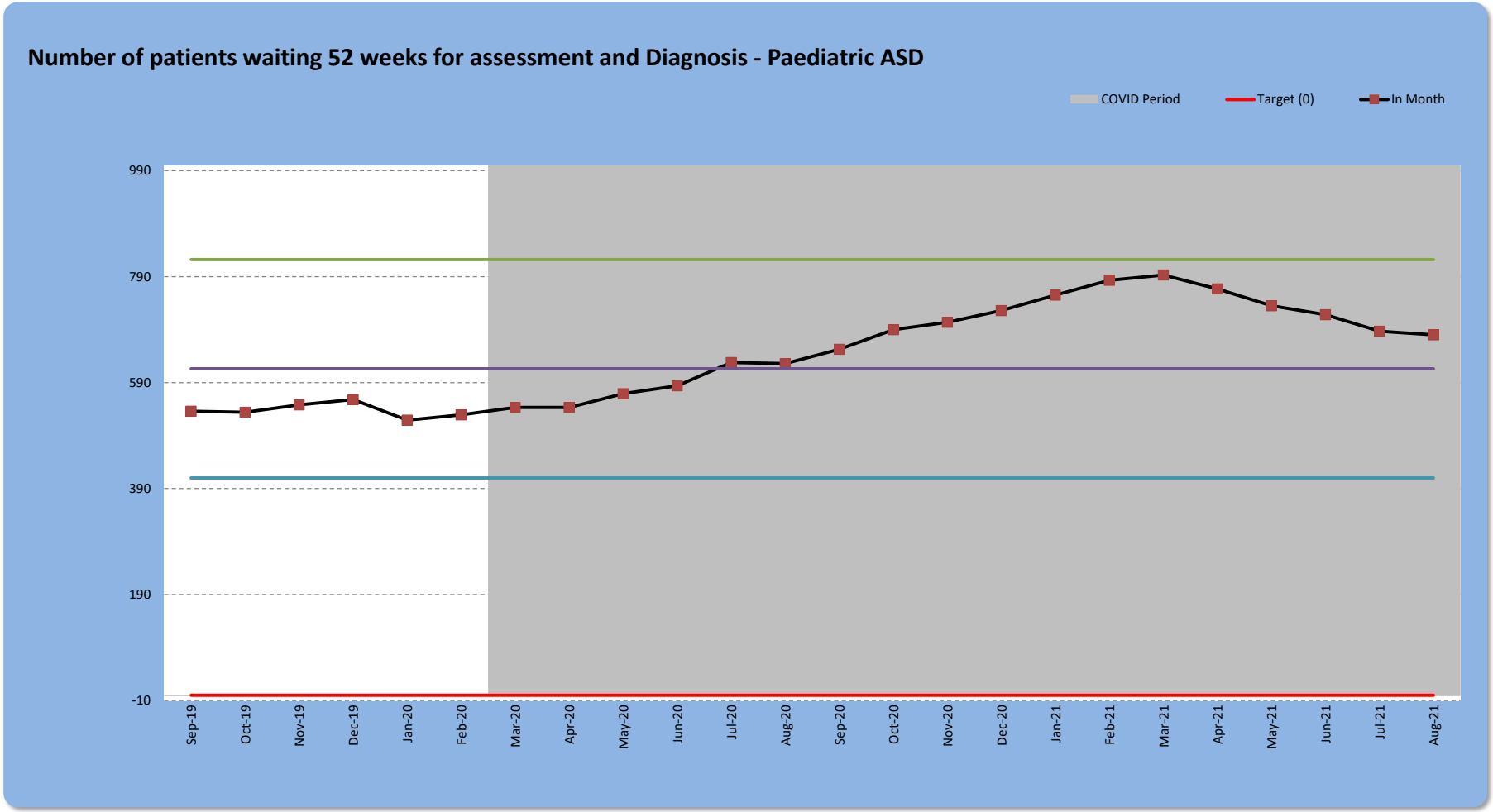
Narrative

Decrease of 7 when compared to the previous reporting period.

Target: 0

Amber: 0

Current month stands at 680



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

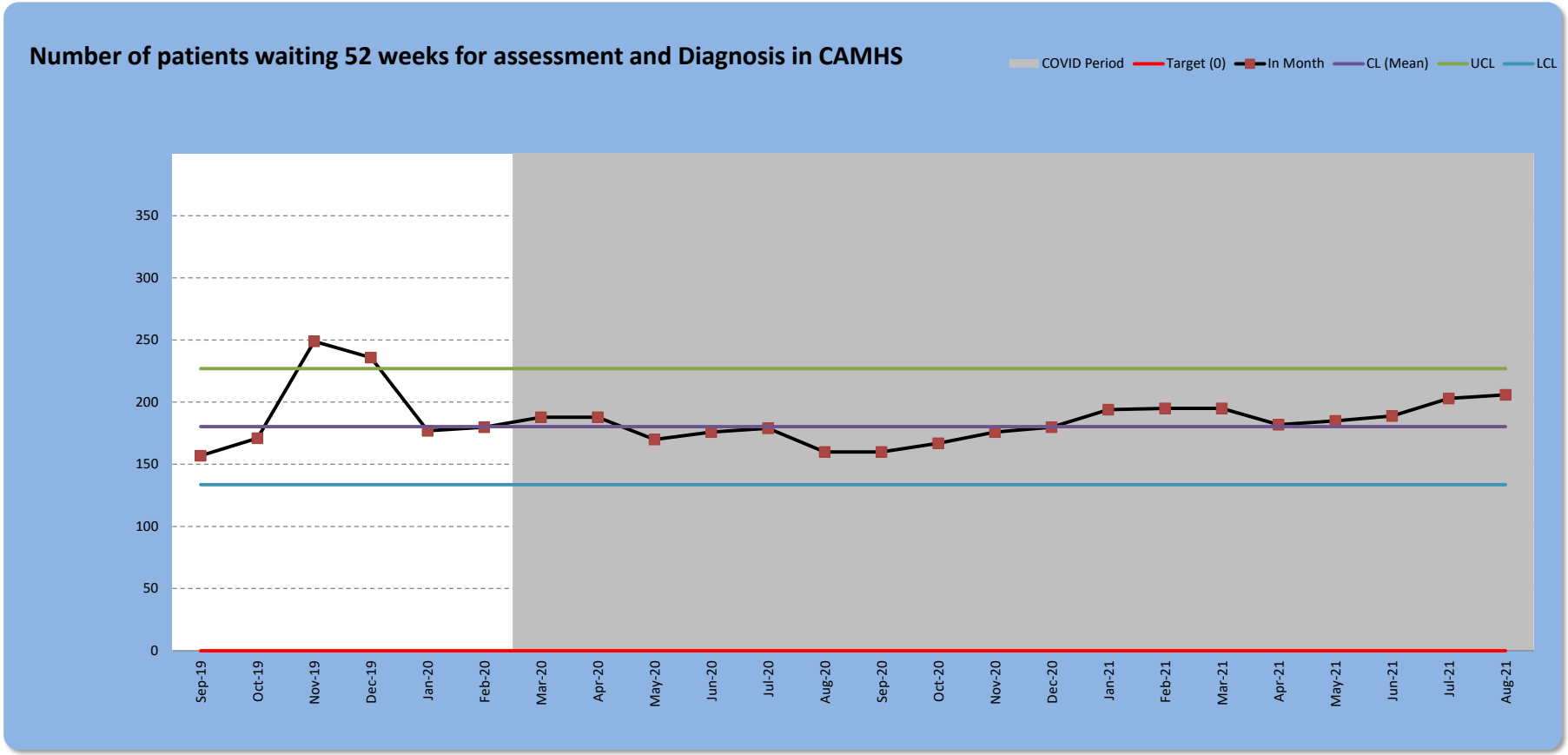
Narrative

Increase of 3 when compared to the previous month.

Target: 0

Amber: 0

Current month stands at 206



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

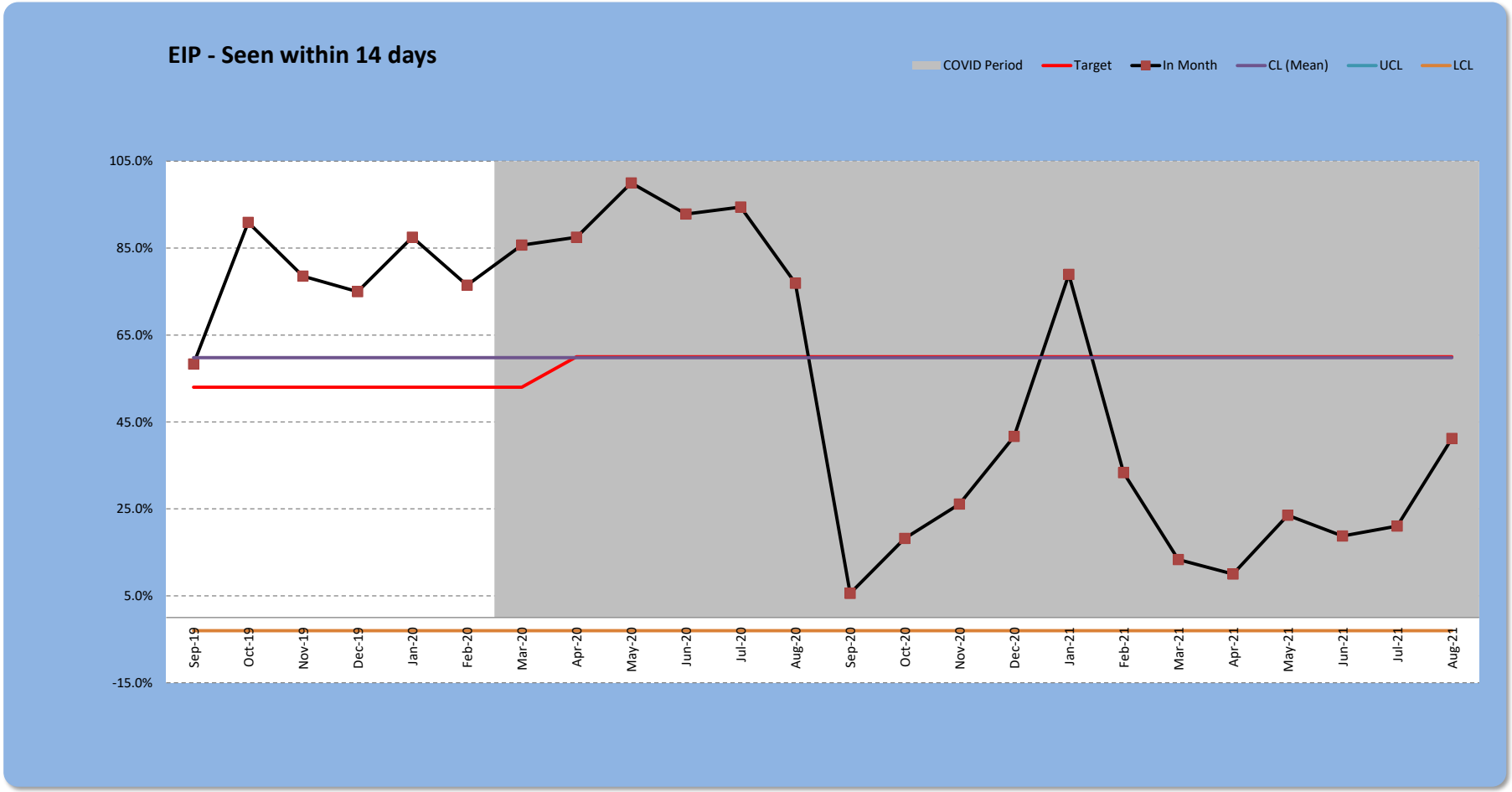
Indicator Title	Description/Rationale		KPI Type
Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	Executive Lead Lynn Parkinson	OP 9

Narrative

Increase of 20.1% when compared to the previous month and remains below target.

Target: 60%
Amber: 55%

Current month stands at 41.2%



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

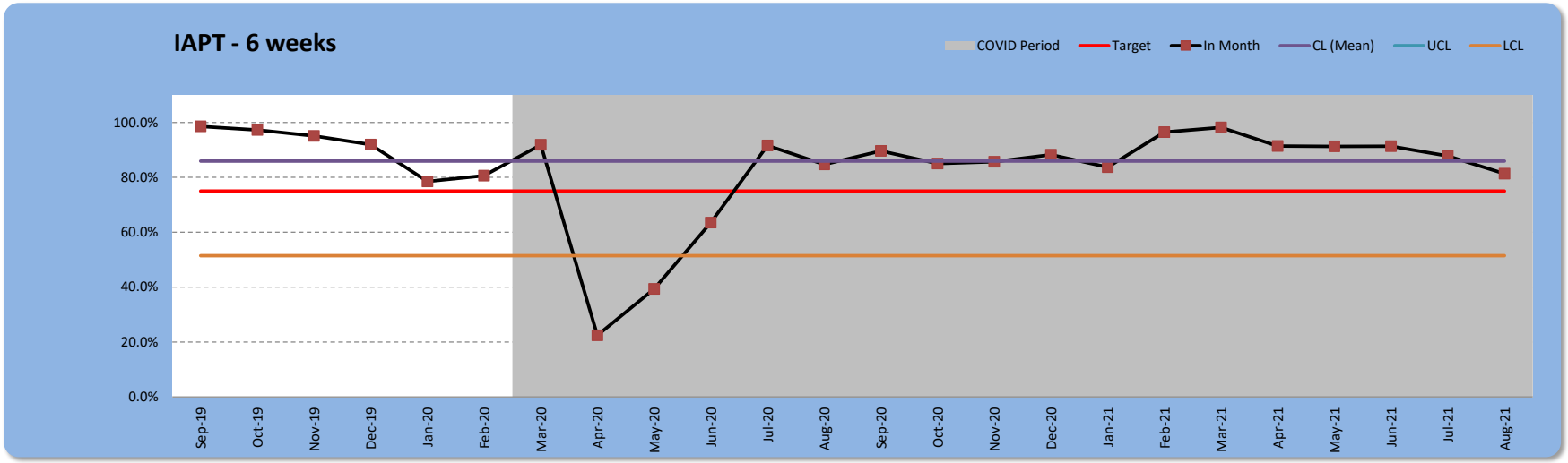
For the period ending: **Aug 2021**

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

Narrative

Decreased by 6.4% in the latest repoting period. Remains above target.

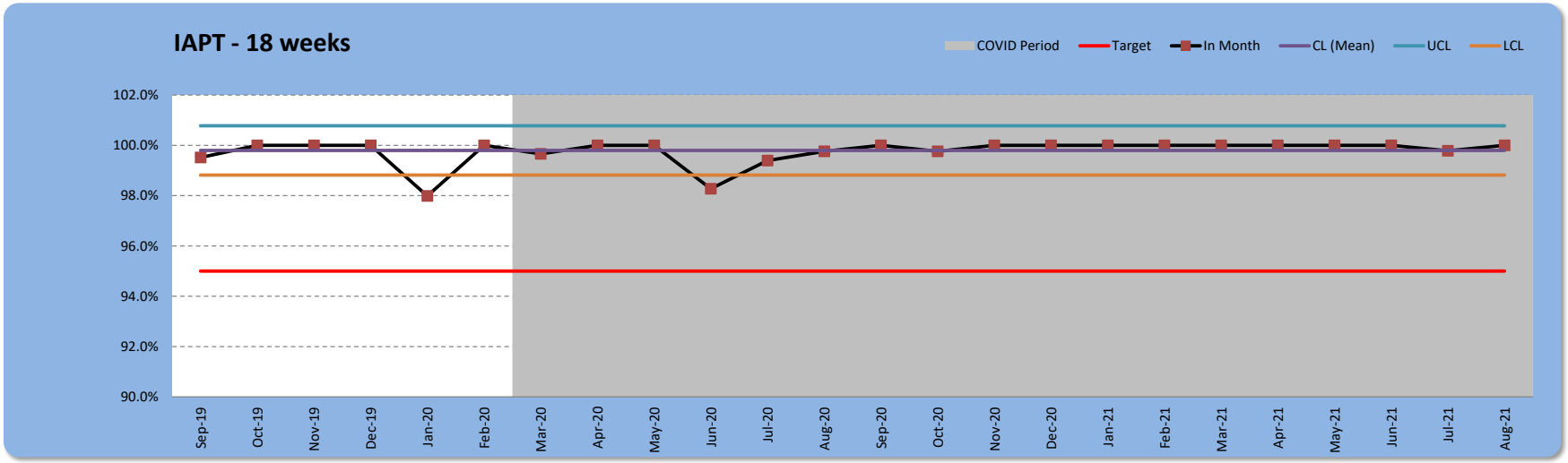
Target: 75%
Amber: 70%
Current month 81.4%



Narrative

No real change in performance levels and remains above target.

Target: 95%
Amber: 85%
Current month 100.0%



PI RETURN FORM 2021-22

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Aug 2021**

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

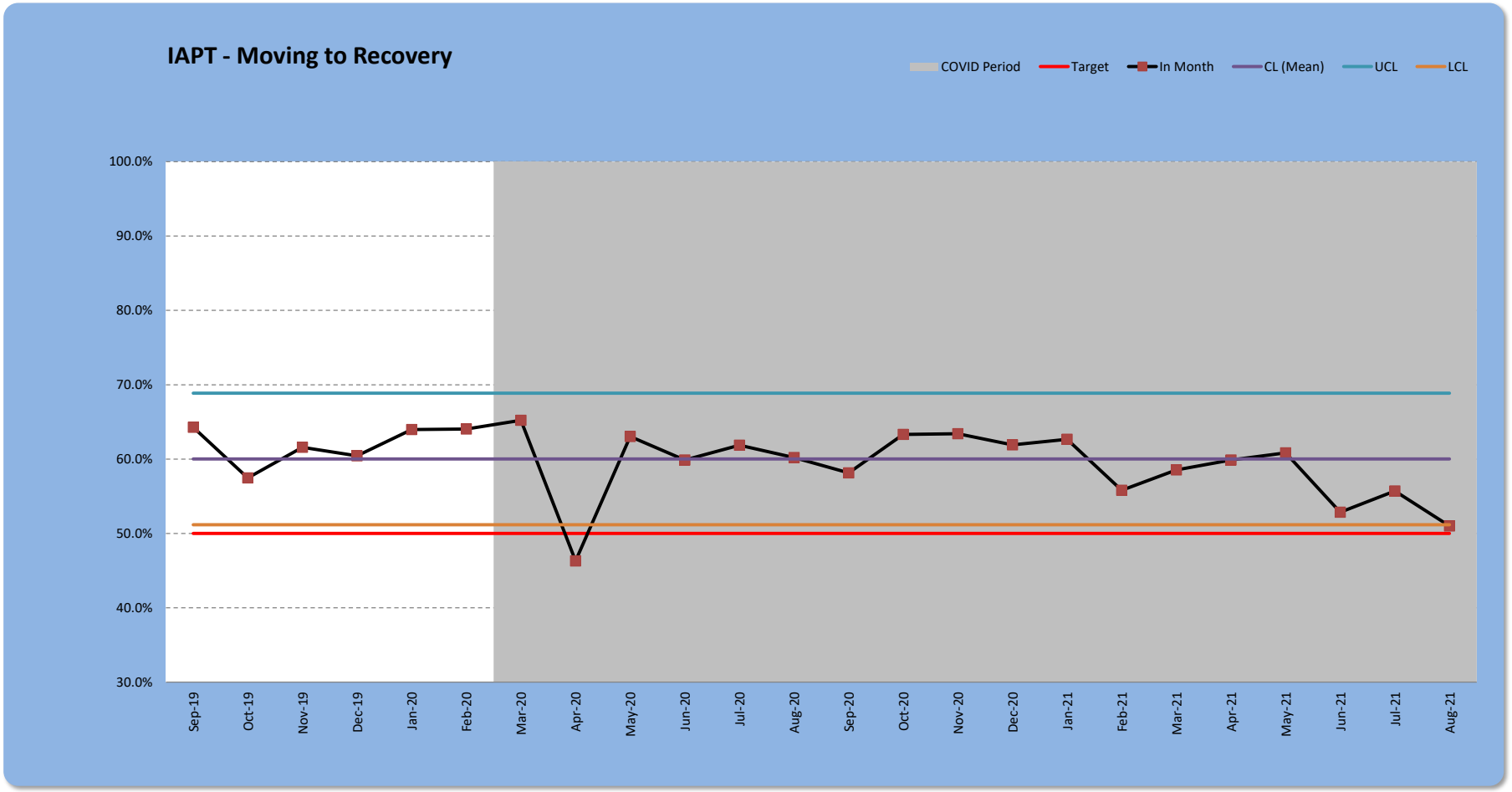
Narrative

Performance has decreased by 4.7% but remains above the 50% target

Target: 50%

Amber: 45%

Current month stands at 51.0%



PI RETURN FORM 2021-22

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Aug 2021**

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

Narrative

In recent times additional Beds have been purchased from NAVIGO and CYGNET but these remain within the data.

An increase of 132 out of area beds days compared to Jul-21

Total number of patients out of area within month **39**

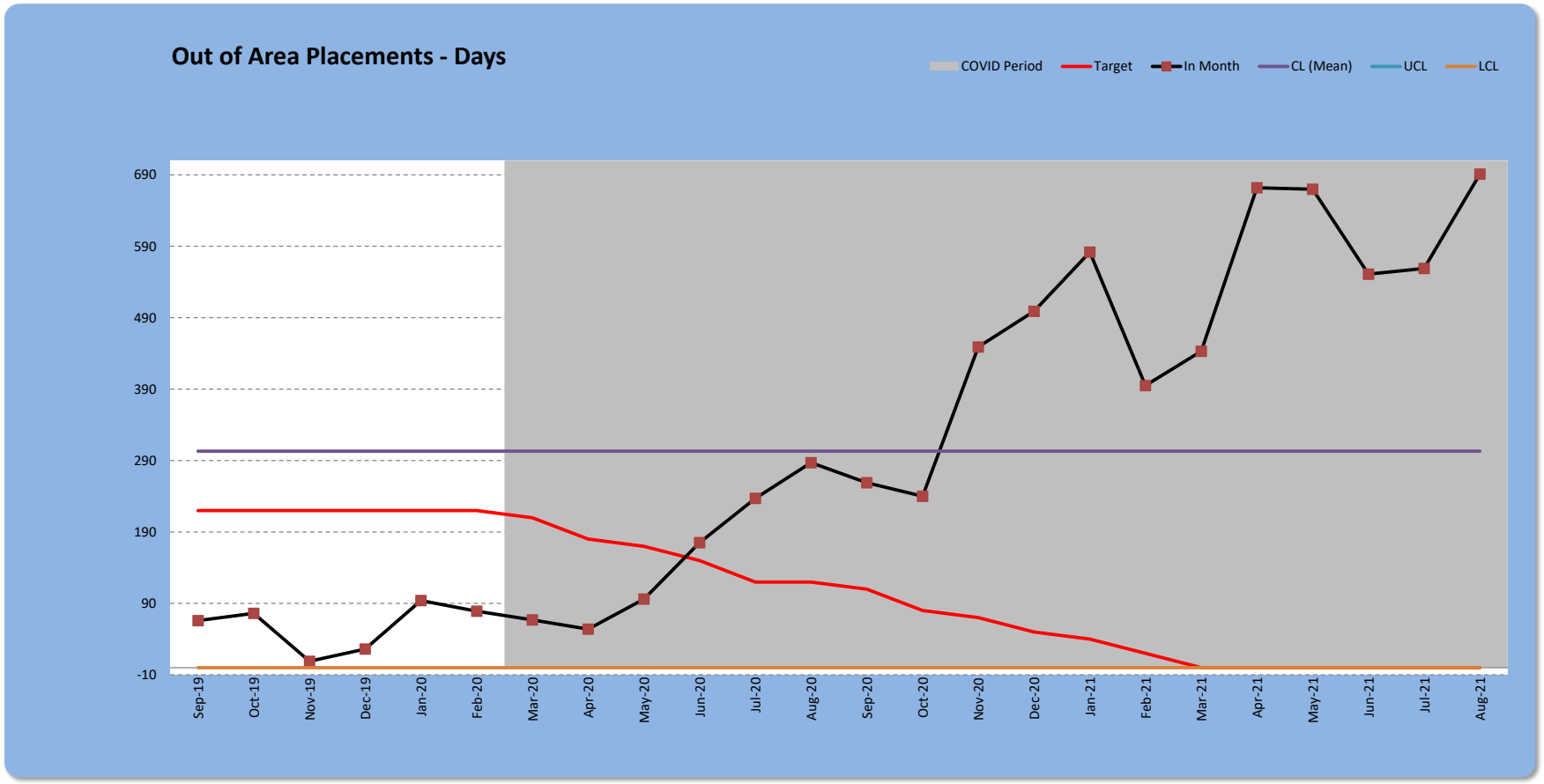
Patients OoA - Split

	# days	# patients
Adult	166	17
OP	359	16
PICU	166	6

Target: 0

Amber:

Current month stands at 691



PI RETURN FORM 2021-22

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Aug 2021**

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

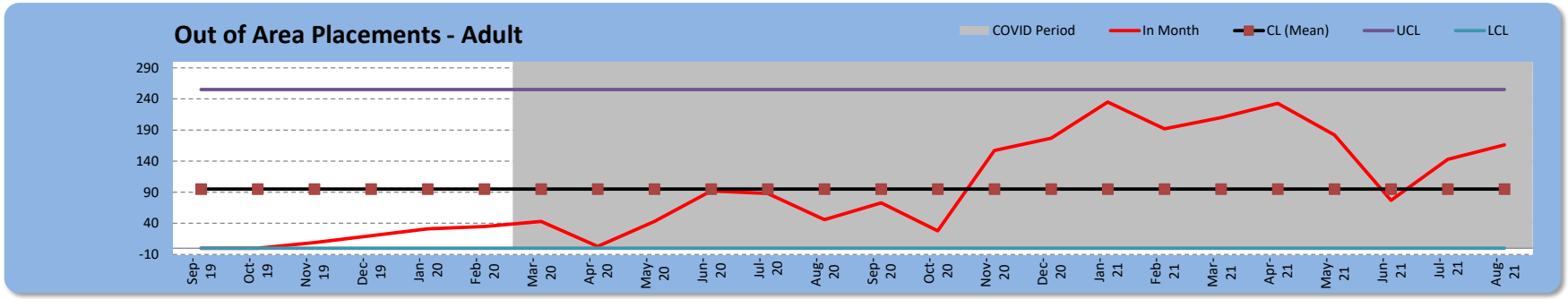
Narrative

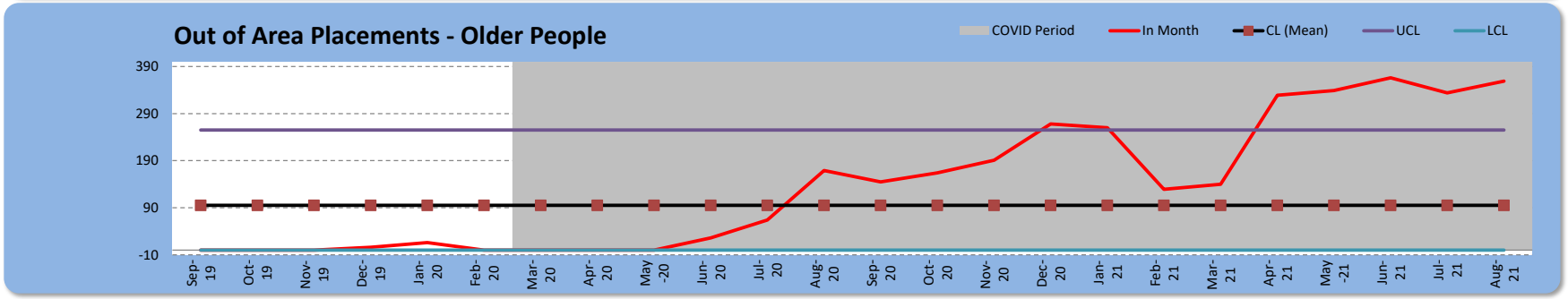
For this sheet, out of area beds are split into the three service areas

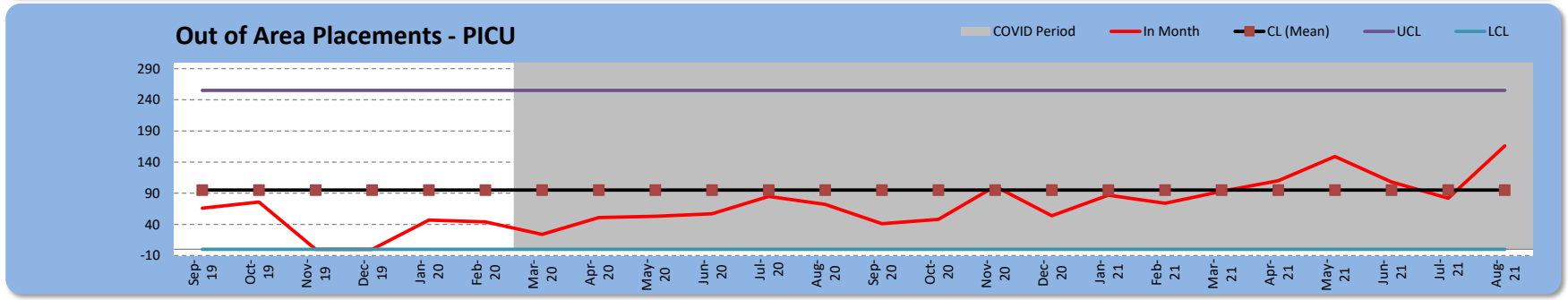
Prior to the Covid period, out of area beds were very low for all services and therefore the Lower Control Level (LCL) is set at zero

The split for the current month is as follows:

Aug-21	
166	Adult
359	OP
166	PICU
691	Total







PI RETURN FORM 2021-22

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Aug 2021**

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

Narrative

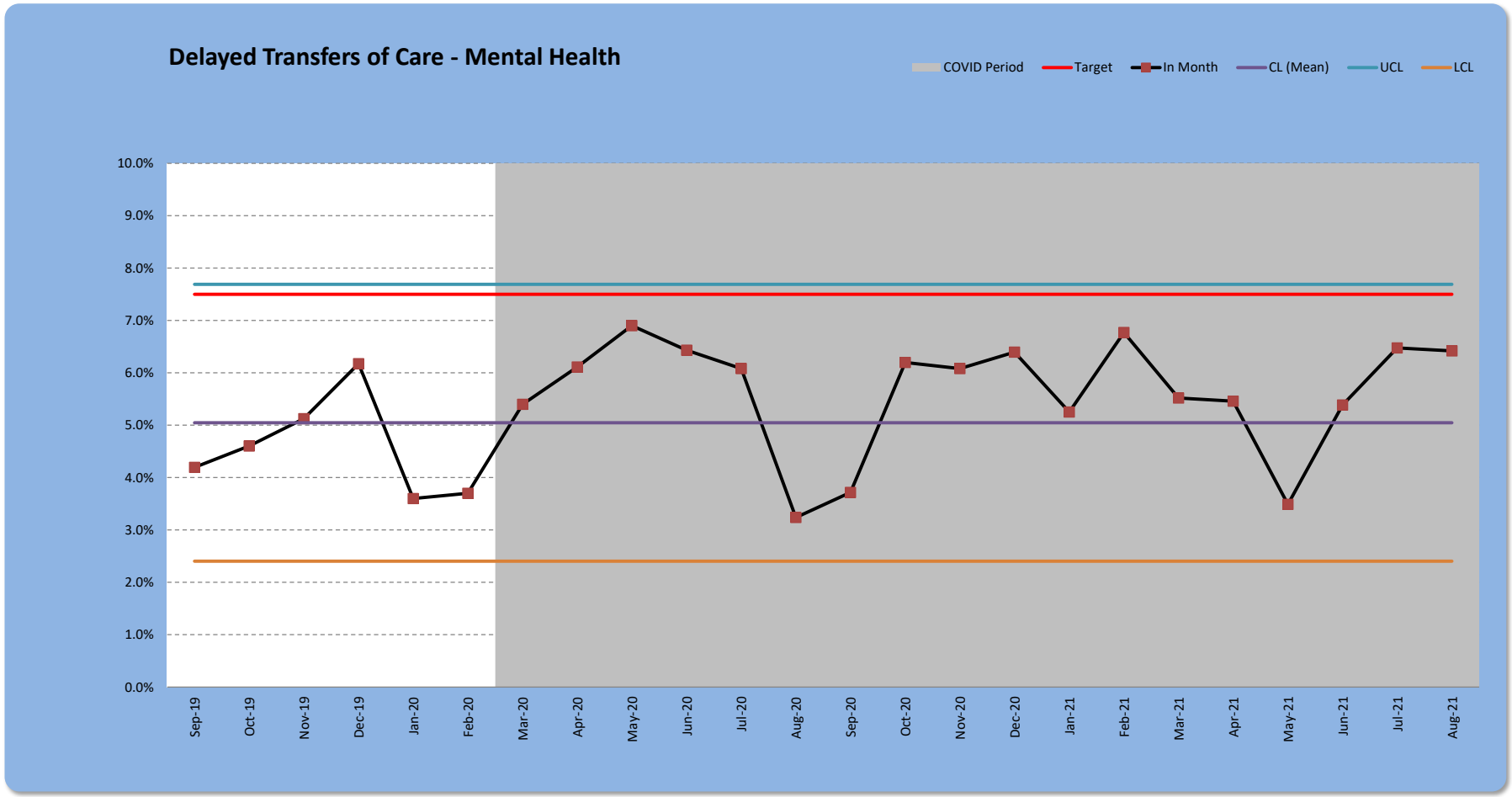
Performance has improved by 0.1% against previous month but remains within target.

Low performance is Good.

Target: 7.5%

Amber: 7.0%

Current month stands at 6.4%



PI RETURN FORM 2021-22

Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Aug 2021**

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

Narrative

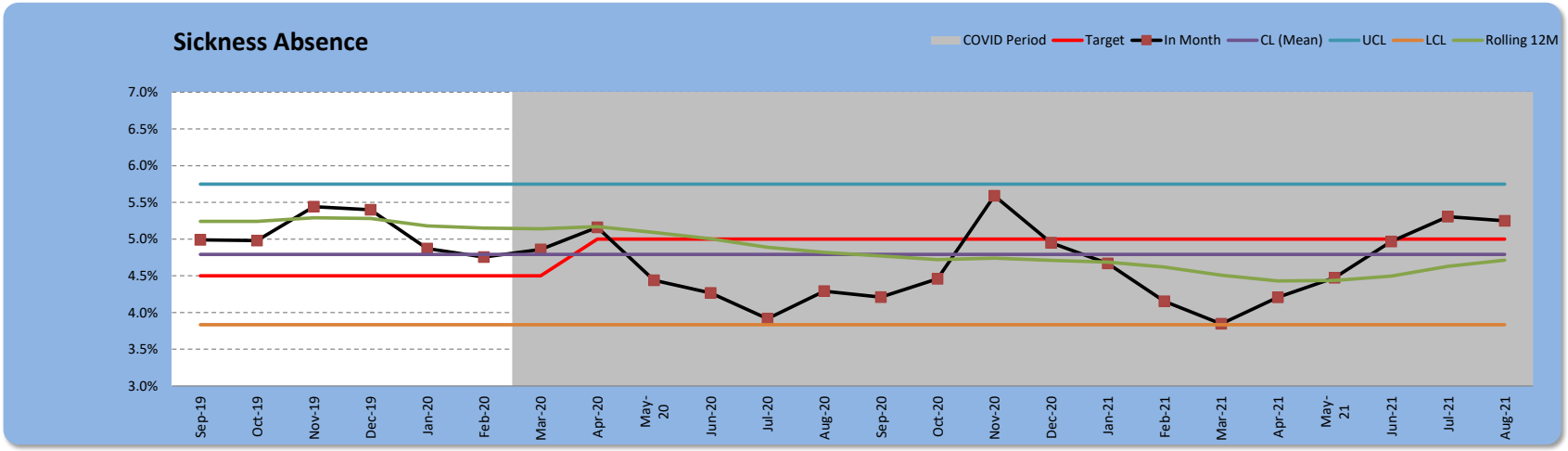
Sickness/Absence Rate has improved by 0.1% when compared to the previous month.

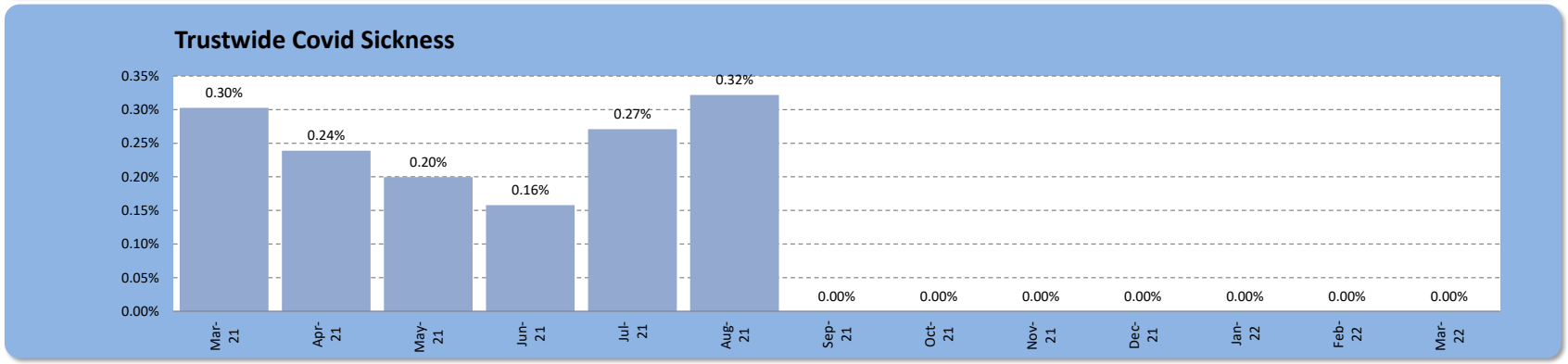
Aug-21 Rolling 12 month figure is within target reporting at 4.70%

Slight increase in Covid sickness reported for this month

Low performance is good.

Target:	5.0%
Amber:	5.2%
Current month	5.3%





PI RETURN FORM 2021-22

Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Aug 2021**

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

Narrative

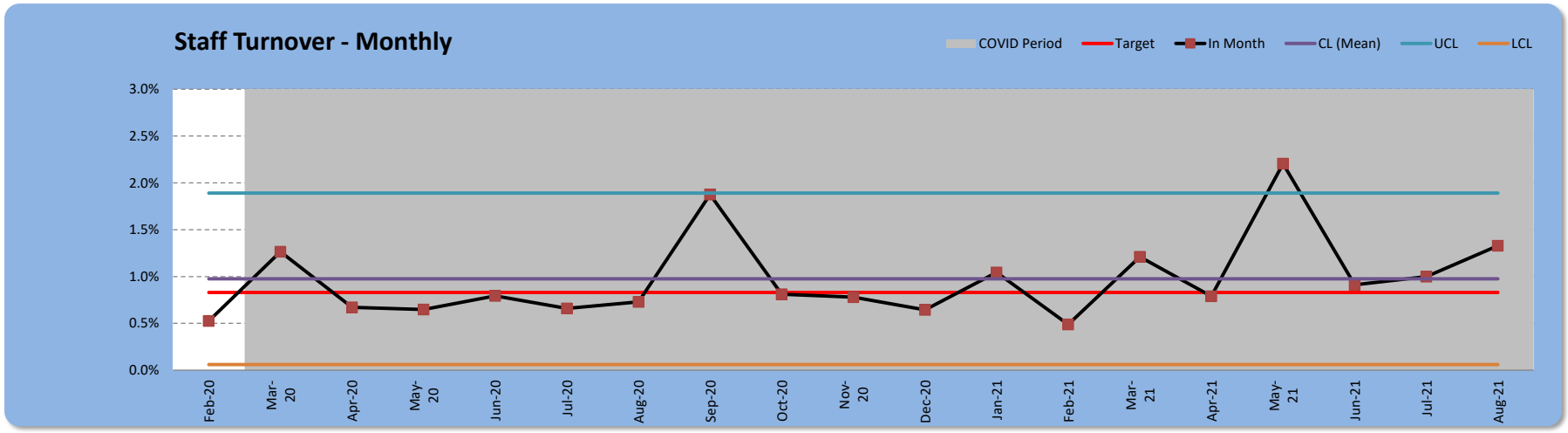
Staff Turnover has increased by 0.3% in the reporting period

Low Performance is good

Target: 0.83%

Amber: 0.70%

Current month stands at 1.3%



Narrative

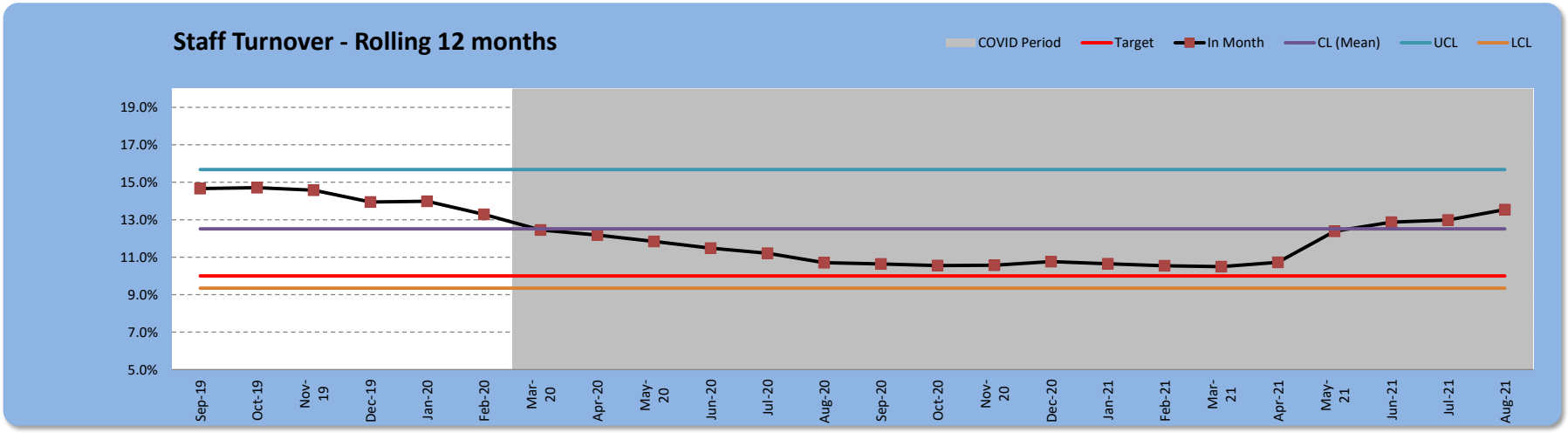
Exceeds Target.

Low Performance is Good.

Target: 10%

Amber: 9%

Current month stands at 13.5%



PI RETURN FORM 2021-22

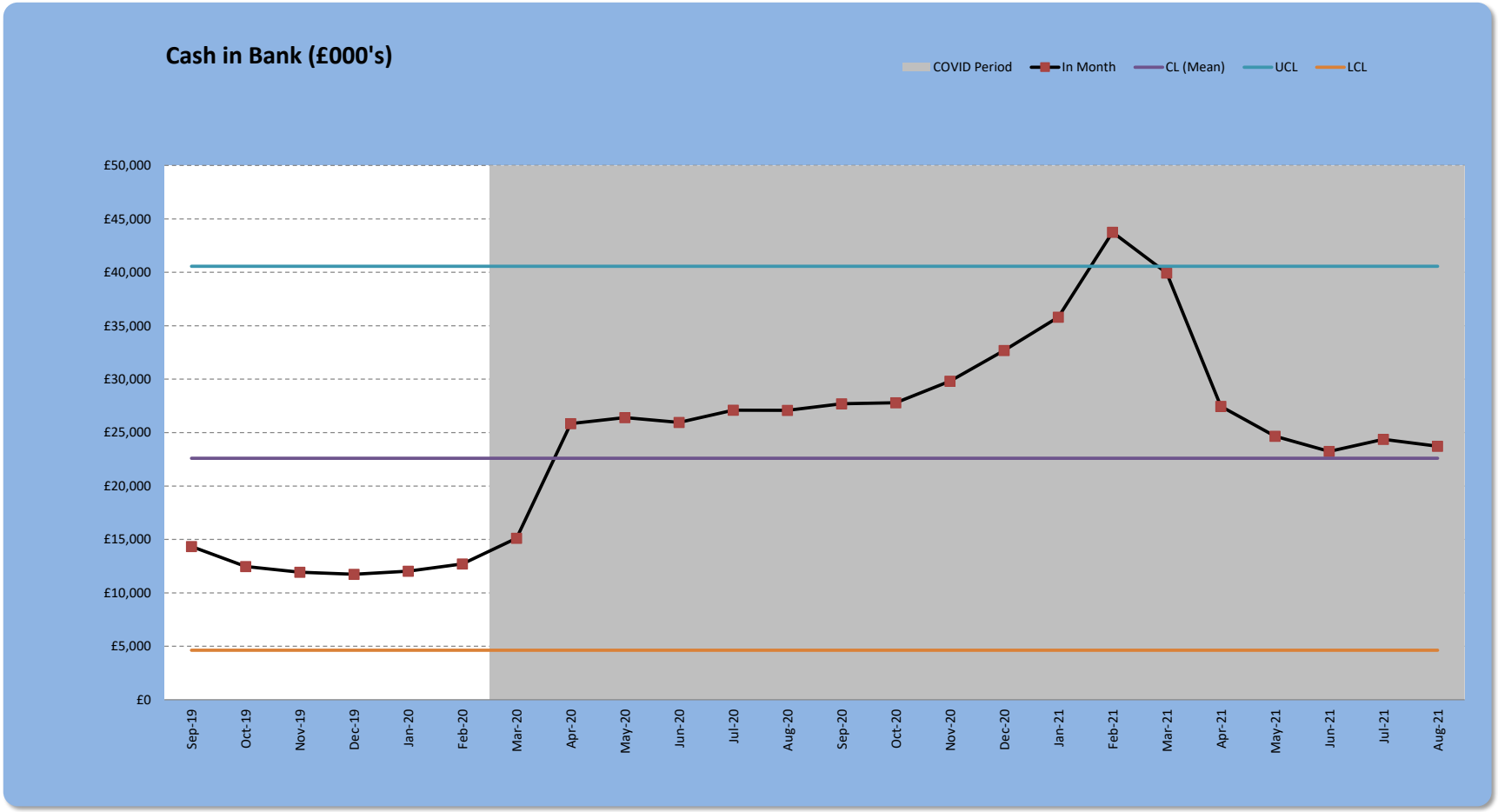
Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Aug 2021**

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

Narrative

The Trust has no target for cash set.



Current month stands at £23,718 ,000

PI RETURN FORM 2021-22

Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Aug 2021**

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

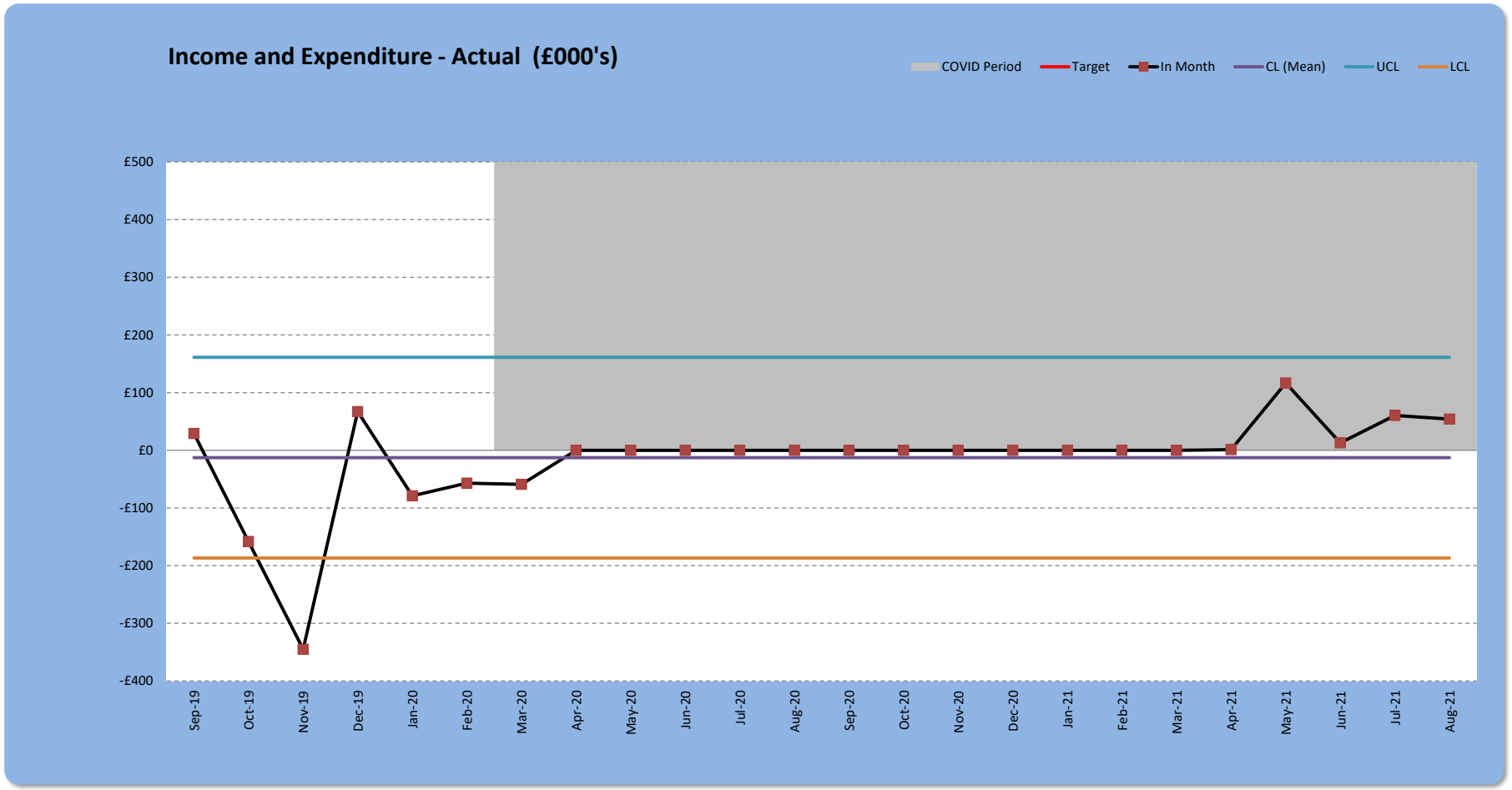
Narrative

The Trust shows an decrease of £6,000 compared to previous month

Target:

Amber:

Current month stands at £54 ,000



PI RETURN FORM 2021-22

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Aug 2021**

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

Narrative

During the month, the following number of complaints were responded to

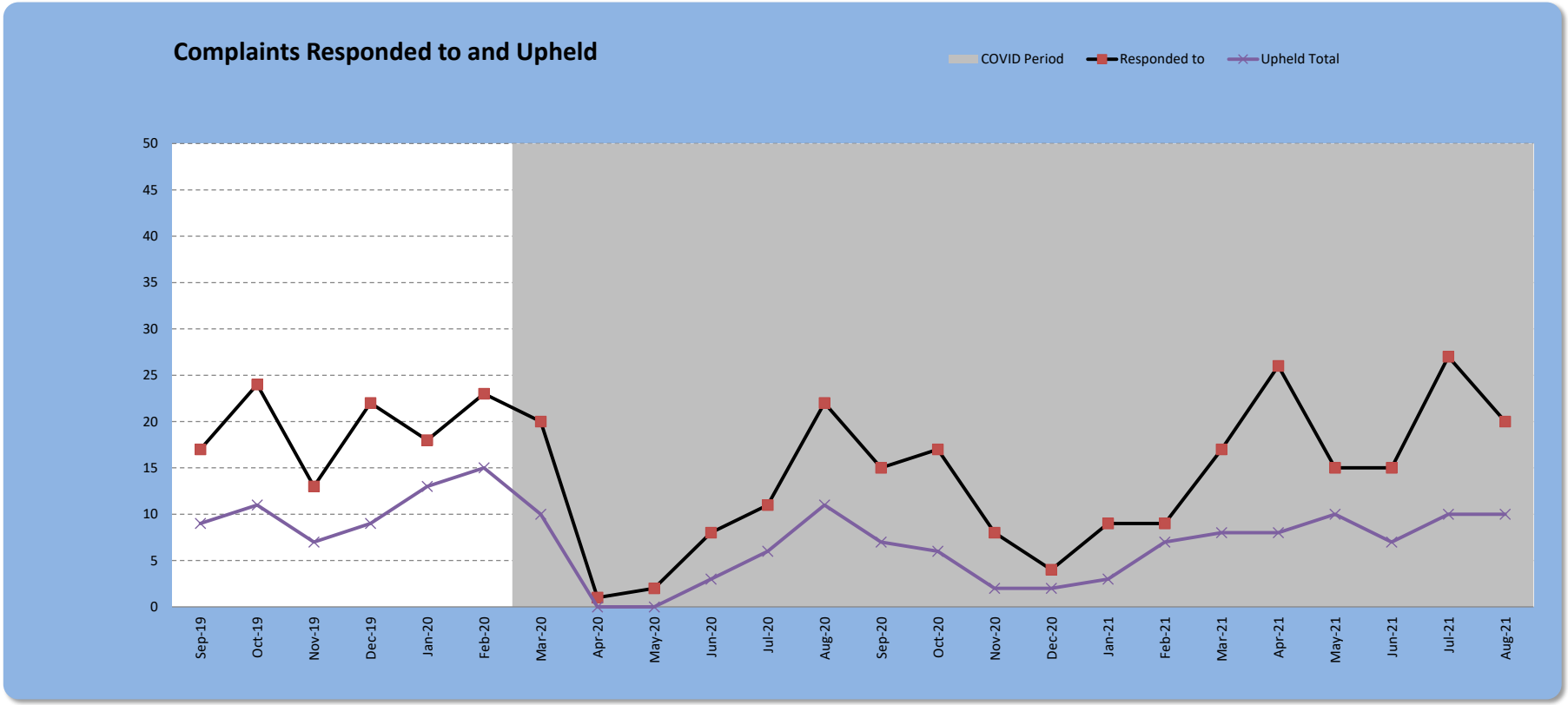
20

Of the number of complaints responded to in the month
10
were upheld which equates to

50.0%

YTD Upheld

50.0%



PI RETURN FORM 2021-22

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Aug 2021**

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

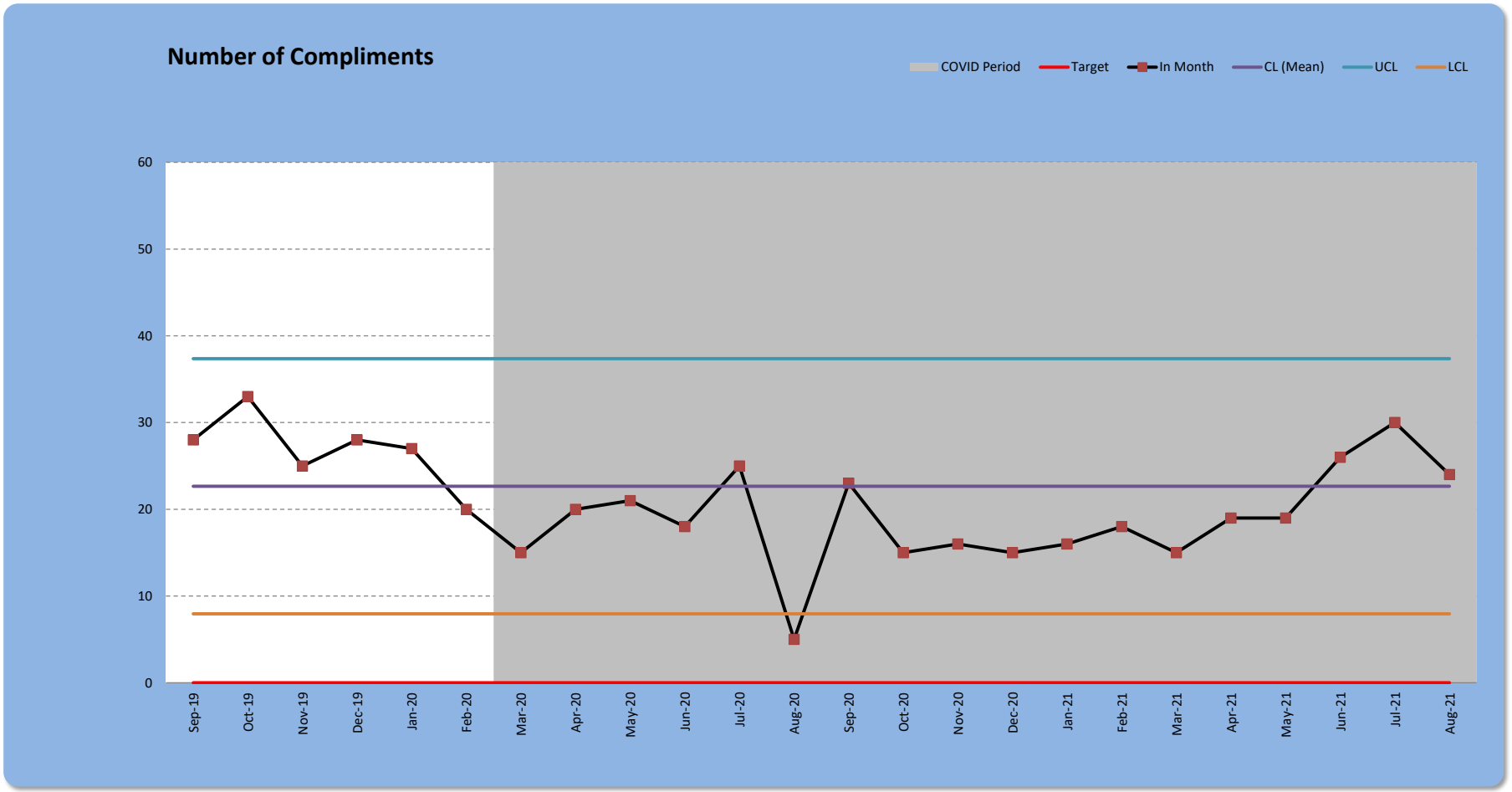
Narrative

There were 24 compliments received in the month

Target: 0

Amber: 0

Current month stands at 24



NHS
Humber Teaching
NHS Foundation Trust

Executive Team:

Chief Executive:	Michele Moran
Chairman:	Sharon Mays
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: 20/09/2021

CYP ASD Waiting List Trajectories- weekly update

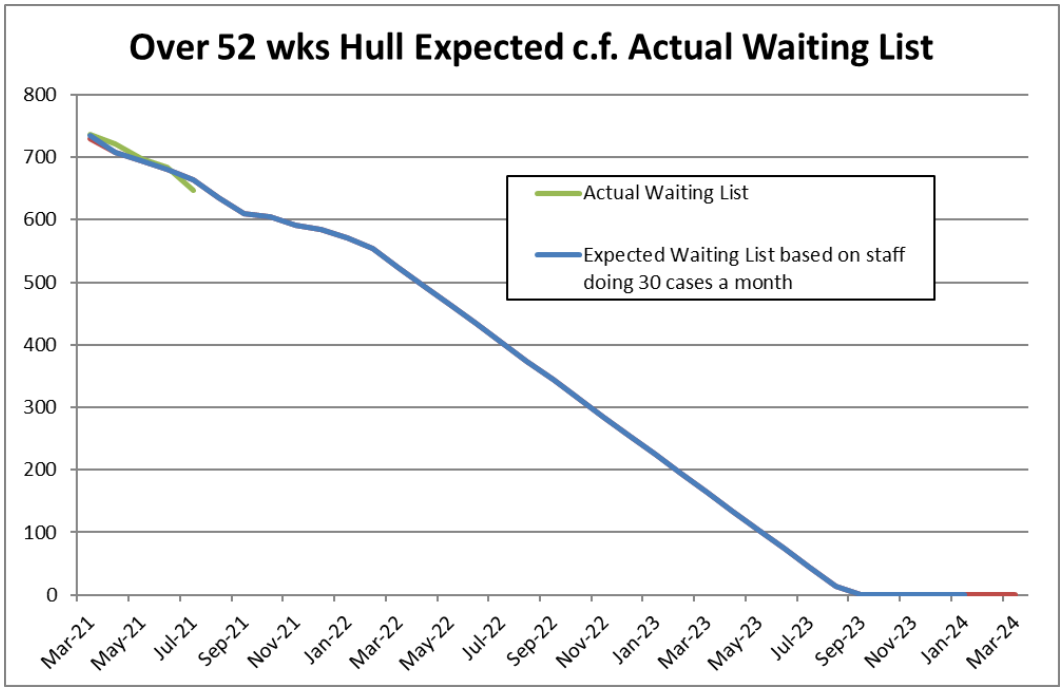
At the beginning of March 2021 there were 1,102 children and young people (CYP) currently waiting for the start of an assessment across both Hull and ERY, of which 810 have waited over 52 weeks, leaving 292 cases under 52 weeks.

To track the service progress in reducing the over 52 weeks waits the below trajectories have been compiled. The trajectory below is based on staff undertaking 30 assessments a month in Hull.

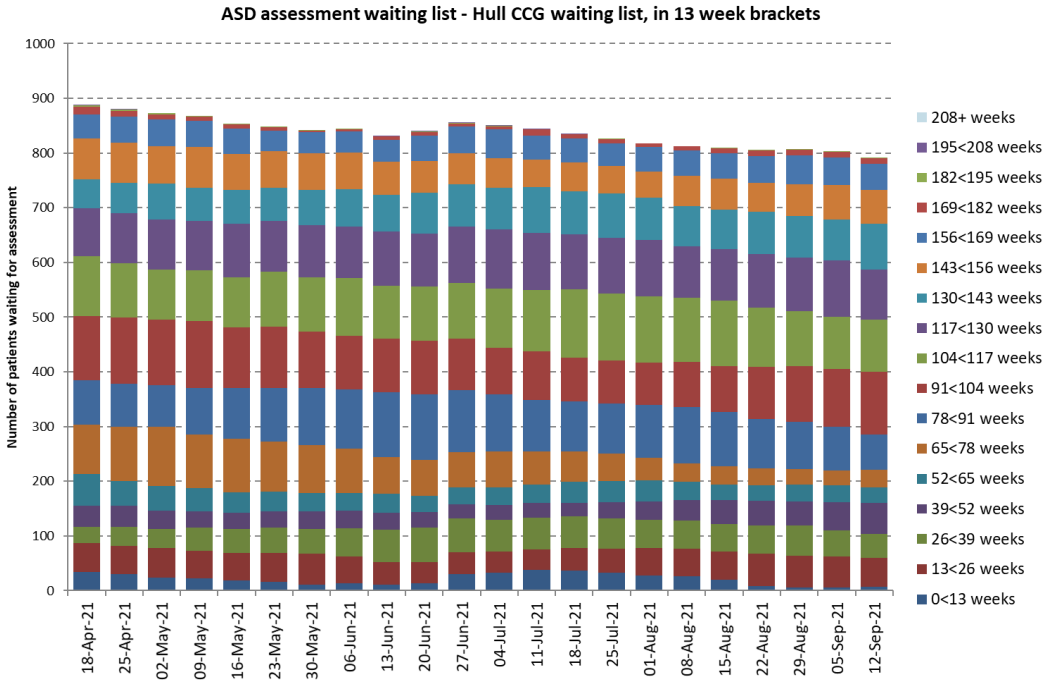
The projections below assume that referrals are seen in date order. It allows for the fact that existing referral waiting times will continue to grow until they are seen, and also for the number of cases which will tip into the over 52 weeks wait zone as time elapses.

Hull actual weekly figures from 3rd March 2021 onwards

Date	Number 52 weeks +	Number 52 weeks -	Total waiting
03/03/21	729	159	888
11/03/21	732	159	891
18/03/21	733	156	889
25/03/21	736	156	892
04/04/21	734	161	895
10/04/21	733	160	893
17/04/21	729	160	889
24/04/21	722	159	881
16/05/21	710	147	857
23/05/21	697	149	846
30/05/21	699	147	846
06/06/21	702	144	846
14/06/21	699	152	847
05/07/21	690	161	851
12/07/21	684	161	845
19/07/21	675	161	836
26/07/21	664	162	826
09/08/21	647	166	813
22/08/21	642	166	806
12/09/21	632	160	792



NB: after Feb 22 more data is required to be inputted to complete this trajectory to estimate the number of cases which will tip into the 52 week waits.

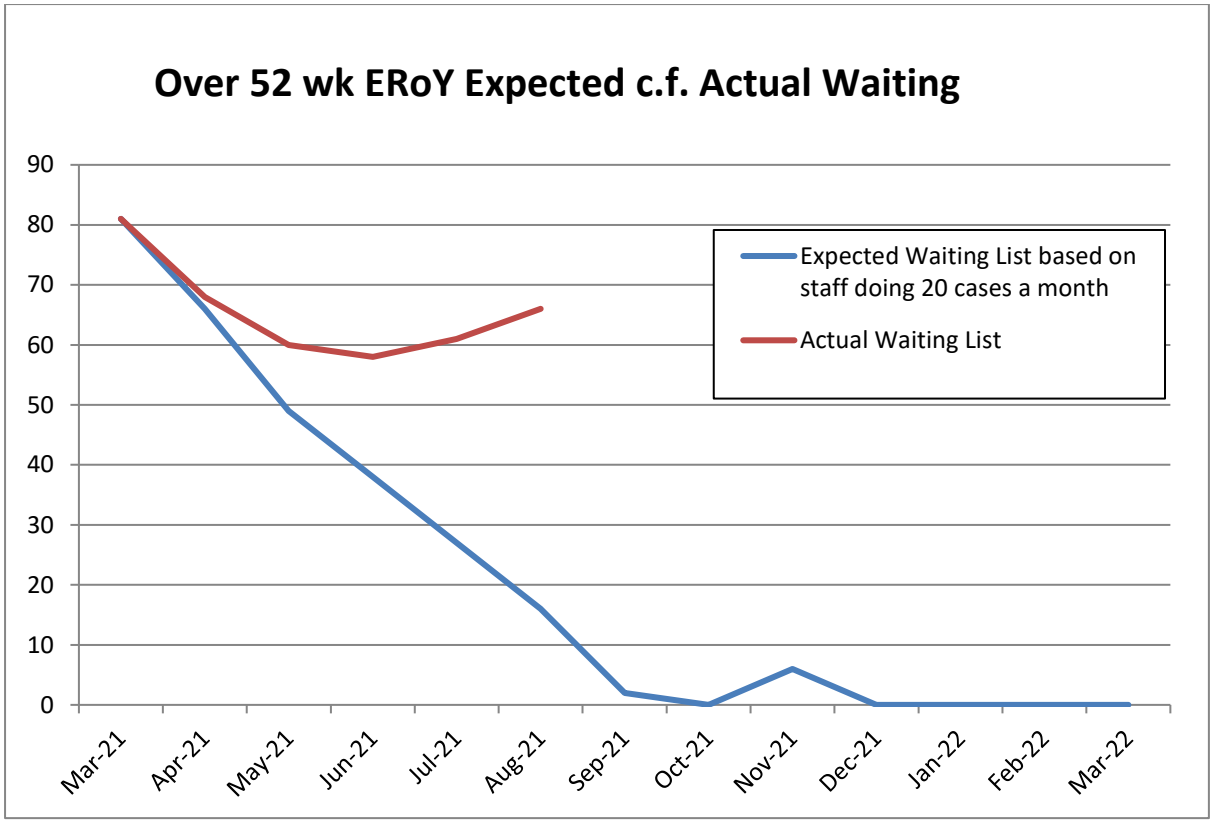


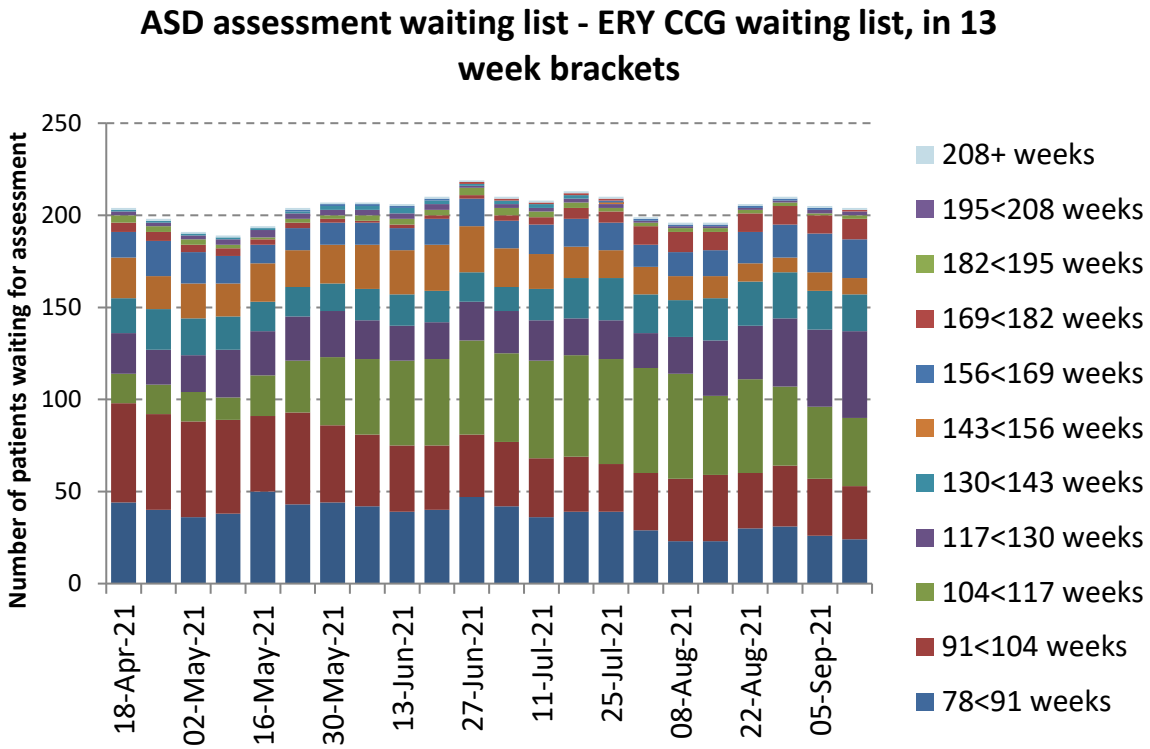
The above chart demonstrates the downwards trajectory in Hull cases if 30 assessments are undertaken a month. The team began implementing a new model in March 2020 which is estimated to speed up the number of assessments which can be completed and will demonstrate progress towards the end of April.

The trajectory for East Riding was based on the commencement of 20 assessments per month. The East Riding team is made up of a small number of staff and staff absence has resulted in a very limited number of new assessments being commencing throughout July and August. The service have commissioned an additional 12 digital assessments per month (total 32 per month across Hull & ER) which will be focussed on those relevant patients on the East Riding waiting list and, going forward, and the Service will manage both the Hull and East Riding waiting lists equitably according to length of wait. Significant recruitment is taking place for Teams Leaders and Psychologists which will support the transformation of the neurodiversity services.

East Riding actual weekly figures from 3rd March 2021 onwards

Date	Number 52 weeks +	Number 52 weeks -	Total waiting
03/03/21	81	133	214
11/03/21	77	135	212
18/03/21	71	130	201
25/03/21	73	136	209
04/04/21	73	141	214
10/04/21	68	142	210
17/04/21	68	140	208
24/04/21	68	131	199
16/05/21	54	143	197
23/05/21	58	152	210
30/05/21	60	150	210
06/06/21	61	149	210
14/06/21	65	141	206
20/06/21	67	143	210
27//06/21	65	154	219
04/07/21	61	149	210
11/07/21	64	144	208
18/07/21	68	145	213
25/07/21	66	144	210
01/08/21	62	137	199
08/08/21	61	135	196
15/08/21	63	133	196
22/08/21	65	141	206
29/08/21	65	145	210
05/09/21	66	139	205
12/09/21	66	138	204





NB: after Feb 22 more data is required to be inputted to complete this trajectory to estimate the number of cases which will tip into the 52 week waits.

Variables and assumptions

The following sections set out the assumptions used for the trajectory. Please note that all variables have more volatile and less predictable during the COVID-19 crisis, so that projections have a greater margin for error.

Waiting over 52 weeks

We have also calculated how many patients will 'tip over' to have waits above 52 weeks each month, based on the actual waiting list, using original referral dates and projecting the elapsed days for each patient each month.

Agenda Item 10

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting– 29 September 2021</td></tr>
<tr><td>Title of Report:</td><td>Finance Report 2021/22: Month 5 (August)</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 August and comment accordingly.
</td></tr>
<tr><td>Purpose of Paper:</td><td>This report is being brought to the Board members to provide the financial position for the Trust as at the 31 August 2021 (Month 5).

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

The Trust Board are asked to note the financial position for the Trust and raise any queries, concerns or points of clarification.</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></td></tr>
<tr><td>Charitable Funds Committee</td><td></td><td>Other (please detail)
Monthly Board report</td><td>✓</td></tr>
</table>
</td></tr>
<tr><td>Key Issues within the report:</td><td>

The Trust recorded an overall operating surplus of £0.245m which is in line with the ICS Months 1-6 expectation of a £0.315m surplus
Within the reported position at Month 5 is Covid expenditure of £1.818m and income top up of £1.055m.
Cash balance at the end of Month 5 was £23.718m
The Year to Date Agency expenditure was £2.861m this is £0.248m less than the previous year’s equivalent month 5 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 – August 2021

1. Introduction

This report is being circulated to the Board to present the financial position for the Trust as at the 31st August 2021 (Month 5). 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 31 August 2021

Under the planning guidance the period 1st April 2021 to 30 September 2021 is referred to as H1.

For the H1 period block arrangements will remain in place for relationships between NHS Commissioners (comprising NHS England and Clinical Commissioning Groups) and NHS Providers Trusts and Foundation Trusts.

The Trust position for H1 has been set in line with the overall Humber Coast and Vale ICS and as part of an efficiency requirement for the ICS all organisations were given a target and the Trust moved from a breakeven position to a surplus of £0.315m for H1.

Signed contracts are not required between NHS organisations for this period.

Table 1 shows for the period ended 31 August 2021 the Trust recorded a surplus of £0.245m, details of which are summarised in the table below.

Taking account of Donated (Asset) Depreciation the overall Operating Total is a £0.272m surplus which is in line with the H1 requirements.

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	**128,525**	**10,710**	**10,851**	**141**	**53,552**	**53,680**	**128**
Clinical Income	**17,597**	**1,370**	**1,219**	**(151)**	**6,941**	**7,177**	**236**
Covid 19 Income	**3,077**	**565**	**685**	**120**	**2,872**	**2,974**	**102**
Total Income	**149,199**	**12,646**	**12,756**	**110**	**63,365**	**63,831**	**466**
Expenditure							
Clinical Services							
Children's & Learning Disability	29,269	2,430	2,405	25	12,179	12,155	24
Community & Primary Care	28,454	2,354	2,413	(59)	11,805	11,820	(15)
Mental Health	48,553	4,220	4,173	46	20,900	20,382	517
Secure Services	11,521	948	906	43	4,723	4,630	93
	117,797	**9,952**	**9,897**	**56**	**49,606**	**48,987**	**619**
Corporate Services							
	28,770	**2,487**	**2,346**	**141**	**12,876**	**12,309**	**567**
Total Expenditure	**146,566**	**12,439**	**12,242**	**197**	**62,482**	**61,296**	**1,185**
EBITDA	**2,633**	**207**	**514**	**307**	**883**	**2,534**	**1,651**
Depreciation	2,942	245	241	4	1,226	1,205	21
Interest	148	12	18	(6)	61	82	(21)
PDC Dividends Payable	2,341	195	195	0	976	975	1
PSF Funding	-	-	-	-	-	-	-
Operating Total	**(2,798)**	**(245)**	**59**	**305**	**(1,379)**	**272**	**1,652**
BRS	(3,113)	(304)	-	(304)	(1,648)	-	(1,648)
Operating Total	**315**	**59**	**59**	**1**	**269**	**272**	**3**
Excluded from Control Total							
Impairment	-	-	-	-	-	-	-
Donated Depreciation	70	6	5	0	29	27	2
Ledger Position	**245**	**53**	**54**	**1**	**240**	**245**	**5**
EBITDA %	**1.8%**	**1.6%**	**4.0%**		**1.4%**	**4.0%**	
Surplus %	**0.2%**	**0.5%**	**0.5%**		**0.4%**	**0.4%**	

2.2 Income

Trust Income is based on block arrangements with Commissioners that are fixed for Months 1 to 6. The current position is showing an overachievement of £0.128m which represents a minor surplus at this stage.

Clinical income is showing an overachievement of £0.236m which is primarily due to additional non recurrent income in months 1-5.

The additional Covid Income relates to that received by the Trust in undertaking the Vaccination programme for Harthill PCN.

2.3 Divisional Expenditure

The overall Operational Divisional Expenditure is showing an underspend of £0.619m.

2.3.1 Children's and Learning Disability

Children's and LD is reporting a £0.024m underspend year to date.

CAMHS Inpatient Service is reporting a significant pressure this financial year with a year to date overspend of £0.326m. The pressure to open the PICU beds and the acuity of the patients has resulted in increased staffing levels and pay is overspent by £0.297m. The cost of the doctors for the ward is £0.151m over spent year to date due to the difficultly recruiting and the use of agency consultants.

Nursing is £0.175m 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 £0.114m. The funding mechanism for Granville is being reviewed with Commissioners.

There are a number of compensating underspends in the Division which brings the position back to the £0.024m underspend.

2.3.2 Community and Primary Care

Community and Primary Care is reporting an overspend of £0.015m.

Within Community services the main pressure at Month 5 relates to Scarborough and Ryedale which has experienced increases in staff recruitment and has also incurred Agency staff support which has resulted in an overspend. This is showing an overspend of £0.083m which is being closely monitored and the Commissioners are aware of the current pressure in demand which has increased throughout the Covid period.

Primary Care is showing an underspend of £0.004m.

2.3.3 Mental Health

The Division is showing an underspend of £0.517m. This is primarily due to vacancies across a number or service areas. There are agency staff being employed to fill essential roles and this is being constantly reviewed.

2.3.4 Secure Services

The year to date position of Secure Services is an underspend of £0.093m.

2.3.5 Corporate Services

Corporate Services are reporting an underspend of £0.567m.

3. COVID Expenditure

At the end of August 2021 the Trust recorded £1.818m of Covid related expenditure and £1.055m of Income Top Up, details of which are summarised below:

Table 2 Covid Costs

Covid Costs	Total £m
Pay	0.709
Non Pay	1.109
Subtotal Expenditure	**1.818**
Income Top Up	1.055
Total (Exp and Top Up)	**2.873**

4. Cash

As at the end of August 2021 the Trust held the following cash balances:

Table 3: Cash Balance

Cash Balances	£000s
Cash with GBS	23,473
Nat West Commercial Account	197
Petty cash	48
Total	**23,718**

For the 2021/22 year to date the Trust has not been in receipt of any capital allocations in advance and therefore the reported position is representative of the underlying cash position.

5. Agency

Actual agency expenditure for July was £0.652m. The year to date spend is £2.861m, which is £0.248m less than the same period in the previous year.

Table 4 Agency Spend v previous year

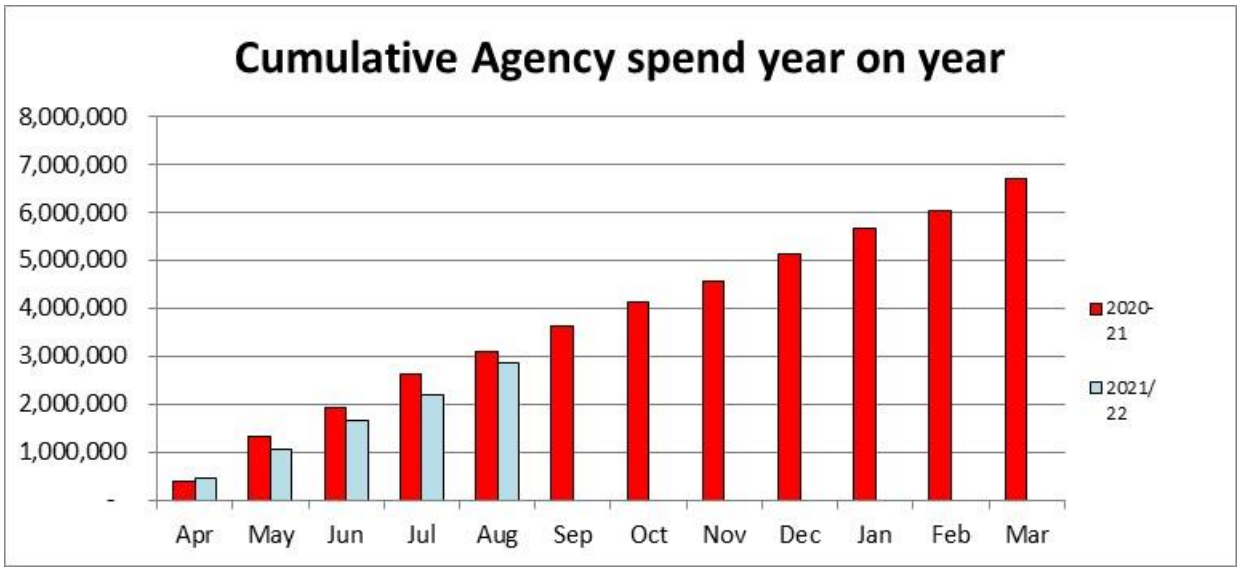


Table 5 Agency spend by staff group

Staff Type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Total
	£000	£000	£000	£000	£000	£000
Consultant	390	342	456	432	505	2,125
Nursing	27	152	106	81	58	424
AHPs	10	51	(1)	6	16	83
Clinical Support Staff	13	26	18	22	42	122
Administration & Clerical	17	20	24	17	30	108
Grand Total	**457**	**592**	**602**	**558**	**652**	**2,861**

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

6. Statement of Financial Position

Appendix 1 shows the statement of Financial Position and that there has been very little movement overall in Taxpayers Equity. The position reflects a movement in net assets equal to the surplus reported for the month

6. Recommendations

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

Appendix 1

Statement of Finance Position

	Aug-21 £000	Jul-21 £000	Movement £000	Comments
Non-current assets				
Property, Plant & Equipment	88,892	87,608	1,284	Additions less depreciation
Intangible Assets	11,050	11,070	-20	
Total non-current assets	99,942	98,678	1,264	
Current assets				
Cash	23,718	24,372	-654	Working capital/other movements
Receivables	7,062	6,337	725	Increase due to large invoices raised in month
Inventory	155	155	0	
Assets held for sale	514	514	0	
Total current assets	31,449	31,378	71	
Current liabilities				
Payables	3,699	3,359	340	
Accrued liabilities	15,062	13,656	1,406	Relates to capital accruals
Other liabilities	6,835	7,298	-463	Relates to deferred income
Total current liabities	25,595	24,313	1,283	
Net current assets	5,854	7,065	-1,211	
Long Term Liabilities				
Non-current borrowings	3,565	3,565	0	
Non-current- other liabilities	3,899	3,899	0	
Total Long term Liabilities	7,464	7,464	0	
Total Net Assets	98,332	98,279	53	
Revaluation Reserve	16,250	16,250	0	
PDC	69,652	69,652	0	
Retained earnings reserve	14,504	14,450	54	
Other	(2,073)	(2,073)	0	
Total Taxpayers Equity	98,332	98,279	53	

Agenda Item 11

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
Title of Report:	Finance and Investment Committee Assurance Report
Author:	Name: Francis Patton Title: Non-Executive Director and Chair of Finance Committee
Recommendation	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper:	The Finance and Investment Committee is one of the sub committees of the Trust Board. This paper provides an executive summary of discussions held at the meeting on 18th August 2021 and a summary of key points for the Board to note.
Governance	Audit Committee – Date: ; Remuneration & Nominations Committee – Date: Quality Committee – Date: ; Workforce & Organisational Development Committee – Date: Finance & Investment Committee – Date: 18.8.21 ; Executive Management Team – Date: Mental Health Legislation Committee – Date: ; Operational Delivery Group – Date: Charitable Funds Committee – Date: ; Other (please detail) – Date:
Any Issues for Escalation to the Board:	The committee recommends that the Board: - • Notes the month four outturn showing a surplus of £0.213m. • Notes the month four BRS performance which is just behind plan. • Notes the update on the PSDS SALIX spend. • Notes and supports the committee's sign off of the Reimbursement of Patient Travel policy.

Executive Summary - Assurance Report:

The aim of this report is to provide assurance to the Board on the financial and investment performance of the Trust and raise any issues that it feels need escalating to the Board for further discussion.

A summary of the key areas discussed are that Month four had an operational surplus of £0.191m, after donated depreciation the position is a surplus of £0.213m.

The Trust has a strong cash position and is controlling creditors and debtors well and the committee complimented the team on this.

In terms of BRS the Divisional & Corporate areas have delivered savings of £1.005m.

The Committee received the latest BAF and risk register which they signed off, an update on the Salix decarbonation and signed off the Reimbursement of Patient Travel policy.

The Committee reviewed the Digital Delivery Group and Capital Programme Board & Estates Strategy Delivery Group Assurance reports.

Key Issues:

The key areas of note arising from the Committee meeting held on 18th August were:

- In terms of the Insight report the key issues raised were: -
    - At Month 3 the Humber Coast and Vale ICS recorded a £13.1m surplus, this represents a favourable variance to plan of £11.1m.
    - The Government has now published its response to the consultation on reforms to the contracted-out services
    - The NHS is to be more closely monitored on its compliance against the Better Payment Practice Code
    - HMRC has announced a further deferral of Making Tax Digital (MTD) for all Government and NHS bodies until at least April 2023

- In terms of month four Trust Position an operational surplus of £0.191m was recorded to the 31st of July 2021. After donated depreciation the position is a surplus of £0.213m. As part of the Efficiency Requirement of the ICS the Trust was required to move from a Breakeven position to a surplus of £0.315m for the period Months1 to 6 (H1).

  Within the reported position is year to date Covid expenditure of £1.488m, and income top up of £0.820m. The Children's and LD Division has a year to date net overspend of £0.032m; the Community and Primary Care Division has a year to date net expenditure underspend of £0.208m (this includes a net surplus of £0.001m relating to Primary Care Sites); the Mental Health Division has a year to date net expenditure underspend of £0.733m; the Secure Services Division is showing a year to date division net underspend of £0.041m and the overall Corporate position is an underspend of £0.486m. The committee sought and received assurance around CAHMS and around the GP discussions at Market Weighton.

  Cash at the end of month two was £24.372m, aged debtors stood at £3.098m (a way forward in relation to the aged Hull City Council debt has been reached and will be settled in the coming months) and aged creditors stood at £3.643m (£0.632m have been approved and can be paid on the system).

  The committee complimented the team on their continued good management of debtors.

In terms of the BPPC the year-to-date performance for non-NHS invoices is 90%, and for NHS 80%. The Non-NHS performance remains stable and there has been a slight improvement in the NHS performance.

- The Committee received the month four BRS update which showed that the Divisional and Corporate Savings have been profiled at £1.193m for Month 4 and are showing savings of £1.005m which is an underachievement of £0.188m There are pressures with Community and Primary Care and Mental Health. Community and Primary Care have an under achievement of £0.024m relating to 2 schemes that were expected to deliver £0.071m annual savings. These schemes have been rated as Red and alternative schemes are being formulated. Mental Health is showing an underachievement of £0.164m and relate to schemes reliant on Commissioner Funding. Negotiations are taking place to ensure that this funding takes place.

- The Committee received the BAF and Risk Register for quarter two and Strategic Goal 5. The only query was that with 8 of the objectives being amber, 1 being red and only one yellow why was the overall rating yellow. The Executive will review this prior to the next meeting.

- The Committee received an update SALIX decarbonation which continues to progress positively against a revised programme and approach. A full review of the professional team and how the proposed works may integrate with the wider refurbishment project at the Humber Centre has been undertaken. This resulted in some changes to the professional team in the interest of focusing on delivery experience and combining the Humber Centre element into the overall Humber Centre programme.

  The East Riding Community Hospital project will progress as an independent project and anticipates having tender returns ready for entering into contract by December with works completed this financial year. The Humber Centre programme is on the same timescale however installation works will be phased to align with the wider refurbishment, works that can be undertaken outside of the wards will be completed this financial year, internal ward works such as BMS and lighting replacement will be completed as part of the ward works progressing throughout 2022.

- The Committee received assurance reports from the Digital Delivery Group and the Capital and Estates Group.

- The committee received and approved a new policy for Reimbursement of Patient Travel. The Policy, which includes the process to be followed for reimbursement, has been written in response to an audit recommendation. The objective is to provide written guidance to be referred to across the Trust.

Humber Teaching NHS Foundation Trust

Agenda Item 12

Title & Date of Meeting:	Trust Board Public Meeting – Wednesday 22 September 2021
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 paper includes details of the meeting held on 22 September 2021 and provides a summary of key points for the Board to note. The minutes of the meeting held on 19 July 2021 are also attached for information.
Governance: *Please indicate which committee or group this paper has previously been presented to:*	Audit Committee – Date: ; Remuneration & Nominations Committee – Date: Quality Committee – Date: ; Workforce & Organisational Development Committee – Date: Finance & Investment Committee – Date: ; Executive Management Team – Date: Mental Health Legislation Committee – Date: ; Operational Delivery Group – Date: Charitable Funds Committee – Date: 22.9.21 ; Other (please detail) Assurance Report – Date: ✓
Any Issues for Escalation to the Board:	No items were highlighted for escalation to the 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	Yes	If any action	N/A	Comment

Caring, Learning & Growing Together

considered prior to presenting this paper to Trust Board?		required is this detailed in the report?		
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
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 22 September 2021 and encloses the agreed minutes from 19 July 2021.

CFC Summary Points from Chair

1. The committee were delighted to welcome Dr Hanif Malik OBE to his first CFC and are very grateful for his contributions.

2. The minutes of 19 July 2021 were agreed as a true record

3. The first draft of the independently examined accounts was received and these will be presented, for approval, at the October board meeting.

4. Overall Health Stars fund balances have reduced to a value of £446,000. Approximately a third of the funds are held for Bridlington and other high balances exist where there are community hospitals.

5. The committee noted the KPI's that £1.04 had been raised for every £1 spent on fundraising and that fundraising costs are 12% of expenditure. These figures are to be looked at in the future to represent a true picture of the charity.

6. The Whitby Appeal has so far raised just over £30,000 and the fundraising bricks were launched in the last period

7. Sarah Daniels has been appointed the Whitby Hospital Lead Artist along with two other supporting artists.

8. Risk number 8 was highlighted throughout the meeting and Charitable Funds Executive Lead, Steve McGowan will be following this up with operational colleagues to support Health Stars to have more fundraising opportunities.

   Risk 8:
   "The absence of fundraising appeals opportunities identified by the trust. In order for Health Stars to succeed in fundraising appeals, clear projects need to be provided and defined by the trust."

Minutes of Previous Meeting

The minutes of 19 July 2021 are attached.

Peter Baren
Chair, Charitable Funds Committee”

NHS
Humber Teaching
NHS Foundation Trust

Charitable Funds Committee

Minutes of the Charitable Funds Committee Meeting

Held on Tuesday 19 July 2021, 10.00am – 12.00pm, via Microsoft Teams

Present: Professor Mike Cooke, Non-Executive Director (Chair)
Peter Baren, Non-Executive Director
Peter Beckwith, Director of Finance
Steve McGowan, Director of Workforce and Organisational Development

In Attendance: Andy Barber, Hey Smile Foundation Chief Executive
Victoria Winterton, Head of Smile Health
Kristina Poxon, Fundraising Manager
Rachel Kirby, Communications & Marketing Manager
Kerrie Neilson, PA (minutes)

Apologies: Michele Moran, Chief Executive

It was declared that the meeting would be recorded for note taking purposes and the recording would be destroyed once the minutes have formally been approved by the Charitable Funds Committee (CFC) at the next meeting on 22 September 2021.

It was noted that today's meeting is Professor Cooke's last CFC meeting before he retires from the Trust on 31 August 2021.

Professor Cooke informed the Committee that Hanif Malik, Associate Non-Executive Director who joined the Trust on 1 July 2021, will become a member of the Charitable Funds Committee and will be in attendance at the next meeting.

43/21 **Declarations of Interest**
Professor Cooke declared his interest as previous Chair of the Yorkshire Wildlife Trust (YWT) for item 7.1 (A Gift of A Vehicle to support the work undertaken between Yorkshire Wildlife Trust and HTFT Health Trainers) on the agenda.

44/21 **Minutes of the Meeting held on 18 May 2021**
The minutes of the meeting held on 18 May 2021 were agreed as a correct record.

45/21 **Action List, Matters Arising and Work Plan**
The Committee discussed the actions list and work plan and agreed that it would be good to see more operational involvement. Mr Barber suggested that the Committee does a 'deep dive' every second meeting and dive into the operational element, and focus on the future, and include Bridlington, Driffield, ERCH, and Whitby. Professor Cooke thanked Mr Barber for his suggestion.

Resolved: The Committee agreed the actions list will be updated accordingly. Professor Cooke asked Ms Neilson to circulate the CFC Board Assurance Reports for June and July with the draft July minutes and ensure CFC Board Assurance Reports are on all future agendas going forward. **ACTION KN.** Professor Cooke asked the Committee to have a full discussion at the next meeting in September about the full work programme, with some ideas from the smile team and the execs representing EMT and Ops. **ACTION ALL**

45.01/21 Impact Appeal Charitable Spending List

Ms Winterton presented the Impact Appeal Spending List explaining that at the last CFC meeting it May, it was requested that a full log of all impact appeal spending be circulated for learning for the Whitby Appeal. It was noted that the paper 2 includes all items originally requested, those funded through monetary donations, those funded through gift in kind and those that did not progress.

Ms Winterton referred to the summary paper, which was presented at the previous CFC meeting, that explained how the £176k of monies raised is being spent. However, there is still £150k, that was for specifically committed projects that have not gone ahead.

Ms Winterton provided the Committee with the headlines, explaining that The Impact Appeal raised £336,000 in total to enhance Child and Adolescent Inpatient Unit Inspire with £176,000 remaining for Inspire Garden, the upgraded Children's Centre Outdoor Area and to support young people's travel and trips. This would leave a further £9,600 approximately for supporting the development.

Ms Winterton advised she is working with Mr Beckwith and Rob Atkinson to get the garden progressed. Mr Beckwith stated that the commitment from Newerby Trust and Help For Health is still there, and the design and scheme is currently being worked up. It was established that the donation is for the benefit of our patients, and the patients in Sunshine House.

Mr Barber added to this and said that there has been strong communication between Smile and the funders and keeping them up to date. He also said that reducing the balance down to £9,657 is a really positive position to be in.

Professor Cooke stated that he is really pleased with the good progress made in terms of raising £336k for the Impact Appeal for Inspire. It was noted that all the money will be spent on Inspire spending all that money, with a little reserve for other contingencies. Of the £176k left £150k is committed to the major renovation outside, including the children's renovated centre itself, as well as Inspire which is real added benefit to the pathway.

Professor Cooke formally thanked everyone involved for pulling the plan together. He stressed that reconciliation needs to happen all the time across the capital scheme.

Professor Cooke asked Mr Beckwith if he is happy with the way Whitby is shaping up. Mr Beckwith confirmed he is happy. He reported that that the garden project is on-site and will be completed before hand-over and that the Artwork is progressing well.

Mr Barber made reference to the Newby Trust and Help For Health and suggested a formal thank you letter is sent for the £150k donation. Mr Barber stated that Smile are more than happy to draft the letter for Michele Moran to sign.

Mr Baren commended the team and said really well done, it is a real success story. He asked if brief updates on each project could be provided going forward.

Ms Kirby confirmed she happy with the way things are working. She updated on plans to catch up on the last 18 months, but due to operational pressures this has not happened.

Resolved: The Impact Appeal spending list was noted by the Committee. It was noted that the Newby Trust and Help For Health have been very flexible and a letter of thanks from CEO will be drafted by Smile. **ACTION AB.** Ms Winterton agreed to provide a brief update on each project going forward. **ACTION VW**

46/21 **Updates from Whitby Sub Group**

Mr Beckwith presented the Whitby Group Assurance Report, which provides an executive summary of discussion held on 22 June and a summary of key issues which the EMT was asked to note on 12 July. The key headlines are noted below:

Mr Beckwith reported that work is progressing on site and the electrical switch over is now complete and the building is due to be handed over 16 August 2021. Ms Kirby is working with the ops team in terms of the opening, there will be a soft launch followed by a formal launch.

Mr Beckwith reported that since the last CFC meeting, he has attended 2 or 3 patient carer experience forum meetings to deal with some of the queries that have come in from the local community, relating to Whitby, the garden, and how the decision was made and how the funding was secured. It was noted that at the last forum, it came up with a proposal to put the fundraising bricks, which was supported by Executive Management Team (EMT) onto the retaining wall.

Professor Cooke asked if the brick scheme worked and asked if it has raised a lot of money. Ms Poxon added to this and expressed her thanks to the EMT for the approval to proceed with the bricks scheme. She reported that there has been a lot of positive response, whilst noting that the bricks would be sold at £20. However, there would be the option to donate more, should people wish too. Work is progressing with Ms Kirby and her team with regards to a soft launch week commencing 9 August, followed by a more public launch week commencing 30 August.

It was noted that there is target fundraising figures of £133,600 worth of additional amenities to really enhance the scheme for patients, and front-line staff have been identified to focus on The Whitby Hospital Appeal, which will provide real and tangible benefits for patients, their loved ones, the community and front-line staff.

Professor Cooke thanked Mr Beckwith for the update and noted that is happy with the way that things are is going and he welcomed questions.

Resolved: The Committee noted the report and verbal updates.

47/21 **Insight Report**

Ms Winterton presented the report which provides an update on topical issues.

Ms Winterton updated the Committee on the fundraising activity in period. It was noted that continue work is continuing behind the scenes on fundraising events, as we transition though each stage of the COVID19 road map. There are a number of 'in person' events in planning for later on in the year, which include a Golf Day, the CEO Challenge and 'Starlight Ramble' which is in collaboration with Burton Constable.

Whilst plans for the Golf Day and the CEO challenge are still in the early stages of planning it was noted that the 'Starlight Ramble' event will be going ahead on 13 November 2021. The event will focus on supporting children's mental health post pandemic. As a family friendly event Health Stars are keen to raise awareness of the support available whilst raising vital funds for areas within Humber Teaching NHS Foundation Trust specialising in this area of care.

It was noted that Ms Poxon met with the Driffield Mayor regarding a pledged donation of £500, Kristina spoke about the fantastic work that is ongoing between the Trust and the Charity and the future plans for supporting all areas of mental health across the Trust and she was able to increase the £500 donation into £3,000.

Ms Winterton reported that there are still places left on Mulgrave Castle 10k Run, which is on 8 August 2021.

In relation to grant applications, work continue behind the scenes to support the larger areas of the enhancements, a breakdown is listed on page 4 of the Insight Report. Whilst grant applications have been unsuccessful to date, the team are continuing to identify new potential funders and opportunities. Ms Winterton confirmed that the contacts of businesses will be refreshed.

Ms Winterton was pleased to report that the "Dost" project team are now working Trust's international recruitment team for Nurses.

It was noted that a range of events are being planned for later this calendar year to increase engagement.

Professor Cooke thanked the team for the report and welcomed comments and questions from the Committee. Mr Baren referred to the date the approach was made to businesses on page 5 of the report. He asked if those could be refreshed, as we are now in July and the Country have now come out of lock-down. He then referred to looking into getting gifts in kinds, for the televisions required for the wards.

Mr Baren referred to previous wishes dating back three or four months and asked for an update on those. Ms Poxon verbally reported that the team are working to see whether those 93 wishes, which was in partnership with the Patient Carer and Experience team, can be outsourced by doing them as gifts in kind. She stated that positive progress is being made and some have already been granted.

The Committee praised the team for the report and hard work.

Resolved: The report and verbal updates were noted by the Committee.
Ms Poxon agreed to provide an additional breakdown on the older wishes, within the report going forward. **ACTION KP.** Ms Winterton agreed to refresh the businesses contacted to date on page 5 of the report. **ACTION VW**

48/21 **Charitable Funds requests that require Committee Approval (over £5,000 up to £100,000)**
Ms Winterton presented the NHS Charities Together Stage 3 Application Report, which provides the Charitable Funds Committee with overview of the application to NHS Charities Together for Stage 3 funding. It was noted that the application is presented in the format that has been requested by NHS Charities Together and is how it will be submitted. The application has been considered and approved by the EMT in June 2021.

The Committee confirmed they are fully supportive of the stage 3 application and really hope the application is successful and if successful, look forward to spending it on staff health and wellbeing.

Professor Cooke commended the Westlands Case Study on Artwork funded from NHS Charities and recommends we promote that to the Trust, Trust Board and others.

Resolved: The Committee noted the NHS Charities Together Stage 3 Application Report and are fully supportive of the stage 3 application and really hope the application is successful.

48.01/21 A Vehicle to support the work undertaken between Yorkshire Wildlife Trust and HTFT Health Trainers Report
The Committee went on to review and discuss the report that was circulated on the morning of Monday 19 July. It was established that the Executives have not yet been sighted on this and it is an Operational decision.

Professor Cooke asked if someone could formally thank the Yorkshire Wildlife Trust.

Mr Baren asked if there is any contribution from charitable funds with regards to the running costs or proving a driver for the vehicle. Mr Beckwith confirmed it no it is all included in the bid.

Resolved: The Committee noted the report and agreed that the Gift of A Vehicle to support the work undertaken between Yorkshire Wildlife Trust and HTFT Health Trainers Report should be directed to ODG. Mr McGowan agreed to take this outside of the meeting and pick it up with Lynn Parkinson and thank the Yorkshire Wildlife Trust. **ACTION SMc**

49/21 **CFC Finance Report**
Ms Winterton presented the report which updates the Charitable Funds Committee on the progress Health Stars is making and to highlight any issues which need to be discussed and/or

approved.
Ms Winterton highlighted the following updates covered in the report:

- Finance update
- Fund Zone Balances

It was noted that the income and expenditure for the first quarter of 2021/2022 are included on page of the report, and in appendix A. Income in May includes grant income of £1,000 and a donation from the Mayor of Driffield of £3,000 along with other smaller donations. Expenditure includes NHS Big Tea activity sent out to all staff and wishes granted.

Unfortunately, income is lower than anticipated due to unsuccessful grant applications. It was noted that general fundraising is starting to pick up again and fund balances are down to £500,000,

Professor Cooke asked about the income that has not yet hit the bank. Ms Poxon stated that as part of the Whitby Hospital Appeal the team have noted it as a pledge but due to paperwork and timings of it hitting the account it has not been included in the report and figures yet.

The Committee discussed and noted that the largest chunk of expenditure was the Impact Appeal.

Mr Barber thanked his team and noted we are in a positive position.

Mr Baren mentioned “Pennies From Heaven” and asked if those could be refreshed at some point. He referred to fund balances and stated that it is positive fund balances have gone down but highlighted that most of the money is in community services, and that there is not an awful lot for mental health. He suggested we think about reaching out to gain money for the mental health going forward. Ms Poxon emphasised that the main focus for the ‘Starlight Ramble’ event taking place in November.
Professor Cooke highlighted the annual World Mental Health Day on 10 October and asked that the Committee give this some thought and discuss this at a future meeting.

Professor Cooke thanked Ms Winterton and the team.

Resolved: The Committee noted the report and verbal updates.

51/21 **Risk Register**
Ms Winterton presented the updated risk register that provides the Committee with assurance for managing risks. She updated the Committee following her recent conversation with Oliver Simms, whereby it was agreed risks for HS1, HS2 and HS4 would be closed down.

Professor Cooke asked if the Committee are happy that those three risks have been closed off. The Committee were all in agreement. Professor Cooke asked Ms Winterton to be mindful of HS1 and HS2 due to the up and coming changes.

Ms Winterton confirmed that HS5 has been left as it was as Oliver Simms felt there are no gaps in assurance.

Professor Cooke welcomed further questions and comments. The Committee agreed the risk register is dynamic and it has evolved from where it was. Professor Cooke asked Mr Beckwith and Mr McGowan to consider the relationships with the operational side of the business and speak to Claire Jenkinson.

Resolved: The Committee noted the report and verbal updates and commended the work on the Risk Register.

52/21 **To Review the Meeting and Agree Content for Assurance Report**
Professor Cooke asked that all the following is included in the July CFC Board Assurance

Report:

- The Committee were delighted to learn that Dr Hanif Malik OBE would be joining the Committee from its 22 September 2021 meeting.
- The minutes of 18 May 2021 were agreed as a correct record.
- A reconciliation of the Impact Appeal against Expenditure was received and discussed.
- The Impact Appeal raised £336,000 in total to enhance Child and Adolescent Inpatient Unit - Inspire with £176,000 remaining for Inspire Garden, the upgraded Children's Centre Outdoor Area and to support young people's travel and trips. This would leave a further £9,600 approximately for supporting the development. The Newby Trust and Help For Health have been very flexible and a letter of thanks from CEO is being drafted.
- An update on Whitby Hospital Redevelopment, the Appeal and the specific asks were shared, and good discussion held about community engagement and relationships. So far £133,600 worth of additional amenities to really enhance the scheme for patients and front-line staff have been identified to focus The Whitby Hospital Appeal and to provide real and tangible benefits for patients, their loved ones, the community and front-line staff.
- Overall Trust Charitable Funds balances have reduced as planned with the specific grants and appeals received being spent on intended schemes as predicted. General fundraising is picking up slowly.
- A range of events are being planned for later this calendar year to increase engagement.
- Ideas for Appeals going forward would be discussed next meeting including consideration of Mental Health Redevelopment enhancement, mother and baby unit and possibly Bridlington Health Village.
- NHS Charities Stage 3 - Funds for Health and Well-being workers for staff were noted
- Westlands Case study on Artwork funded from NHS Charities was commended as was progress with CFC Risk Register.
- The Chair thanked colleagues for their support and Smile Foundation for the partnership formed and suggested role clarification between Executive Team, Charitable Funds Committee and Operational input could be helpfully discussed. This should link to the review of frequency, timing and content of future meetings and a more strategic work programme.

Resolved: It was noted that all of the above will be included in the July CFC Board Assurance Report and be sent to Professor Cooke for final approval, prior to submission to the July Trust Board. **ACTION KN/SMc/MC**

53/21 **Any Other Business**

Professor Cooke asked the Committee to think about what the Whitby Appeal should look like for 2021/2022 and 2022-2023. He also asked the Committee to think about how we build those right relationships and get that receptive context for the next idea. He emphasised the importance to keep and eye on the Trustee and Exec continuity.

Ms Winterton advised she is speaking at the Senior Leadership Forum this afternoon therefore she will reach out ideas on what the next appeal could be.

Mr Barber said in terms of moving forward, there are some positive on-going discussions around Mother and Baby Unit and support for mother and babies mental health. He also stated that it would be really good for Smile to link in with Claire Jenkinson before the next CFC meeting. Mr McGowan agreed with Mr Barbers suggestion and stated that it would be good to also link in with Michele Moran and Lynn Parkinson.

Mr Baren and the Committee all felt the meeting went very well. The Committee formally thanked Professor Cooke for all of his contributions and wished him all the very best for the future. The Committee will miss Professor Cooke's valuable input.

Mr McGowan formally thanked Professor Cooke, on behalf of the Committee and said he and the Committee really appreciates all of the support and help, which is always done with humour,

and is greatly received.

Ms Kirby informed the Committee that this is also her last CFC meeting. If the meetings remain on Tuesday's, then Ms Kirby maternity cover will attend the meeting. The Committee wished Ms Kirby all the very best.

Ms Winterton also thanked Professor Cooke for everything and for pushing the team to be the very best they can be.

Professor Cooke concluded the meeting by formally thanking everybody for their support. He went on to remind the Committee to constantly look ahead, and look for opportunities, and ensure we have continual clarity and keep working on those relationships.

Resolved: The Committee agreed that it would be useful for Mr Barber to link in with Claire Jenkinson, ahead of the next meeting. Mr McGowan agreed to speak to Claire Jenkinson in the first instance with regards to her attending future CFC meetings. **ACTION SMc/AB**
The Committee agreed to think about what the Whitby Appeal should look like for 2021/2022 and 2022/2023. **ACTION ALL**

54/21 **Items for Escalation or Inclusion on the Risk Register**
There were no items which required escalation.

55/21 **Date and Time of Next Meeting**
Wednesday 22 September 2021, 10.00am – 12.00pm, via Microsoft Teams.

Signed: …….Chair: Professor Mike Cooke

Date: ……

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting September 29th 2021
Title of Report:	Quality Committee Assurance Report
Author/s:	Name: Mike Smith Title: Non-Executive Director and Chair of Quality Committee
Recommendation:	To approve ☐ To receive & note ✓ For information ☐ To ratify ☐
Purpose of Paper:	The Quality Committee is one of the sub committees of the Trust Board This paper provides an executive summary of discussions held at the meeting on 11th August 2021 with a summary of key issues for the Board to note. The approved minutes of the meeting held on 2nd June 2021 are presented for information.
Governance:	See table below
Key Issues within the report:	The following items were noted for highlighting to the Trust Board • The Safeguarding Annual Report and presentation gave great assurance, and it was felt the presentation would be beneficial at the Trust Board • The Psychology Review and Highlights report was recommended to the Workforce and OD committee and the Trust Board • The refreshed Infection Control Strategy was recommended to the Trust Board • The Annual Infection Control report was approved and recommended to the Trust Board • The Annual Patient and Carer Experience report was strongly endorsed and recommended to the Trust 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		Other (please detail) QC Assurance Report prepared for the Board	✓

Monitoring and assurance framework summary:

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

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

Executive Summary - Assurance Report:

Key Issues

The key areas of note arising from the Quality Committee meeting held 11th August 2021 were as follows:

The chair welcomed Rachael Sharp, Head of Safeguarding for the presentation item on safeguarding, along with Catherine Hunter for the QI Strategy and Kate Yorke for the Psychology review and highlights report.

It was noted this was the last meeting that Mike Cooke would chair, and that Mike Smith would be interim chair moving forward.

The minutes of the meeting held 2nd June 2021 were agreed, with a minor amendment and all closed actions noted with updates given. The Quality Committee Assurance report was noted, and the updated work plan reviewed with the change to quarterly meetings from November 2021 agreed, with the recommendation to the Trust Board that the Quality Committee reserve the right to arrange an extra meeting if required.

Discussion item – Safeguarding at Humber Annual Report – successes and challenges
An overview of the Safeguarding Annual Report 2020-21 was presented giving good assurance on the work of the safeguarding team, with a good discussion held. It was felt it would be beneficial for the presentation to be seen at the Trust Board.

Quality Insight Report
The Committee was updated on the proposed new NHS mental health standards and confirmation provided on our position against these standards. Successful nominations for the HSJ Safety Awards were highlighted applauding the four teams shortlisted. A follow up on the actions from the internal audit on divisional governance arrangements was noted along with the update on the Peer Review Process and the reported Never Event following completion of the investigation. The Zero Events 2021-22 Annual Report was also noted, and a summary of the Trust quality performance indicators was discussed.

Psychology review and highlights report
Kate Yorke was thanked for her presentation of the report which detailed the work of the psychology team including examples written by staff about their experiences of working for the Trust. The report was recommended to the Workforce and OD Committee.

Quality Committee Risk Register Summary

The Risk Register summary was interrogated and welcomed noting the early intervention's team improvement plan against some of the national indicators and the current national pressures on CAMHS services and beds .

National Confidential Enquiry 2021
Tracy Flanagan gave a verbal update to the Committee following the report being published and it was agreed a presentation and update on action would be brought back to the Quality Committee at a future meeting.

The QI Approach (strategy)
The Committee heard from Catherine Hunter on the refresh of the strategy which was completed with consultation with staff, patients and carers to ensure there was co-production. The document updates on work competed so far along with building on the current position and work planned.

Homicide action plan – progress update
Dr Fofie updated the meeting on the NICHE action plan noting many actions have been closed since the last update, and work is currently underway to close all the actions before the next meeting with NICHE . Good progress was noted

Mortality Report
The report was shared with the Quality Committee. It was felt the commissioning of public health support was beneficial and suggested a follow up on this report at a later stage. The Committee noted and welcomed the report.

Annual Infection Control Report 2020-21
The Committee approved the annual report and recommended this to the Trust Board. It was noted the usual high IPC performance indicators were still maintained despite the pandemic work

Annual Ligature Report 2021
Lynn Parkinson presented the annual report to the Committee noting the progress since the last update report, confirming the work is overseen by the Clinical Environmental Risk Group as well as the Capital Programme Group.

Annual Patient and Carers Experience (PACE) report 2020-21
Mandy Dawley presented the annual report highlighting the work completed over the past year with changes that had taken place due to Covid-19. The Committee thanked MD for a great report which was strongly endorsed and recommended to the Trust Board

Policies reporting to Quality Committee
There were no policies presented for approval this month.

Minutes from reporting groups
The latest approved minutes from the Quality and Patient Safety Group (QPaS) were noted along with a summary of the last meeting. The chair thanked the QPaS group for their support to the Quality Committee over the last four and a half years.

It was noted the following policies were approved through QPaS with minor amends:-
- Supportive Engagement Policy
- NICE implementation Policy
- Nursing Revalidation Policy
- Safeguarding Adults Policy

The latest approved minutes from the Drugs and Therapeutics Group (DTG) were noted along with a summary of the last meeting. The chair thanked the DTG for their support to the Quality Committee.

Committee review - We held a positive review of four years of Quality Committee progress and its support for patients and front-line staff on quality assurance and quality improvement over time.

The approved minutes from the 2nd June 2021 are attached below as appendix one

Humber Teaching NHS Foundation Trust

Quality Committee

Minutes

For a meeting held on Wednesday 2 June 2021
9.30 – 12.30 (Virtual meeting via MS Teams)

Present		
Core Members		
Mike Cooke	Non-Executive Director (Chair)	MC
Mike Smith	Non-Executive Director	MS
Dean Royles	Non-Executive Director	DR
Hilary Gledhill	Director of Nursing, Allied Health & Social Care Professionals	HG
John Byrne	Medical Director	JB
Lynn Parkinson	Chief Operating Officer	LP
Kwame Fofie	Clinical Director and Deputy Medical Director	KF
Sam Jaques-Newton	Head of Allied Health Professionals and Practice Development	SJN
Su Hutchcroft	Compliance Officer (minute taker)	SH
In attendance		
Michele Moran	Chief Executive	MM
Colette Conway	Assistant Director of Nursing, Patient Safety and Compliance	CC
Trish Bailey	Clinical Lead, Children and Young Peoples Services	TB
Sam Faine	Clinical Programme Manager, Quality Standards and practice Development	SF
Cathryn Hart	Head of Research and Development	CH

45/21	**Apologies for Absence** Apologies were received from Tracy Flanagan and Weeliat Chong (invited for item 16)
46/21	**Minutes of the Last Meeting** The minutes of the meeting held on 7 April 2021 were accepted as a true record with the following amendment:- • Item 29/21 (page 4 second paragraph after bullet points. 'MC commented' should read 'MS commented'.
47/21	**Action List and Matters Arising** The action log was noted with the actions closed and the following updates:- • Item 15/21 (Feb 2021) LP explained the rising demands within children and young people had been reviewed and accurately reflected in the risk register, as an overarching risk. LP noted that pressures had risen further over the lasts seven days. The division is ensuring the risk is live and dynamic with KF closely engaged with the division regarding the pressures. It was noted the current situation with CAMHS beds nationally is still problematic which is having a knock on effect on our services. TB updated as of yesterday, in the Yorkshire and Humber regions 24 young people were waiting for beds with seven over the last weekend from West Yorkshire. This is a huge challenge with high level of acuity and being unable to discharge patients to community services, due to the pressures there. It was noted the Inspire unit is not full to capacity but full due to acuity levels. MM confirmed she is aware and supportive of the bed reduction from an ICS (integrated care systems) point of view and explained there is an escalation group which MM chairs, linking with providers and commissioners across the region, along with engaging with her counter-parts to work any actions. It was noted there will be no quick solution to this situation, but confirmed this has been escalated in the correct manner, with MM leading both a system wide and region wide group.

	LP commented regarding escalation, noting a particular issue with East Riding local authority with pressures and a number of breakdowns in looked after children placements so there is also local escalation through the emergency planning route looking at this on a place by place basis, connected to the work MM is involved with. MC thanked both for the information and noted this would link with the later item regarding Inspire on the agenda
48/21	**Quality Committee Board Assurance Report** The Assurance report presented to the May Trust Board was noted, with good assurance from the committee which was also picked up in the Quality Committee Annual Effectiveness report. MC thanked HG and JB for their contributions.
49/21	**Work Plan 2020 / 2021** The work plan was noted and no queries raised.
50/21	**Presentation – Inspire our Quality Improvement Journey** TB thanked the committee for the opportunity to show the work that had gone on and took the meeting through a presentation highlighting the following • Orion – general adolescent unit with 9 beds • Nova – 4 bed PICU planned to open at the end of June • Journey started with listening exercises with staff and young people accessing the services • Noted lots of work on reporting of incidents but on review levels were as expected from this type of unit and information shared with staff • Strong commitment to young people , engaged staff team with creative ideas • Improvements made by team included establishing staff meetings, discussion of all incidents in reflective space, and representation at trust safety huddle daily, with safeguarding involved at weekly MDT and constant staffing review • Improvements suggestions from young people included ways of giving support and involvement in their care • Improvements included standard invite to young people to attend their MDT in a variety of ways dependant on need, and advocacy services being available • Three priority areas for staff including ongoing communication, developing and expanding of roles and acknowledging wellbeing and needs • Three priority areas for young people including young people at centre of care, support for families/carers and inclusion of young people in future recruitment of staff • Next steps include a refresh of the quality plan taking into account views of young people and staff as move towards opening PICU and continue to encourage the culture of working together using the principles of the quality circle MS thanked TB for an excellent presentation showing the amount of groundwork put in. Enquired regarding the money left in the charity fund for Inspire and if anything had come from young people's ideas of what to buy. TB confirmed they had just put in an application for virtual 'throw board' which once tested at Inspire other services may be interested in. Noted they are always asking for ideas from the young people, which has included bringing in external activities and have developed a relationship with theatre companies in Hull so having conversations with them for potential activities DR commented he enjoyed the presentation and enquired regarding the staff priorities and where there any ambitions of staff to be trained in quality improvement and embedded managerially. TB confirmed this is on the agenda at the CAMHS clinical network and staff have picked up on training within Trust but is also about focusing on trying to get staff to think about areas they can change MC thanked TB for the presentation and noted it as really good to see the reflection practice in the presentation and good to know it is played back to staff and current residents as appropriate. Noting the two sets of initial priorities for staff and service users being slightly different, wonder if these could be aligned over time. TB explained regarding the MDT issues, staff were all new and had not worked together coming from other areas both across the Trust and externally and needed time to get embedded into the process.

	She is currently meeting with the clinical leads across community and inpatients to develop solid pathways and avoid Inspire becoming an isolated unit. MC stated the unit has done really well so far but the mix of acuity currently, noting the waiting list when opening PICU may lead to really hard admissions along with the high expectations on the unit and being a tough service to run. TB remarked the last four admissions meet the criteria for PICU so staff have had preparation for this. One of the main improvement actions going forward will be revamping the access criteria into the services so allow us to say when individuals would not work alongside current service users. The opening of PICU in June was discussed along with the need to escalate the risk. LP noted a number of young people lately are in the PICU acuity and also in the period being close to their 18th birthday and enquired regarding where transition is in the plan. TB noted the recent challenges in service recently, patients are not local and this creates a huge challenge getting engagement with their local service so part of reviewing the criteria is to build in a complex case review before admission looking at discharge with a commitment from the local authority placing the young person, to meet with us at least once a week, with a clear escalation policy if commitment not kept. HG commented on a great QIP, transformational and focussing on the continued development of the right culture, with young people and staff support at the heart of it. Noting progress seen since the unit opened including through the datix reports. Taking the point regarding the outward looking focus, knowing the work in being done, felt it is worth this being included in the QIP. MM thanked TB, knowing the issues at the start of the project, commended the staff, and felt we need to do more to publicise some of the great work we have been doing, not just the escalation piece but trauma informed care particularly through articles of best practice and what has been learn to help staff. TB agreed and noted some work that is currently going on. MC observed the committee recognises the need to try and help to profile the really good work contained behind the commissioning and open of a new CAMHS unit but also the acuity of PICU and would like to ask EMT to think about escalating this into the general risk register before the end of June and to be able to monitor the impact after opening. Well done and requested TB to thank the team directly for all their input and the committee look forward to supporting this in the future. **ACTION** - to publicise some of the great work achieved by CAMHS (TB) - to request EMT to escalate into the general risk register, the opening of PICU and acuity (LP) TB remarked Inspire continues to go through a turbulent time and wanted to acknowledge the great support from adult mental health and specialist division and everyone has put their hands out to help and want this recognised.
51/21	**Quality Insight Report** MC noted a good report as usual and handed over to HG who highlighted the key aspects of the report: • Patient Safety Partners, which are in the national patient safety strategy and also included in our own patient safety strategy. This work slowed due to covid nationally but we are progressing and will feed into the national picture. CC is leading this work for the Trust and the report gave an update on the work with service users and staff around what they expect from the roles and what they feel would be good for the Patient Safety Partner to be involved with, alongside the national guidance. • Allied Health Professional (AHP) update, giving an insight into the AHP workforce roles • SI Reports – noting three SI's declared over the last quarter which have been to QPaS. The divisions are working on the action plans along with reducing the number of overdue actions. CC confirmed more actions have been signed off since the report was written with these also being discussed and noted in accountability reviews • Accessible information update giving details regarding the standard • Incident reporting noted a general trend in increase, showing the start when Inspire opened, with the numbers and units showing where the increases are. There are high levels of acuity in services across the trust but HG explained that although there is high incident reporting, these are majority low/no harm in all units/services, with Ullswater reporting 100% of incidents low/no harm.

	HG confirmed it was positive that incidents are being reported and all incidents are reviewed in the daily huddle with any learning identified • Never Event – HG confirmed there has been one never event, currently being investigated as an SI and once the report has been completed, will be reported back to Quality Committee • An update on the current Family and Friends test along with complaints information MS noted the really excellent verbal commentary on the incident reporting rates which explains the increase in all areas and suggested a narrative should be included in the reports in future MC requested MS to take over the chair whilst MC had to leave the meeting to reset MS Teams.
52/21	**Quality Committee Risk Register summary** HG highlighting the following information:- • 13 risks rated at 9 or above including, four workforce, one service capacity, five waiting list issues and three around quality of care • A new risk added is around next of kin not being recorded which has been picked up with the duty of candour work. CC is leading a price of work to increase recording of this. MS noted there is an issued with Mental Health Legislation around next of kin and nearest relative which is not necessarily the same. CC confirmed she is working with Lisa Davies to look who is next of kin and who is the person to contact in an emergency along with working with clinical systems to ensure recorded correctly. MS thanked HG for the report
53/21	**NHS England commissioned independent investigation into the care and treatment of MSC Trust Action plan – progress update** MC resumed chair of the meeting KF explained the first part of the paper had been previously presented at the Trust Board (part II) and explained he was now working through the recommendations from the NICHE report, working closely with the division and Paul Johnson, Sarah Bradshaw, Weeliat Chong and HG to ensure we have covered all the recommendations with the ethos of learning, noting the action plan at the end of the report and gave an update on the six recommendations. KF noted that everyone is working extremely hard to ensure all actions are completed and there is a follow up meeting with NICHE to discuss progress updates on their recommendation and action plan, and is confident these actions will be completed on time. HG confirmed there has been a lot of work to get actions completed and evidencing the embeddedness in practice and is good to see the auditing in place with actions needing to show the compliance. It was noted the meeting with NICHE in June is regarding the publication with NHSe and once we have a date this will trigger the report going to the Trust Board, and should be either June or July. MC felt it was great to hear the protocol for lithium use and understanding that someone with bi-polar effective disorder may have 30 times more tendency to do certain acts than someone without, showing a real live risk of both suicide and ideation giving a difficult case with some good learning. MC asked KF if we have widened the learning across the Trust. KF confirmed taking the lithium as example, have worked with pharmacy and have a register of everyone on lithium to have that audit trail moving forward. Having been through Drugs and Therapeutics (DTG) and QPaS this will be cascaded through divisions as well as producing learning from this. MC thanked KF and noted the opportunity to look at the document in draft form, with the seven page summary being very helpful, along with the learning from NICHE.
54/21	**Recovery Strategic Framework** LP wanted to credit the leadership of this work to Lauren Sanders who is a member of the recovery college and who expressed an interest and was seconded lead this work but was unfortunately unable to attend the meeting today. LP feels this has been a thorough and detailed piece of work and the report includes both the executive summary and full document which has been developed since last

autumn with a programme of work predicated on achieving as much co-production as possible, working with service users, staff, partners and the wider community. There has been at least 260 people actively engaged in developing the framework based on the first recovery strategy 'Bridging the Gap' which covered the principles that underpin the work we do with service users in the Trust and developed the recovery collage. This framework builds on that platform, with a number of virtual workshops held during the second wave of covid, along with the overarching steering group having been refreshed in terms of membership.

The framework sets out seven key priorities which align to the Trust strategic goals. The strategy has also been predicated on a recovery framework CHIME. This is new to the Trust but universal in its use and sets out the key principles around our recovery work. It was noted each of the seven objections have a plan in their own right which will be underpinned with actions we will commit to, and undertake as a Trust to further embed the approach. Although it has a mental health focus, there has been good engagement from the physical health services who can see the benefit for them.

There is an operational plan sitting alongside the framework, around another set of engagement workshops about implementation of the work. Each of the seven objectives has a worksteam and lead in its own right and the recovery steering group will continue to oversee this work with LP being executive lead. It was noted this sits alongside work of Patient and Carer Engagement and the People Plan, which recognises the wealth of assets we have across the Trust including staff lived experience allowing us to harness the experience and assets we have, making this a more integrated strategy than in the past, to enable embedding in to the work we do.

LP confirmed the executive summary was presented to the Trust Board but this may be the first time members of the committee have seen the full document and due it the key connection with Quality LP wanted the group to have awareness of the work and suggested periodic updates around the actions.

Comments were invited from the committee

- It felt owned and engaged
- The executive summary was appreciated to sit alongside the framework, with a good layout and approach
- DR enquired regarding statistics of ambitions eg staff training in areas of recovery with milestones of what is expected
- MS noted he had been doing some work in another organisation around culture and diversity and noted again excellent summary with the points regarding data and aspirations but also gives a good idea of what to expect. When reading the document he started looking at the language used with an example on page 24 with 'outdated views and non-recovery focused attitudes' and page 47 states 'move away from rigid, prescriptive and patronising models of mental health interventions' and was concerned if the language will strike certain staff.
- MC noted the organisation has a lot of different frameworks but he like the implementation feel to this with the emphasis on how we are going to deploy. The word agency felt like jargon, following MS's point regarding language used. Commented there is a section on strategic idea but nothing to say what is going to happen. Felt there was not enough about carers or supportive individuals around the person they want in their life. Great title. Suggested if trying to deploy would they consider recovery awards in future years and have a section about those people who have benefited and get it right, noting a model that is really successful with long term conditions and in an integrated Trust we should be exploring this area.

MC noted good recognition from everyone confirming it was good to see at Quality Committee before the Trust Board

LP responded to the questions above, noting the data and the evidence being good points, and the strategy for reasons mentioned is focused on what are we going to do with the principles. This has started with an action plan and the steering group tasked to oversee the actions are implemented as well as deciding on how they are going to be evidenced, to include data that we have access to, as well as connected to patients and staff surveys as well as the Family and Friends test information. This will include qualitative feedback from service users who have experienced this.

Regarding the points made around language LP noted some of the language comes from the co-productions workshops and service users felt quite passionate about this, but agree that what is meaningful for someone is not necessarily the same for other people. This has had a lot of consideration but will keep working on this as the work is taken forward.

	MC thanked LP for the report and the Quality Committee endorsed the approach and welcomes the deployment and would welcome an updated on the deployment and quality improvement that come from this.
55/21	**Mortality report (verbal update)** JB noted the annual mortality report relates to covid and follows on from the three month report seen last year which was liked but had some gaps. It was agreed to bring an annual report back with a full comprehensive picture of what has happened during Covid. Funding has been secured for a Public Health registrar from Hull City Council to work with JB on the report, working alongside BI and a draft should be ready around the end of June. This will follow the usual governance process but may go straight to Board due to the time lag of meetings. Ultimately there will be an annual public health based report giving more information than last year report based on one quarter's data. The committee agreed they were happy with the approach and look forward to seeing the report when completed.
56/21	**Clinical Skills Competency Framework** SJN introduced SF who started with the Trust in March and has written the paper which was approved at QPaS in April, where it was felt it should come to Quality Committee. The paper details the implementation and rollout of the competency skills framework, which is based on the Miller's framework, a structured approach to assessment and looking at how practitioners develop from novice to expert. The framework sets out both core and role specific competencies across the organisation to ensure that both registered and non-registered nurses and allied healthcare professionals will have the required knowledge and skills. Practitioners will be assessed against the standards to ensure both effective and safe care. SF is currently undertaking pilots at two sites, Mill View Court and Ryedale Community Services due to finish in July 2021. Currently there are four core competencies being supported by the training department which include:- • Pressure ulcer prevention and management • Falls preventions • Care and management of the deteriorating patient including NEWS2, sepsis and vital signs monitoring • Nutrition and hydration There will be a dedicated intranet page containing all the competencies going live in June and capacity in ESR to capture the compliance enabling managers to have reporting on staff compliance. All the competencies will be added to the HealthAssure system to ensure good governance and version control similar to the Trust policies. The clinical skills assessment standard operating procedure (SOP) has been drafted and will be taken to PHMD group for approval in June. Feedback from managers and practitioners has shown they feel invested in and valued by the process. HG noted this work has developed from reviewing incidents over the last few years and have found competency issues. It was noted the pilots were both areas noting issues in the past. The process should make sure staff always have the latest evidence based practice and are working to this and with proper assessment should enable really good clinical practice. DR thanked SJN for the update. Good to see the development but noted when looking at clinical skills, where is the line drawn? Commenting how to improve the quality of the care you give, is a core clinical skill and that the softer aspects of clinical care, not just the competencies but also the understanding that it is part of everyone's job to know how to improve the process they are dealing with is also important. MM confirmed it was great to see this work, which has taken a while to create and reiterated the earlier point being is a really good example where we have learnt lessons from SI's and near misses being really positive to see and commend the work, It would be good to see a progress update back through Quality Committee in a few months to show the assurance processes are working. MC noted the endorsement for both SJN and SF who have only been with the Trust for a short period of time and thanked them for the report.

Appendix 1

57/21	**Quality Accounts 2020-21 draft** MC noted the hard work which has been put into the document and invited the meeting to comment. It was noted there has been no requirement document received for the Quality Accounts this year. CC confirmed there is a prescribed format for the accounts which has to be followed and stated that although hard work it has been good to pull it all together to see what has been done over a difficult and challenging year. Following discussion the following suggestions and comments were made:- • It was felt it was hard to read in one go, but when reading in sections found it enjoyable • Some work pulling the document together could make it easier to read • It was suggested the front page picture should be changed for one representing covid over the past year • Page 192, MS noted that he is the non-exec lead for emergency planning • Impact – reading through the chief exec forward has some really excellent details but gets lost as it comes after the calendar and felt this should be in front as a proper forward. • Really good information, noted patient experience was page 96 but felt this needs to be further forward along with the impact of covid. • A couple of errors were noted and need amending o Quality committee meets 6 times a year o Noted annex three stated no internal audit required but could mention the internal audits that have been completed o To check the dates to ensure these are correct. • JB noted we are producing a report which is not required this year and will not be carried on going forward and would like to commend CC for the hard work put in. Regarding the comments we now create a range of the annual reports across the Trust. This was agreed and felt it could be made a lot shorter The meeting had a five minute comfort break and restarted at 11.20am MC requested any reflections and what's wanted with this version of the quality accounts HG noting earlier comments, confirming the format is identical to last year's document with the communications team formatting the document, and will look at moving the items discussed earlier and redact information where possible. It was confirmed although we have not officially been asked for quality accounts this year there is no guarantee that we may not be asked in the near future and there is an expectation to produce. It was acknowledged that is a long document which does put people off reading. It was confirmed the document will go out to consultation to stakeholders this week. MC and MM thanked CC and SH for their work on the accounts.
58/21	**Clinical Audit Annual Report 2020-21** SJN updated the meeting explaining the report outlines the audit activity for 2020-21, as well as an overview to the Trust activity in relation to national audits, medicines safety, medicine optimisation audits, service evaluations and audits undertaken on MyAssurance. The Trust's commitment to clinical audit was reflected in the internal audit undertaken by AuditOne in October 2020 as part of the internal audit plan, which reported the Trust provided gave a good level of assurance around its clinical audit system and process gave a high level of compliance with the control frameworks. There were six minor actions identified and these have now been implemented. The clinical audit and service evaluation policy has been revised and each division is expected to deliver against the standards of five clinical audits each financial year, along with strengthening of the clinical audit governance process in the past six months with all divisions having clinical networks and governance groups. Clinical audit is also included in the divisional accountability reviews, to ensure divisions are accountable for monitoring audits within the clinical networks.

	Despite significant pressures due to the pandemic all four divisions have contributed to the clinical audit plan in 2020-21, and extensive work has been undertaken with the clinical audit team, clinical networks and divisional clinical leads to ensure that each network has an opportunity to contribute. All divisions are on track to meet the requirement of five clinical audits to be undertaken this year. MC thanked SJN for the report and noted it was really useful to see the information. HG commented she was pleased that audit activity had taken place over the last year, noting that Secure Services and Primary Care are areas that need to improve the audit activity moving forward but observed they have still managed to undertake some audits during the pandemic and confirmed she is happy the processes are now in place and clinical audit should start to become embedded in practice. JB felt it was a really helpful report and was glad to see the current status as felt clinical audit had lost its value for a period of time due to various changes. The document shows what audit can do, noting audit can be used for professional curiosity, improvement and assurance, with these audits not being the same and a balance of all types is really needed. It was good to see the work in primary care with the pincher tools captured, and noted this report should also be linked to the other governance work. MM agreed it was good to see the report as this was an area that had struggled in the past and is now getting back on track. Felt it could do with a little bit more details regarding what difference the audits have made. Section A does mention how outcomes are used but this could be expanded in future reports with the difference made and how we are using the outcomes to build on section eight. Good report and good process. MS noted regarding the outcomes explaining that the MyAssurance audit tool has been used by the MHL team to add an element noted by the CQC and is a developing programme and the tool is used proactively to audit to find information out.
59/21	**Research and Development Report** CH joined the meeting for item 15, and JB introduced the report noting this report is also seen at Board and highlights the key points over the last year. CH highlighted some of the activities over the past year many of which are also included in the quality accounts as well as setting the scene for this year. • The report gives assurance in relation to performance targets, with a particular view to 2020-21, noting we exceed targets for patients, carers and staff recruited into studies. • Non-covid research has now been re-opened after been paused due to urgent public health research, moving into the managed recovery phase of research • Consultation had just finished around the CQC and what they will include around research. There may be some changes coming up which have not yet been announced • Clinical research network, where the majority of external funding comes from, has an objective set by the government that 45% of general practices are involved in research so this will be passed on us as a Trust and may be monitored on this • UK government has just published the new vision for research with five key themes which match a lot of the priorities in our own strategy • Funding has now been announced and this year it has been confirmed that funding will be increased due to previous year's performance. • Covid-19 research – was involved in the large national studies and still involved with the WHO studies led by Professor Calum Semple, who will also be speaking at this year's annual conference. • The annual conference programme is currently being developed with a number of good speakers already booked • Linked with a speaker at the conference we are also going to be a feasibility site for a diabetes study for those with severe mental illness. • Have been producing videos this year acknowledging the move into the virtual work and these can be translated into a number of different languages and subtitled • Have co-produced an animated video which takes a patient through the full journey when asked to take part in a research study and what they can get from it and have received some external funding for this

	MC thanked CH for the report and noted the nine new principle investigators mentioned in the report. Well done to CH and MM who chairs the clinical research network. MS thanked CH for the excellent report, and confirmed the QR code worked in the report and thanked CH as this led to an idea regarding the use in CAMHS for accessing information. KF noted he has had conversation to try and get medics more involved with the possibility of looking for a lead medic. LP agreed regarding getting medics involved and felt research has now got that momentum and energy back. MM thanked CH and her team for all the work.
60/21	**Annual controlled Drugs Report 2021** JB explained following last year's annual report, it was suggested it would be good to see a six month update and explained the report is very data driven. There is a lot of prescribing across the services but not a huge amount of errors in relation to the amount prescribed. It was noted there are no themes on errors but a mixture across the services and the key element is to link this with the PINCER audit work and primary care, as the vast bulk of prescribing and risk sits in primary care which links back the conversation regarding bi-polar and lithium and the repeat prescribing of this is through primary care. MC thanked JB for the update asked him to thank WC and Ann Wetherill for the report.
61/21	**Policies for approval** There were no policies requiring approval this month. HG confirmed all clinical policies were currently in date.
62/21	**Quality and Patient Safety Group minutes (14 April 2021)** The minutes of the 14 April and summary of the May meeting were noted with no comments raised. MC noted the good attendance and thanked the group for the good work.
63/21	**Drugs and Therapeutics Group minutes** It was noted there was not meeting held of DTG since the last Quality Committee prior to the papers being sent out. The latest meeting was on 27th May and information will be presented to the next Quality Committee.
64/21	**Items Arising from the meeting requiring Communication, Escalation or Risk Register consideration and any lessons learnt** The following items were agreed for escalated to the Trust board via the Assurance report: • The high acuity and high demand on the waiting list for children and young people both area wide and nationally plus the opening of the new PICU and would like the executive team to look at a risk entry encompassing these three areas
65/21	**Any Other Business** There was nothing raised at this meeting.
66/21	**Date and time of next meeting** The next meeting will be held on Wednesday 11 August 2021 at 9.30am via MS Teams. The meeting details will be updated nearer the meeting date.

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Agenda Item: 14

Title & Date of Meeting:	Trust Board Public Meeting – 29th September 2021
Title of Report:	Workforce and Organisational Development (OD) Committee Assurance Report
Author:	Name: Dean Royles Title: Non-Executive Director and Chair of Workforce and OD Committee
Recommendation	To approve: ; To note: √ To discuss: ; To ratify: For information: √ ; To endorse:
Purpose of Paper:	The Workforce and Organisational Development Committee is one of the sub committees of the Trust Board This paper provides an executive summary of discussions held at the meeting held on 15th September 2021 and a summary of key points for the board to note. The minutes of the meeting held on 21 July are attached for information.
Governance	Audit Committee: ; Remuneration & Nominations Committee: Quality Committee: ; Workforce & Organisational Development Committee: 15.9.21 Finance & Investment Committee: ; Executive Management Team: Mental Health Legislation Committee: ; Operational Delivery Group: Charitable Funds Committee: ; Other (please detail):
Any Issues for Escalation to the Board:	• Framework of Quality Assurance for Responsible Officers and Revalidation report was approved for Michele's signature

Executive Summary - Assurance Report:

The aim of this report is to provide assurance to the board around the workforce and organisational development within the Trust and raise any issues that it feels need escalating to the board for further discussion.

A summary of the key areas within the Workforce Insight report and risk register were discussed. The committee received a presentation on the 2020 staff survey results for the Nursing Directorate. Updates from the reporting groups Equality, Diversity and Inclusion, Staff Health and Wellbeing and the Medical Education Committee were received as well as

reports on the Recruitment Task and Finish Group, Trust Reset and Recovery plan, Framework of Quality Assurance for Responsible Officers and Revalidation and Absence Deep Dive Update.

Key Issues:

The key areas of note arising from the committee meeting held on 15 September 2021 were:

Minutes of the meeting in July were approved and action log updated.

An overview of the Absence Deep Dive was given. The deep dive was brought to this month's committee as it was taken off the last meeting due to number of agenda items to cover. Thanks were given to Emma Collins who produced the report, and the committee welcomed the detailed and well presented report. An update was given to the committee on how the data within the report is picked up in services accountability reviews and also shared through the Trust as a whole. The Committee will receive follow up deep dives on this in 6 months with additional information on benchmarking on reasons for absence from other organisations as well as actions taken to improve the data going forward.

A presentation on the staff survey results from the nursing directorate was presented to the committee. The presentation outlined the teams covered in the nursing directorate, the overall results showing above Trust averages, engagement results, improvements from the previous year, actions taken following 2019 results which resulted in the improvement for the 2020 results, opportunities for improvement, must improve areas, areas of strength and the key actions going forward. The Committee agreed to postpone further presentations until results of the next survey are available. The Committee noted that due to meeting frequency changing to quarterly, two division presentations will take place at each meeting going forward. It was agreed to have a general staff survey update at the November meeting.

The assurance report from the Staff Health and Wellbeing group was received. The Committee received an updated in terms of the progress of the kitchen breakout areas, appointment of a new wellbeing co-ordinator, an update on the workplan and risks which have wellbeing implications. Assurance was given that the workforce performance data is reviewed each month and links in with the workplan.

The Committee received no update from the Equality Diversity and Inclusion Group as no meeting had taken place since the committee last met.

The Medical Education Committee minutes and assurance report were taken as read. The Committees attention was drawn to the positive training survey data which showed no concerns, the strong recovery element involved in the meeting and the groups focus on delivering training which is all on track. Thanks were expressed to Soraya Mayet.

The Workforce Insight report was received showing that overall, the data is positive given the current circumstances and the challenges faced from the pandemic. Following the excellent presentation at an earlier Governors meeting on training and development a discussion was held on statutory and mandatory training compliance in terms of what could be done for those that are still showing low completion rates. The Committee agreed that a focused piece of work on non-compliant training areas was needed and this is to be brought to the next meeting in November highlighting the actions to be taken and trajectories for compliance.

The Risk Register was noted and thorough work had been done to update the register, further work was needed on some risks in terms of clarification.

No policies were presented for approval.

The Hard to Fill Recruitment Task and Finish group update was presented to the Committee. The Committee were asked to note that the group still meet monthly to progress further with the improvements that have already happened including the nursing team that is now fully recruited to as well as getting the nurse transfer policy implemented and progressed. The Committee felt assured that the group continues to have good focus and the finance supporting this from the finance and investment committee is helping.

Framework of Quality Assurance for Responsible Officers and Revalidation report was brought to the committee for approval. The Committee agreed the report which will now be signed by the CEO and presented in the board assurance reported for information.

Humber Teaching NHS Foundation Trust

Minutes of the
Workforce and Organisational Development Committee
Held on
Wednesday 21st July 2021
14:00-16:00pm
Microsoft Teams

Present:
Members:

Mr Dean Royles (DR)	Non-Executive Director Chair
Mrs Lynn Parkinson (LP)	Chief Operating Officer
Mr Francis Patton (FP)	Non-Executive Director
Professor Mike Cooke (MC)	Non-Executive Director
Mrs Hilary Gledhill (HG)	Director of Nursing
Peter Baren (PB)	Non-Executive Director
Steve McGowan (SMc)	Director of Workforce and OD

Other attendees:

Mrs Karen Phillips (KP)	Deputy Director of Workforce and Organisational Development
Dr John Byrne (JB)	Medical Director
Abbie Hudson (AH)	Senior HR Business Partner (from 15:00 to 15:34)
Miss Jessica Norton (JN)	Personal Assistant (Note taker)

56/21	**Apologies for Absence** Ms Katy Marshall (KM) Head of Learning & Organisational Development
57/21	**Declarations of Interest** None declared.
58/21	**Minutes of the meeting held on 12th May 2021** The minutes of the meeting held in May were accepted as an accurate record subject to addition of action on page regarding a request for Mr Beckwith and Mr Omand. Also requires changes to the plan sentence from 'being' to 'been', change turnover from takeover and one Mr Cooke to add an e.
59/21	**Action Log** Action Log was reviewed and discussed. It was noted that the action list was smaller than in other committee meetings. Committee agreed that this was a positive as actions are been completed in a timely manner.
60/21	**2021 Staff Survey (Medical Director)** Dr Byrne gave a presentation to the committee on the medical directorate's staff survey results. The presentation covered the directorate's strengths, engagements scores, opportunities for improvement, must improve areas where areas scored below 40% and future plans. To help maintain and improve on last year's scores, the directorate's plans include giving people rest as well as focusing on keeping people on leadership programmes, doing team-based activities as part of the recovery plan, and moving forward with the good work that was done last year. The directorate have seen positive results with the leadership programme. In terms of the low scoring patient safety scores, though the team have never had any disciplinaries, they can be involved in them and due to working in complaints; the team may have found patient and service user's safety problems more common in their line of work. Professor Cooke said that the directorate have good results considering it was done during the first

	lockdown. Dr Byrne stated that his team have done a good job. There is a lot of leadership and the softer things the team do in terms of engagement which are important as is the quality improvement piece which is coming through. He added that the team also contributed operationally during COVID including helping with vaccinations etc. Mrs Parkinson agreed that the team's contribution as part of the EPRR response was a huge asset. Dr Byrne added that it is great having the HR business partners who help the conversations with the teams. Dr Byrne expressed interested in the upcoming deep dive agenda item as he would like to see if career opportunities are part of the leaving reasons and whether this will improve now that leadership courses are available. **Resolved:** Presentation was noted.
61/21	**Chairs logs from any groups reporting to this committee** a) Mrs Parkinson updated the committee on the progress of the Staff Health, Wellbeing Engagement Group. The report and workplan included in the papers were taken as read. Mr Royles commented on the high levels of engagement at the meeting. Mr. Patton noted on the work plan that some sites haven't responded to the request for details on the work needed on their kitchens and breakrooms. He added that the plan is good but there are a lot of actions with a completion date in June, July and August yet they are still open. He would like to see what impact these have had once completed, if completed. If not, what are their new completion dates. Mrs Parkinson confirmed she will reflect that in the next committee update. Mrs Parkinson states that the kitchens were flagged as area of concern and this is being taken forward by the estates team. Mr Royles said that it was good to hear debates on the items put forward at the meetings and how invested people are in the group. Mr Baren stated that Charitable Funds Committee had previously discussed the application for the together fund which is for staff, health and wellbeing and wondered how the group was contributing and how it will benefit staff once the funding is received. Mrs Parkinson confirmed that the funding is fully connected to the groups work and the new health and wellbeing role is part of that. Mr McGowan added that the funding is in the action plan and is integral to improve things. Professor Cooke said that £66k for two years is good and Charitable Funds Committee supported the funding. Mrs Parkinson thanked Professor Cooke and said that the work is evidence of how we support staff. She added that there is more to do in relation to this but glad that we can see the change. Mr McGowan agreed with Mrs Parkinson and that the staff survey is a good indicator of the good work ongoing and the improvements going in the right direction. b) Mrs Phillips updated the committee on the progress of the Equality, Diversity and Inclusion Group. The last meeting was held on 27th May. There has been consultations and meetings about WRES, WDES and gender pay gap report as well as sharing the EDI annual report. Only challenge is that we have an engaged BAME networks but we have no chairs for the other groups. Professor Cooke was pleased to see the technical reports and that the group had had chance to debate. Professor Cooke queried whether the group had reviewed the recovery and restore plan and whether, in terms of no chairs, is there support and mentoring opportunities to develop someone into these roles? Mrs Phillips said that John Duncan has being supporting the networks and he has developed a framework to support chairs in navigating the process. She confirmed that there is the opportunity to support and mentor someone through the chair process and there is already someone keen to step into the LGBT chair role. In terms of the recovery plan, Mrs Phillips said that equality, diversity and inclusion as well as health and wellbeing will be a thread through the plan and as such, it is a topic of conversation. To date it has yet to be fed into the Equality, Diversity and Inclusion meeting but will plan to do so at next meeting. Mr Royles was pleased to see the commitment from the groups as a lot of the work can be thankless. To aid the chairs, a budget has been agreed for networks to have administration support. Mr Patton said well done to the unspecified entries and queries how the Equality, Diversity and Inclusion event went. Mrs Phillips confirmed it was well received with good speakers.

	c) Dr Byrne updated the committee on the progress of the Medical Group. The minutes were attached for reference and taken as read. He said that the group are in a hiatus period to get ready to go live in late August. The inductions for doctors will start in August and this seems to all be going to plan. Mr Patton said it is a great report and that he likes the work Gillian Hughes has submitted for. He was disappointed that we do not have the capacity to take more on in terms of GPs. Dr Byrne said that this is an issue across Hull as we have lost quite a few GPs and the medical school has been expanding but they have not checked that trusts can pick up the slack. There are organisations which are increasing their intake figures but not checking that others can support them. In terms of the Workforce Committee frequency, a review of the frequency of the meetings is being considered. Should the committee agree to change the frequency to quarterly, the work plans of the committee and those that report to the committee will need to be changed to reflect this new frequency. **Resolved:** Chairs logs were welcomed and noted.
62/21	**Workforce Insight Report** Workforce insight report was taken as read. Highlights include: • Slight increase in turnover and sickness but still better than previous years • Statutory mandatory training is on target • Appraisal window is working well with window due to close end of the month. • There are concerns around those Statutory mandatory training courses which haven't got the compliance rates needed. The concerns are covered at Operational Delivery Group, Executive Management Team meeting and at accountability reviews to push the message out there to services. In terms of the compliance, this is in context of recovery and delivery of services in difficult times. Committee noted that there is movement in the right direction in terms of compliance. They also noted that, for nearly all outstanding DBS checks and training, the staff have already had training and checks it is just their refresher training that is out of date rather than not having any check or training at all. Mr Patton added that at Barnsley, they adjusted some of the targets considering the impact and pressures of COVID to give people more space. He further added that the Trust has seen an increase in turnover and sickness and though we are performing well, we need to keep monitoring these figures. Mr Patton asked whether, if we took out the TUPE staff from Whitby from the turnover figures, what would they look like and, on apprenticeships, do we take them all on at the end? Mr McGowan confirmed that the Trust does take on all apprentices at the end of their apprenticeships. All those appointed have a guaranteed role at the end of their course. In terms of the TUPE, Mr McGowan confirmed he will look at what the figure is and send it around the committee. Mrs Parkinson added that, for the target reduction and lengthening of the renewal, she is aware that pressures are high, but she does not want to create an operational task where the training outstanding gets higher. Professor Cooke was pleased to see the 129 staff who were externally recruited. He queried whether there are any trends in terms of where we are doing well? Additionally, he queried for those rule breaks, are there any repeat offenders? Mr McGowan said that, in terms of recruitment, this is positive for the Trust. He stated that he isn't aware of any trends. Mr McGowan drew attention to the recruitment team report which shows recruitment was high in primary care and children's divisions with unplanned and planned mental health not far behind. The report showed nurses had 48 new starters. Those services with vacancies are putting them out to advert and TRAC is allowing the recruitment team to report on vacancy and fill rates. Mr McGowan added that there is a concern on those doing over 60-hour weeks. There is a good monitoring process in place for rule breaks with most of those reported are staff that have being making a conscious decision to do the extra hours with manager sign off. This isn't therefore poor management but desperation to fill shifts. Professor Cooke asked about whether this concern is part of the safer

	staffing report to make sure it is monitored closely? Mrs Parkinson agreed with Mr McGowan that the services have the operational management and governance around rule breaks, with some having to be authorised by Mr Parkinson directly. In terms of looking at those repeatedly working, this can be seen in the reports. It is difficult when you must balance recovery but also cover empty shifts. This is the managers biggest concerns and as such looking to increase the substantive bank and in Mental Health unplanned, they are looking at other ways to address this issue. It is a worry but have window of opportunity to increase bank before winter pressures set in. Mrs Gledhill added that test track and trace is causing issues as it is pinging staff to isolate so staffing levels and absences are worse now than when in lockdown. There is some guidance out on this which has come out today to all staff at the Trust. The Trust are aware that staff are under significant pressure to cover shifts. Mr Baren asked about hard to recruit vacancies including consultants and nurses. He queried what the position would be in the future and whether there would be a marked increase or would we be staying still due to low retention rates. Dr Byrne said that for consultants, they will be at 20% and so far, they have had great success achieving this. For GPs, they are a highly mobile workforce, so staff do come and go. Mrs Gledhill drew attention to the glide path included in the paper further on the agenda. She highlighted that they have had more nurses joining than planned but unfortunately more are then leaving. She stated that the work the team are doing on international recruitment is going to help increase figures and see more come in than leave but there still is a piece to be done on retaining staff. Mr McGowan added that they have freed up capacity in his directorate to put in a manager of bank role. Graham Hickson has started in this position and is making strides in this and hopefully this will be a push to get more on the bank. **Resolved:** The report was noted. **Establish the turnover figure without TUPE staff included and send around the committee. Action: SMc**
63/21	**Risk Register** The risk register was taken as read. Professor Cooke asked whether a short time risk of the test track and trace app on workforce would be worth adding. Mr Patton added that those conversations around pressures need to be kept an eye on it terms of its amber status. Committee noted that, on those additional actions, they are to be completed now or by next meeting so the committee will look for an update at next meeting on what impact they have had on the scores. Mrs Parkinson confirmed that the test and trace risk was picked up at Operational Delivery Group and Oliver Simms is taking that risk forward. Mrs Phillips confirmed that her and Oliver did have discussion and will see movement at next meeting on those actions Mr Patton raised. **Resolved:** The risk register was noted.
64/21	**Policies** No policies presented
65/21	**2020/21 Leavers Deep Dive** Miss Hudson presented the leavers deep dive to the committee. The leavers deep dive is scheduled to take place every six months with the sickness deep die being brought to the next committee meeting. The paper was taken as read and the highlights included: • The Trusts leavers position has improved between 1st April 2020 – 31st March 2021 • There was a reduction of turnover by around 2% from 12.6% to 10.53% • There was a reduction of vacancy rates by 4.5% from 14.53% to just above 10% • There was a reduction of sickness absence from 5% to 3.5% • The trust had lower turnover across the Humber Coast and Vale and the national average • In terms of length of service, majority who left had 3-5 years' service except for nursing which was around 1-2 years' service. • Most leavers were in the Scarborough and Ryedale region. Of those who were TUPE, the leavers had 10-20 years NHS experience.

	• Highest reasons for leaving were retirement, promotion opportunity and then work life balance. End of contract or to take on training were close behind. • 18% of leavers left and came back of which 10% were retiring and return. • Quarter of total leavers were nurses with highest in primary care closely followed by children's and LD division. Mr Royles said that the report shows some good data. Mr Patten added that it is an excellent piece of work, but he would like to know what the Trust is going to do next with this information. Professor Cooke agreed with Mr Patton on the well-presented report. He asked what Mrs Parkinson is worried about from an operational aspect. Mr Royles found the report interesting in terms of the difference between planned and unplanned leaving reasons. He was also interested about those that put career development as a reason, but he is aware that work is underway on this aspect. Mr McGowan said that, in terms of what is next, some of the work was for Mrs Parkinson to have intelligence on what has happened so she can have conversations with her managers. The HR business partners can also use this data to speak to managers to see what can be changed to improve this going forward as the work needs to be done at a service level to improve the position and the challenges need to be made at that level rather than higher. Miss Hudson echoed what Mr McGowan said about having the conversations with managers to feed into their action plans with the services. Miss Hudson said that they are looking at the data in terms of age range of staff to identify the level of the aging workforce and to try and level it by driving the apprenticeship policy and working smarter to even the age gap. Mrs Parkinson confirmed that this has being shared with her managers and there are already plans in place. Committee agreed that it is a helpful report which leads to asking more questions. The report shows the benefit of exit interviews and lets areas get into detail of staff absences. Mrs Phillips agreed with Mrs Parkinson and that need to bring in softer intelligence. In terms of the deep dive, people are happy with the content and context of the report. Mr Baren wants focus on the actions rather than the figures. Mr McGowan confirmed that this report has been available for a couple of months now and as such actions are already underway in terms of bank work and other actions to help retention rates. Dr Byrne said that we have improved acquisitions but queried whether it is now time to check if we understand the challenges that would appear later down the line. He added that we seem to always ask finance and quality questions, but do we ask workforce questions. Mr Royles agreed that this would be a good challenge moving forward. Mr Patton supported Dr Byrne on this. Mr Patton felt assured on this but felt that we just need to be assured on what we are doing on it. **Resolved:** The report was noted.
66/21	**EDI Annual Report** Mrs Phillip presented the paper to the committee. The report taken as read. The paper gives a good review and reflection on the previous year. The paper was a collaboration with Dr Byrne and Mandy Dawley. Highlight was drawn to the summary of WRES and WDES and the progress and improvements made. Mr Patton expressed thanks to those who prepared the report. He noted the huge amount of information which is included in the report. He suggested a one-page diagram summarising the issues, what has been done and what can be done. He notes that the information is in the report, but it is information heavy and it would be good to reduce it as a one-page summary for the organisation. Professor Cooke confirmed that the report will be coming to the quality committee. He noted that on page 192 for the NHS employers there is an infographic for the whole NHS so could use this as template as Mr Patton suggests. He agreed with Mr Patton's suggestion as a one-page summary would give entry points for those less technical. Thanks were given to John Duncan and Mandy Dawley on how they work together **Resolved:** The report was noted.
67/21	**WRES and WDES 2021 Reports**

	The reports were taken as read. Targets and objects have been consulted upon as part of Equality, Diversity and Inclusion group. Decision has been made to keep this at high level as appreciate people are busy. **Resolved:** The report was noted.
68/21	**Gender Pay Gap Report** Mrs Phillips presented the update. There has been no major change to the report and comparatively the Trust is in a good position compared to the national average. The aim is to put all the actions into one plan which will then feed into the workforce plan and Equality, Diversity and Inclusion plan so everyone can see them all in one place. **Resolved:** The report was noted.
69/21	**2021/22 Workforce Plan** Mrs Phillips updated the committee on the workforce plan. The plan has moved forward since 2019 and has come on a long way with huge engagement by those involved. Mrs Phillips expressed thanks to the HR business partners who have worked tirelessly on this as well as Mrs Parkinson for her support of the process. There is growth in establishment but there is still work to be done in terms of improving skill mix and working with managers to capture this. The team have built a review process into the plan with managers and will continue to emphasise collaboration with leads moving forward. Mr McGowan confirmed that action 7.2 changes links in with the Finance and Investment Committee and he provided clarification on action 7.6 budget reduction. Professor Cooke noted that the plan is bigger but only covers one year. He suggested the Trust look at the future to cover more long range for those due to retire in the next 3-5 years. Mr Royles said that the Integrated Care System will be looking at a 5-year workforce plan so will be conversations at Integrated Care System level as well as Trust level. Mr McGowan confirmed that he would be happy to talk about this in the system. **Resolved:** The report was noted.
70/21	**Safer Staffing Report Oct 2020 – March 2021** Mrs Gledhill presented the safer staffing report to the committee. The report was taken as read. The report covers data during the pandemic and the Trust has come out well in terms for number of staffing incidents reported and shows that the safety rates were maintained. The Trust Board get monthly updates in terms of the dashboards and this report will be going to the Trust Board next week. Work needs to be done to update rosters so looking to pull through new roles including nurse associate roles as well as band 6s on shift. That work on rosters has started with Tracy Flanagan and Claire Jenkinson. Committee agreed that it is a pleasing report considering the pandemic circumstances. **Resolved:** The report was noted.
71/21	**Recruitment Task and Finish Group** Mr McGowan presented the updated plan for May which was circulated around the committee prior to the meeting. Some of the content of the report was previously discussed as part of the insight report. The committee noted the progress made and the good position of the hard to fill roles. Mr McGowan added that the group are committed to monitoring the progress of the hard to fill roles. They have achieved last year's target in terms of recruitment but due to retention the difference isn't as noticeable as would like. There are some areas which, due to being a small staffing group, a small change can change the figures dramatically. Mr Royles added that there is money in the system in relation to retention to get programmes in with little or no programmes been seen in primary care and GP. He wondered whether offering a pilot in those areas may help the Trust get access to some funds. Mr McGowan liked the suggestion and will speak to Jane Hawkard and Helen Cammish.

	Resolved: The report was noted. **Mr McGowan to investigate funding available in the system in relation to retention** **Action: SMc**
	Trust Reset and Recovery Plan An overview of the Recovery Plan was delivered by Mr McGowan. The plan was taken to Executive Management Team meeting and signed off. All suggestions were put into the plan and most were supported to aid recovery of individuals or services. The money has now been given to those approved in the plan and managers have being actioned to spend the money on what they wanted it for. This work links in with the Finance and Investment Committee in terms of the money been spent. Mr Royles added that a lot of organisations are doing a lot, but this is the first he has seen where it has been done in a report which is a good way to present the work. **Resolved:** The report was noted.
73/21	**To Review the Meeting** Committee agreed that it was a good meeting with good discussions and good papers with good executive input. Professor Cooke stated that this would be his last workforce committee meeting before he retires. He feels that this meeting is a meeting which has come a long way and is now seeing progress. Mr Baren added that it is great to see that this committee exists and the focus it has. Some at the committee where originally worried that there may be too much data than analysis at the meeting, but the meeting has shown that this is not the case and shows the hard work that is put in by all that attend and contribute to the papers. Thanks were given to Professor Cooke for his input to the meeting and the knowledge he has brought to the committee and the Trust as a whole.
74/21	**Any Other Business** No other business raised.
75/21	**Date and Time of Meetings in 2021:** Wednesday 15th September 2021 2-4pm Wednesday 17th November 2021 2-4pm

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Agenda Item 15

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
Title of Report:	Mental Health Legislation Committee Assurance Report following meeting of 05 August 2021.
Author/s:	Name: Michael Smith Title: Non Executive Director and Chair of Mental Health Legislation Committee
Recommendation:	To approve: ; To receive & note: ✓ For information: ✓ ; To ratify:
Purpose of Paper:	The Mental Health Legislation Committee is one of the sub Committees of the Trust Board This paper provides an executive summary of discussions held at the meeting held on 05 August 2021 and a summary of key issues for the Board to note.

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

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

Key Issues within the report:

Please ensure you also complete the monitoring and assurance framework summary below:

- Steering Group working effectively and has been quorate for last few months.
- Mental Health Legislation Performance Report shows all areas seem to be within tram lines; any concerns are escalated to Committee by the Operational Steering Group.
- Received Quarter 1 RRI report and noted PATS and DMI training were getting back on track as a new venue had been sourced regarding social distancing
- Excellent presentation from CQC – extremely valuable to know how to use data in terms of patient improvement and best practice.
- Committee to seek Board approval for the decision to not exclude Governors in the criteria to be a Hospital Manager.

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	

Key Issues:

Committee noted key items and assurances:

- Insight report – Trust fully involved in 2 consultations: Mental Health Act Review and Mental Health Units Use of Force Act 2018.
- Out of area – Committee had a long discussion and heard how the figures correlate with the reduction in bed base. Committee assured that subject to infection rates we will succeed in achieving repatriation and figures appear to be showing that.
- Quarterly performance report – all areas seem to be within tram lines and, as previously reported above, out of area placements. No S4s for 4 months in a row. Operational steering group receive more in depth data for discussion and escalate any concerns to the Committee.
- Noted RRI report and made linkages with closed cultures work. It was reported that PATS and DMI training were getting back on track as a new venue had been sourced regarding social distancing. We were pleased to hear of the reestablishment of the RRI patient group.
- Chair asked about the patient council and whether he could attend. Committee was pleased to receive case studies and see pictorial work which helps bring reports to life.
- Closed cultures – Committee commended the poster and web page and were interested in taking some steps towards how this work could be communicated regarding Learning Disability and dementia patients.
- Exclusion criteria of Hospital Managers – Committee agreed Associate Hospital Manager (AHM) issue was not an issue – reviewed policy, which currently states governors can't be hospital managers because of potential conflict of interest however Committee perceived this to be more of a theoretical risk as opposed to an actual one. This was a legacy decision set which says that governors could not be AHMs – Committee reviewed and agreed no conflict of interest. Committee to seek Board approval for this decision.
- CQC presentation – excellent presentation from CQC – extremely valuable to know how to use data in terms of patient improvement and best practice. Discussion around proactive use of data and what stories we can tell with the data we collect. It was clear

that the CQC wanted to be able to utilise the data to the best advantage. Simon Plummer, MHA reviewer, will be our permanent lead and wishes to build on the positive relationship established with his predecessor, Laura. Also a new MHA Reviewer will be starting from the beginning of October.

- Noted that the CQC are currently looking at S136 timescales for assessment.
- Noted policy list up to date.
- Noted the work of the steering group - Committee was satisfied from scrutinising the steering group minutes and report that sufficient oversight was in place with regard to operational performance aspects of the MHA.

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Agenda Item 16

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
Title of Report:	Audit Committee Assurance Report
Author/s:	Name: Peter Baren Title: Non Executive Director, Chair of Audit Committee
Recommendation:	To approve: ; To receive & note: ✓ For information: ; To ratify:
Purpose of Paper:	The Audit Committee is one of the sub committees of the Trust Board. This paper provides an executive summary of discussions held at the meetings held on 10 August 2021 and a summary of key issues for the Board to note.
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: ; Other (please detail) Assurance report: ✓
Key Issues within the report:	Identified in 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	

Executive Summary - Assurance Report:

A meeting of the Audit Committee took place via MS Teams on 10 August 2021. It is a requirement of the Terms of Reference and the NHS Audit Handbook for an assurance report to be prepared for the Trust Board as soon as is practical after the meeting takes place and presented at the next Trust Board meeting.

Key Issues:

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

Internal Audit Progress Report (Audit Yorkshire)
Counter Fraud Progress Report
Update on progress of Counter Fraud recommendations
External Audit Progress Report
Procurement Activity Report
Tender Waiver Update
Insurance Provision
Actuary Report
Board Assurance Framework
Trustwide Risk Register and Primary Care/Community Services RR Deep Dive
Information Governance Assurance Report and Minutes
Information Governance Annual Report
Cyber Security Update
Virtual Establishment visits
Emergency Preparedness Resilience and Response Assurance Process
Update on any changes to Contracts/Agreements

Risks and Major Items Discussed

Five final Audit Assurance Reports from the 20/21 workplan were received and discussed, and one relating to 21/22.

Clinical Governance Arrangements	**Limited Assurance**
Board Assurance Framework	**High Assurance**
Performance Reporting and Management	**High Assurance**
IT Patch Management	**Significant Assurance**
Nurses Revalidation	**Significant Assurance**
Data Security and Protection Toolkit Stage 2 20/21 submission	**High Assurance**

The Committee were assured that the reports overall were demonstrating a very satisfactory level of assurance and that the actions were reasonably short dated. On each report where actions had passed their due date, then those had been completed. With regard to the Clinical Governance audit, there were a number of risk actions recommended, most of which were already implemented.

Updates were received regards the status of the 21/22 Plan, which was generally on track subject to a minor amendment to the timings, which was accepted..

The analysis of outstanding Internal Audit recommendations showed that one was outstanding for 19/20 and 18 for 20/21 (out of 74), with 6 of those showing a revised implementation date. This was agreed as working well, although it was re-emphasised that revised dates must be approved by the Executive Management Team (EMT).

The Counter Fraud report contained an update on counter fraud activity and progress against the agreed work plan. The 20/21 Annual Report was presented and discussed, which was in line with previous reports and 'in the mix' when compared with other Trusts. The results against the Counter Fraud Functional Standard Return were discussed and accepted. Two Proactive reviews had been performed, and a number of recommendations made, which were all in hand. The system for managing the follow up of these recommendations has now been changed to broadly follow the system used in the Internal Audit recommendations follow up. A significant improvement in the implementation rate was anticipated for the next meeting. A number of fraud alerts had been issued in the period, with no evidence that the Trust had been a victim of any. One 'working while sick' referral was still being investigated.

The external auditors confirmed that the yearend sign offs had been completed with the exception of Value for Money (VfM), which was in hand.

The Procurement activity had been over £40m in the 6 month period, with systems working well. The Committee heard about the team's involvement in recruiting overseas Band 5 nurses, which was encouraging. Three new single tender waivers have been issued since the last report. These related to telephone/IS support from MIND (£396k), IT services to Yorkshire & Humber Care Record (YHCR) (£180k) and Adult Mental Health inpatient bed provision (£282k). The Committee will have a further review of the level of single tender waivers at the next meeting after the changes to the report detail has been implemented and an Operational Delivery Group (ODG) group have further reviewed the prior period waivers..

The Insurance provision review highlighted the additional cost of Clinical Negligence insurance, up to £634k from £494k last year. Most of this increase related to claims experience.

The Actuary report on the Local Govt Pension Scheme was received and discussed. The reasoning behind the increase in the balance sheet provision, to £3.5m from £1.2m was noted, and generally related to the assumptions made on inflation and discount rates, which were consistent with other schemes. Further analysis of members was requested for the next meeting.

The Q2 working version of the 21/22 BAF was presented, with progress against each of the six Strategic Goals. While these were all considered, the Committee has specific oversight of Goal 3, which was discussed in more detail as well as some presentational suggestions.

The seven risks on the Trustwide risk register were tabled and discussed. It was noted that four of the seven Group risks related to workforce, one to Finance and two operations. Some clarity on the closing of previous actions and the related effect on risk was requested for the next meeting, along with any movement in the risks from period to period... Nine risks rated at 12+ were included on the Primary Care and Community Services risk register, and the systems/plans to manage these explained and discussed in detail with the divisional representative. The assurance was accepted and it was clear that the register was an active, living document with constant review. An update on the Mental Health Services division risk register was noted, including the related improvements in scores to last time.

The Cyber Security update was accepted with a more detailed review of the updated actions against the CORS assessment of the Trust to be received at the next Committee.

The Information Group (IG) Annual Report for 20/21 was approved subject to a couple of minor amendments. The Report was very well received and demonstrated good assurance that IG matters were being managed effectively. The report showed that the Trust met the Standards Met Toolkit, all policies were up to date, IG training over 95% compliant, compliance with subject access requests and FOI requests as well as a summary if incidents, follow up and reports to the Information Commissioners Office (ICO). An increase in resource was noted and the burden on both the team and clinical staff in meeting the Subject Access Requests (SARs) was seen as a more general issue on which some group lobbying may be useful, as there is no cost involved in raising a SAR, but a significant cost in dealing with them. It was agreed that the final report be shared with other Board members.

The IG group minutes were accepted and the Confidentiality Code of Conduct was ratified.

The remote work on establishment visits was noted, with good progress made. One internal audit establishment visit could be planned later in the year if clinically safe to do so.
.

Agreed actions
A number of actions were agreed at the meeting which have been included in the action list.

Matters deferred for future consideration
While all above reports were received there were a number which require follow up action as noted above

Matters to be brought to the attention of the Trust Board
The main areas for the Board to note/approve are:

The high levels of internal audit work and recommendations
The approval of the Information Governance Annual Report
Increased Clinical Negligence insurance cost

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Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
Title of Report:	Humber Coast and Vale Specialised Mental Health, Learning Disability and Autism Provider Collaborative – Commissioning Committee Report
Author/s:	Peter Baren Non-Executive Director and Chair of the Commissioning Committee
Recommendation:	To approve: ; To receive & note: ; For information: √ ; To ratify:
Purpose of Paper:	The 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 Tuesday 24 August 2021 and a summary of key points for the Board to note.
Governance:	Audit Committee – Date: ; Remuneration & Nominations Committee – Date: ; Quality Committee – Date: ; Workforce & Organisational Development Committee – Date: ; Finance & Investment Committee – Date: ; Executive Management Team – Date: ; Mental Health Legislation Committee – Date: ; Operational Delivery Group – Date: ; Charitable Funds Committee – Date: ; Other (please detail) *Commissioning Committee* – Date: *24 August 2021*
Key Issues within the report:	**Partnership Agreement** Final draft has been shared with provider partners the final draft reflects all comments received with no significant change to the previous version reviewed by the Trust Board in July 2021. **Financial Due Diligence** Regional NHS E Director of Finance has shared written confirmation of the additional funding to be allocated to the Provider Collaborative following rigorous due diligence process. **Go Live Date** Planned for 1 October 2021. The main outstanding issue is the funding of Enhanced Packages of Care – which NHS E regionally are awaiting a national solution.

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 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 August 2021:

Insight Report

Insight Report was shared with the Commissioning Committee which provides a summary of activity during the last quarter and national update on Provider Collaborative. The committee noted that initial information regarding Phase 2 of Provider Collaborative has been shared by NHS E with further updates regarding timescales to follow.

Finance

NHS E have now written and allocated additional finance resource to the original finance offer. However, growth for CAMHS and AED has been withdrawn and this has been pushed back to NHS E/I. We await a national NHS E solution to the funding of Enhanced Packages of Care (EPoC).

Quality Assurance and Improvement

Draft Governance framework and metrics report has been shared with providers for comments. Serious Incident Process is nearing completion and will be shared at the next Commissioning Committee.
TUPE of NHS E Case Managers – 2 Band 8A Case Managers will TUPE on 1 October. A vacant Band 7 case manager – funding will transfer, and will the committee support the proposal to increase the grade to Band 8A as this will be a post for CAMHS and AED and due to current complexity with CAMHS it was viewed

this to be a more appropriate grade.

Work Streams

CAMHS

- Number of young people receiving care outside of natural clinical flow had increased to 12 at 13.8.2021 but has since reduced to 10. Of which 3 young people are in receipt of Low Secure CAMHS. If Mill Lodge and Inspire were fully operational and did not have the current staffing issues, then the remaining 7 young people could be cared for within HCV in-patient services.

- Continued significant pressure on both community and in-patient teams due to increased referrals and acuity.
- Mill Lodge are exploring the developing dedicated day care to provide alternatives to in-patient admission.

Adult Eating Disorder

- Currently 2 people in beds outside of HCV. We are continuing to review these placements with NHSE to ensure timely discharge and that no new admissions are made outside our natural patient flow
- No delayed discharges reported
- FREED Champion - business case has been drafted and service specification is in draft with key partners for consultation prior to sharing with the adult eating disorder work steam meeting
- Schoen Clinic have agreed to offer post discharge follow up to people from HCV to ensure prompt timely discharge and provide support to community teams.
- NHS E have commissioned a further 2 beds from NAViGO – Rharian Fields – this is short term to support Midlands and south of England who are struggling with bed capacity.

Adult Secure

- Personality Disorder (PD) – it was agreed that providers will progress discussions about the Pathway development Service (PDS) reviews of all ONCF PD diagnosed patients.
- Learning Disability and Autism (LDA) – We have met with the Transforming Care Partnership (TCP) leads to compare patient lists of all LDA patients within the HCV and have agreed that the TCP leads will regularly share patient pathway information to ensure that our information is as up to date as possible.
- Single Point of Access (SPA) – The service specification for the SPA is currently being reviewed by lead provider; this will be shared with the wider PC for comment shortly.

Learning Disability and Autism Pathway Panel

The scope of NHS-Led Provider Collaboratives (PCs) includes AED, CAMHS and adult low and medium secure mental health and learning disability and autism services. Provider Collaborative aim to reduce the use of restrictive inpatient practices and generate savings for reinvestment in the community by bringing people back from out of area to be cared for closer to home, preventing avoidable admissions and designing new models of care which enable people to be supported in the community.
Following discussion with representatives from both the North Yorkshire and York and Humberside Transforming Care Partnership Boards an outline proposal for the new Panel has been shared with both TCP Boards it was agreed that one overall LD and Autism Pathway Panel so that we can strategically review the needs of people with learning disability and autism across HCV. The panel will meet quarterly from September 2021 and NHS E have advised an Annual Report is expected from each LD & Autism Pathway Panel.

Risk Register

The Risk Register was reviewed at the meeting and many of the risk ratings reduced due to the improved

financial allocation and work undertaken on quality assurance.

Partnership Agreement

All partners have now commented on the Partnership Agreement and a final version has been shared to enable partners to share with the Boards during August / September 2021.

Risk and Gain Share will be finalised ready for review by the Trust Board prior to Go Live.

Quoracy
Due to meeting members annual leave, the Commissioning Committee meeting on 24 August 2021 was not quorate.

Humber Teaching NHS Foundation Trust

Agenda Item 18

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting 29 September 2021</td></tr>
<tr><td>Title of Report:</td><td>Patient and Carer Experience Annual Report (2020/2021) including Complaints and Feedback</td></tr>
<tr><td>Author/s:</td><td>Mandy Dawley (Head of Patient and Carer Experience and Engagement)

Susan Cameron (Complaints and Feedback 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>To ask the Trust Board to ratify the Patient and Carer Experience Annual Report (2020/2021) including Complaints and Feedback.

Please access the digital report using the following link:
https://sway.office.com/rmu6aWWV0FmJ8Sp9

A detailed 44-page document has been reviewed in the Quality and Patient Safety Group; it will be published and is available on request.</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>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>11.8.21</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>Quality and Patient Safety Group</td><td>6.7.21</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>Over the past year the Trust has had to change the way it engages and involves our patients, service users, carers, staff and partners in Trust activities including;
virtual church services and virtual awareness weeks have been introduced and have enabled a wider reach of the community
new triage process for complaints has been implemented
virtual patient and carer experience forums have been introduced
By listening to feedback, it has helped us to understand and</td></tr>
</table>

	influence our service provision as well as shape the services we deliver. Key highlights from the past year include: • Virtual forums have led to the co-production of quality improvement initiatives, e.g., a PACE champion is now working with the Trust's Autism services. • Patients feel safe in our care (FFT feedback and Inpatient Mental Health Services survey feedback) • Assessments without leaving the house are valuable, virtual technology is very efficient and has prevented isolation and loneliness, but some people did not feel that they had adequate IT equipment (Trust survey) • The Trust is demonstrating that it is committed to involving all stakeholders by involving patients, service users and carer in recruitment panels (Panel Volunteer) • Browseloud website accessibility tool has seen an increase in use during the past year • The Lord Mayor of Hull awarded the Trust Chaplain with the Lord Mayor's Civic Crown Award for the work she has been doing with virtual services and chaplaincy • A number of the Trust's PACE champions were successful in acquiring Peer Support Worker posts and are drawing upon their own personal lived experiences to provide authentic engagement and support for people accessing our mental health services • NHS England and Improvement invited the Trust to participate in their national storytelling initiative; to share stories of our journey since the pandemic started. **Priorities for 2021/22** Over the next twelve months we will demonstrate improvement based on patient, service user and carer involvement and will achieve this by continuing to deliver the priorities set out in our coproduced five year PACE strategy (2018 to 2023). We will continue to deliver on the initiatives that were implemented because of Covid- 19, e.g., virtual church services and awareness weeks and will pay particular attention to the following key priorities: • We will capture the views of young people by introducing a Youth Board (Humber Youth Action Group). *Source; national networking*

	• We will continue to seek new and innovative ways to collect feedback to inform service redesign and improvements. *Source; Patient and Carer Experience Strategy (2018 to 2023)* • We are listening and we want you to know that you are being heard; we will continue to let you know how your feedback has shaped the services we currently deliver and influence future service provision • We will strengthen our approach to involving carers, families and loved ones in service redesign and improvement by introducing a Carers Involvement forum. *Source; Staff Champions of Patient Experience forum* • We will support our approach to values-based recruitment so that we employ the right staff by continuing to implement the framework to involve patients, service users and carers in recruitment. *Source; Quality Accounts Priority 21/22* • We will actively listen to people from all backgrounds to ensure that the voices of our wider communities are heard to inform service redesign and improvements. *Source; Equality, Diversity and Inclusion priority* • We will commence implementation of the Patient Safety Partners role in line with the National and Trust Patient Safety Strategies (July 2019) • We will develop a Patient and Carer Experience training package to be hosted on the Trust's Recovery College platform to equip individuals with knowledge and information to support them when getting involved in Trust activities. *Source; Patient and Carer Experience Strategy (2018 to 2023)*

Monitoring and assurance framework summary:

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

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

Humber Teaching NHS Foundation Trust

Agenda Item 19

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 29 September 2021</td></tr>
<tr><td>Title of Report:</td><td>Quality Improvement Strategy (2021-2026) – Draft</td></tr>
<tr><td>Author/s:</td><td>John Byrne, Executive Medical Director

Catherine Hunter, Quality Improvement Manager</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td>x</td><td>To note</td><td></td></tr>
<tr><td>To discuss</td><td></td><td>To ratify</td><td></td></tr>
<tr><td>For information</td><td></td><td>To endorse</td><td></td></tr>
</table>
</td></tr>
<tr><td>Purpose of Paper:</td><td>To ask the Trust Board to review and approve the Draft Quality Improvement Strategy 2021-2026.</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>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>08/21</td><td>Workforce & Organisational Development Committee</td><td></td></tr>
<tr><td>Finance & Investment Committee</td><td></td><td>Executive Management Team</td><td>07/21</td></tr>
<tr><td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td>06/21 & 07/21</td></tr>
<tr><td>Charitable Funds Committee</td><td></td><td>Other (please detail)</td><td></td></tr>
</table>
</td></tr>
<tr><td>Key Issues within the report:</td><td>The attached strategy replaces the Quality Improvement Approach and was developed with the support of a member of the Patient and Carer Experience Forum following a consultation with Staff, Patients, Service Users and Carers.</td></tr>
</table>

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Please ensure you also complete the monitoring and assurance framework summary below:	The findings from the consultation enabled the development of the Quality Improvement purpose and priorities for 2021-2026. The strategy covers the following key areas. • A review of the current position of the Quality Improvement programme and achievements to date • Our 12 new priorities, progress towards them, key milestones, and their alignment to the Trust's Strategic Goals • Our approach to the delivery of the programme • How we will measure success A draft sway of the key aspects of the strategy is being developed and can be viewed here. On approval and completion, this will be used on the Intranet and Internet. The Trust Board is asked to approve the Quality Improvement Strategy 2021-2026.

Monitoring and assurance framework summary:

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

Quality Improvement Strategy 2021 - 2026

The journey continues

DRAFT 2

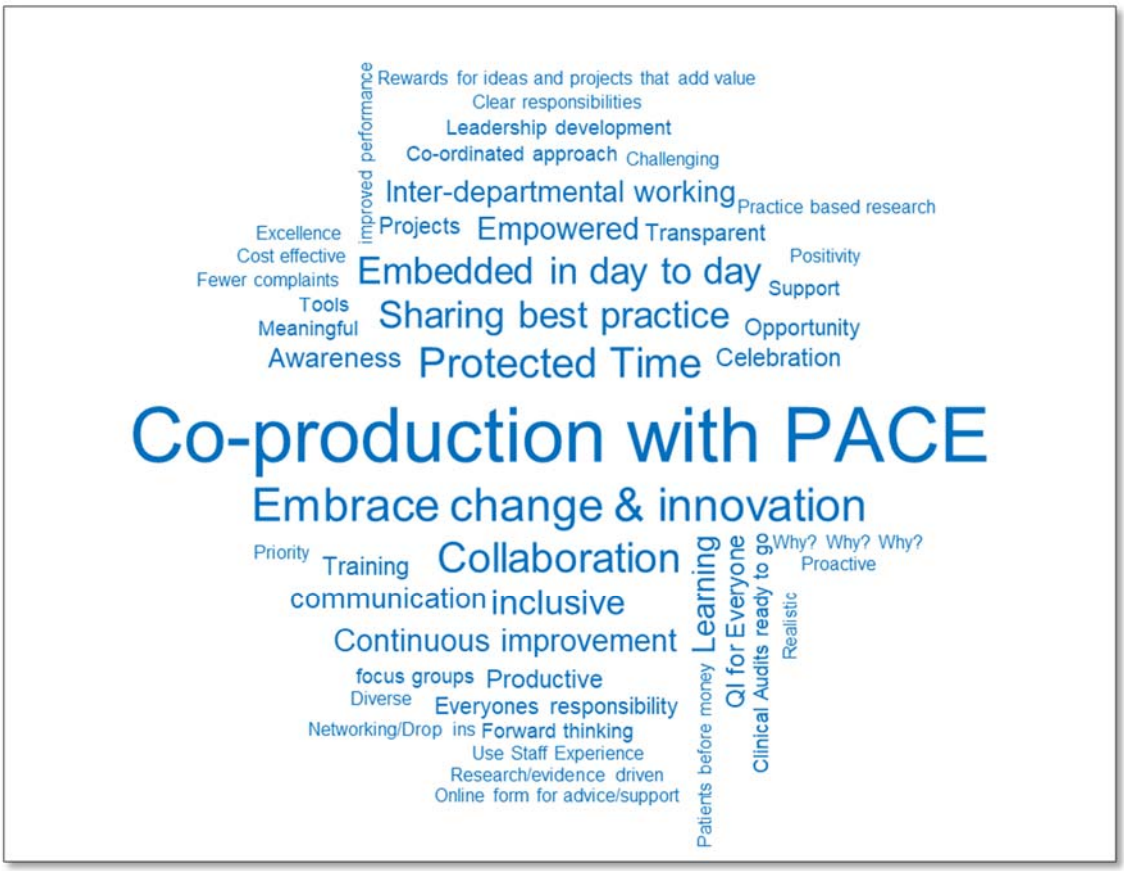

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Table of Contents

1. Foreword

Message from John Byrne,
Executive Medical Director and Lead for Quality Improvement

I am delighted to introduce you to our refreshed Quality Improvement Strategy for 2021-2026.

Quality improvement is central to what we do and all staff, service users, patients and carers should feel empowered to identify an area for improvement and have the right skills and time to deliver it. This strategy outlines how we will progress from the fantastic achievements of our Quality Improvement Approach to further embed the culture of Quality Improvement over the next five years.

With input from our Staff, Patients, Service Users and Carers, our strategy sets out twelve new priorities and a strengthened approach to further embedding a culture of continuous improvement.

This Quality Improvement Strategy alongside our Patient and Carer Experience Strategy, our Patient Safety Strategy and the PROUD leadership programme will continue to support our commitment to improve quality, safety and experience of care.

Message from Elaine Peirce,
Member of the Patient and Carer Experience Forums and Chair of the Carers Advisory Group

The East Riding of Yorkshire Carers Advisory Group (CAG) are very pleased to have been given the opportunity to support the Trust in the development of the refreshed Quality Improvement Strategy. The Trust has, once again, demonstrated their continued commitment to listening to the voices and opinions of Patient, Carers and Service Users to inform their strategies. We look forward to developing this partnership in the future.

2. Executive Summary

Our Purpose:

Quality Improvement will support our patient and carer centred vision for a holistic person-centred approach, which will offer seamless, consistent services and ensure patient involvement in all decisions around care.

Developed by our Patient and Carer Experience Members

Welcome to the Quality Improvement Strategy 2021-2026 which reviews and updates on our Quality Improvement Approach 2018-20 and has been developed with the support of our Staff, Patients, Service Users and Carers.

This document sets out what work has been undertaken over the last two years and outlines how we will continue our Quality Improvement journey for small change activities over the next five years.

The principal of the Quality Improvement approach is that our Staff, Patients, Service Users and Carers are best placed to identify an improvement opportunity and will continuously try to improve how they work and the quality of care and outcomes for our patients. To do this, they should have the skills and feel empowered to undertake the activity using an incremental small step change methodology as provided by the Model for Improvement.

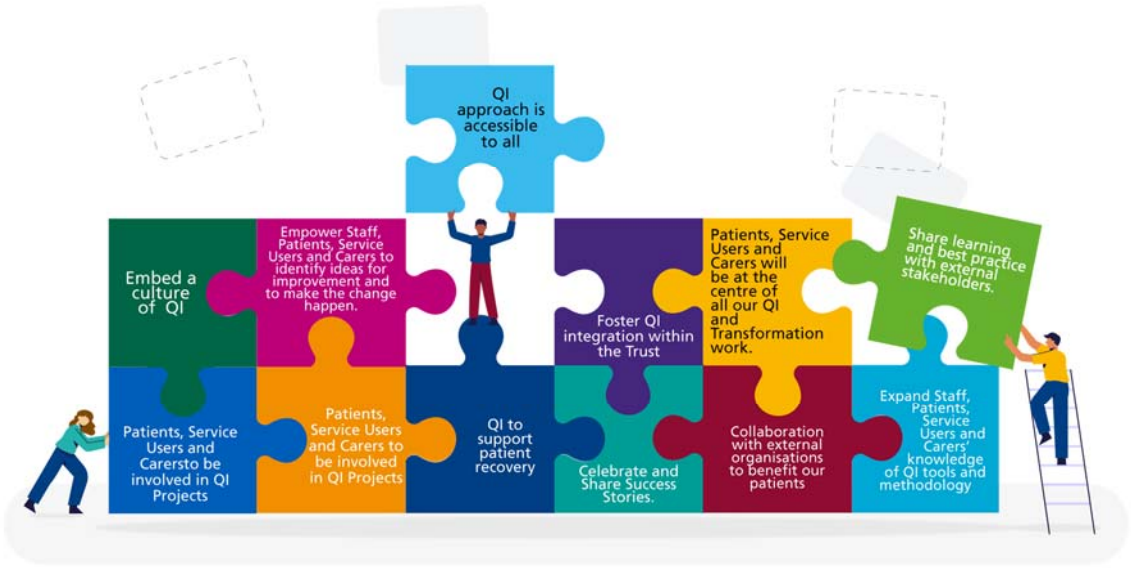
Our Patients, Service Users and Carers identified a key vision for the Trust to have a holistic person-centred care approach and for Staff, and the Patient and Carer Experience and Quality Improvement Teams to support them in achieving this.

In addition to the small-scale improvement activities identified by our Staff, Patients, Service Users and Carers, the Quality Improvement programme will work alongside services undertaking large scale transformational change to ensure improvement methodology is used where appropriate.

Similarly, where we have identified learning from investigating patient safety incidents, we are increasingly utilising improvement methodologies to look at how this learning can shape practice and service delivery. Where possible, Patients, Service Users and Carers will have the opportunity to co-work with the Trust during our service improvement activities.

Our Staff, Patients, Service Users and Carers are at the heart of our organisation and to the Quality Improvement programme and have supported the development of our 12 priorities for 2021-26.

This strategy sets out how we will achieve the priorities through the provision of the tools and support for improvement ideas and the celebration of success.



Progress against the twelve priorities will be monitored by the Operational Delivery Group through

- Quality Improvement Charters from each Division/Directorate
- Training Places
- Patients, Service Users and Carers engaged in our Quality Improvement activities
- Qi Activities undertaken in partnership with other organisations
- Staff survey outcomes
- National Patient and Carer Feedback Scores

Further details are available in Appendix C.

3. Purpose of the Quality Improvement Strategy

Our Quality Improvement Strategy Refresh sets out our approach to the delivery of our vision, mission, and strategy through the delivery of our Quality Improvement programme.

The Quality Improvement Strategy covers the five-year period from June 2021 to May 2026 and covers the continuing journey to embed a Quality Improvement culture and replaces the Quality Improvement Approach 2018-2020. The priorities were updated following a consultation with Staff, Staff Champions of patient and carer experience and volunteers from the patient and carer forums and have been aligned to support the delivery of the Trust's six strategic goals.

The strategy will be supported by an annual roadmap which will outline the key identified priorities and the proposed activities for the year with progress being reported quarterly to the Operational Delivery Group. The roadmap will be continually reviewed and updated to ensure it still reflects the views of Patients, Service Users and Carers and reflects the best way of achieving an embedded culture with the tools available.

The strategy will include

- Further developing and strengthening the approach to embedding a culture of Quality Improvement
- Training and Support to those delivering improvements activities
- Celebration of success through Quality Improvement Forums, Quality Improvement Weeks and communications
- Quality Improvement Conference to share good practice and success both internally and externally
- Joint working across the Trust
- Ensuring that Patients, Service Users and Carers are at the centre of the Quality Improvement approach

4. Our Mission, Vision and Strategic Goals

Mission

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

Vision

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

Values

CARING for people while ensuring they are always at the heart of everything we do.

LEARNING and using proven research a a basis for delivering safe, effective, integrated care.

GROWING our reputation for being a provider of high quality services and a great place to work.

Strategic Goals

Innovating quality and patient safety

Developing an effective and empowered workforce

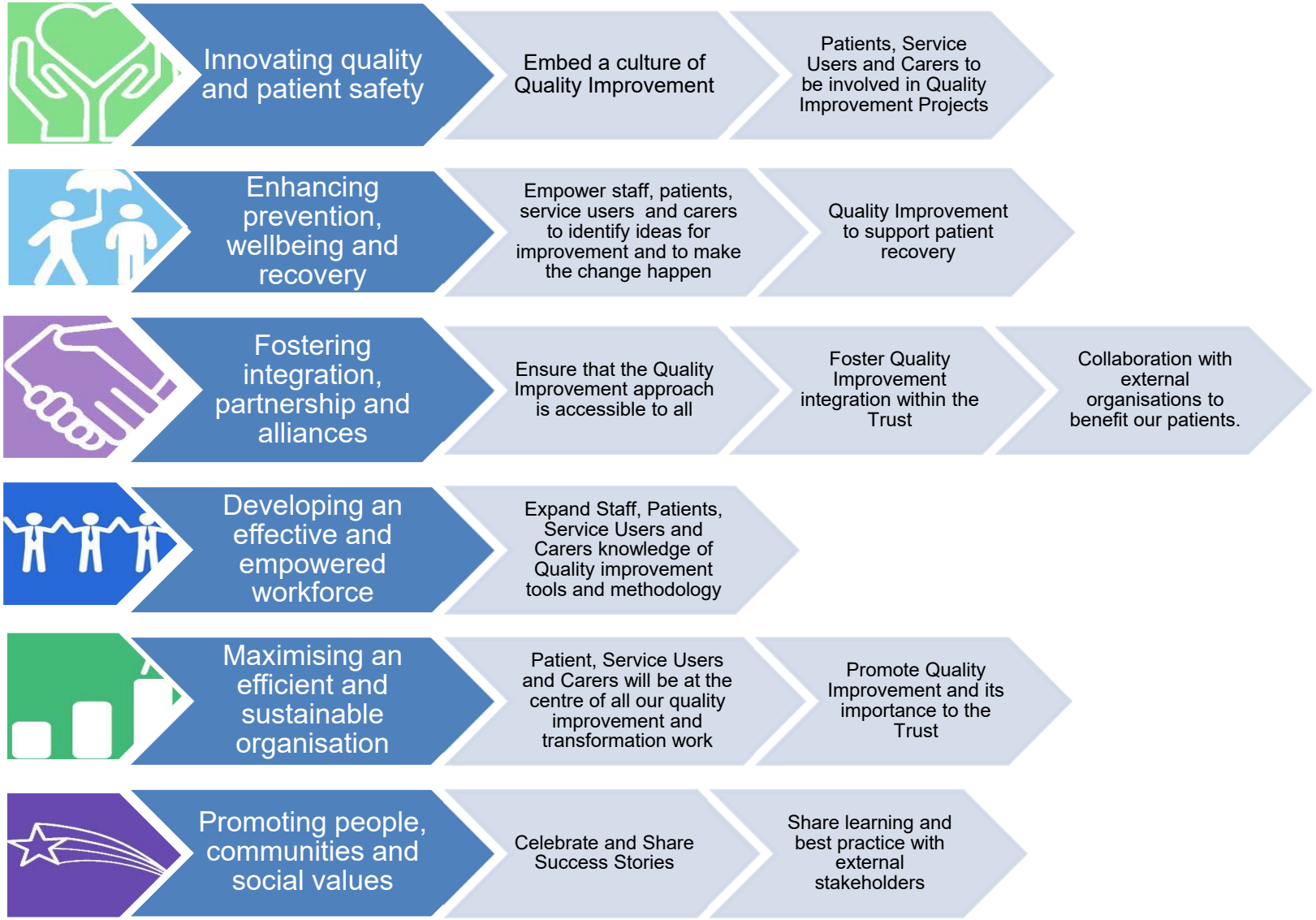
Enhancing prevention, wellbeing and recovery

Maximising an efficient and sustainable organisation

Fostering integration, partnership and alliances

Promoting people, communities and social values

5. How the Quality Improvement Plan will Influence our Strategic Goals



6. Strategic Context

> "The single most important change in the NHS... would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end".
>
> *Don Berwick founder and former president of the Institute for Healthcare*

The Health and Social Care Act 2012, states that NHS England has a duty to continually drive improvements in the quality of care across a comprehensive health service; there has been a number of publications since which provide insight into how a Trust can embed the quality improvement culture.

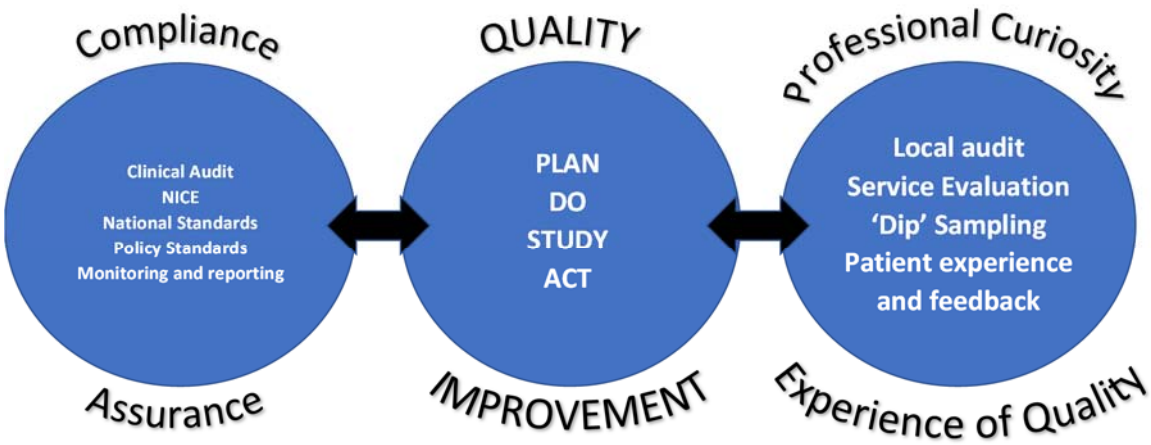
Since the publication of the NHS Long Term Plan in 2019, the Trust, like all areas of England, has been working towards the introduction of the partnership working with all NHS, local councils, GP practices and other strategic partners including voluntary, community and social enterprise sector to support the vision for Integrated Care Systems (ICS).

With the request for legislation to remove barriers and introduce the ICS bodies, the provision of mainly local integrated care for physical and mental health across all areas including all the NHS, councils and GP practices will affect the future direction of the Quality Improvement programme in the Trust and support our Patient, Service User and Carers Quality Improvement purpose statement for "a holistic person-centred approach, which will offer seamless, consistent services and ensure patient involvement in all decisions around care ".

Humber Teaching NHS Foundation Trust has been on its improvement journey for the last three and a half years and, during this time, the Trust has introduced the Model for Improvement Methodology which allows us to deliver small change led by Staff, Service Users, Patients, Service Users and Carers and from which we can learn lessons and spread the good practice.

The model for improvement also sits alongside our approach to clinical audit and our processes for reviewing our compliance against existing and new NICE guidance. Improvement methodologies are a vital mechanism for supporting the changes in practice required to ensure we are providing effective and evidence-based care.

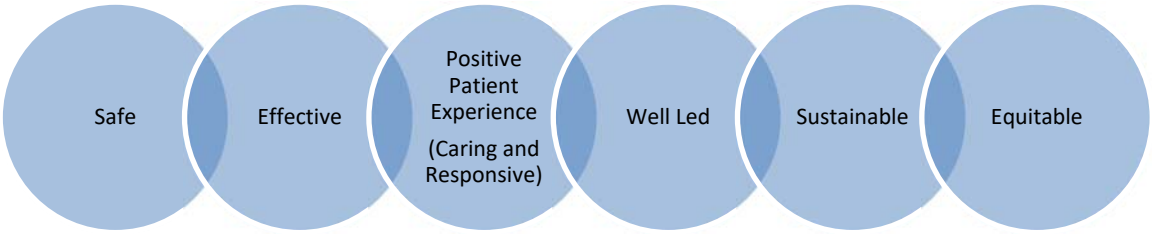
High performing organisation



Mandated Essential

We have seen our Care Quality Commission (CQC) rating go from 'Requires Improvement' to 'Good' and we acknowledge that, through having a fully embedded QI approach it will help the Trust to deliver its aspiration of improving staff and patient experience and outcomes and achieving a CQC rating of 'Outstanding'

To fully embed a culture of Quality Improvement, The National Quality Board, who provide coordinated leadership for quality on behalf of the national bodies, defines a single shared view of high-quality as six dimensions and the Trust will continue to consider and balance these often-competing dimensions over the next five years and beyond.



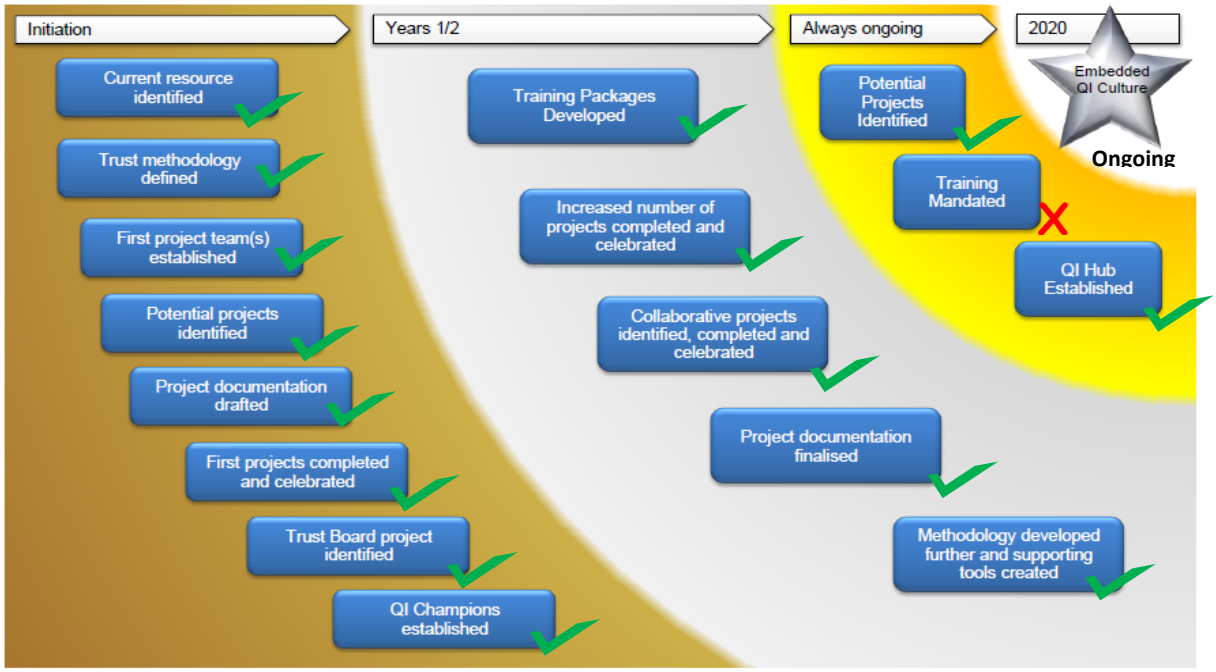
In the Health Foundation "Quality Improvement Made Simple" paper, it outlines that Quality improvement is about "giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them." and describes three key areas to be developed and fostered to embed a Quality Improvement Culture: Leadership and Governance, Improvement Culture, behaviours and skills and the External Environment. Our Quality Improvement Approach is that our Staff, Patients, Service Users and Carers are best placed to

identify and undertake improvement activities and the QI strategy with its twelve priorities further supports the three key areas to further embed a culture of Quality Improvement

With an ambition to become a Quality Improvement Centre of Excellence, there will be a requirement for time and resources to ensure that staff at all levels, our patients/service users and carers receive the training and support necessary to invest in the Quality Improvement journey to achieve our priorities for 2021-2026 and to deliver our purpose as identified by our patients, service users and carers of “a holistic person-centred” approach.

7. Quality Improvement Priorities

7.1 Progress Against QI Approach 2018-2020



The programme achieved all the milestones identified other than mandating the Quality Improvement Training with some additional information included in Appendix A and our progress in 2019 to 2021 is shown in Appendix D.

The journey to embed a culture of Quality Improvement continues in the reviewed and new priorities for 2021-2026.

7.2 Quality Improvement Priorities: Progress and Milestones

7.2.1 Trust Goal: Innovating quality and patient safety

Priority: Embed a culture of Quality Improvement
What we are currently doing ▪ The Trust has identified the "Model of Improvement as its methodology and this is promoted through the Training offer, a Help Sheet on the Intranet and ad hoc communications. ▪ Quality Improvement attends Team and Clinical Group meetings to provide updates and offer small Model for Improvement activities ▪ Updates are provided via the communications emails and twitter ▪ Facilitation of the QI Weeks and QI Forums ▪ The process for identifying and completing a charter is shared in presentations and in the training programme ▪ The QI Consultancy updates to enthusiasts enables word of mouth sharing to Teams.

▪ Intranet holds all completed charters and QI Stories and the Internet has examples of QI Stories ▪ Promote QI is the responsibility of everyone ▪ Leadership training includes QI module	
Milestones	
Years 1-2	▪ Clinical Network Groups aware of Quality Improvement activities taking place in the Division and can access advice/support ▪ Divisional Clinical Leads are aware of Quality Improvement activities taking place in their Division and can access advice/support ▪ Corporate Teams are aware of the Quality Improvement Programme and know how to access training and improvement resources ▪ Demystify Quality Improvement ▪ Share Quality Improvement activities with the Trust ▪ Simple process is in place to identify, register and complete Quality Improvement activities ▪ Staff to feel empowered to identify small improvement activities and deliver improvements ▪ Support to Teams to embrace Quality Improvement and provide advice on how to get started. ▪ Develop process for learning lessons and feeding back to teams ▪ Engage with National Network of QI Activities ▪ Embed ethos that Quality Improvement is everyone's responsibility
Years 2-3	▪ Explore other marketing options available to raise awareness of the Quality Improvement Approach and its Tools ▪ Divisions/Services to have time to generate ideas and deliver quality improvement activities ▪ Ensure that all Business-as-Usual Improvement Activities are recognised as Quality Improvement ▪ Quality Improvement Training to be provided to all Managers/Leaders
Year 5	▪ Develop Quality Improvement Dashboard ▪ Quality Improvement Methodology is embedded in the Trust ▪ Embedded 'Learning' Organisation ▪ Identify champions for each service

Priority: Patient, Service Users and Carers to be involved in Quality Improvement Projects	
What we are currently doing	
▪ Quality Improvement is a member of the Patient and Carer Forums ▪ Patient and Carers attend QI Consultancy ▪ Some Patients/Service Users and Carers involved in QI activities ▪ Patient, Service Users and Carers receive invites to QI Week and Forums ▪ Patient, Service Users and Carers received invite to develop the QI Strategy	
Milestones	

Years 1-2	▪ Patient, Service Users and Carers involved in QI activities ▪ Raise Awareness of Quality Improvement and 'How to get involved at PACE forums ▪ Recovery College Introductory Module available
Years 2-3	▪ Patient, Service Users and Carers have a clear process to raise their improvement ideas.
Year 5	▪ Database of Patient, Service Users and Carers with special interest in all areas of the Trust

7.2.2 Trust Goal: Enhancing Prevention, Wellbeing and Recovery

Priority: Empower Staff, Patient, Service Users and Carers to identify ideas for improvement and to make the change happen	
What we are currently doing Ethos introduced as part of all training and presentations When approached, encouraged to engage in an activity	
Milestones	
Years 1-2	▪ Promote Staff, Patient, Service Users and Carers to feel empowered to identify an idea and engage in the activity
Years 2-3	▪ Idea Generation Session to be co-produced with Service Development Team
Year 5	▪ Staff, Patient, Service Users and Carers are empowered to identify and progress a Quality Improvement idea. ▪ Staff are empowered to identify and progress a Quality Improvement Idea

Priority: Quality Improvement to support patient recovery	
What we are currently doing ▪ Some QI activities support patient recovery ▪ Development of Quality Improvement module for Recovery College is underway	
Milestones	
Years 1-2	▪ Quality Improvement Module to be created for Recovery College
Years 2-3 Year 5	▪ Involvement of Patient, Service Users and Carers in Quality Improvement Activities to build confidence and aid recovery ▪ Quality Improvement Activity Ideas to support Patients/Service Users Recovery

7.2.3 Trust Goal: Fostering integration, partnership and alliances

Priority: Ensure that the Quality Improvement approach is accessible to all
What we are currently doing ▪ The Quality Improvement Approach for Doctors is in its infancy and Model of

Improvement cycles are being undertaken where required ▪ Process in place outlining idea generation through to celebration ▪ Awareness presentations and communications to staff	
Milestones	
Years 1-2	▪ Quality Improvement Approach for Doctors (short placements) in place ▪ Service Reports to update staff and outline how they can get more involved ▪ Continue on journey to raise awareness of the QI programme
Years 2-3	▪ Review of level of knowledge within Services at Clinical Network Groups to monitor if progress is ongoing
Year 5	▪ Review of level of knowledge within Services at Clinical Network Groups to monitor if progress is ongoing

Priority: Foster Quality Improvement integration within the Trust	
What we are currently doing ▪ Close working with the Patient and Carer Experience Team ▪ Developing extended Doctor offer with Clinical Audit ▪ Working with Clinical Leads and Networks to develop closer ties	
Milestones	
Years 1-2	▪ PACE and Quality Improvement to continue work together to ensure that Patients, Service Users and Carers are included in the Quality Improvement Approach ▪ Clinical Audit and Quality Improvement provide joint training to Doctors and explore ways of working ▪ Quality Improvement Methodology to support Teams to undertake improvement work identified via Friends and Family Tests ▪ Support offer developed for Clinical Networks
Years 2-3	▪ Research and Development and Quality Improvement to explore joint ways of working ▪ Quality Improvement methodology to support Patient Safety ▪ Explore joint working with Volunteers
Year 5	▪ Joint working with all services across the Trust

Priority: Collaboration with external organisations to benefit our patients.	
What we are currently doing ▪ Initial meetings with QSIR Contacts ▪ Some project activities demonstrating joint working	
Milestones	
Years 1-2 Years 2-3 Year 5	▪ Quality Improvement and Services to embrace multiagency partnerships to support Quality Improvement Activities ▪ Networking with other local NHS QI Leads

7.2.4 Trust Goal: Developing an effective and empowered workforce

Priority: Expand Staff, Patient, Service Users and Carers knowledge of Quality improvement tools and methodology	
What we are currently doing ▪ Training and Support offer in place and reviewed regularly to ensure it is fit for purpose ▪ Quality Improvement Toolkit underway with How To sheets available on the Intranet	
	Milestones
Years 1-2	▪ Develop bespoke training session for PACE involved in Quality Improvement Activities ▪ Develop Recovery College Module to introduce Quality Improvement ▪ Accessible advice and support ▪ Delivery of Training and Support Offer in Trust ▪ Develop Quality Improvement Toolbox
Years 2-3	▪ Develop Idea Generation session for Teams
Year 5	▪ Explore media options to teach Quality Improvement Tools

7.2.5 Trust Goal: Maximising an efficient and sustainable organisation

Priority: Patient, Service Users and Carers will be at the centre of all our quality improvement and transformation work	
What we are currently doing ▪ Offer to PACE attendees to participate in strategy ▪ Co-produced strategy ▪ Question added to charter to enable tracking of inclusion of Patient, Service Users and Carers ▪ Close working with the PACE team.	
	Milestones
Years 1-2	▪ Ensure Patients, Service Users and Carers are offered opportunities to be involved in the Quality Improvement Programme ▪ Work with the transformational programmer to identify and provide guidance on projects which align with Quality Improvement ▪ Continue to attend PACE forums to raise awareness ▪ Encourage all Charter Leads to include patients and cares where possible
Years 2-3 Year 5	▪ Patient, Service Users and Carers involved across all aspects of Quality Improvement

Priority: Promote Quality Improvement and its importance to the Trust	
What we are currently doing ▪ Communications to Trust ▪ Quarterly updates to Operational Delivery Group ▪ QI Infographic to be added to intranet to ensure everyone can see what is happening and when.	
Milestones	
Years 1-2	▪ Develop key messages for Quality Improvement with Quality Improvement and PACE Champions ▪ Use Global, Intranet, Internet and Twitter to update on Quality Improvement as per Communications plan ▪ Develop annual infographic to celebrate QI achievements ▪ Service Specific Reports
Years 2-3	▪ Review key messages for Quality Improvement
Year 5	▪ Review key messages for Quality Improvement ▪ Champions in all services

7.2.6 Trust Goal: Promoting people, communities and social values

Priority: Celebrate and Share Success Stories	
What we are currently doing ▪ Work underway to re-structure the Intranet pages to make divisional charters more accessible ▪ QI Stories for completed charters ▪ Use of Social Media to promote activities ▪ Quality Improvement Forums have taken place annually ▪ Quality Improvement Week was introduced in 2020 and was popular with staff ▪ Work is underway to facilitate a Quality Improvement Forum for Learning Disabilities	
Milestones	
Years 1-2	▪ Ensure Quality Improvement Stories include Qi activities where Patients, Service Users and Carers developed ideas and supported the activity ▪ Intranet and Internet pages to share success stories ▪ Quality Improvement Stories for completed activities ▪ Sharing of Quality Improvement Activities as they progress ▪ Bi-annual Quality Improvement Weeks/Forums ▪ Quality Improvement Conference ▪ Quality Improvement Forum for Learning Disabilities
Years 2-3	▪ Bi-annual Quality Improvement Weeks/Forums ▪ Quality Improvement Conference ▪ Quality Improvement Conference for Learning Disabilities ▪ Explore options for Virtual 'Celebration' Wall
Year 5	▪ Bi-annual Quality Improvement Weeks/Forums ▪ Quality Improvement Forum for Learning Disabilities

Priority: Share learning and best practice with external stakeholders	
What we are currently doing ▪ Quality Improvement forum and QI Stories invites and communications ▪ Use of twitter to promote activities	
	Milestones
Years 1-2	▪ Communicate partnership working to staff/stakeholders ▪ Quality Improvement successes via social media and QI Stories ▪ Quality Improvement Conference ▪ Promote learning from Quality Improvement activities ▪ Share Quality Improvement Spread Success Stories ▪ Communication to external stakeholders
Years 2-3	▪ Build relations with stakeholders ▪ Develop external stakeholders' network ▪ QI Newsletter produced quarterly ▪ Quality Improvement Conference
Year 5	▪ Explore all opportunities to showcase QI Stories

The milestones will be developed and explored each year to further develop sub tasks.

Appendix B provides further information about our approach for delivering our QI Priorities for 2021-2026

7.3 Plan on a Page

7.4 How will we measure success of our progress towards an embedded QI culture?

We will measure the progress of the Quality Improvement Programme towards the success of our priorities by

- Quality Improvement Charters from each Division/Directorate
- Training Places
- Patients, Service Users and Carers engaged in our Quality Improvement activities
- QI activities with other organisations
- Staff survey outcomes
- National Patient and Carer Feedback Scores

Appendix C contains further details for the measurements.

8. Additional Information

Key Internal Documents/information

Trust Strategy (2017-22)

Operational Plan (2018-19)

Patient and Carer Experience Strategy 2018-2023

Patient Safety Strategy (2019-2022)

Service and Quality Plans

COVID-19 Health & Wellbeing Hub (humber.nhs.uk)

Key External Documents

The Health Foundation - Quality Improvement Made Simple (April 2021)

Quality improvement made simple | The Health Foundation

The National Quality Board - Shared commitment to quality (Dec 2016)

https://www.england.nhs.uk/wp-content/uploads/2016/12/nqb-shared-commitment-frmwrk.pdf

NHS England - The NHS Five Year Forward View (Oct 2014)

https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The King's Fund - Embedding a Culture of Quality Improvement (Nov 2017)

https://www.kingsfund.org.uk/sites/default/files/2017-11/Embedding-culture-QI-Kings-Fund-November-2017.pdf

The King's Fund – Improving Quality in the English NHS (2016)

Improving quality in the English NHS | The King's Fund (kingsfund.org.uk)

9. Contacts and further information

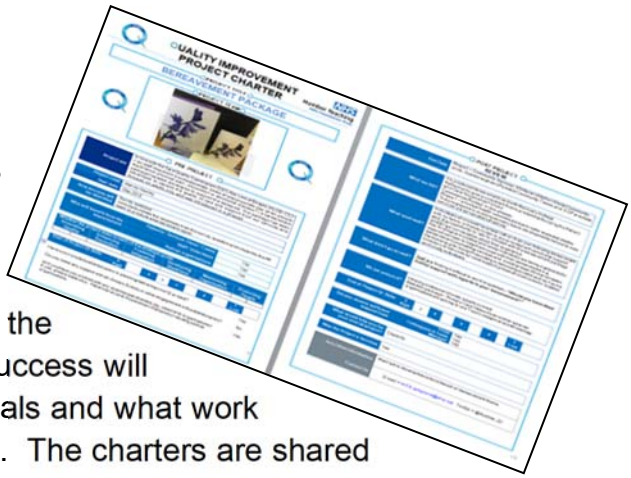
If you need this strategy to be made available in alternative formats, you can contact us in the following ways:

Humber Teaching NHS Foundation Trust
Trust Headquarters
Willerby Hill
Beverley Road
Willerby
East Riding of Yorkshire
HU10 6ED

Tel: 01482 301700
Email: hnf-tr.qimprove@nhs.net
Twitter: @humber_QI

Appendix A - What are we already doing?

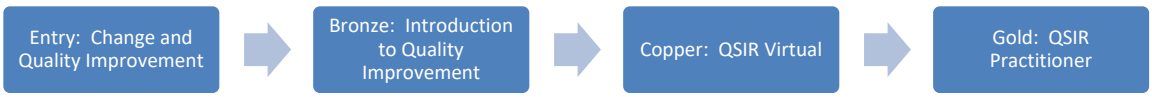
The Quality Improvement Approach 2018-20 was introduced in June 2018 and focussed on three main areas;



Capturing Quality Improvement Activities

The programme uses Quality Improvement Charters to track and celebrate its activities. Whilst ensuring consistency, the charter captures the aim of the work, how success will be identified, alignment to Trust strategic goals and what work has been undertaken and the lessons learnt. The charters are shared on the Intranet when complete and anyone completing an activity is asked if they wish to provide a 10-minute QI Story presentation to the Trust via Microsoft Teams.

Training and Support



A training and support pathway provides staff with four levels of training and an offer of support through the monthly QI Consultancy, where Enthusiasts meet and share ideas and issues or ad hoc support. The training and support offer are reviewed regularly to ensure the offer remains appropriate.

Awareness and Celebration

Raising awareness of the programme and celebrating achievement is a key area, with celebration events being offered in the form of Quality Improvement Forums and Quality Improvement Weeks where activities are presented by staff and service users.

Other methods of celebrating include;

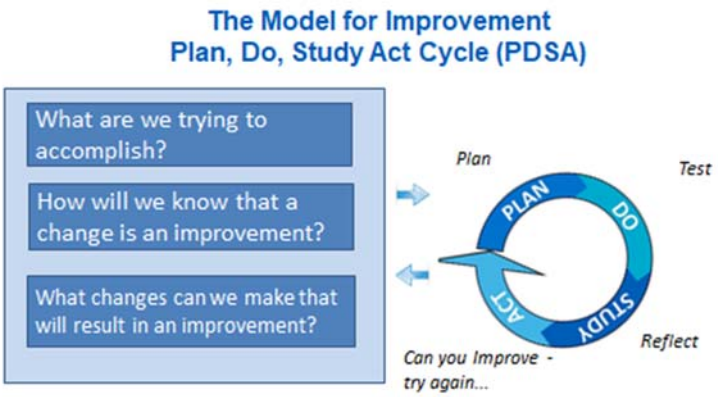
- Updates via the Trusts communication emails
- ad hoc Quality Improvement Stories
- attendance at team and clinical meetings
- tweets via @Humber_QI twitter account.

Appendix B - Our approach to Implementation

The delivery of the Quality Improvement Strategy will continue to follow the approach that Staff, Patient, Service Users and Carers are best placed to identify ideas for improvement and to undertake the improvement activity but will be supported by teams from across the Trust including the central Quality Improvement team providing advice, direction, and ad hoc support.

The main requirements are that those identifying improvement should have the skills/training to delivery the programme and the capacity to undertake the activity.

To support the activities, the intranet has been developed and continues to grow as a hub of information, including completed charters, QI Stories and the training and support offer, with the QI Consultancy offering opportunities to talk about ideas and remove 'blockages' with a wider group of QI champions



The Trust's methodology will continue to be the Model for Improvement but allowing other methodologies such as the Productive Series and Lean where expertise exists, in addition, a Quality Improvement Toolbox will continue to be developed to provide a variety of options to enable the delivery of the improvement such as creativity and diagnostic tools.

Communication will remain a key component of the programme, to celebrate success and provide updates. It will include the following options, although this list will be reviewed based on available options during the Strategy life cycle.

Internally	Externally
QI Forums/Weeks QI updates via Global QI Stories Attendance at Staff Meetings Quarterly updates to the Operational Delivery Group Intranet Pages QI Hub Board at Trust HQ for displaying achievements and project opportunities	QI Forums/Weeks Twitter Local NHS Organisation Updates Opportunities for partnership work communicated to stakeholders

A pathway for the registration, learning and celebrating of improvement activities has been created to support those who are embarking on their first activity;

Appendix C - Measurements for monitoring the success of the QI Programme

The following measures will be used to monitor the success of the QI programme.

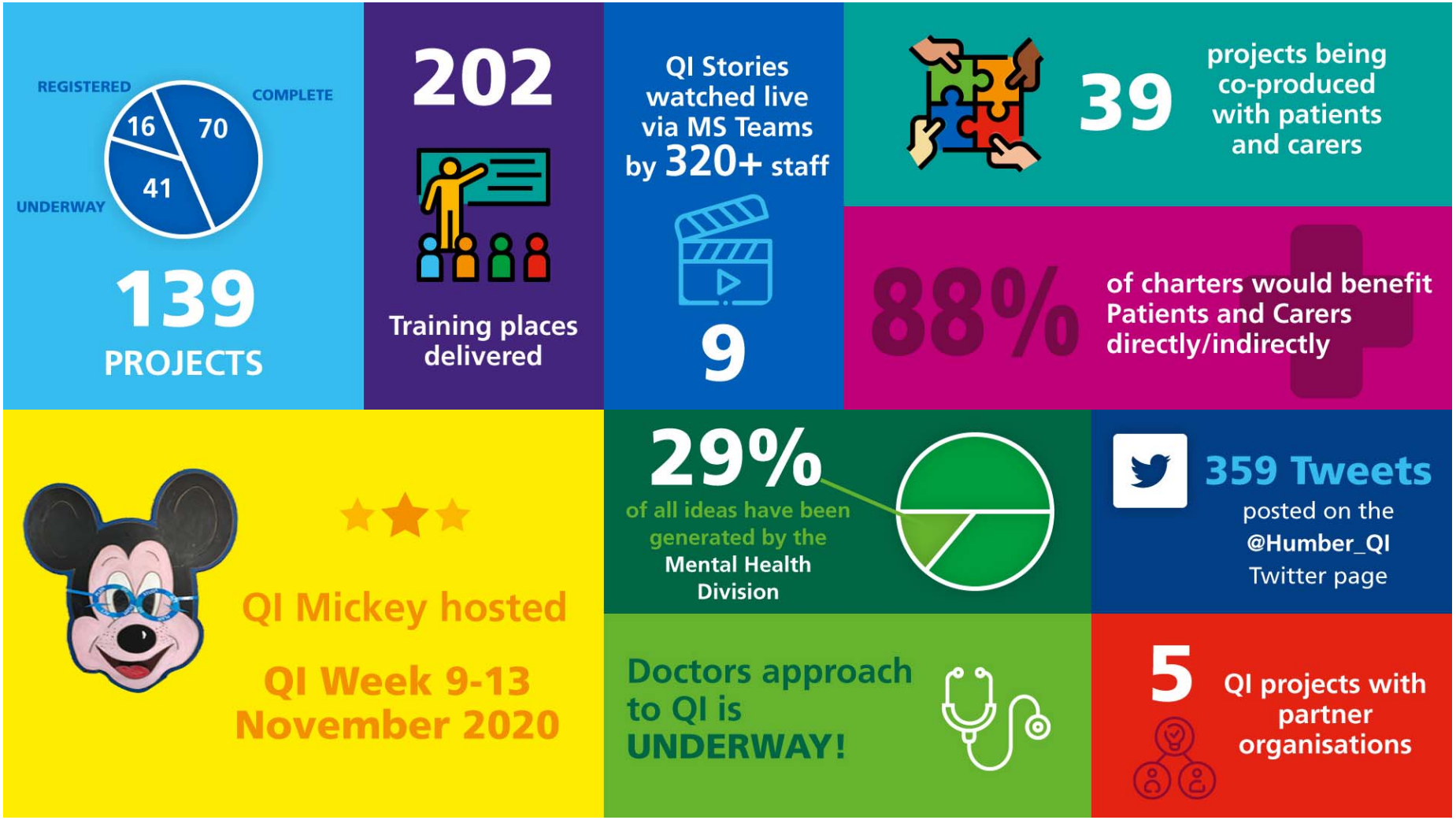
In addition, each Quality Improvement activity success will be measured against its own criteria as outlined on the Quality Improvement Charter. The charter template will continue to be regularly reviewed to ensure sufficient data is being captured and progress towards the milestones linked to each priority will be tracked as part of the Operational Delivery Group Reports.

Measure	Information Provided By	Frequency of Review/Reporting
EMBEDDING A QI CULTURE		Reported to Operational Delivery Group via quarterly report
20% increase in the number of QI charters submitted annually by Divisions/Directorates	Charter Tracker	
33% reduction in staff expressing insufficient capacity as a reason for not undertaking a QI activity by 2026	Charter Tracker	
Staff survey outcomes to be monitored from the Annual Staff Survey as an indicator for staffs empowerment to identify/undertake[HC(TNFT1] improvement. Prioritise work with Division/Directorates who are not improving.	**Annual Staff Survey** 4a. There are frequent opportunities for me to show initiative in my role. 4b. I am able to make suggestions to improve the work of my team / department. 4c. I am involved in deciding on changes introduced that affect my work area / team / department. 4d. I am able to make improvements happen in my area of work.	
Staff and PACE Surveys to monitor progress in embedding culture and further developing the milestones for each priority.	Survey	
PROVISION OF SKILLS		
200 training places to be provided annually	Training Tracker/ESR	

COPRODUCTION		
75% of all QI activities will include Patients, Service Users and Carers by 2026	Charter Tracker	
Process introduced for reviewing results of Friends and Family Tests and supporting service response to recommendations.	Friends and Family Tests Process in place	
Review and compare year on year the outputs from the Patients and Carer Surveys and work with the Patient and Carer Team to support engagement on QI activities.	Patient and Carer Surveys ***Community Mental Health Service User Survey*** 37. In the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care? ***Mental Health Inpatient Service Survey*** No specific questions but overall trends in improvement monitored and, where appropriate, support offered. ***National GP Patient Survey*** Monitoring of trend in the following question and, where appropriate, support offered % of patients who describe the overall experience of this GP practice as good.	
PARTNERSHIP WORKING		
40% of QI activities will be undertaken in partnership with other organisations by 2026	Charter Tracker	
Network of QI Leads in local area introduced., sharing and exploring ways if joint working	Network in place and meeting quarterly.	

The Transformation programme will continue to report benefits and success measures to the Transformation Group.

Appendix D - Quality Improvement in Numbers 2020/21 (June 2020 – March 2021)



NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 20

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 29 September 2021</td></tr>
<tr><td>Title of Report:</td><td>Clinical review of issues arising from the transfer of Community Paediatric Medical Services of City Health Partnership to Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust</td></tr>
<tr><td>Author/s:</td><td>Lynn Parkinson
Chief Operating Officer</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>Outcome of a full investigation into the issues identified during the transfer of services that highlighted delays to patient pathways and the implications of this.
The report outlines clear areas of learning.</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>
<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>Other (please detail)
HUTH Board
CHCP Board
Hull CCG Board
ER CCG Board</td><td></td></tr>
</table>
</td></tr>
<tr><td>Key Issues within the report:</td><td>The contractual commissioning of the Community Paediatric Medical Service was transferred from City Health Care Partnership to both Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust on 1 April 2019. On transfer it was found that there were delays in patient referrals and out-patient reviews, which impacted on the assessment and treatment pathways for these children, and may have caused harm.

The report provides a chronology of events which include HTFT accepting a transfer of neuro diverse cases, each of which were reviewed with Consultant Psychiatrist oversight.

The report details the joint working with HUTH on the management of the legacy cases. HUTH similarly undertook a full Independent Medical Review of all cases transferred.

Overall 29 cases were identified as potentially experiencing harm through delayed pathways, of which:

17 experienced no harm
3 Mild harm</td></tr>
</table>

	8 Moderate harm 1 Severe harm The report provides the areas of learning from this investigation.

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
	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	

CLINICAL REVIEW OF ISSUES ARISING FROM THE TRANSFER OF COMMUNITY PAEDIATRIC MEDICAL SERVICE OF CITY HEALTHCARE PARTNERSHIP TO HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST AND HUMBER TEACHING NHS FOUNDATION TRUST

Report Date: 24 November 2020

Chairman's Introduction

Community Child Health (CCH) has been described as the 'largest paediatric sub-specialty focusing on the care of vulnerable children and families, and children with long-term conditions'. *(RCPCH Community Paediatric Workforce Short Report 2017).*

These include children with:

- Developmental disorders and disabilities.
- Complex health needs (including end of life care).
- Behavioural presentations of neurodevelopmental disorders (e.g. Autism, ADHD).
- Safeguarding concerns, who are "Looked After" or being adopted.

It is recognised that "CCH often falls 'below the radar' of NHS Trusts, commissioners and public attention" and that "failings in these services can affect the longer-term health and wellbeing of children and families throughout their lives". Furthermore, significant difficulties in medical recruitment and retention make these services themselves very vulnerable.

This report reviews the shortcomings of a service where severe workforce shortages and a reliance on locum staff, together with a prioritisation of statutory work over clinical need, and there was serious harm for one child, moderate harm for eight children and mild harm for three children. In other cases, harm might have occurred were it not for care given out-with community paediatrics, most notably by the Paediatric Department of HUTH. Whilst the absolute number of cases where harm occurred is low (12 out of 2,427) and the situation described may not be unique, the impact on this particularly vulnerable group will have not been insignificant.

As the Independent Chair of this review, I have been impressed by the honesty and candour of all involved and the firm commitment to find out what happened, offer a sincere apology and in so far as it is possible, to make amends to the child or young person and their family. Over and above this, there has been a strong desire to apply the lessons learnt to building a robust community paediatric service with clinical governance structures in place to prevent future failings. Above all, I have been very struck by the deep sense of regret that children were not cared for as they should have been, and the very real and passionate concern for the future wellbeing of the children concerned. That most of the changes described have been implemented within a matter of months is most impressive, not least in the context of the difficulties in recruitment and retention, and is a tribute to the dedication and hard work of those now seeking to serve these children and young people. I am also impressed that there is a joint "whole system" commitment from commissioners and providers to give appropriate support to develop Community Paediatrics in Hull and the East Riding of Yorkshire which bodes well for the future. I would wish to record my thanks to all who have taken part in this process, and in particular, to Dr Alistair Morris who gave invaluable expert independent advice, and to Debbie Lowe and Paula South who ably assisted in drafting this report, despite the pressure of COVID-19 related work.

1) Introduction

This report outlines the findings of the inquiry into issues arising upon the transfer of Community Paediatrics Medical Service provision in Hull and the East Riding of Yorkshire.

The work described has been undertaken by the Community Paediatric Oversight Group, a system wide partnership, inclusive of NHE England/Improvement, NHS Hull Clinical Commissioning Group (HCCG), NHS East Riding of Yorkshire Clinical Commissioning Group (ERYCCG), Hull University Teaching Hospitals NHS Trust (HUTH), City Health Care Partnership (CHCP) and Humber Teaching NHS Foundation Trust (HTFT). It has been led by Professor Andrew Cant (Consultant Paediatrician and Chair of the Northern England Clinical Senate) with input from an independent Consultant Paediatrician (with a specialist interest in neurodisability), Dr Alistair Morris. The Terms of Reference can be found in Appendix 1.

2) Background

The contractual commissioning of the Community Paediatric Medical Service was transferred from City Health Care Partnership to both Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust on 1 April 2019.

On transfer it was found that there were delays in patient referrals and out-patient reviews, which impacted on the assessment and treatment pathways for these children, and may have caused harm.

This report aims to give a detailed understanding of what happened, the nature of any harm suffered by patients, the action taken to mitigate any harm, a review of the reconfigured Community Paediatric Services and a summary of lessons learnt.

3) Chronology of Events Leading Up to this Review

September 2013

Following a formal tender process by both Hull and East Riding of Yorkshire CCGs for the Community Paediatric Medical Service, the contract was awarded to the City Health Care Partnership (CHCP). On 1 September 2013 the service was transferred from HUTH (formally known as HEY, Hull and East Yorkshire Hospitals NHS Trust) to CHCP.

At the point of transfer, the Key Performance Indicators for the Looked After Children Initial Health Assessments were acknowledged as already being below the required standards. There were long patient waits and high waiting list volumes. This was attributed to a high level of cancelled clinics (a total of 20 previous appointment dates had been cancelled at this time). In acknowledging this, CHCP undertook a capacity review in relation to the health assessment / adoption medical clinics. This was to ensure that capacity met demand.

December 2013

The CHCP Community Paediatric Medical Service was initially based at The Children's Centre, Walker Street, Hull with some clinics running across the Hull and East Yorkshire area. This had to be relocated to the Octagon Children's Centre following flooding caused by a tidal surge.

July 2014

On 3 July 2014 CHCP escalated concerns and provided a report to the CCGs' Contract Monitoring Board. This was in response to issues identified in relation to both the 18 week Referral to Treatment times and potentially 52 week clinic waits. The report also outlined issues around the provision of medical staffing and therefore a concern around an inability to meet capacity.

A recovery plan was submitted as part of the assurance report. It acknowledged it would take 12 months to transform the service to meet contractual requirements and mitigate the risk. Whilst the transformation work was undertaken, a clinical triage system was implemented to prioritise referrals.

Throughout this 12 month period, workforce challenges were apparent which were acknowledged as a contributory risk factor for the success of the Community Paediatric Medical Service.

September 2014

CHCP engaged with colleagues from HUTH to explore potential for a joint recruitment to resolve workforce shortages. The Community Paediatric Medical Service at this time being 4 whole time equivalent (WTE) medical staff below the number to effectively deliver the service. It had been agreed that a budget for two Consultant vacancies would be retained by HUTH to support the development of specific clinical pathways following the transfer, however recruitment was challenging.

Significant challenges were escalated at this time. An ongoing inability to recruit to the substantive Consultant Community Paediatrician vacancies was an established risk. Engagement therefore began between both CHCP and HUTH to try and find innovative ways to meet the demand on the service and maintain the statutory whilst keeping to timescales.

November 2016

The Care Quality Commission (CQC) undertook an inspection from 19 November to 22 November 2016 as part of the CQC's Independent Community Health Services Inspection Programme. The service was rated as 'good'. The inspection found that patients and their relatives were consistently positive about the care they received. All staff consistently communicated with patients in a kind and compassionate way, treated them with dignity, and respected their privacy. Furthermore, that the services were planned and delivered to take account of people with complex needs. There were arrangements to enable access to the service for people in vulnerable circumstances. It was, however, acknowledged in the report that within the Community Paediatrics Medical Service there needed to be a more robust effort to recruit to the vacancies, and alternative skill mix solutions should be explored.

April 2017

In the light of the CQC findings, a service development plan was developed and shared with the CCGs outlining a proposal to train and establish the roles of Advanced Nurse Practitioners (ANPs) within the service to build capacity in relation to the medical vacancies. Later in 2017, two full time student ANPs commenced in post, with the expected date for completion of training and commencing independent practice being summer 2019.

July 2017

HUTH Paediatricians undertook an analysis based on data supplied on the contact with 175 children with a diagnosis of ADHD.

January 2018

Meeting established at HTFT to discuss transfer of proposed cases, involved in this were clinical leads and Hull CCG Quality Leads and Commissioning Leads. The number identified was found to be significantly higher than expected. Concerns were raised that the paediatric assessment process may not have been robust, as diagnosis was mainly based on a singular assessment by locums. It was concluded therefore by the CAMHS Consultant that many may need a reassessment if transferred. There continued to be a significant increase in requests for ADHD assessments.

June 2018

HTFT started to receive, as agreed, new ADHD / Autism referrals, some of which had already been seen with CHCP for initial contact. It was at this time that HTFT were informed that CHCP had given notice to commissioners that they wished to terminate the contract for the Community Paediatric Medical Service.

September 2018

The HTFT Child and Adolescent Mental Health Service (CAMHS) confirmed that they would accept new referrals to the service for assessment for Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

October 2018

On 18 October 2018 CHCP gave formal notice of the intention not to continue with the contract for the Community Paediatrics Medical Service beyond 31 March 2019.

They had continued to experience challenges in securing the workforce required to deliver an effective service. This was due to the resignation of the Clinical Director, who was due to retire, as well as the resignation of two further colleagues within the service (a substantive Consultant Community Paediatrician and a substantive Speciality Doctor, both of whom took up other posts within other organisations).

On 19 October 2018 a Hull and East Riding ‘system approach’ workshop was convened by Hull CCG and focused on the neurodisability consultant workforce and clinical pathways.

On 23 October 2018 HUTH notified that the impact of none CCG commissioned work on paediatric neurodisability capacity meant that HUTH could not manage children who should be managed by the Community Paediatric medical clinicians as this was impacting on workloads of clinicians at HUTH and waiting times for services formally commissioned from HUTH.

October 2018 – SI declared by HUTH in regards to a child with cerebral palsy who had not received appropriate care and support by the Community Paediatric Medical Service.

November 2018

On both the 12 November and 19 November 2018 meetings were held between CCGs, HUTH and CHCP to discuss an options appraisal, based on the notice given by CHCP of their relinquishing of the medical element of the Community Paediatric Service. Separate service specifications were discussed to determine which elements would transfer, these included:

- Community Paediatric Medical Service for Hull & ERY.
- Looked After Children (LAC) Health Service for Hull.
- LAC Fostering and Adoption Assessment and Medical Service.
- Children's Community Nursing Service for Hull.
- Sunshine House Children's Respite Centre was also included for Hull and ERY.

A further review of the service specification by commissioners informed by the changes within NICE Guidance resulted in the ADHD and ASD pathways being separated from the Community Paediatric Medical Service. Provider organisations including HTFT, CHCP and both CCGs agreed that future responsibility for diagnosing ADHD and ASD would be undertaken by Humber (HTFT). However, following this decision, referrals were still being accepted by the Paediatricians despite the pathway changes and there were significant challenges for Humber clinicians.

February 2019

A series of teleconference meetings were held to plan the transfer of the identified ADHD caseload to HTFT. Clinical service leads met and worked through the entire caseloads that had been identified. As agreed, there was a plan put in place for each child and in March 2019 weekly meetings between HTFT / CCGs / CHCP commenced.

March 2019

On 28 March 2019 letter templates were agreed for sending to patients notifying of transfer of service. These were joint letters on behalf of CHCP, HUTH and both CCGs. It was agreed that in adherence to GDPR a pragmatic approach would be taken, and that due to the time frames all reasonable efforts would be made to inform patients. All children with an appointment in the following 6 months were written to by CHCP, and a note was added to all clinic appointment letters post 6 months to advise of the transfer. Partner services such as Community Children's Nursing and 0-19 teams were also notified.

In response to both the risks and challenges in delivering this service a Service Development & Improvement Plan 2019/20 was made part of the CCGs' programme area for Children, Young People and Maternity. The aim of this being to ensure a single point of access and clear referral pathways were in place. A priority area within this was for LAC. There was an ambition to provide the core service within standard hours of Monday to Friday: 08:30 - 18:00 hours (except public holidays).

SI investigation concluded and reported.

April 2019

On 1 April 2019 the care and treatment for a total of 2,427 patients were transferred from CHCP to HUTH as planned and agreed. The HUTH service being led by Dr Chris Wood, Clinical Director for Children's Services and Dr Sandhya Jose as the Clinical Lead for Community Paediatrics.

Prior to transfer, a child was identified as having come to harm and this was investigated as a Serious Incident by HUTH. This identified gaps in the Community Paediatrics Medical Service and the appropriate use of pathways. As a result of the HUTH learning from the incident declared in October 2018, and as part of the agreed robust governance approach to the transfer, mobilisation and stabilisation of the Community Paediatric medical service, all 2,427 patients transferred had their case notes reviewed by HUTH and an assessment was made as to whether the patient had come to potential harm. The review process was essential in order to ensure that each child/young person was appropriately prioritised and managed by a clinician and pathway according to their condition and NICE guidance. Patients were prioritised for clinical review and assigned to appropriate clinical management pathways.

Formal discussions were commenced with the view to HTFT taking on the legacy ADHD caseload from CHCP; HTFT, HUTH and CHCP being involved in discussions with the commissioners from Hull and ER CCG. As acknowledged there were emerging concerns at the point of this transfer from CHCP and it was agreed that all cases and reviews would be 'up to date' so that HTFT could plan to review the individual children's cases sequentially.

Of the caseload of 74 transferred to HTFT it was found that 3 were not on medication and therefore review was not deemed necessary, although they did not return to CHCP. HTFT undertook a process of prioritised reviews and found that there were a total of 21 cases from ERY CCG, 1 of which was not on medication and 53 from Hull CCG, 2 of which were not on medication.

17 cases had not been reviewed for over a year since the last review, 4 of which had not been seen since 2017 whereas NICE Guidance suggested 6 monthly reviews which was the agreed local standard. 8 ERY and 10 Hull cases were found to be not on shared care pathways with Primary Care and therefore needed to be prioritised.

During this time a number of parents contacted CHCP asking for urgent appointments for prescriptions, all of which were dealt with. Furthermore, the review of the cases indicated that some cases needed to be transferred to HUTH and HUTH identified the same reverse scenario.

HTFT shared the findings and escalated concern internally and externally and all cases were reviewed with a Consultant Psychiatrist providing medical oversight from April 2019. A further locum was employed in May 2019 to undertake reviews, and administrative support sourced to input children onto the clinical system. Both a leaflet and letter were sent to all parents outlining the standard of care they can expect from HTFT.

In response to these concerns, a business case was to be developed by Hull CCG for the prioritisation panel in June 2019 for a recurrent service to meet increase in referrals, as this was over and above expected from the legacy caseload transferred from CHCP. In response to the concerns raised in respect of gaps in services and potential harm, it was agreed that the CCGs would facilitate a meeting with all partners, and a conference call was initially convened.

May 2019

A conference call was facilitated in which Paediatricians reported that they had had approximately 2,427 referrals transferred from CHCP to HUTH, and high number were overdue follow-up, with some not having been reviewed since 2015.

Referrals reviewed at this point were placed in 3 categories:

1. Discharge.
2. Follow-up.
3. Unclear pathway.

It was agreed to cross reference with children open to HTFT and the providers came to an agreement with the CCG regarding transfers to HTFT from CHCP. It was agreed that all transferred cases had to have a diagnosis and be on medication for ADHD and that if the primary concern was for another health issue that this would remain with the Paediatricians, as Psychiatrists were concerned about prescribing ADHD medication alongside medication for serious medical conditions e.g. cardiac problems.

As acknowledged, HUTH were not commissioned to work with young people with ADHD and so therefore it was suggested that a shared care clinic was set up within the hospital on a regular basis so that Paediatricians and Psychiatrists could work side by side on these joint cases. This was an action supported and continues as required through liaison with Psychiatrist and Paediatrician.

Following this and later in the month a concerning case was identified by a Social Worker involved. As acknowledged some children potentially having unidentified Learning Disability (LD) and / or ASD who are not able to access the QB test for ADHD due to their understanding or struggling with routine / environmental change. It was identified that there was a need to undertake cognitive testing due to possible LD and align to appropriate pathway.

The conference call progressed to the forming of a Community Paediatrics Oversight Group.

August 2019

Membership of group included all partner organisations, with both NHSEI and the CCGs being present. The Chair was initially the Chief Nurse from HUTH. In August 2019 however, it was acknowledged that an Independent Chair was needed. Professor Andrew Cant was appointed to this role following discussions with NHSEI.

The group continued to meet regularly with representation from both clinical and operational leads being consistent throughout.

November 2019

In November 2019 it was accepted by the group that an independent medical review of the cases where HUTH clinicians had identified potential harm was required with the focus of this being on identifying potential or actual harm. Dr Alistair Morris was appointed to this role.

December 2019

HTFT completed the transfer of 130 children; access assessments were undertaken for all priority cases. All children were appropriately reviewed and shared care protocols were set up with named GP. Since that time, routine reviews have been established for all children using a new pathway of review in place for ADHD and Autism.

Two 17-year olds did not engage with the process and did not attend and so additional clinic dates have been offered. Ensuring consistent quality of locum psychiatry care has been challenging, however this has improved with appropriate longer-term contracts and support in place.

4) Independent Medical Review

An external review of cases and the new Community Paediatric Service Design was commenced at the request of the Community Paediatrics Oversight Group by Dr Alistair Morris, MBBS, MRCPCH, MSc Child Health, PGDip Neurodisability Consultant Paediatrician with a special interest in Neurodisability from Calderdale and Huddersfield NHS Foundation Trust.

The focus of review was to:

1. Review a random selection of 'No Harm' cases to provide assurance of appropriate assessment.
2. Review cases identified as having suffered harm and with Dr Sandhya Jose / Dr Chris Wood, decide on level of harm and actions taken to mitigate this harm.
3. Identify any common themes resulting in this harm.
4. Appraise the service design for new Community Paediatric service.

The findings of Dr Morris' external review were submitted to the Community Paediatrics Oversight Group in March 2020. Dr Morris found that:

- 2,427 cases were transferred from CHCP to HUTH. Of these 46.2% were discharged after the desk-top of the clinical records. The remaining 53.8% were triaged and reviewed through a face to face or telephone appointment by HUTH.
- Of these 68 were identified as having suffered potential harm by the HUTH clinicians on first review. On second review 28 were classified as having suffered no harm and 40 were classified as having suffered potential or actual harm.
- Of these remaining 40, 11 cases had been transferred to HTFT and therefore no up to date clinical information was available to Dr Morris to make an assessment. From the information provided there was potential for harm due to non-timely medication review in these cases which is well recognised.

Cases were reviewed by:

1. Taking a random selection of the 28 cases identified by the HUTH as having suffered no harm to confirm that no harm had occurred and that HUTH's decision was appropriate.
2. Reviewing all 29 remaining cases (including the investigated SI) identified as having suffered possible or actual harm to assess and rate any harm.

No Harm Cases

Every 5th case in the list was reviewed. Dr Morris agreed with HUTH in all cases that no harm had occurred. He was confident that their assessment has been appropriate for this group of cases.

Potential Harm Cases

Of these 29 cases, Dr Morris considered that:

- 17 suffered No Harm.
- 3 Mild Harm (minimal harm – patient(s) required extra observation or minor treatment).
- 8 Moderate Harm (short term harm – patient(s) required further treatment, or procedure) (7 confirmed, 1 potential).
- 1 Severe Harm - this was the SI already investigated by HUTH (permanent or long term harm).

Common themes presented by Dr Morris to the Community Paediatrics Oversight Group:

- *Delay in timely follow-up of patients* – this was both planned (i.e. decision to follow up patient in 2 years when needed earlier review) but mostly unplanned (i.e. decision to follow up in 1 year but not seen for 3 years). In Dr Morris's opinion the latter was due to lack of capacity resulting in a decision between CHCP and CCGs in October 2016 to prioritise statutory work.
- *Lack of understanding of roles / responsibilities* – this was particularly obvious in management of spasticity. Dr Morris considered this to be the role of the Community Paediatrician to commence antispasmodic treatments such as Baclofen before onward referral. There was a lack of continuity of care and there appeared to be a belief that the Orthopaedic Surgeons would do this (outside their remit) or requests for the GP to refer onto Neurology or tertiary Neurology without the commencement of basic management.
- *Lack of clear patient management pathways and MDT working* – there are clear guidelines for the management of spasticity (NICE CG145 2012) and hip monitoring in cerebral palsy. There is no evidence that these were followed.
- *High dependency on locums* – this resulted in patients seen by multiple practitioners with no oversight for their investigations or care. There was a lack of understanding of local services / processes and a passive approach to management and investigation of these children – often brought back for review without commencement of therapy.
- *Mitigation by other services* – in a number of the no harm cases there was a lack of timely review by Community Paediatrics, however this was mitigated by other clinicians and therapists.

5) Community Paediatrics Oversight Group Findings

(i) Delay in timely follow up of patients – this was both planned, i.e. decision to follow up patient in 2 years when needed earlier review but mostly unplanned, i.e. decision to follow up in 1 year but not seen for 3 years. The latter due to lack of capacity and a decision between CHCP and CCGs in October 2016 to prioritise statutory work.

(ii) There were multiple 'front doors' for children/young people in terms of accessing neuro-disability services, lack of clinical streaming and clear entry points to services for parents was identified as a contributing factor in preventing patients accessing appropriate and timely assessment and treatment.

(iii) There was an apparent lack of understanding of roles and responsibilities, particularly obvious in the management of spasticity. It would be an expected role of the Community Paediatrician to commence antispasmodic treatments such as Baclofen before onward referral. There was a lack of continuity of care and there appeared to be a belief that the Orthopaedic Surgeons would provide such treatment (outside their remit) or requests for the GP to refer on to Neurology or tertiary Neurology without the commencement of basic management.

(iv) Clear patient management pathways and MDT working were not evident, for example, there are clear guidelines for the management of spasticity (NICE CG145 2012) and hip monitoring in cerebral palsy. There is no evidence that these were followed.

(v) There was a lack of an established clinical pathway for conditions including Cerebral Palsy or Down's syndrome although this was mitigated by patients entering the HUTH neuro-disability pathway.

(vi) Medical workforce shortages due to difficulties in recruitment and retention remained a constant challenge with high dependency on locums, resulting in patients seen by multiple practitioners with no oversight for their investigations or care. There was a lack of understanding of local services / processes and a passive approach to management and investigation of these children who were often brought back for review without commencement of therapy. It is acknowledged that challenges in medical recruitment and retention were significant contributing factors to CHCP's inability to deliver the contracted service.

(vii) The City Health Care Partnership (CHCP) received increased referrals and demand for assessments for both ADHD and ASD, which coupled with workforce shortages meant patients and their families experienced excessive waiting times.

(viii) The lack of a shared record keeping system led to significant delays in referrals and sharing of information, a key issue in respect of notification to health services of children who have become Looked After.

(ix) When concerns regarding risk were raised with commissioners, escalation processes were used appropriately and responses made. However, there was a disconnect between the contractual performance of the service and patient safety.

(x) Clinical prioritising was evident in managing patient referrals to assessment and treatment, however, harm occurred due to long waits for patients referred. This was because of a weighted priority of statutory duties associated with LAC and Special Educational Needs (SEND) over the clinical needs of other patients.

(xi) In a number of the no harm cases there was a lack of timely review by Community Paediatrics, however this was mitigated by other clinicians and therapists or the families themselves.

(xii) In response to concerns raised and a reported serious incident, assurance and governance has been gained by promptly establishing the Community Paediatrics Oversight Group with an Independent Chair and an Independent Paediatrician reviewing cases.

(xiii) The new service structure design from HUTH and committed to by the CCGs, has taken the lessons learnt from this incident and, dependent on the posts being filled, will significantly reduce the risk of a recurrence. It is important that appropriate monitoring is in place whilst this new service becomes established and the risk over recruitment remains.

6) Actions Taken to Mitigate Harm Suffered by Children

(i) Under the GMC Duty of Candour the organisations have a legal requirement to inform people (or their families / carers acting on their behalf) when they have been harmed as a result of the care or treatment they have received. There should be assurance that this has been done for those identified as moderate and mild harm.

(ii) Following the desktop validation over the course of 2019, all the children in the transferred caseload including those deemed to have suffered harm were seen with their carers by a Consultant Paediatrician. All children with a diagnosis of cerebral palsy have been transitioned to a dedicated clinic led by a Paediatrician with training in Neurodisability and their clinical needs are being addressed with involvement of the multidisciplinary team and regular reviews.

(iii) Incidents where harm was believed to have occurred have been logged within the clinical governance systems; there is a system wide commitment that parents/carers receive an apology and full explanation of the nature of the shortcomings in their child's care.

(iv) The family of the child who suffered serious harm have received a full explanation, a copy of the SI report and an unreserved apology.

(v) An interim apology is being sent to the other children found to have suffered harm, pending consent from the families to the then provider for them to conduct individual case reviews.

(vi) A process to formally address the Duty of Candour requirements needs to be put in place following confirmation of the number of patients who have been deemed to have been harmed (12).

7) Review of Service Re-design and Recovery Plan Instituted by HUTH Community Paediatric Team

(i) An initial clinical desktop validation was completed as agreed and within the schedule by 31 August 2019 and HUTH quickly established a governance structure and implemented a recovery plan to manage the clinical risk associated with the transfer of a large cohort of children/young people through these work streams:

- Referral pathways
- MDT pathways
- Audit and governance
- Workforce
- Service feedback
- Case validation and identification of harm.

(ii) HUTH carried out extensive workforce modelling both using previous demand figures provided by CHCP and guidance from the British Association for Community Child Health on expected future demand. This showed a need to resource 9 WTE Consultant Paediatric or Associate Specialist posts and two Nurse Practitioner posts.

(iii) In modelling their service delivery HUTH have incorporated national learning and pathways provided by the National Confidential Enquiry in Paediatric Outcome and Death – Chronic Neurodisability (NCEPOD) and the National Institute of Clinical Excellence (NICE). Of particular note they have incorporated designated time for MDT meetings, ward reviews, and palliative care work as well as education and training.

(iv) On the basis of the scope of the Community Paediatric Medical Service submitted by HUTH, it was concluded that this would create a high-quality community paediatric service for Humber and East Yorkshire as long as the posts could be filled, which is a significant challenge due to the national shortage of Community Paediatricians.

(v) In the light of taking on such a large cohort to ensure a robust case management process was in place, an electronic referral triage system was established.

(vi) All referrals for the Neurology / Neurodevelopmental / Community Paediatric Medical Service were collated and triaged by a Consultant, thus ensuring each child was seen in the most appropriate clinic. Any referrals falling outside of this streaming were immediately signposted to suitable alternative services.

(vii) From the outset all referrals for statutory assessments (SEND / LAC) have been placed in a separate dedicated referral pathway.

(viii) The clinical lead has established dedicated specialised clinics e.g. neuro-genetic, neurodisability and neurodevelopmental. Underpinning these are local pathways with defined clear roles and responsibilities for different clinicians caring for the child or young person as part of a multidisciplinary team comprised of medical staff, therapists and social care enabling holistic child and family centred care.

(ix) Working in collaboration with both HUTH and HTFT there are plans to establish a regular MDT for Autism/other conditions where shared working would be beneficial. Within HUTH MDT pathways were put in place for all the following clinical streams:

- Complex disability MDT (monthly).
- Neuroradiology MDT (weekly).
- Neurophysiology MDT (monthly).
- Neuro-genetic MDT (monthly).

- Neuro-ophthalmology MDT (monthly).
- Palliative care MDT (6 monthly).

(x) Workforce remained an ongoing challenge, with significant shortfall in the medical team. Whilst working to appoint to two additional substantive Consultants and a Nurse Practitioner in the near future, the service remained heavily reliant on agency locums with robust oversight and quality assurance processes in place. In progressing with the transfer of care however a number of designated lead roles were successfully established to align with the paediatric services and clinical streaming provided by HUTH, these included:

- Cerebral palsy service lead role: Dr Lorna Highet.
- Neurogenetic service lead role: Dr Lorna Highet/Kate Woodrow (Nurse Practitioner).
- Neurology/Neurodevelopmental/Epilepsy service lead role: Dr Sandhya Jose.
- Neuromuscular service lead role: Dr Vishal Mehta.
- Autism MDT support: Dr Francis Umerah.
- Sleep service lead role: Dr Sandhya Jose/Kate Woodrow (Nurse Practitioner).

(xi) HUTH have now undertaken a full revalidation with two key aims, namely to ensure 100% of children were identified and assigned to correct pathways and to prioritise review of patients where care has deviated from accepted practice. The care of 130 children and young adults with ADHD was transferred to HTFT in November 2019, additional locum capacity being secured to ensure timely medical review of these patients. HTFT and commissioners are working to ensure there are additional substantive staff to give sufficient long-term capacity to care for these patients. The HUTH team will work with HTFT to identify any patients who should have been referred for an autism assessment and ensure diagnosis tracking and a review process is in place in HUTH in order to identify these children and young people.

(xii) HUTH have completed three audits. These were related to the following:
- Trisomy 21.
- Neurofibromatosis (NF1).
- SEND pathway.

(xiii) The baseline compliance to NICE Guidance for Cerebral Palsy has been assessed and HUTH are currently reviewing compliance with NCEPOD standards.

(xiv) In making further improvements, HUTH have now increased the capacity of complex disability clinics and developed a clinic area that is disability friendly. They have also expanded the remit of the Complex Disability MDT to include all complex neurodisability patients for Hull and the East Riding establishing secure links with the tertiary Spasticity Team.

(xv) The new service structure design from HUTH, with wholehearted committed support from the 2 CCGs, has taken the lessons learnt from this incident and, dependent on the posts being filled, will significantly reduce the risk of a recurrence. It is important that

appropriate monitoring is in place whilst this new service becomes established and the risk of insufficient workforce remains.

(xvi) More robust governance arrangements are now in place as part of the Humber Coast and Vale integrated care system. Humber partnership arrangements have been established to accelerate progress in delivering the NHS long term plan (Appendix 5), including the establishment of the Humber Clinical and Professional Leaders Board which provides clinical and professional expertise to design and drive forward 6 key collaborative programmes of work, one of which is Children's and Young People's services. This has a Senior Responsible Officer at CEO level and will enable a more robust approach to clinical decision making, prioritisation and risk management.

(xvii) In the opinion of Dr Morris, the model developed is likely to attract Community Paediatricians to the posts as the model demonstrates a true commitment to the service and the development of the staff. The clinic structure and the time dedicated to MDT meetings and ward reviews would be the envy on many Community Paediatric Departments. Nationally there has been a lack of importance placed on Community Paediatrics by Acute Trusts and CCGs. This model, which has been committed to and funded by the CCGs, should expect to provide a nationally leading service for the children and young people of Humber and East Yorkshire.

(xviii) HTFT are developing Neuro Diversity Pathways (ADHD, Autism, Dyspraxia and Tourette's syndrome) working in partnership with all stakeholders including young people and families and local authority services e.g. Education.

(xix) HTFT has established a paediatric / CAMHS interface meeting that takes place bimonthly and provides the opportunity for senior clinical leads and operational service delivery leads to discuss any individual care or shared care delivery service concerns. The agenda is set by both organisations and enables an opportunity to address issues and celebrate good practice.

8) Lessons Learned

Since the transfer of this service and this review, learning has already been applied and incorporated into the design of a new Community Paediatrics Service.

(i) In modelling a Community Paediatric Service national learning and guidance should be followed, for example using pathways provided by the National Confidential Enquiry in Paediatric Outcome and Death (NCEPOD) – Chronic Neurodisability: Each and Every Need which describes the need for expert assessment, multidisciplinary investigation and management along appropriate clear care pathways understood by patients, parent/carers and referrers. In developing the service for specific conditions, the management team at HUTH have used the National Institute of Clinical Excellence (NICE) Guidelines.

(ii) Designated time should be set aside for MDT meetings, ward reviews, palliative care work as well as education and training. Dedicated clinics dealing with individual conditions and areas should be set up e.g. neurogenetic, neurodisability and

neurodevelopmental. Each clinic should have its own separate clinical lead managing that clinic and those patients. HUTH have already implemented these recommendations.

(iii) There needs to be clear committed clinical leadership for a Community Paediatric service with appropriate time within the job plan of the Lead Consultant. This was appropriately and promptly put in place when HUTH assigned Dr Sandhya Jose to lead the development of clinical pathways and service structure and function.

(iv) There should be local pathways with clear roles and responsibility for different clinicians caring for the child or young person. The multidisciplinary team comprises of medical staff, specialist nurses, therapists and social care so a full holistic discussion can take place around the child and their family.

(v) Care must be taken to ensure that meeting performance targets and achieving financial balance are seen in their clinical context.

(vi) Despite national shortages of Community Paediatricians these difficulties are not insurmountable. As HUTH have demonstrated, with clear leadership and dedicated hard work a service can be successfully reconfigured despite the uncertainties inherent in a transfer of service providers.

(vii) Following service change, care pathways should be audited; HUTH have completed three audits.

(viii) Regular paediatric/child and adolescent mental health services interface meetings can provide an opportunity to discuss individual cases and service delivery to ensure patients' needs are considered from all angles and that no child's care falls between providers.

(ix) When service shortcomings lead to patient harm, there should be a prompt and open minded review of what has happened by all the stakeholders. Patients and their carers should receive an apology and full explanation. There should be a critical analysis of the lessons learned and changes implemented. This is most likely to be achieved if all commissioners and provider stakeholders actively participate.

9) Conclusion

Reviews of services failing to meet patients' needs always make sad reading, especially when set against a background of immense difficulties of staff recruitment and retention. This review is no exception, and the impact on children, young people and their families is a matter of deep regret.

This report also highlights the honest and open appraisal of what happened, the “whole system” willingness to invite independent external review, and the prompt and most energetic action in the light of the lessons learnt. Despite workforce challenges, the reconfigured Community Paediatric Service should be much better placed to care for this vulnerable group of patients and to be an exemplar of good paediatric practice.

Professor Andrew J Cant, B.Sc, M.D., F.R.C.P., F.R.C.P.C.H.

(Chair of the Community Paediatric Oversight Committee)

APPENDICES

Appendix 1

Contractual Transfer of Community Paediatric Medical Service Oversight

TERMS OF REFERENCE

1. Background/Rational

The contractual commissioning of the Community Paediatric Medical Service was transferred from CHCP to both Hull University Teaching Hospitals NHS Trust and Humber Teaching NHS Foundation Trust on 1 April 2019.

Following this transfer, it was found that there were delays in patient referral and out-patient review to a degree that may have impacted upon the assessment and treatment pathways for these children. It was found that the waiting times for referrals and reviews were greater than was reasonable.

2. Aims and Objectives

Our aim was to understand what happened and why, to identify any cause for concern, to achieve an agreed satisfactory position in which all referrals and reviews are seen in a timely manner, risks identified and mitigated, and all cases managed safely and effectively. Furthermore, to ensure that lessons are learnt and shared, to inform the wider transformational programme for children and young people, system wide, for the future.

a) To ensure validation of all cases currently held on system partner's referral, assessment and treatment systems.

b) To validate the number of children and young people per provider on active waiting lists for referral and treatment.

c) To ensure scrutiny in tracking and maintain oversight of the timeline of validation via live progress reporting and feedback from dedicated work stream on caseload review and management.

d) To provide the surveillance and management of any identified concerns and risks for system partners.

e) To direct and mobilise support to achieve robust management systems and processes, ensuring mitigation to the identified risks is in place.

f) To identify those children and young people who have not been seen as they should, the referral, assessment and review process, including those who have relocated.

g) To maintain oversight and gain assurance in respect of capacity and resources required in managing caseload referrals, care and treatment reviews.

h) To ensure there is ongoing support for children, young people and their families and carers.

i) To ensure a clear and consistent plan for communication, messaging and engagement is in place across Hull and the East Riding of Yorkshire. Ensuring communications are planned and co-ordinated in respect of the audience which may include regulators, NHSE-I, media and MP's.

j) To seek assurance in respect of any unintended consequence or evidence of harm or safeguarding concerns, reporting and investigating this as aligned with the national framework for reporting.

k) To acknowledge key lines of enquiry and further areas of scrutiny and identify where learning has occurred and a change to current commissioning and service provider arrangements is to be considered or applied.

l) Receive recommendations for the work stream in relation to improvements in clinical practice, commissioning and pathway development.

m) To inform and make any necessary recommendations to the wider transformational programme for children and young people system wide.

3. Reporting Arrangements

A record of all meetings will be taken and held, the notes of which may be used to inform Senior Management and Executive Teams within individual organisations.

4. Organisational Membership

- An Independent Clinical Chair appointed after consultation with NHSE&I.
- Hull University Teaching Hospitals NHS Trust.
- City Health Care Partnership.
- NHS Hull Clinical Commissioning Group.
- NHS East Riding of Yorkshire Clinical Commissioning Group.
- Humber Teaching NHS Foundation Trust.
- NHSE&I.

Attendance will be monitored throughout an agreed time by the Executive Oversight Group and any concerns will be raised with the Chair of the meeting and associated work-stream meetings. The quorum for the meetings will be not less than three member's representative from system partners. The meetings will be held bi-monthly.

5. Review of the Terms of Reference

The Terms of Reference will be reviewed and ratified by the Executive Oversight Group as and when required.

6. Governance Framework

All system partners will ensure there is both internal communications and escalation within their own governance process.

7. Membership

- Independent Chair.
- NHSE&I Representative.
- Chief Operating Officer or nominated deputy.
- Nominated Director/Deputy of Commissioning (Hull CCG, ERY CCG).
- Expert Clinician/Senior Paediatricians.
- Director of Nursing / Deputy (CCG & provider representative).
- Chief Operating Officer (HUTH, HTFT, CHCP) or nominated deputy.
- Strategic Commissioning Lead for Children & Young People (Hull CCG, ERY CCG).
- Communications representative (when required).

8. Quoracy

This will be achieved by representation from all system partners who shall appoint a single representative member as lead person and decision maker. The appointed member will be responsible for ensuring the ongoing throughput within their own internal organisation and governance processes.

Appendix 2

The Provider Clinical and Operational Review Groups

Chair: Provider nominated.

Membership:

- Expert Clinician/Senior Paediatrician Clinical Leads (HUTH, HTFT).
- Chief Operating Officer (HUTH, HTFT).
- CCG representative strategic commissioning leads for Children and Young People.

The Provider Clinical and Operational Review Group: Objectives

a) Validate all cases currently held on each system partner's referral, assessment and treatment systems, in keeping with agreed timelines from the Oversight Group.

b) Identify those children and young people not seen in a timely manner in the referral and assessment process, including those relocated.

c) To identify any concerns and risks for system partners, ensure support is in place to achieve robust management systems, with particular regard for capacity and resource issues, and ensure mitigation is in place.

d) Review and monitor the time trajectory of referrals, review and assessments, through live progress reporting and caseload management systems.

e) To identify and acknowledge any unintended consequence or evidence of harm or safeguarding concerns, reporting and investigating this as aligned with the national framework for reporting.

f) To review existing clinical pathways for children identifying where they require strengthening and development, advising the Executive Oversight Group and other interrelated groups of any findings and recommendations of actions required.

Appendix 3

Lookback and Lessons : Objectives (To be carried out by Executive Oversight Group)

a) To review the transfer of both referrals and the case load for the Community Paediatric Medical Service using the agreed methodology of 'appreciative enquiry'.

b) To acknowledge key lines of enquiry and further areas of scrutiny and identify where learning has occurred and a change to current arrangements is to be considered or applied.

c) To seek assurance in respect of any unintended consequence or evidence of harm or safeguarding concerns, reporting and investigating this as aligned with the national framework for reporting.

d) To make recommendations about future learning opportunities across system partners, to influence the change to current arrangements.

e) To support system partners in the sharing of learning and implementation plans through their internal governance systems and processes, both internally and to wider groups.

Appendix 4

Independent Review of Community Paediatric Care and Service Design – Humber and East Yorkshire

Dr Alistair Morris MBBS, MRCPCH, MSc Child Health, PGDip Neurodisability

An external review of cases and the new Community Paediatric Service Design was commenced at the request of the Community Paediatric Oversight Group by Dr Alistair Morris, MBBS, MRCPCH, MSc Child Health, PGDip Neurodisability Consultant Paediatrician with a special interest in neurodisability from Calderdale and Huddersfield NHS Foundation Trust.

The focus of this being to report against the findings on Transfer of Community Paediatric Service from CHCP to HUHT on 1 April 2019 and to make recommendations for actions in ensuring a robust Community Paediatric Service.

As acknowledged prior to transfer a child was identified as having come to harm and this had been investigated as a Serious Incident by HUTH and identified gaps in the service and use of pathways. Therefore, all patients transferred (2,427) had their case notes reviewed by HUTH and an appraisal was made as to whether the patient had come to potential harm.

As acknowledged the Child and Young People with ADHD and ASD were transferred to HTFT.

The focus of review was to:

1. Review a random selection of 'No Harm' cases to provide assurance of appropriate assessment.
2. Review cases identified as harm and with Dr Jose / Dr Wood decide on level of harm and any due diligence needed with regard to this.
3. Identify any common themes resulting in this harm.
4. Appraise the service design for new Community Paediatric Service.

The findings of the external review were submitted to the Community Paediatrics Oversight Group.

1. Review of Cases

2,427 cases were transferred from CHCP to HUTH. Following desktop review 46.2% were discharged. The remaining 53.8% were triaged and reviewed by HUTH.

Of these 68 were identified as having potential harm by the HUTH on first review. On second review 28 were classified as no harm and 40 were classified as potential or actual harm.

Of these remaining 40 – 11 cases had been transferred to CAMHS and therefore no up to date clinical information was available to myself to make an assessment. From the information provided there was potential for harm due to non-timely medication review in these cases which is well recognised[1].

The structure for the review of cases was to:

1. Review a random selection of the 28 cases identified by the HUTH as no harm, to confirm that harm had indeed not occurred and that HUTH decision was appropriate.
2. Review all 29 remaining cases (including the investigated SI) identified as possible or actual harm to assess and rate any harm.

No Harm Cases

Every 5th case in the list was reviewed. I agreed with HUTH in all cases that no harm had occurred. I am confident that their assessment has been appropriate for this group of cases.

Potential Harm Cases

Of the 29 cases there was:

- 17 No Harm.
- 3 Mild Harm (minimal harm – patient(s) required extra observation or minor treatment).
- 8 Moderate Harm (short term harm – patient(s) required further treatment, or procedure) (7 confirmed, 1 potential).
- 1 Severe Harm - this was the SI already investigated by HUTH (permanent or long term harm).

Under the GMC Duty of Candour the organisations have a legal requirement to inform people (or their families / carers acting on their behalf) when they have been harmed as a result of the care or treatment they have received. There should be assurance that this has been done for those identified as moderate and mild harm.

From my review of these cases there are some common themes that resulted in harm to these patients:

1. Delay in timely follow up of patients – this was both planned (i.e. decision to follow up patient in 2 years when needed earlier review) but mostly unplanned (i.e. decision to follow up in 1 year but not seen for 3 years). In my opinion, the latter was due to lack of capacity resulting in a decision between CHCP and CCGs in October 2016 to prioritise statutory work.

2. Lack of understanding of roles / responsibilities – this was particularly obvious in management of spasticity. I would see the role of the Community Paediatrician to commence antispasmodic treatments such as Baclofen before onward referral. There was a lack of continuity of care and there appeared to be a belief that the Orthopaedic Surgeons would do this (outside their remit) or requests for the GP to refer onto Neurology or tertiary Neurology without the commencement of basic management.

3. Lack of clear patient management pathways and MDT working – there are clear guidelines for the management of spasticity (NICE CG145 2012) and hip monitoring in cerebral palsy. There is no evidence that these were followed.

4. High dependency on locums – this resulted in patients seen by multiple practitioners with no oversight for their investigations or care. There was a lack of understanding of local services / processes and a passive approach to management and investigation of these children – often brought back for review without commencement of therapy.

5. Mitigation by other services – in a number of the no harm cases there was a lack of timely review by Community Paediatrics. However, this was mitigated by other clinicians and therapists or the families themselves.

Conclusion

Whilst the absolute number of cases where harm occurred are relatively low (12 out of 2,427), the impact on this particular vulnerable group of patients and their families is significant. My assessment of harm has focused on evidenced physical harm and fortunately in a number of cases where no harm was identified this had been mitigated by a number of other services outside Community Paediatrics. It does not take into account any psychological harm to the child or family, e.g. delayed diagnosis, as this is not able to be easily measured objectively from the clinical record but is well recognised[1].

I would also conclude that the new service structure design from HUTH (reviewed below), and committed to by the CCGs, has taken the lessons learnt from this incident and, dependent on the posts being filled, will significantly reduce the risk of a recurrence. It is important that appropriate monitoring is in place whilst this new service becomes established and the risk over recruitment remains.

2. New HUTH Community Paediatric Service Design

The RCPCH Community Paediatric Workforce Short Report (2017)[1] was written in conjunction with the British Association for Community Child Health (BACCH) to describe the workforce challenges within Community Child Health in 2017. It is equally applicable in 2020.

The report describes Community Child Health (CCH) as the 'largest paediatric sub-specialty focusing on the care of vulnerable children and families, children with long-term conditions'. This includes children with:

- Developmental disorders and disabilities.
- Complex health needs (including end of life care).
- Behavioural presentations of neurodevelopmental disorders (e.g. Autism, ADHD).
- Safeguarding concerns, who are "Looked After" or being adopted.

It is recognised in the report that "CCH often falls 'below the radar' of NHS Trusts, Health Boards, commissioners and public attention" and that "failings in these services can affect the longer term health and wellbeing of children and families throughout their lives".

I reviewed the extensive workforce modelling provided by HUTH. This used the RCPCH / BACCH workforce calculator[2] alongside previous demand figures provided by CHCP and guidance from the British Association for Community Child Health on expected future demand. The calculator showed a need to resource 9 WTE Consultant Paediatric or Associate Specialist posts and two Nurse Practitioner posts to provide a safe and sustainable service for the population of Hull and East Yorkshire.

The short report clearly demonstrates the need for clinical leadership with appropriate time within their job plan to achieve their role. This was appropriately put in place early through Dr Jose by HUTH to lead the development of clinical pathways and service structure and function.

In modelling their service delivery HUTH have incorporated national learning and pathways provided by National Confidential Enquiry in Paediatric Outcome and Death (NCEPOD) – Chronic Neurodisability: Each and Every Need[3] which describes the need for expert assessment, multidisciplinary investigation and management along appropriate clear care pathways understood by patients, parent/carers and referrers. In developing the service for specific conditions, the management team at HUTH has used the National Institute of Clinical Excellence (NICE) guidelines[4,5].

Of particular note, they have incorporated designated time for MDT meetings, ward reviews, palliative care work as well as education and training.

The clinical lead has established dedicated clinics dealing with individual conditions areas e.g. neurogenetic, neurodisability and neurodevelopmental. Each clinic has its own separate clinical lead managing that clinic and those patients.

Underpinning these are local pathways with clear roles and responsibility for different clinicians caring for the child or young person. The multidisciplinary team comprises of medical staff, therapists and social care so a full holistic discussion can take place around the child and their family.

Conclusion

On the basis of the scope of Community Paediatric Medical Services submitted by HUTH, I would conclude that this will create a high-quality Community Paediatric Service for Humber and East Yorkshire as long as the posts can be filled. This will be the greatest challenge as there is a national shortage of Community Paediatricians[1]. In my opinion, the model developed is likely to attract Community Paediatricians to the posts as it demonstrates a true commitment to the service and the development of the staff from both within the department and by the commissioners.

The clinic structure and the time dedicated to MDT meetings and ward reviews would be the envy on many Community Paediatric Departments. Nationally there has been a lack of importance placed on Community Paediatrics by Acute Trusts and CCGs. This model, which has been committed to and funded by the CCGs, I would expect to provide a nationally leading service for the children and young people of Humber and East Yorkshire.

References

1. The State of Child Health Short Report Series: Community Paediatrics Workforce https://www.rcpch.ac.uk/resources/community-paediatric-workforce-short-report-2017.

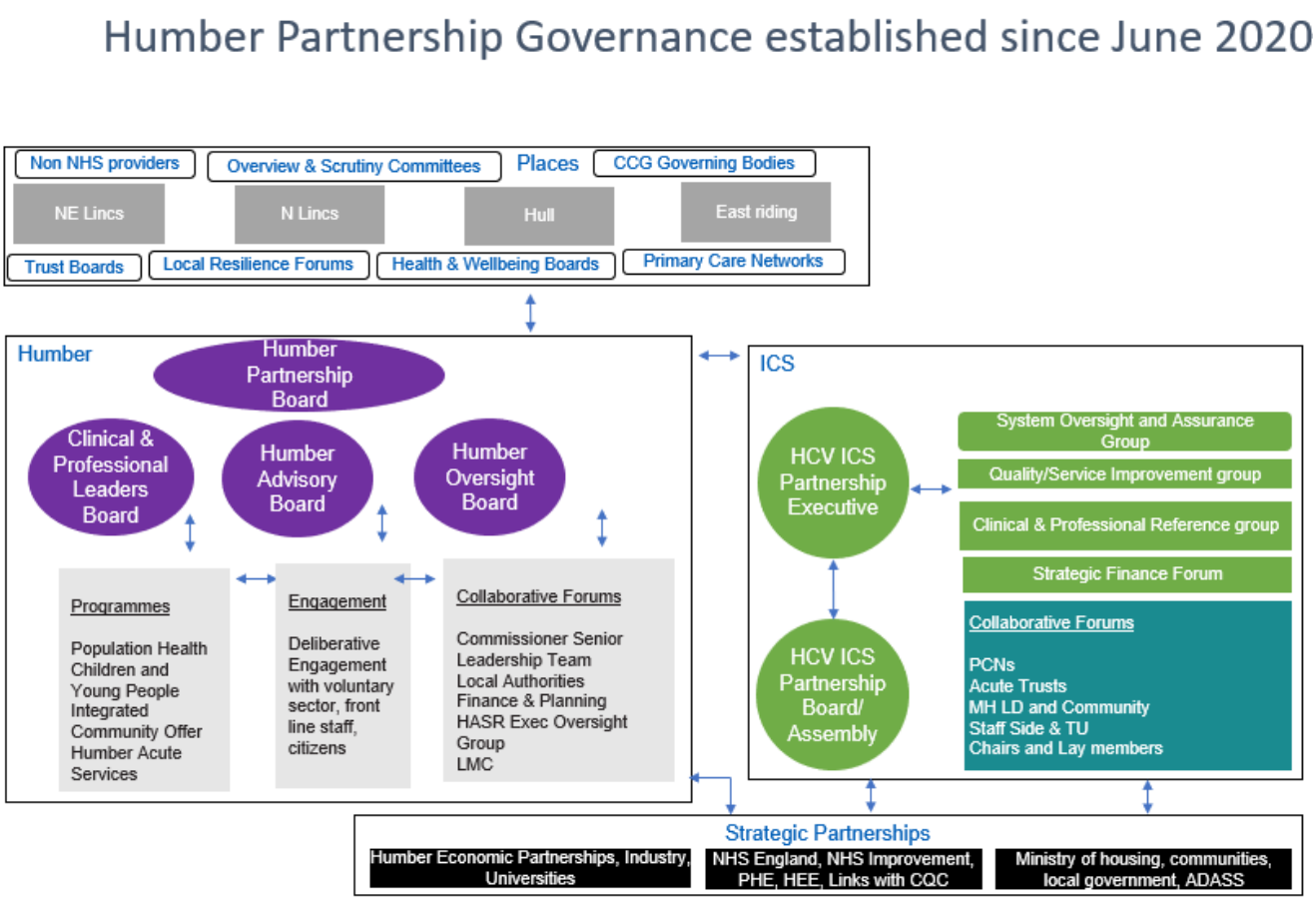
2. RCPCH / BACCH Community Paediatric Workforce Calculator available at : https://www.rcpch.ac.uk/resources/covering-all-bases-community-child-health-workforce-2017.
3. NCEPOD Chronic Neurodisability: Each and Every Need (March 2018) https://www.ncepod.org.uk/2018cn.html.

4. NICE Guidance NG62 Cerebral Palsy in under 25s: assessment and management https://www.nice.org.uk/guidance/ng62.

5. NICE Guidance CG145 Spasticity in under 19s: management https://www.nice.org.uk/guidance/cg145.

6. NHS National Reporting and Learning System Degree of Harm FAQ https://improvement.nhs.uk/documents/1673/NRLS_Degree_of_harm_FAQs_-_final_v1.1.pdf.

Appendix 5 – Future Governance Arrangements



NHS
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NHS Foundation Trust

Agenda item 21

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 29th September 2021</td></tr>
<tr><td>Title of Report:</td><td>Infection Prevention and Control Strategy Refresh (2021-2022)</td></tr>
<tr><td>Author/s:</td><td>Executive Lead: Hilary Gledhill, Executive Director of Nursing, Allied Health and Social Care Professionals

Author: Deborah Davies, Lead Nurse – Infection Prevention and Control</td></tr>
<tr><td>Recommendation:</td><td><table>
<tr><td>To approve</td><td>x</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 Board are asked to support a refresh of the current Infection Prevention and Control Strategy 2018-2022</td></tr>
<tr><td>Governance:</td><td><table>
<tr><th></th><th>Date</th><th></th><th>Date</th></tr>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td></td><td>Workforce & Organisational Development Committee</td><td></td></tr>
<tr><td>Finance & Investment Committee</td><td></td><td>Executive Management Team</td><td></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>Other (please detail)</td><td></td></tr>
</table></td></tr>
<tr><td>Key Issues within the report:</td><td>The current Trust IPC Strategy was developed in 2018 and since its introduction staff have become familiar with our vision and the goals we are aiming to achieve.

Significant progress has been made against the majority of goals however the COVID-19 pandemic has severely slowed progress in the elements of the strategy where face to face patient and public engagement is required.

It is proposed that the strategic objectives will remain in alignment with the current Trust Five Year Plan until December 2022.

• 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 value</td></tr>
</table>

Caring, Learning
& Growing Together

Monitoring and assurance framework summary:

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

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

NHS
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NHS Foundation Trust

Infection Prevention and Control Strategy Refresh 2021-2022

Caring, Learning
& Growing Together

Infection Prevention and Control Strategy 2021-2022

1. Introduction

The acquisition of any healthcare associated infection (HCAI) remains a major cause of avoidable patient harm and has been shown to pose a serious risk to patients, clients, staff and visitors in a health and social care setting. This has never been more apparent as during the emergence and ongoing effect of the COVID-19 pandemic. The impact has and continues to have a significant effect on both staff and patients and has manifested itself in a variety of ways.

The need to embed infection prevention measure in everyday practice therefore has never been more essential and sustained effort is required to drive improvements in order to keep all our patients, staff and visitors safe.

Our Infection Control Strategy was originally developed in 2018 and since its introduction staff have developed an understanding of the vision, values and goals and how achievement of them applies to the work that is delivered by themselves and their teams.

The Covid-19 pandemic has seen some of the most challenging times that both staff and patients have had to face but, due to the hard work and dedication of all of the teams, we have still managed to progress a significant number of our IPC strategic objectives. Where the objectives have relied on face to face engagement however progress has been much slower than we would have liked and we are also still dealing with uncertainties around what the services and environments will look like post pandemic.

The Infection Prevention and control Team recognise that the pandemic has delayed some aspirational element of the infection control strategy that was developed for 2018 to 2021. It is therefore proposed that this strategy period will be refreshed and extended for a further period to ensure that we are fully able to fulfil all the aspirational goals we set but also us to reflect on our journey though the pandemic, ensuring all relevant lessons are learned.

2. The Trust Population and Services

The Trust is a multi-speciality health and social care teaching provider, committed to Caring, Learning and Growing. The Trust provides community, mental health, primary care and specialist healthcare services to approximately 600,000 residents across the East Riding of Yorkshire and Kingston upon Hull.

3. Humber Mission, Vision and Values

Awarded ‘Foundation Trust’ status in 2010, Humber Foundation Trust has grown and diversified to provide integrated health and social care. We work hard to ensure we are accountable and deliver the best possible services in a highly competitive market. Our mission, vision and values are outlined below

As part of the five year plan (2017-2022) the Trust identified six strategic goals to support its ambitions and address improvement requirements. They remain linked to government initiatives, regulatory findings and local health needs assessments based on discussions with patients, carers and families, staff, governors and partners. The goals remain in line with national requirements relating to improving quality and access, delivering transformation and financial

stability and are targeted to address challenges stemming from an aging population with people having changing health care needs and life style choices

Infection Prevention and Control Strategic Objectives

Humber Teaching NHS Foundation Trust recognises that the prevention of infection is fundamental to the quality of care delivered and is committed to ensuring that a consistently high standard of infection prevention and control practice is seen as an essential requirement of assuring high quality patient safety and care within all of our services. The public, patients and visitors quite rightly expect to have a safe stay and receive a high standard of care when admitted or entering any of our care settings.

In line with all other health and care systems the emergence of Covid-19 in 2020 has resulted in us having to develop alternative means to deliver some of the work that was originally planned due to the major challenges that the infection has presented. It is therefore essential that we continue to learn from both our experience and that of others both locally and nationally to prepare for any possible future waves of the virus, but also to build on our learning to bring about positive change and renewal improving the health and wellbeing for everyone, well beyond this crisis.

We intend to remain focused on the 6 strategic goals that we already have in place but aim to capture and implement all the systems learning from COVID-19 to ensure we have resilience to manage any future outbreaks and seasonal pressures.

Goal 01 - Innovating quality and patient safety.

'We will ensure that exemplary infection prevention and control practice is embedded in practice throughout all areas within the Trust.'

Where are we now?

The Trust remains committed to a culture of zero tolerance against the avoidable acquisition of infection and we are proud to report that we have continued to perform well against both national and locally agreed targets.

- The rates of infection for the Trust overall have remained low with no cases of bacteraemia, or hospital onset Clostridiodes difficile to report.
- High standards of hand hygiene compliance have been maintained throughout the year with an average compliance score of 98%.
- Infection control training compliance has exceeded 90% for both clinical and non- clinical staff.
- No inappropriately placed urinary catheters have been inserted within our community or community inpatient settings.
- We have developed and implemented a robust Infection Prevention and Control (IPC) audit and monitoring programme within each clinical inpatient unit.

We acknowledge however that despite the implementation of extensive IPC measures we have not managed to wholly prevent the transmission of COVID-19 within our clinical settings. We have however minimised the number of patients and staff affected by the prompt detection and effective outbreak control procedures and management initiated.

Over the next year we aim to;

Remain focused on minimising the risk to of any patient, staff member or visitor acquiring a Health Care associated infection (HCAI) when admitted or entering any of our care settings

To achieve this we will;

- Identify all learning required from our COVID-19 response, embedding any identified best practice within our ways of working in advance of any resurgence or seasonal pressures in 2021/22.
- Identify any variations in infection prevention and control practice within our clinical teams and address any areas or issues where improvement is needed.
- Utilise the nationally produced IPC COVID-19 Board Assurance Framework document to assess and measure our Trust IPC performance identifying gaps in practice.

- Undertake a post infection review of any outbreaks/ cases of hospital onset communicable disease / HCAI to ensure that we capture and implement the learning required.
- Extend the Infection Prevention and Control Monitoring (IPC) programme to incorporate all of our community and outpatient clinical settings.

How will we know we have been successful?

- No person within our services will be harmed by an avoidable infection.
- We will achieve full compliance against all the elements outlined in the Health and Social Care Act 2008, code of Practice on the prevention and control of infections
- We will demonstrate full compliance against all the key criteria within the nationally produced COVID-19 Infection Prevention and Control COVID-19 Board Assurance Framework document.
- Care Quality Commission inspection reports will demonstrate evidence that exemplary infection prevention and control practices are in place in both the Trust inpatient and non-inpatient clinical areas.

Goal 02 - Enhancing prevention, wellbeing and recovery

"We will ensure all patients are informed about all aspects of their care and ensure they are involved in key decisions'

Engaging with patients, service users and carers is essential in the planning, designing and delivery of any care. Benefits include a more responsive service, improved patient outcomes, improved patient experience and shared decision making. This has never been more important than during times of significant change and uncertainty such as the pandemic

By ensuring patients are provided with clear, easy to understand information about their health/infection and taking the time to talk them through it and answer questions is an important step taken towards helping the patients make the best choices with regards to their management of health.

Where are we now?

A review of all patent related infection control information has been undertaken to ensure that it remains current and in line with national guidance and is available on both the Trust Internet and Intranet sites.

We however acknowledge that due to the COVID- 19 restrictions we have not had the opportunity to spend as much time with our patients and patient groups as we would have liked to learn from their experiences during this pandemic.

Over the next year we will;

- Create additional opportunities to actively engage with our patients and patient groups so that we can identify what we can do to improve their experiences when suffering from a communicable infection such as COVID-19.
- Learn and change our practice where required so we are continuously improving in line with best practice and the patient's needs
- Develop an enhanced IPC communication platform to maximise involvement with our patients, service users and carers

How will we know we have achieved this?

We will;

- Demonstrate that adjustments have been made to our care delivery when required as a consequence of the patients' or carer's feedback.
- Have developed a suite of patient information leaflets that reflect the patients need and are current, evidence based and readily accessible to all.

Goal 03 - Fostering Integration, partnership and alliances

We remain committed to working in partnership to improve the care we provide by being open, transparent and inclusive'.

Where are we now?

We acknowledge that working collaboratively across organisational boundaries has been an essential component in the reduction of HCAI and as such the Infection Prevention and Control Team have availed themselves of every opportunity to work in partnership with colleagues across the across the region and the local health and social care economy to support a system wide approach to the COVID-19 pandemic.

Regular collaborative meetings attended during 2020-2021 included;

- The Humber Coast and Vale Healthcare Associated COVID-19 Infections Meeting Group
- The newly formed 'North East and Yorkshire Lead Nurses Forum'. This has provided the opportunity to review and provide feedback on national guidance

The Lead Nurse has maintained regular contact with the members of both the Yorkshire Infection Prevention and Control Society Meeting and the IPC Mental Health Special Interest Group by a monthly virtual meeting and the regular usage of 'WhatsApp' This has been invaluable in the provision of mutual support and sharing of information during such a challenging period. Learning has been shared both locally and nationally but it has also greatly helped to aid in the interpretation of the constantly changing COVID guidance.

Over the next year we will;

- Sustain the positive engagement with our colleagues across the local and regional patch.
- Avail ourselves of every opportunity to represent the Trust on both local and national IPC working parties and or groups.

How will we know we have achieved this?

We will have;

- Demonstrated shared learning with regional partners by the continued attendance at regular and local and regional meetings
- Demonstrate representation on national working parties and groups
- Contributed to the consultation process of national and regional IPC guidelines and policy.

Goal 04 - Developing an effective and empowered workforce

'We are committed to ensuring that exemplary infection prevention and control principles are firmly embedded within every staff members daily practice'

As a Trust we remain committed to demonstrate excellence in the quality of care we deliver to our patients. We want to ensure that every member of staff delivers care that remains evidence-based.

Where are we now?

The pandemic has required us to deliver a significant amount of additional of training as services have had to strengthen the staff's skillset. We have reviewed our current training approach and where training was previously undertaken face-to-face we have developed a variety of online /virtual sessions to support staff.

The IPCT have developed/and/ or provided input in to a variety of other policies and Standard Operating Procedures (SOPS) that have, and continue to support staff in the delivery of care including the emergence of COVID -19.

Over the next year we aim to;

- Enhance further the virtual IPC educational activities and resources available to promote the application of IPC best practice.
- Review and refresh the infection prevention and control mandatory training programme to ensure it remains responsive to both national requirements and staff needs.
- Explore ways to increase further the level of communication and engagement with staff working in community settings.

How will we know we have achieved this?

We will have;

- Developed a focused, relevant and accessible IPC training programme which takes into account of individual learning needs and local and national requirements.
- Developed e-resources that enhances the IPC agenda and supports the application of clinical best practice.
- Maintained an excellent Trust wide compliance rate.
- Increased the number of infection prevention and control link practitioners within the community settings.

Goal 05 - Maximising an efficient and sustainable organisation

'We are committed to providing a health care environment that is clean safe and facilitates the prevention and control of infection'

The design, planning, construction, refurbishment and ongoing maintenance of the healthcare facility plays a crucial in the prevention and control of infection. The physical environment has to assist, not hinder, the undertaking of good clinical interventions. The failure to assess the IPC risks properly can lead to expensive redesign later and expose the patient and healthcare worker to infection hazards.

Where we are now?

The Trust has an ongoing programme of capital investment which is approved by the Trust Board annually. The subsequent deployment of approved capital is delegated to the Capital Programme Board which meets monthly and reviews overall programme allocations and delivery. The pandemic has however highlighted challenges within our predominantly aging estate and a massive additional amount of work is still required to improve both staff and patient safety. Multi-disciplinary environmental risk assessments have been undertaken across the trusts sites to ensure that workplaces both clinical and non-clinical are compliant against the national recommendations for making the work place a COVID safe environment. The risk assessments remain under constant review to ensure they remain compliant with IPC standard precautions.

Over the next 1 year we will;

- Ensure that there are robust measures in place to ensure that Infection Prevention and Control is seen as a priority during any work that is being planned /completed.
- Ensure that infection prevention and control (IPC) is designed-in at the planning and design stages of a new-build or refurbishment project and that input continues up to the final build stage.
- Ensure that there is timely, comprehensive and collaborative partnership between all parties to achieve IPC goals specific to each construction project;

How will we know we have achieved this?

- We will achieve full compliance against all the elements outlined in the Health and Social Care Act 2008, code of practice on the prevention and control of infections (2015)
- We will demonstrate full compliance against all the key criteria within the nationally produced COVID-19 Infection Prevention and Control COVID-19 Board Assurance Framework document.
- Evidence will be available of IPC involvement and sign off available for all stages of any completed building projects.

Goal 06 - Promoting people, communities and social values

'We will promote the importance of infection prevention and control community wide'.

We are extremely disappointed to note that our usual high level of IPC engagement and attendance at both national and local events has not been possible during 2020 due to the impact of the pandemic. It is hoped that all promotional events and IPC involvement will be resurrected in the oncoming year.

What do we now need to do?

A member of the IPCT will continues to represent the team as a "champion" within the Patient Experience Forum and work will continue to explore all potential opportunities to engage with patients and the public to seek their views and to receive feedback about the services we provide.

We will have;

- Promoted and celebrated all relevant national and local patient infection prevention and control safety initiatives.
- Adopted the usage of a variety of key media styles, including the internet, intranet, and social media to promote effective infection prevention and control practice.

6. Strategy implementation, monitoring and review

The DIPC will lead in the implementation of this strategy ensuring the objectives are converted in to deliverable actions. The DIPC will be supported by the Health Care Associated Infection Group who will co-ordinate the delivery of the approved action plans.

Delivery against the strategy will be formally monitored through the Quality Committee. A detailed work plan will be produced to support the delivery of these objectives and an update of progress will be provided as part of a Bi-annual Director of Infection Prevention and Control Report and the Annual Infection Control Report.

The Trust Board will receive the annual report, supplemented by exceptional reports on operational priorities as required.

The Trust Annual Report will contain a formal statement of IPC activity during the previous year as part of the Assurance Framework. In order to support further development, the Trust will continue to benchmark performance against national best practice.

A detailed work plan will support the delivery of these objectives and an update will be provided as part of the bi-annual Director of Infection Prevention and Control Report.

The strategy will be delivered through;

- The formulation and delivery of a Trust IPC Annual Healthcare Associated Infection Reduction Quality Improvement Programme.
- The completion and regular updating of the IPC Board assurance Framework Document.
- Clear lines of responsibility and effective performance management of all service leads.
- The formulation of IPC policies and procedures which reflect national policy, statutory requirements, latest guidance and local need.
- The inclusion of IPC issues in all business planning processes as a matter of course.
- A varied Trust IPC educational Programme taking in to account a variety of differing learning styles.
- Local and Trust performance management; performance against HCAI targets are reported through the Trust key performance indicators.
- A programme of IPC assurance reporting, led by the matrons and other clinical leads; including progress with IPC audit action plans, environmental issues and observation of clinical practice.

7. Roles and responsibilities

The effective prevention of HCAI requires the commitment and active involvement of all employees. It is therefore vital that the IPC process is communicated and embedded throughout the organisation.

The **Chief Executive** has overall responsibility for IPC, on behalf of the Board of Directors of the Trust. In addition, the Chief Executive is responsible for ensuring that the Trust is in a position to provide overall assurance that the organisation has in place necessary controls to manage infection prevention and control. The Chief Executive will need to provide evidence that the Trust's IPC Strategy is being implemented, with systems and processes being regularly reviewed and that, where deficiencies are identified, developments and improvement mechanisms are being put in place with the overall aim of continuous improvement.

All Board members share in the overall corporate responsibility to support the implementation of the IPC Strategy.

The **Director of Infection Prevention and Control** has specific responsibilities to advise the Board on all issues relating to Infection Control.

The DIPC will;

- Oversee the production and implementation of local IPC policies.
- Oversee the work of the IPCT within the Trust.

- Report directly to the Chief Executive and the Board and not through any other officer.
- Have the authority to challenge inappropriate clinical practice, poor standards of hygiene and antibiotic prescribing decisions.
- Assess the impact of all existing and new policies and plans on IPC and make recommendations for change.
- Be an integral member of the Trust's clinical governance and patient safety teams and structures.
- Produce an annual report on the state of HCAI in the Trust and release it publicly.
- Have overall responsibility for creating a culture of safe and effective practice to reduce HCAI and to ensure that infection prevention and control is accepted as an individual and Trust-wide responsibility.

Care Group Leads

The Care Group Leads will be responsible for ensuring that the IPC Strategy is implemented effectively across all services, which will include;

- The dissemination of the Strategy and allocation of responsibilities for implementation to Service managers and staff.
- Identifying specific IPC issues that might not have been addressed explicitly within the strategy.
- Ensuring that IPC is incorporated into all service planning, performance management, project management, and other related processes.
- Establishing key IPC risk indicators which are monitored, reviewed, and reported as part of the Quality and Patient Safety Committee agenda.
- Ensuring that IPC is included as a core item on all management team briefings / meetings.
- Ensuring that, where necessary, HCAI prevention and control risks are reported on the Risk Register.
- Reporting on performance against agreed IPC objectives, ensuring that any investigations or enquiries into HCAIs or other IPC issues (including root cause analyses) are completed promptly, thoroughly and to agreed timescales.

Matrons / Clinical Lead / Service Manager

Matrons and Clinical Leads / Managers within the Trust have responsibility for;

- Leading and driving a culture of cleanliness in clinical areas.
- Monitoring standards of cleanliness in clinical areas.
- Ensuring implementation of Trust HCAI prevention and control policies and procedures.
- Ensuring that there is promotion of HCAI prevention and control awareness responsibilities amongst employees, services users, contractors, and partners.
- Participation in root cause analysis where required to promote learning and practice improvement.
- Ensuring all IPC aspects of clinical practice are implemented as per IPC policies and procedures, through the use of mandatory hand hygiene assessments, the "Perfect Ward framework and the Trust's clinical competency framework.

Infection Prevention and Control Link Practitioners

The IPC link practitioner's role is to act as a facilitator of good practice in IPC within their own area of work. The link practitioner will;

- Attend IPC link meetings and feedback the information gained to colleagues.
- Act as a resource to staff in their own area of work.
- Participate in standard setting, monitoring and audit.

Infection Prevention and Control Nursing Team

The Infection Prevention and Control Team are responsible for leading the implementation of high standards of IPC practice throughout the Trust. They will work closely with the Infection Control Doctor and the DIPC in promoting good care, training other members of staff, and monitoring performance against IPC targets. They will also support incident and outbreak control procedures, and help to investigate outbreaks of infectious disease.

All Trust staff, in whatever role, have a responsibility to ensure patient safety through the implementation of the best possible IPC practice. As an employee of the Trust, everyone has a responsibility for and a role to play in managing infection prevention and control, which includes:

- Being aware of Trust IPC policies and procedures.
- Adhering to IPC standards as required within their job description/role.
- Alerting managers to any IPC risks or environmental deficits that require urgent attention.
- Participation in mandatory IPC training and hand hygiene assessments (where appropriate).
- Maintaining a clean and safe environment.

Agenda item 22

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 29th September 2021</td></tr>
<tr><td>Title of Report:</td><td>Infection Prevention and Control Annual Report 2020-2021</td></tr>
<tr><td>Author/s:</td><td>Executive Lead: Hilary Gledhill, Executive Director of Nursing, Allied Health and Social Care Professionals

Author: Deborah Davies, Lead Nurse – Infection Prevention and Control</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td>x</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 purpose of this report is to provide assurance to the Trust Board of the progress made in the prevention and control of healthcare associated infections (HCAI) for the reporting period from 1st April 2020 to 31st March 2021.

It provides an overview of the key work undertaken highlighting the progress and achievements made against year 3 of the Trust Infection Prevention and Control Strategy 2018-21. It also provides a summary of the work completed and challenges that have occurred as a consequence of the ongoing COVID-19 pandemic.</td></tr>
<tr><td>Governance:</td><td>
<table>
<tr><th></th><th>Date</th><th></th><th>Date</th></tr>
<tr><td>Audit Committee</td><td></td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>11.8.21</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>
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	Charitable Funds Committee		Other (please detail) HAIG QPaS	6.8.21 19.8.21
Key Issues within the report:	• No hospital onset cases of MRSA. MSSA, E.*coli* bacteraemia or *Clostridiodes difficile* identified during the period of reporting. • High standards of hand hygiene compliance have been maintained throughout the year with an average compliance score of 98%. • The Trust mandatory infection control training compliance rate has exceeded 90% for clinical and non- clinical staff. • No zero events noted for urinary catheter insertions reported via the Trust DATIX system within our community or community inpatient settings. Key challenges noted. • The environmental constraints within the Trust estate to maintain social distancing. • The lack of en-suite provision in the Trust inpatient estate. • The additional work required to ensure that the Trust complies with all ventilation requirements as outlined within the newly published *Health Technical Memorandum 03-01 Specialised ventilation for healthcare premises guidance* June 2020			

Monitoring and assurance framework summary:

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

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			

Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Humber Teaching
NHS Foundation Trust

Infection Prevention and Control

Annual Report

2020-2021

Caring, Learning
& Growing Together

1. Summary

Keeping patients safe from avoidable healthcare associated infections remains one of the key priorities of Humber NHS Teaching Foundation Trust and as such there is a continuing commitment to ensure that the effective prevention and control of healthcare associated infections (HCAIs) is firmly embedded into everyday practice.

The purpose of this report is to provide assurance to the Trust Board of the progress made in the prevention and control of healthcare associated infections (HCAI) for the reporting period from 1st April 2020 to 31st March 2021. In addition the report provides assurance that appropriate measures are being followed to maintain the safety of patients, visitors and staff. Whilst the last year has been dominated by the global COVID-19 pandemic, there have been a number of key achievements which are listed below and will be covered in more detail in the report.

Key achievements for 2020/21

During the past year the trust has delivered the following achievements:

- No hospital onset cases of MRSA. MSSA, E.*coli* bacteraemia or *Clostridiodes difficile* have been reported.
- High standards of hand hygiene compliance have been maintained throughout the year with an average compliance score of 98%.
- Infection control training compliance has exceeded 90% for both clinical and non-clinical staff.
- No inappropriately placed urinary catheters have been reported within our community or community inpatient settings.
- The matrons have been nominated as a finalist for a Health Service Journal award for their innovative work in the management of PPE usage. The outcome is currently awaited. Helen Courtney, Matron in Secure Services spearheaded the campaign to introduce Pocket PPE Packs to all clinical staff, addressing the need to quickly don PPE in dynamic situations.

Key Challenges

Environmental constraints within areas of our estate has posed one of the largest challenges. As with a large proportion of other Trusts across the NHS the ageing estate was not historically designed to manage a pandemic of this magnitude. The limited staff changing facilities, the size of the inpatient units footprint affecting the ability to social distance and the lack of en-suite provision in some inpatient areas are noted to pose significant challenges.

Work is also required to review and implement the recently produced nationally HTM ventilation guidance (HTM 03-01) to ensure the ventilation is adequate in areas where patients particularly with an infectious disorder such as COVID–19 may be cared for.

2. Introduction

The Trust recognises that the effective prevention and control of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

In accordance with the requirements of the Health and Social Care Act (2008); Code of Practice on the Prevention and Control of Infections (2015) each healthcare organisation is required to produce an annual report providing assurance that effective IPC systems and processes are in place.

This report covers the period April 2020 to March 2021 and provides information and assurance to the Trust Board of Directors of the progress made against the Trust Infection Prevention and Control Strategy 2018-2021 and to agree proposed objectives for improvements and developments in infection prevention and control practice during 2021/2020.

3.0 Goals agreed for 2020/2021 as outlined within the IPC strategy 2018-2021

3.1 Goal 01 – Innovating Quality and Patient Safety

'We will ensure that exemplary infection prevention and control practice is embedded in practice throughout all areas within the Trust and that staff are confident in recognising and addressing infection prevention and control concerns'

3.2 Governance Arrangements

The Trust Board recognises and agrees their collective responsibility for minimising the risks of infection and agrees and supports the means by which these risks are controlled. These are outlined in the Trust 'Infection Prevention and Control Arrangements Policy' N-014.

The *Chief Executive* accepts, on behalf of the Trust Board, responsibility for all aspects of Infection Prevention & Control activity within the Trust. This responsibility is delegated to the Executive Director of Nursing, Allied Health and Social Care Professionals who has the role of Director Of infection Prevention and Control within her portfolio and reports directly to the Chief Executive and the Board. Six monthly progress and exception reports have been presented to and monitored on behalf of the Trust Board via the Quality Committee.

The provision of the Infection Prevention Strategy 2018-2021 is seen as an essential element in continuing the Trusts focus on reducing HCAI's and in ensuring compliance to Care Quality Commission (CQC) Outcome 8 (Regulation 12) Cleanliness and Infection Control standards and to national and local targets. The strategy reflects the Trusts vision to be a leading centre of clinical and academic excellence by providing patients with the best possible care through continuous improvement and innovation.

3.3 Key forums for the Management and Monitoring of Infection Prevention and Control Activities

The Quality Committee

The purpose of the Quality Committee is to assure the Trust Board that appropriate processes are in place to give confidence that all quality, patient safety performance and associated risks are monitored effectively and that appropriate actions are taken to address any deviation from accepted standards and to manage identified risks.

The Quality and Patient Safety Group

The Quality & Patient Safety Group is accountable to the Quality Committee. It has been established to oversee and coordinate all aspects of quality improvement (patient experience/patient safety & clinical effectiveness), assurance and clinical governance activity and delivery. This includes all infection prevention and control activity within its portfolio.

Healthcare Associated Infection Group (HAIG)

The HAIG is a multi-disciplinary forum for providing expert advice and organisational perspective and oversight for all matters relating to infection prevention and control.

The HAIG Group provides a forum which receives, reviews and implements national and local policy relating to infection control practice. This forum enables the process of communication, debate, sharing of knowledge and opportunity. The number of meetings was increased during 2021 to allow the opportunity to share the ever-changing IPC guidance and to share learning. 10 formal meetings were held during 2020-2021.

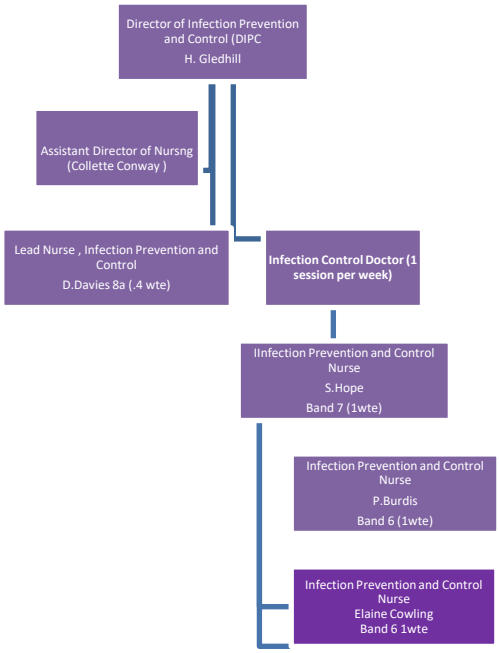
The Drugs and the Therapeutic Group

The Drugs and Therapeutic Group monitors and advise on the optimal and cost - effective prescribing of antimicrobial agents and facilitate the development, implementation and audit of policies, guidelines and protocols related to antimicrobial prescribing, with reference to local variations in antimicrobial susceptibility.

3.4 The Structure and Responsibilities of the Infection Prevention and Control Team (IPCT)

The structure of the nursing team during April 2020 to March 2021 can be seen in Table 1 below. The increasing workload has been a significant challenge during 2020-2021 due to the massive amount of work generated as a consequence of COVID-19 and the level of organisational support required to assist in the interpretation and implementation of constantly changing IPC national guidance. The Lead Nurse increased her hours to provide additional support to the Trust and this continued throughout the year. To improve the resilience team funding was approved for an additional IPC post with the post holder being in situ from November 2020.

Table 1. The structure of the nursing team as of March 2021



The Lead Nurse IPC continues to provide expert clinical advice and is operationally responsible for the development of policies, guidance, infection prevention practice and the delivery of an infection prevention and control educational and training programme trust wide. She has met with the Director of Infection Prevention and Control throughout the year with an increase in meetings noted due to the continuing pandemic status.

Medical support has been provided via a service contract with Closer Healthcare Limited. The 'Infection Prevention and Control Doctor' is currently contracted to provide support for 1 session per week. The contract has been reviewed during 2021 and continues to provide an effective and responsive service when required.

The Infection prevention and control service is provided through a structured annual programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients, and visitors. The main objective of the annual IPC programme is to maintain the high standard already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust.

The IPC Team have been integral to the management of COVID-19 suspected and positive cases and as the pandemic intensified providing support to the Gold, Silver and Bronze Command structures and also dialling into national webinars to ensure they had the most up to date information and guidance which has enabled them to translate this into practice and provide advice, support, guidance, and reassurance to all staff across the Trust.

National Infection Prevention & Control guidance has been followed throughout the pandemic. This has been a monumental challenge at times as there have been 26 updates to the national guidance between April 2020 and March 2021 (39 updates in total since the start of the pandemic). Each piece had to be reviewed, translated into practice, and communicated out to services in a timely manner.

Throughout the pandemic, the IPC Team have maintained a proactive approach with the emphasis on being visible and approachable, particularly ensuring that expert advice and support could be readily accessed by all staff across the Trust. They have been resilient throughout and flexible in their approach. It is pleasing to report however that the team's efforts were acknowledged during May 2020 when they received a Trust GREATix award for going above and beyond in terms of patient safety. The Lead Nurse was also recognised for her leadership efforts by being chosen as a finalist in the Nurse of the Year category in the Hull Healthcare Awards. Unfortunately she was 'pipped at the final post' but she remains very proud of her nomination.

3.5 The IPC Link Practitioner Network

The IPC Link Practitioner programme remains an important support to staff in each clinical area and a large amount of the infection prevention team's time has been spent on ensuring that each area has access to a link practitioner who has received guidance and training to fulfil this role. The membership is now made up of a variety of grades and professions reflecting the diversity of services across the organisation.

There are currently approximately 117 active IPC Link Champions across the Trust within all Care Groups. The link champions have a clearly defined set of responsibilities that describes what is expected of them to ensure the safety of patients, visitors and colleagues. They are expected to utilise their knowledge and skills to support compliance with national standards and help embed IPC practice into everyday clinical care. Work continues as an ongoing priority to ensure that every

service within the Trust has access to a link practitioner and work continues with the relevant Care Group to address these gaps.

3.6 Performance against the Key Performance Indicators for the Mandatory Surveillance of Healthcare associated Infections

Healthcare associated infections remain one of the major causes of patient harm and although nationally there continues to be a reduction in the number of patients developing serious infection such as MRSA bacteraemia and Clostridium difficile the rates of other HCAI have risen due to the emergence of newly resistant organisms.

Our performance, in accordance with all other NHS Trusts has been measured against a clearly defined set of standards (Key Performance Indicators) which includes the mandatory surveillance of specific categories of HCAI. This allows national trends and position to be identified but also enables regional and local benchmarking. A root cause analysis is completed for any case deemed to have been of hospital onset and action plans are developed where issues are identified.

3.6.1 Meticillin-resistant *Staphylococcus aureus* (MRSA) Bacteraemia ✓

(Achieved Trust agreed threshold). 0 apportioned MRSA bacteraemia cases have been identified within the reporting period.

3.6.2 Meticillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia ✓

(Achieved Trust agreed threshold).

There has been 0 Trust apportioned cases of MSSA bacteraemia identified during 2020-2021. The Trust therefore achieved its contractually agreed trajectory.

3.6.3 Clostridiodes difficile infection ✓

(Achieved contractually agreed threshold) 0 trust apportioned cases reported within the Trust in 2020/2021.

3.6.4 Escherichia *coli (E.coli)* Bacteraemia ✓

Escherichia coli (*E.coli*) is a common bacteria found in the intestines of humans. There are many different types, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E coli bacteria cause a range of infections including urinary tract infection, cystitis and intestinal infection and bacteraemia.

Urinary tract infection attributed to the use of an indwelling urinary catheter is one of the most common infections acquired by patients in health care facilities. The high frequency of use of indwelling urinary catheters means there is a substantial burden attributable to these infections. Catheter-acquired urinary infection is the source for about 20% of episodes of healthcare acquired bacteraemia in acute care settings and over 50% in long term care facilities. The most important interventions to prevent bacteriuria and infection are to limit indwelling catheter use and, when catheter use is necessary, to discontinue the catheter as soon as clinically feasible.

3.6.5 "No patient in our community inpatient services should have an inappropriate catheter inserted within our care"

As part of the Trust Safety Programme the inappropriate insertion of urinary catheters was added to the 2019-2020 trust 'Zero Events'. Data collection was commenced within the trust community inpatient wards for each urinary catheter inserted. All care episodes were reviewed by the Matron, Bladder and Bowel Team and the IPCT to determine the appropriateness of each of the intervention.

On the 1st October 2021 the programme was also extended to include all urinary catheters inserted in the community due to a newly diagnosed clinical need. It is pleasing to report that no catheters reported via the Datix system were deemed to have been inappropriately inserted during the period of reporting within either the community or community hospital setting.

A total of 65 urinary catheters insertions were recorded on the Trust Datix system from the 1st April-31st March 2021. 29 (29%) were inserted within Malton Hospital, 17 (26%) in Whitby Hospital and 19 (45%) in the community settings.

Table 2. Urinary Catheters Inserted According to Insertion Location

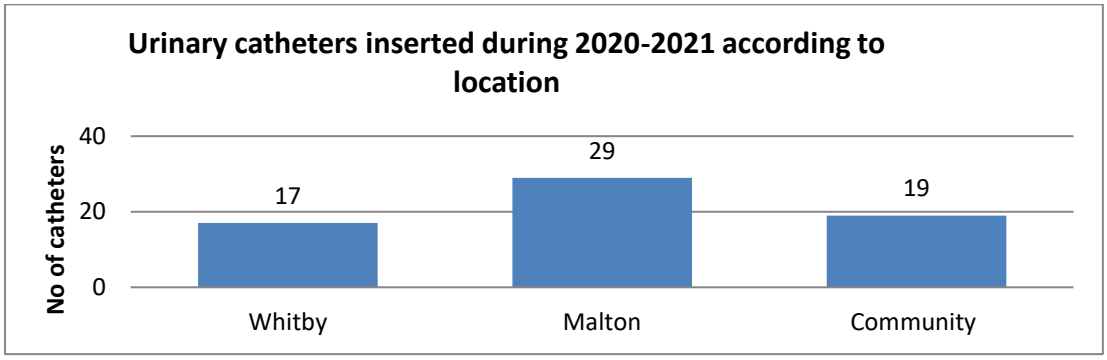
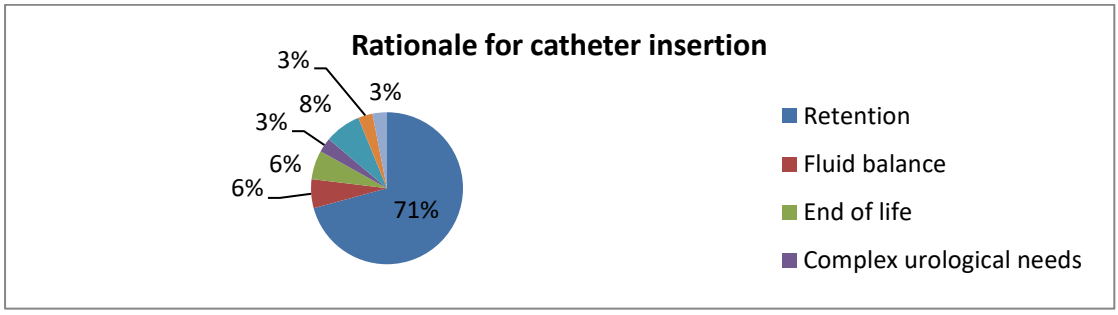


Table 3.Rationale for Urinary Catheters Inserted Within the Community and Inpatient Settings 2020-2021



46 (71%) catheters were inserted due to retention and it is pleasing to note that a bladder scan was performed where appropriate and in accordance with national and local guidance.

2 (3%) catheters were inserted due to complex urological needs. Both were noted to be appropriately inserted and under the care of the urologist.
2 (3%) catheters were inserted due to neurological pathology.
Tissue integrity issues were identified in 5 of the insertions (8%) All were regularly reviewed and removed as soon as the patient's skin improved.
Patient comfort accounted for 2 (3%)

The 4 (6%) urinary catheters inserted to ensure accurate fluid balance recording were inserted in accordance with the NICE guideline [NG148] Published date: 18 December 2019. Acute kidney injury: prevention, detection and management

End of life continence care is seen to be an essential part in ensuring comfort and dignity for the patient in the final stages of their life. In all the 4 (6%) cases identified the use of the urinary catheter was clinically justified.

Of the 33 (51%) of devices inserted as a replacement for a previously inserted catheter there was evidence that the ongoing need for a long-term device was reviewed in all the cases identified. Pleasingly in a number of patients who did not appear to have clear justification/ clinical information within their clinical notes from previous insertions a trial without catheter was completed to determine if indeed a replacement was required

Data reconciliation has occurred monthly to validate the numbers reported within the inpatient settings however this has not been achievable due to the workload of the community teams. The number that have been reported however highlight a high level of staff expertise. Work will continue to ensure and maintain a high level of knowledge and compliance.

3.6.6 Hand Hygiene Compliance ✓ (Achieved Trust agreed threshold)

Hand Hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team continued to promote hand hygiene compliance in accordance with the "WHO five moments for hand hygiene". Hand hygiene compliance, including bare below the elbows is a mandatory requirement for all individuals who provide clinical care as part of their duties.

Opportunistic hand hygiene observations were conducted by the link practitioners within the inpatient and primary care settings on a quarterly basis utilising the Trust approved Hand Hygiene Quality Improvement Tool. As can be seen below in Table 4 the annual compliance threshold of 95% has been achieved in all 4 quarters during 2020/2021.

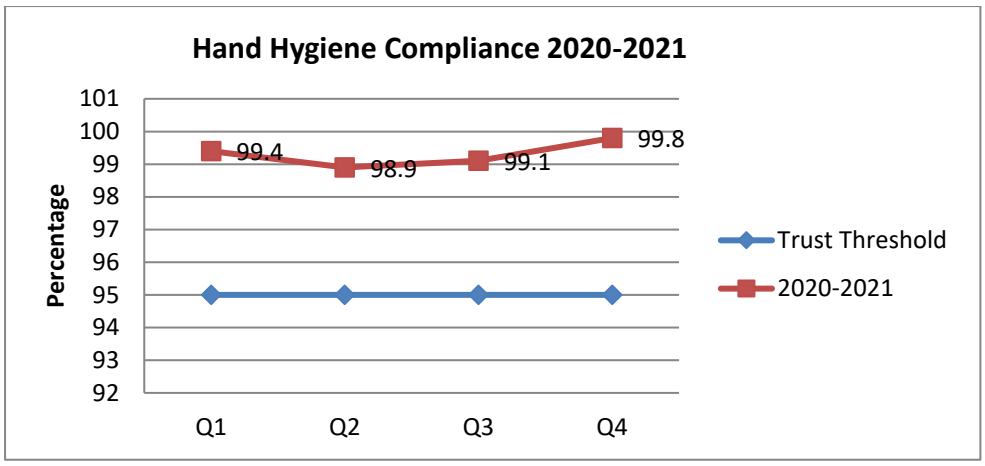
Areas which did not consistently achieve 95% compliance in all quarters include,
Westlands (no data submitted quarter 1) and Derwent (no data submitted quarter 1)
Both areas have now completed and submitted data for subsequent quarters.

Ouse 93% (Q3). Although hand decontamination had occurred in accordance with the 5 moment principles the 'bare below the elbow' requirement was not always adhered to due to either clothing or a wristwatch impeding the access required to effectively decontaminate the wrists as part of the correct technique.

Swale 90 % (Q1) and 90% (Q2). Although hand decontamination had occurred in accordance with the 5 moment principles the 'bare below the elbow' requirement was not always adhered to due to either clothing or a wristwatch restricting access to decontaminate the wrists as part of the correct technique.

Improvement plans were put in place and 100% compliance was achieved in quarter 4 for both areas identified above.

Table 4. Trust Hand Hygiene Compliance Percentage According to Quarter 2020/2021



3.7 Outbreaks of Communicable Infection

Outbreaks of infection continue to be the major cause of infection related incidents in any hospital in the United Kingdom. An outbreak is defined as two or more individuals presenting with the same symptoms suggestive of a communicable disorder connected by place and time. Norovirus historically is the most common organism implicated in any hospital outbreak however no (0) norovirus outbreaks have been identified during 2020/2021.

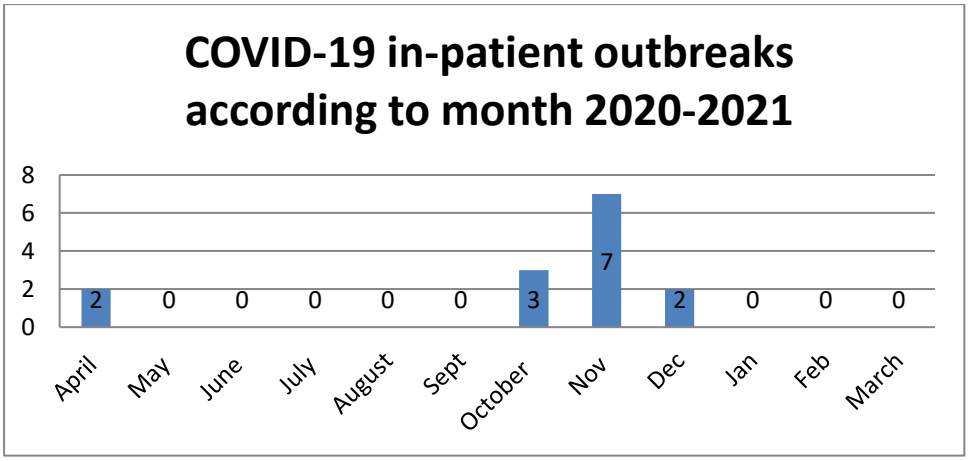
3.8 COVID-19 Outbreaks

In line with the mandatory national reporting requirements the Trust have reported 14 outbreaks of COVID-19 and the locations can be seen in Table 5 in accordance with the month of reporting. The outbreaks can be separated into 2 distinct waves which reflected the local community position.

As can be seen Q3 was the most challenging period within the Trust. This position correlated with a marked increase of community transmission across the region and surrounding community.

Incident and Outbreak Control Group meetings have been held where necessary to support clinical areas in determining whether an incident or outbreak is occurring, ensuring patient safety and preventing onward transmission.

Table 5. COVID-19 Outbreaks According to Month 2020-2021



An outline and summary of the learning identified from the outbreaks identified throughout the year are outlined below. A formal debrief programme has been completed within each clinical area following the culmination of the outbreak, allowing lessons to be learned and actioned by the respective areas

Table 6; COVID-19 Details of Outbreaks and Learning Identified 2020-2021

Unit	Date Outbreak declared	Date outbreak finished	No of patients affected	No of staff affected	Learning highlighted as part of the debrief.
Maister	5.4.20	6.5.20	5/9	1	• The outbreak was managed in accordance with both national and local guidance • Patients did not present with typical COVID symptoms • Significant challenges were faced in the management of patients who have no ability to understand the restrictions and measures required to minimise transmission. • The current environmental estate does not provide adequate provision for suitable donning and doffing of the PPE.
Swale Unit Humber Centre	27.4.20	24.5.20	6/10	0	• Regular communication and IPCT visits to the patients led to a very good level of patient compliance. This included amendments/ curtailment to the activity programme / the requirements for meals being served on the unit not in the communal dining area /no visits to the shop /e-cig machine/ bank. Alternative measures were put in place to address the issues associated with this. Positive feedback received from the patients.

					• Delay noted in the original notification of a potential outbreak to the IPCT • Social distancing measures not adhered to in the office setting in the initial stages of the outbreak • Amendments were required to the Trust policy as a consequence of the pandemic. This included information on the use of scrubs and the laundering requirements.
Inspire unit	20.10.20	28.10.20	0	4	• Good adherence was noted to PPE guidance in the clinical areas. All the young people remained COVID-19 negative throughout the period. • Improvement required to staff's adherence to social distancing and PPE guidance in non-clinical spaces. • Improved communication required with external contractors to ensure that they comply with the trust policies. • Parents and patients informed of outbreak in a timely manner and guidance amended re visiting produced. • Regular Consultation with NHSE (Commissioners) • Staffing issues dealt with in a timely manner
Frankland Unit, Whitby Hospital.	11.10.20.	2.11.20	2	3/71	• Patients isolated as per policy and escalated by staff promptly. • Staff screening completed in a prompt and efficient manner but delays in the turn round of the results heightened staff anxieties • COVID 19 risk assessment documentation to be amended to a more user friendly version. • Improved inter departmental communication required. • Staff reminded of the requirement to refrain from work if symptomatic.
Lilac Unit, Townend Court.	17.10.20.	30.10.20	1/3	2/35	• Good co-ordination between the ward & the IPCT. • IPC visits and support – F2F, virtual and via telephone • Staff swabbing arrangements and peer support to arrange this and have this completed as quickly as it was • Effective communication with patients / patient families • Good support acknowledged from the Community teams • Communication between staff / staff teams difficult & fraught due to level of pressures on qualified staff & senior management team. • The COVID-19 pathway to manage patients with learning difficulties requires a review. It was felt that moving patients across to the Hawthorne Nightingale may not be appropriate.

Ouse Unit	7.11.20	23.11.20	2/13	3/28	• No issues with compliance identified
Newbridges Unit	6.11.20	20.11.20	1/17	5/38	• Patient screening not completed in accordance with Trust guidance. This would have helped in identifying if the patient was in an incubatory phase at admission.
Mill View Court	20.11.20	5.11.20	2/10	2/31	• PPE guidance and social distancing not adhered to by all staff. This has now been addressed and subsequent visits undertaken by the matrons and the IPCT have demonstrated good staff compliance.
PICU	13.11.20.	27.11.20	2/5	8	• Appropriate use of PPE and physical health monitoring. • Timely receipt of positive Covid-19 swab result. • Outbreak meetings felt to be useful for finer details and information sharing between units. • Challenges identified with the lay out of the unit to address the PPE donning and doffing requirements.
Derwent Unit.	18.11.20	30.11.20	1/5	3/25	• COVID-19 patient swab not labelled correctly resulting in a delay.
Ullswater Unit	12.11.20	12.11.20	3/8	7/27	• Staff movement noted between the unit staff and the core team members to cover breaks for the positive patient in long term segregation due to severe staffing pressures • Close contact in the courtyard noted before the positive results known
Westlands Unit	13.11.20	21.12.20	5/13	5/38	• Breeches noted in PPE use noted to the associated challenges with the patient
Granville	1.12.2020	5.2.21	2/12	5	• All families have spoken of the appreciation in the honesty and reassurance that was provided • Staff demonstrated confidence in their appropriate use of PPE and were reassured in regard the stock availability. • Effective workplace planning in place which reduced the transmission risks between bungalows • Support from the Psychology team was deemed to be supportive and beneficial. • The installation of the Portacabin has greatly assisted in reducing the impact of delayed handovers due to staff queuing to change.
Maister	4.12.2020	1.1.21	6	7	• Significant challenges were faced in the management of patients who have no ability to understand the restrictions and measures required to minimise transmission.

The Trust's outbreak policy was updated during 2020-21 to reflect the challenges that have occurred due the emergence of COVID-19 and continues to be adhered to by the IPC team and respective Care Groups.

3.9 Antimicrobial Stewardship

Work has continued throughout the year to review/improve prescribing practice across all areas within the Trust. Electronic prescribing is now in place in all clinical in-patient areas supporting an improved level of stewardship. The system provides empirical guidelines embedded into the system as a prompt but also allows all antimicrobial prescriptions to be checked and the appropriateness to be validated by the pharmacists in a timely manner.

A robust audit programme remains in place within the GP practices allowing bench marking to take place across all GP practices within the region. Any areas of high antibiotic usage or low compliance are identified and actioned when applicable. All findings are reviewed and monitored by the Drugs and Therapeutic Group, the Primary Care Clinical Network meetings and the Healthcare associated Infection Group.

Audits completed during 2020-2021 demonstrated that the volume of antibiotics prescribed in all our primary care practices was rated as appropriate however there is work to do to reduce the amount of Trimethoprim prescribed in 3 of our primary care practices. Plans are currently in place to undertake a full review of the use of Trimethoprim in the 3 areas highlighted to explore the rationale for prescribing.

Disappointingly we were not able to undertake the usual Trust-wide joint IPCT and pharmacy promotional campaign as part of antibiotic awareness week but an event is currently being planned for the World Antimicrobial Awareness Week 18th– 24th November 2021.

4. Goal 02 – Enhancing Prevention, Wellbeing and Recovery

'We are committed to keeping patients informed about all aspects of their care a ensure they are involved in key decisions'

4.1 Patient Information

Patients quite rightly want to be engaged in their health care decision making process and there is good evidence that those who are engaged as decision makers tend to have better outcomes. To support this good quality health information is deemed to be essential. A review of all patent related infection control information has been completed in 2020/2021 to ensure it remains current and in line with national guidance and is available on the Trust Internet and Intranet sites. This has also now been rebranded to reflect the corporate vision.

To support patients and the public a variety of COVID-19 information posters and guidance were developed by the IPCT in the absence of any national literature being readily available during the early stages of the pandemic. Further work continues to ensure any gaps are identified and addressed particularly to ensure all groups of our patients are catered for.

5. Goal 03 – Fostering Integration, Partnership and Alliances

We are committed to working in partnership to improve the care we provide by being open, transparent and inclusive'

Working collaboratively across organisational boundaries is acknowledged to be an essential component in the reduction of HCAI and as such the Infection Prevention and Control Team have availed themselves of every opportunity to work in partnership with colleagues across the across the region and the local health and social care economy to support a system wide approach to the COVID-19 pandemic. Regular collaborative meetings attended during 2020-2021 include,

- The Humber Coast and Vale Healthcare Associated COVID-19 Infections Meeting Group

- The newly formed 'North East and Yorkshire Lead Nurses Forum'. As a consequence of attending this group the Lead Nurse has had the opportunity to review and provide feedback to the national IPC cell on the nationally proposed suite of IPC tools that are currently being designed to cover every aspect of outbreak management. The remit was to ensure applicability to mental health and learning disability areas. Feedback was duly provided.

The Lead Nurse has maintained regular contact with the members of both the Yorkshire Infection Prevention and Control Society Meeting and the IPC Mental Health Special Interest Group by a monthly virtual meeting and the regular usage of 'WhatsApp' This has been invaluable in the provision of mutual support and sharing of information during such a challenging period. Learning has been shared both locally and nationally, but it has also greatly helped to aid in the interpretation of the constantly changing COVID guidance.

6. Goal 04 – Developing an effective and empowered workforce

'We are committed to ensuring that exemplary infection prevention and control principles are firmly embedded within every staff member's daily practice'

Infection control and the prevention of all infection remains a priority within the Trust and ultimately is the responsibility of everyone who works within the Trust. Care should be exemplary and delivered by staff who understand and effectively discharge their roles and individual responsibilities for the prevention and treatment

of HCAI. Work undertaken in 2020/2021 to support all staff in the delivery of their responsibilities includes:

6.1 The Development and Availability of Infection Prevention and Control Policies

In line with the Health and Social Care Act 2008 Code of Practice (2015) the Trust infection prevention and control policies, protocols and clinical pathways have been reviewed and updated by the IPC team ensuring that practice and guidance is current and evidence based. The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. All policies are available for staff to view on the Trust intranet. The IPC have a rolling programme of policies which require updating each year. In addition, policies are updated prior to review date if national guidance changes. Policies and protocols reviewed within 2020-2021 are shown in Table 11 below.

Table 7. Policies and Standard Operating Procedures Reviewed during 2020-2021.

Name of Policy/ SOP	Details of policy content / amendments made to existing document	Date of next scheduled review
Standard Precautions Policy (N034)	A full review and update undertaken to reflect the additional PPE requirements during the COVID-19 pandemic.	January 2023
The Management of an Outbreak of Communicable Infection Policy (N-009)	Review undertaken • Minor amendments made throughout the document • An additional section (5.9) and supporting appendix (7,8,9,10) added to reflect actions to be taken during the COVID-19 Pandemic	October 2023
Guideline for the Management of a Patient with a Transmissible Spongiform Encephalopathy (TSE) (G391)	Full review of the national guidance undertaken. No changes required to the clinical content. Minor amendments made to formatting, wording and references updated with latest version dates	May 2024 .
Isolation Precautions Policy	Scheduled review. Minor changes required only which have not impacted upon the clinical application of this policy. COVID-19 added to appendix 1. An update completed of all the links in appendix a to ensure that all isolation requirements for selected infections information is in accordance with current national guidance.	May 2024
MRSA (Meticillin Resistant Staphylococcus Aureus Policy (N-021)	Full scheduled review. Minor changes required only which have not impacted upon the clinical application of this policy.	October 2023
Clostridioides Difficile Infection Policy (Prevention and Management) (N-010)	Minor changesonly required to reflect the current organisational and committee structures.	March 2024

During the exponential surge period in the UK there was a series of rapid and frequent changes in national guidance, which required implementation at very short notice. A plethora of guidance and action cards has been developed in conjunction with colleagues across the patch and these have been made available on the Trust Intra-net site alongside frequently asked questions, documents, videos, posters and other materials, to ensure up to date information is available to all staff to access. This includes the production of.

- A Standard Operating for The Management of a Patient Suspected or Confirmed As COVID-19 Positive in All Community Services
- A Standard Operating Procedure for the Management of a Patient Suspected or Confirmed as COVID-19 In All Inpatient Mental Health /Learning Disability Units and Community Wards
- Infection Control Guidance for Physical Restraint of Patients Suspected Confirmed as Having Covid-19
- Guidance on Resuscitation and The Use of The Respect Form for A Patient With COVID-19 Including IPC Procedure (G399)
- Standard Operating Procedure for The Selection of Respiratory Protective Equipment (RPE) And Fit Testing Requirements Within A Clinical Environment

The IPCT have also participated in the reviews and amendments of the.

- Guidance for Staff Responsible for Care after Death (Last Offices)
- Uniform, Dress Code and ID Badge Policy (HR-029) to cover the additional requirements that COVID-19 has brought. A constant review of the policies will continue, and changes will be made to ensure all our policies reflect the current national guidance.

During 2020-2021 the IPC Team have also continued to produce a suite of Guidance at a Glance documents for key IPC practice. The one page documents provide staff with a quick reference guide relating to specific IPC policies. In addition to the updating of policies and provision of guidance at a glance, posters have been developed in partnership with the Trust Communication Team to share key IPC messages
All documents have been managed and approved in accordance with the Trust Document Control Policy.

6.2 Infection Control Training Programme

The IPC educational programme is an integral part of the Trust Mandatory Training Programme for all staff and the commitment to education continued to be a priority throughout the year.

The IPC Nurses (IPCNs) participate in the Trust's Corporate Induction programmes for all staff newly appointed by the organisation. Each session delivered contains all the essential elements to comply with all mandatory training requirements. It also includes an introduction to the team and provides training on how to access all

essential IPC information via the Trust Intranet. An online infection prevention and control package remains available for the completion of infection training and it is pleasing to report that the monthly compliance data has remained consistently high

During the period April 2020 to April 2021 the IPCT have also continued to provide a comprehensive, evidence-based infection prevention and control education programme for both clinical and non-clinical staff utilising the virtual platform and e-learning packages. The packages utilised have been reviewed and amended to include the most up to date Infection Prevention and Control Covid-19 guidance.

Additional online 'Keeping Safe During COVID-19 and PPE training' sessions have been undertaken via MS Teams attempting to fit in with different areas requirements and shift patterns.

As shown in Table 8 below the Trust Infection prevention and control compliance target of 85% has been exceeded in every month during 2020/2021.

Table 8. Infection Prevention and Control Training Compliance 2020-2021

Compliance percentage	April 20	May 20	June 20	July 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Level 1 Clinical staff	92.7	93.8	94.0	94.0	94.6	95.0	95.7	95.7	95.8	96.8	97.3	97.3
Level 2 Nonclinical facing staff	94.7	93.5	93.0	93.0	92.2	92.0	92.3	92.3	93.3	92.4	93.1	93.1

6.2.1 PPE Training

Training to ensure that PPE is correctly used has been one of the fundamental measures to prevent the transmission of all infection and infectious diseases and is particularly pertinent in the current COVID-19 pandemic. In addition to the mandatory training programme the IPC team and link practitioners have completed a large number of additional training sessions to ensure staff are confidant and competent in the use of PPE. This has also included bespoke sessions for the Domestic and Estates Teams ensuring that they remain fully conversant with all changes to the infection control requirements when entering both clinical and non-clinical areas.

Compliance has been measured throughout the last year by the link practitioners, matrons and IPC nurses utilising the MY Assurance Standard Precautions and the COVID- 19 observation tools and compliance has generally remained high overall.

Within the mental health and learning disability service matrons have been extremely proactive in ensuing that staff used PPE only when clinically appropriate. They were instrumental in the development of a 'pocket PPE pack' designed to provide the staff with the ability to quickly don PPE in dynamical changing situations. At the time of writing this report they have been informed of their success on being nominated as a

finalist for the annual Health Service Journal award for their innovative work. The outcome is eagerly awaited.

6.3 Fit Testing Educational Training Programme

In accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH) the undertaking of fit test training has been in place within the Trust since 2018 for anybody who potentially would be required to complete a procedure deemed to generate aerosol when caring for a patient who was suspected or confirmed as having a transmissible respiratory infection such as influenza.

The process of fit testing is a means of checking that the respiratory equipment utilised is compatible with a person's facial features and seals adequately to their face. If the seal is inadequate, contaminated air will take the path of least resistance and will travel through leaks in the face seal. Consequently, a poor seal to the face will reduce the level of protection afforded to the wearer.

At the end of March 2021 691 clinical staff were reported to have been fit tested within the Trust ensuring that all clinical areas have a core team of staff trained if required to undertake an aerosol generating procedure in the completion of their clinical duties. The additional workload has placed a massive additional burden for the IPCT to deliver this training. Additional trainers however have now been recruited and trained to support the delivery in a variety of clinical settings.

Despite the use of a Fitted Facepiece category 3 (FFP3) mask being the preferred option for enhanced PPE when airborne infection control precautions are required, it has not always possible to gain a good fit of an FFP3 mask for all Staff, therefore the Trust has invested in a number of Powered Air Purifying Respirator (PAPR), more commonly known as respiratory hoods to ensure staff safety.

A SOP for The Selection of Respiratory Protective Equipment (RPE) and Fit Testing Requirements within a Clinical Environment has been developed to support staff and has been supplemented by a programme of online presentations to support the newly recruited the newly recruited trainers in their new role.

7. Goal 5 - Maximising an efficient and sustainable organisation

'We are committed to providing a health care environment that is clean safe and facilitates the prevention and control of infection'

7.1 Infection Prevention and Control Audit Programme

In line with the requirements of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (2015) the Trust has an IPC audit programme in place which is both environmentally and clinically focused

and targeted at improving infection prevention and control practices for all disciplines across the Trust. Any environmental concerns determined to be of immediate risk are escalated via the Care Group structure and the Clinical Environmental Risk Group.

The environmental audit programme is completed either by the Infection Prevention and Control Team, the infection control link practitioners or the matrons. Any issues identified during the completion of the audit visits were dealt with on the day of the visit wherever possible. The audit results are included as part of the quarterly matron report and are scrutinised at the Healthcare Associated Infection Control Group meeting where each matron is invited to present their reports and improvement plans where required. Despite the demands of the pandemic it is a great credit to the clinical inpatient areas that the audit programme has been maintained throughout this year in the majority of areas. The results of the IPC environmental audits completed in the in-patient areas during 2020-2021 can be seen in the table below.

Table 9. Inpatient Environmental Audit Results 2020/2021

Inpatient Unit	Q1	Q2	Q3	Q4	Main issues identified in areas when compliance score under 90%
Avondale	99%	94%	90%	93%	
Mill View Court	99%	93%	95%	95%	
Newbridges	96%	89%	98%	91%	Lime scale present on water outlets. Inappropriate storage of clinical items impeding cleaning at high level.
PICU	99%	93%	98%	94%	
Westlands	86%	91%	90%	91%	
Maister	98%	98%	94%	94%	
Mill View Lodge	88%	94%	94%	89%	One bathroom noted to be utilised as a storage facility – inadequate level of cleanliness noted. Inappropriate items disposed of in the sharps container.
Derwent	99%	93%	93%	91%	
Ouse	98%	94%	91%	99%	
Swale	97%	95%	95%	99%	
Ullswater	95%	90%	91%	96%	
Pine View	98%	95%	93%	93%	
Lilac	99%	99%	98%	98%	
Willow	99%	100%	96%	98%	
Granville	98%	93%	95%	94%	
Whitby Frankland Ward	91%	91%	95%	96%	
Malton Fitzwilliam Ward	98%	91%	95%	94%	
Orion (CAMHS GAU)		90%	95%	94%	
STaRS		99%	95%	100%	

Key to scores Good Improvement required

Table 10. Primary Care Environmental Audit Results 2020/2021

Surgery	Sep	Oct	Nov	Dec	Jan	Feb	March	Main issues identified in areas when compliance score under 90%
Northpoint	**82**	**82**	**91**					Sep Cleaning issues and marked wall damage / lime scale on taps Nov Most issues reported as resolved
Princes	**93**			**91**				
Peeler	**96**				**98**		**96**	
Fieldhouse					**96**			
Manor House		**79**			**86**			Oct Chips on old Furniture. Clinical sinks not IPC compliant Wall damage. Cleaning check lists not available in all rooms. Jan Sinks remain non-compliant
King Street			**96**					
Market Weighton		**93**						
Practice 2							**80%**	Staff hand hygiene assessments and Donning and Doffing training not evidenced for all staff. HTFT specifications for cleaning standards not achieved. Issues noted with sharps bin collections. Water flushing has not been taking place (estates aware).

Key to scores Good Improvement required

As can be seen in Table 10 above work still is required in a small number of the practices to improve the physical environments and the level of cleaning but this is acknowledged and being addressed. Historically an IPC audit has only taken place annually in all primary care areas where good compliance has been noted however this is currently being increased to quarterly in line with the inpatient settings. Any area which has failed to reach a satisfactory standard has an individual action plan in place and progress is monitored via the Healthcare Associated Infection Group.

Work is still ongoing at Manor House, but a significant improvement has been noted since the since the acquisition during 2019 (an audit score of 51% achieved on acquisition). This has now moved into the acceptable range (87.2%)

Chestnuts Surgery has now been relocated to King Street surgery as part of the redevelopment of primary care services.

An individual action plan has been developed to address the issues identified at the recently acquired Practice 2 in Bridlington (March 2021)

7.2 The Introduction of the National COVID-19 IPC Board Assurance Framework (BAF) Document.

On the 5th of May 2020 NHSE/I issued a BAF document to support IPC and the management of COVID-19. The BAF has been reviewed and updated by the Infection Prevention and Control Team and has now been placed as a standing agenda item on the Healthcare Associated Group Meeting. The report was presented to the Trust Board of Directors providing assurance that we are meeting our responsibilities in the management of the pandemic. The BAF has now been included within the 2021/22 IPC work plan. To aid in the monitoring of IPC performance the BAF framework document has also been utilised within each of the clinical in-patient areas.

7.3 Environmental COVID-19 Risk Assessments

Multi-disciplinary environmental risk assessments have been undertaken across the trusts sites to Trust to ensure that workplaces both clinical and non-clinical are compliant against the national recommendations for making the work place a COVID safe environment. The risk assessments remain under constant review to ensure they remain compliant with IPC standard precautions.

7.4 COVID-19 Observational Audit (March 2020)

In March 2021 Public Health England (PHE) produced a national Checklist and Monitoring Tool for the Management of COVID-19. The tool has been designed to assist in the provision of assurance but also to help identify any preventative actions that need to be taken to reduce risk across different settings. A compliance audits was performed by either the Infection Prevention and Control Team or Matron responsible for the clinical inpatient area during March-April 2021. A good level of compliance was reported across the units. Areas needing improvement or further consideration included;

1. The inability to initiate a separate entrance and exit system in the inpatient areas.

As the tool is deemed to be generic in nature it is felt that it does not reflect the specific security requirements that need to be in place particularly within a mental health settings as having a separate entrances and exit is not always achievable within our estate. Access to all the units is controlled however providing the ability ensuring social distancing measures continue to be adhered to and there is reduced footfall to any one area.

2. Keypads utilised in a large majority of units rather than the alternative of a swipe card system.

It is acknowledged that there is a variety of different security locks across the system and some cannot be changed due to operational and security reasons. It has been

agreed however that keypads will not be used in any new builds refurbishments unless operationally and clinically indicated. A further review and potential replacement programme will be initiated as part of the improvement works that has commenced in each of the clinical inpatient areas.

3. Inconsistent quality to signage at the entrance to the units.

Although COVID-19 signage was available at each entrance to the units the audit found that the signage was of differing quality and did not always depict the details of the pathway that is in operation within the clinical area. A bespoke standardised poster has now been developed and produced in partnership with the Trust Communications Team. These have been circulated to all Unit Managers.

4. Low observed compliance rate of patient facemask use within the clinical area.

Facemask use was noted to be low across all inpatient units despite staff reporting that patients were encouraged when appropriate to do so. Due to the patient population it is accepted that this may not always be possible, and this will continue to be documented within the patients notes.

5. Reported lack of senior leader visibility within the units during the period of the pandemic.

Although the units reported the availability of executives, senior staff and executives via virtual means most areas reported a perceived lack of visible senior presence (with the exception of the matrons) within the clinical areas during the year of the pandemic. It was recognized that the number of visits had reduced but mainly due to the Trust actively encourage national encouraging the adoption of national work from home guidance to ensure the staff safety and reduce transmission risks.

The results were presented at the EMT meeting on the 12th April 2021 and work has commenced to restore the "support and challenge" Executive walk rounds programme.

7.5 Environmental Facilities Development/Refurbishment

The design, planning construction refurbishment and ongoing maintenance of the environment plays an important part in minimising the transmission of infection and the physical environment should assist not hinder good practice. It is therefore important that the IPCT is involved in all new builds and refurbishment projects to provide advice from the infancy of the projects.

During 2020-2021 the Infection Prevention & Control team and the Estates Department have worked closely to ensure that the new and existing patient facilities are constructed in a way that enhances good infection control practice. By considering

infection prevention & control requirements at the early stages, infection control can be ‘designed in’ to a new build or refurbishment.

Despite all endeavours and best efforts it is acknowledged that the maintenance of the environment continues to pose an ongoing challenge. There is a continual need to repair damage caused by individual patients whilst within our care for and the significant amount of resources required to maintain an ageing estate. This has been compounded by the additional COVID 19 requirements that have been placed upon us.

A significant amount of IPCT input has been required and is still needed throughout the ensuing months to ensure that all areas within the Trust continue to provide a safe environment for both patients and staff. To prioritise the work required a joint estates and IPC group meeting has been formed which has provided focus on achieving compliance with all elements required within the Hygiene Code and the COVID-19 Board Assurance Framework Document. This has seen as vital to improve the environment for patients and staff.

In conjunction with the Estates Team and Matrons a joint walk round of each clinical inpatient area has been undertaken to determine the work that is required to improve the facilities within the inpatient and primary care setting to assist staff comply with all IPC measures required such as the ability to effectively don and doff personal protective equipment as well as being able to promote social distancing within all areas. A Board paper was produced by the estates lead and approval has been agreed for all work to be completed. A schedule of work has been agreed and work is in progress at the time of writing this report. Additional facilities have been secured including the renting/purchasing of modular buildings and portacabins.

During 2020- 2021 IPC advice and input has been provided in the;

- The re-development of the Primary Care Services in Cottingham.
- The completion of due diligence in the acquisition of Manor House Surgery
- The refurbishment of the Greentrees Unit (now named Pine View)
- The major redesign of Whitby Community Hospital. The first phase anticipated to open August 2021.
- The facilitation of dedicated “COVID-19” wards at Mill View Court and Darley Ward within the Humber Centre. The Trusts decision to open designated COVID-19 wards to care for COVID-19 positive patients is felt to have had a positive impact on the management of the positive patients, particularly when isolation facilities on the unit were inadequate or the patient compliance was noted to be challenging putting other patients at risk of an increased risk of transmission.
- The Facilitation of the Trusts COVID-19 Vaccination Hub.

- The setting up of a “COVID Pod” and a further ward facility at Whitby to deal with a potential surge of patients appearing during the pandemic. Both of these facilities have now been stepped down.

7.6. Ventilation Requirements within the Electro-Convulsive Therapy Department (ECT)

The requirement for good ventilation has been acknowledged as essential in any workplace environment and this becomes more important during a period of pandemic. Employers are duty bound by law to ensure an adequate supply of fresh air enters the workplace to reduce the risk of spreading coronavirus.

It is recognised that there are inherent aspects of ECT that potentially increase the transmission COVID during the ECT procedure. Many patients are older adults who are at higher risk of COVID-19 than the general population and have comorbidities and the ECT procedure under anaesthesia involves airway management requirements. Additionally the lack of ventilation identified within the department facilitated the potential for increased aerosol dispersion.

Control measures were put in place to reduce the potential risk associated with the procedure. This included a significant reduction in the patient numbers allowing an appropriately timed ‘fallow period’ a robust patient triage process which included a rigorous COVID-19 screening regime for all patients. The Departments ECT protocol was amended to reflect this. This was placed upon the Trust register and progress was reviewed via the Command structures weekly. Approval was promptly secured for the installation of a mechanical ventilation system to improve the air changes within the department. Installation commenced in March 2021 and at the time of writing this report the ECT suite is now fully operational

7.7 Water Safety Management

The water utility provider supplying the Trust, Yorkshire Water, undertakes to provide a reliable supply of wholesome, safe water to the Trust. It is the function of the Water Safety Group (WSG) to provide assurance that the water, once within the Trust’s infrastructure, is safe and that risks from chemical and microbial hazards are minimised.

The Water Safety Group (WSG) continues to work to raise awareness of water safety issues throughout the Trust and to take steps to improve arrangements for water safety and governance.

The presence of legionella in the water systems has continued to be actively managed and monitored throughout the year. Additional control measures such as flushing have been required in a variety of areas during the period of the pandemic due to the no /low occupancy whilst staff were working from home

Quarterly WSG meetings has continued throughout the year and a subgroup of the Water Safety Group meet fortnightly to monitor progress of any outstanding actions until a positive outcome has been achieved. No major issues currently identified.

The Trusts Water Safety Policy and plan which is needed to satisfy the requirements of HTM 04-01 addendum currently remains under review.

An externally validated audit of performance was conducted by the Trust appointed Authorised Water Engineer in December 2020. The purpose of the audit was to assess and compare all element of the Trust performance against all operational and legislative compliance pertaining to water safety and overall Risk Management & Control. The audit findings demonstrated 'reasonable assurance' which is an improvement on the Trusts previous position.

8. Goal 06 – Promoting People, Communities and Social Values

'We will promote the importance of infection prevention and control community wide'

We are extremely disappointed to note that usual high level of IPC engagement and attendance at both national and local events has not been achieved this year due to the impact of the pandemic. It is hoped that all promotional events will be resurrected in the oncoming year.

A member of the IPCT however continues to represent the team as a "champion" within the Patient Experience Forum and work will continue to explore all potential opportunities to engage with patients and the public to seek their views and to receive feedback about the services we provide.

9. Summary

The emergence of Covid-19 in 2020 has resulted in an extremely challenging period but the infection prevention and control team remain proud of the effort made to help steer the Trust throughout the pandemic, providing immediate support to ensure the safety of staff patients and visitors remain paramount. Overall the IPC Annual Report for 2020/21 has demonstrated many achievements but also the areas where improvement is still required. It is acknowledged that the effects of lockdown restrictions has severely impacted upon the fulfilment of the strategic objectives which rely heavily on the ability to communicate and engage with the public in a face to face manner. Whilst the use of technology has been embraced it is recognised that this is not always the most appropriate method to engage with disadvantaged or hard to reach sections of our population. Despite all the challenges of COVID-19, systems and process for the management of all infections have been reviewed and updated,

new audit processes and tools have been implemented and governance arrangements and assurance strengthened.

Our priority for 2021-2022 will be to continue to deal with the ongoing effects of the pandemic. We will also however continue to reflect and learn from our and other Trust's experiences to ensure we are adequately prepared for any further surges and continue to play our part as we move to COVID-19 being endemic in our population. To support this work we will continue to utilise the nationally produced IPC Board Assurance to determine our programme of work throughout the next year.

Agenda Item 23

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 29th September 2021</td></tr>
<tr><td>Title of Report:</td><td>Q2 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 Q2 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>08/ 2021</td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>08/ 2021</td><td>Workforce & Organisational Development Committee</td><td>09/ 2021</td></tr>
<tr><td>Finance & Investment Committee</td><td>08/ 2021</td><td>Executive Management Team</td><td>09/ 2021</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>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 1 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.

Overview of Board Assurance Framework from Quarter 1 2021-22 to Quarter 2 2021-22.

Strategic Goal 1 – Innovating Quality and Patient Safety

- Overall rating maintained at Yellow for Quarter 2 2021/22.

Strategic Goal 2 – Enhancing prevention, wellbeing and
</td></tr>
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	recovery - Overall rating maintained at Amber for Quarter 2 2021/22. **Strategic Goal 3 – Fostering integration, partnerships and alliances** - Overall rating maintained at Green for Quarter 2 2021/22. **Strategic Goal 4 – Developing an effective and empowered workforce** - Overall rating maintained at Yellow for Quarter 2 2021/22. **Strategic Goal 5 – Maximising an efficient and sustainable organisation** - Overall rating maintained at Yellow for Quarter 2 2021/22. **Strategic Goal 6 – Promoting people, communities and social values** - Overall rating maintained at Green for Quarter 2 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 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	

BOARD ASSURANCE FRAMEWORK				Trust Board							
ASSURANCE OVERVIEW				29th September 2021							
Strategic Goal	Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Risk Appetite	Assurance Rating					Highest current risk
						Q 2	Q 3	Q 4	Q 1	Q 2	
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 audit of Trust significant event investigation process.	Director of Nursing	Quality Committee	OPEN	Y	Y	Y	Y	Y	16
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 as a result of COVID-19 national situation.	Chief Operating Officer	Quality Committee	SEEK	A	A	A	A	A	16
Fostering integration, partnership and alliances	G	Active engagement continues across all stakeholder groups with demonstrable benefits. Trust taking active role in partnership work. Chief Executive involvement in core HCV planning group alongside the North Yorkshire and York (NYY) and Humber system work, as well as participating in a small national working group on Mental Health recovery. Ongoing work will influence and feed into the wider system. HCV has been successful in the application to become an Integrated Care System (ICS) which indicates confidence in the area and its leaders.	Chief Executive	Audit Committee	SEEK	G	G	G	G	G	6
Developing an effective and empowered workforce	Y	Statutory and mandatory training performance remains above target (90.0% at June 2021 against target of 85%). Rolling turnover is improved compared to 12 months previous. GP vacancies now below target, Nursing vacancies improved compared to 12 months ago. Consultant vacancies remain above target. All staff survey theme scores improved in 2020 compared to 2021.	Director of Workforce and OD	Workforce and OD Committee	MATURE	Y	Y	Y	Y	Y	20
Maximising an efficient and sustainable organisation	Y	Trust financial position at Month 4 2021/22 reported a surplus of £0.191m which is in line with the ICS H1 control total of £0.315m. Cash position has stabilised with GBS bank balance at £25.449m. BPPC is cumulatively 90% 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.
Yellow	Partial Assurance	- System well-designed but requires monitoring/ low priority recommendations. - Some effective controls in place. - Some appropriate assurances are available.
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.
Red	No Assurance	- System not working / actions not addressed. - Effective controls not in place. - Appropriate assurances are not available.

BOARD ASSURANCE FRAMEWORK

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

Positive Assurance	
Assurance	**Source**
- Audit and Effectiveness Group which receives assurances in relation to all aspects of CQC compliance.	QPaS
- CQC Engagement Meetings.	
- Continued improvement maintained in relation to clinical supervision.	Quality Ctte Trust Board
- Overall rating of 'good' in 2019 CQC inspection report	
- Patient Safety Strategy 2019-22	
- CQC 'must do' actions completed.	Quality Ctte
- Internal audit of SEA (significant event analysis) and clinical audit process.	

Negative Assurance	
Assurance	**Source**
'Requires Improvement' rating for Safe domain in CQC report.	Trust Board CQC Report

Gaps in Assurance
What do we not have
Good rating in 'safe' domain for CQC rating. Full assurance around compliance with CQC KLOE in respect of the Safe domain.

Objective	Key Risk(s)	Q1 21-22 Rating	Q2 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.	**12**	**12**	**6**	⇔
	NQ48 – Currently the quality of staff supervision is unknown by the Trust which may impact on effective delivery of Trust services	**12**	**12**	**3**	⇔
	OPS11 – Failure to address waiting times and meet early intervention targets which may result in increased risk of patient harm and impact to the Trust's CQC rating in the 'Safe' domain.	**16**	**16**	**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.
(NQ37) Validated tool to agree establishments	
(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
(NQ48) Review of Trust Clinical Supervision arrangements to incorporate a clinical supervision quality framework.	Organisational evaluation of supervision using the Manchester tool (30/09/2021)
(NQ48) Appropriate training package linked to Clinical Supervision specifically focused on quality of supervision.	Review of the existing model to look at the separation of Clinical/Professional supervision from managerial supervision (31/03/2022)
(NQ37) Focus on safer staffing from a multidisciplinary team approach.	Business case to be developed to support multidisciplinary rosters implementation / rollout of E-roster to remaining outstanding teams (31/12/2021)
(NQ38) Action plan to address carer involvement audit results.	Development of action plan to address carer involvement audit findings (31/12/2021)
(NQ38) Further development and embedding of learning the lessons arrangements.	Implementation of quarterly mini-Learning the lessons sessions via MS Teams (31/12/2021)

BOARD ASSURANCE FRAMEWORK

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

Negative Assurance	
Assurance	**Source**
- Increase in demand for Covid-19 aftercare and support in community health services and primary care. Community health services will need to support the increase in patients who have recovered from Covid-19 and who having been discharged from hospital need ongoing health support.	Trust Board Quality Ctte
- National increase in demand for CAMHs in patient and mental health inpatient beds.	

Gaps in Assurance
What do we not have
Recovery-focussed culture within the Trust.

Objective	Key Risk(s)	Q1 21-22 Rating	Q2 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.**	9	9	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	16	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 CAMHS Core Team with high acuity of patients and high volumes of referrals resulting in long waiting times.	-	16	4	New Risk
	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	4	New Risk
	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.	-	15	6	New Risk
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 areas (Review at 30/09/2021
(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 (Review at 30/092021)

BOARD ASSURANCE FRAMEWORK				Assurance Level	Q2	Q3	Q4	Q1	Q2
STRATEGIC GOAL 3	FOSTERING INTEGRATION, PARTNERSHIPS AND ALLIANCES	Lead Director: Chief Executive	Lead Committee: Audit Committee		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)	Q1 21-22 Rating	Q2 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	
(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	Assurance systems for Service Plans/ Strategies Internal Clinical Audit programme R&D programme
(FII185) Formal programme to review and benchmark Trust position.	
(FII222) Commissioning committee now live and governance arrangements in place.	Monthly reporting to Commissioning Committee, FIC and Trust Board.
(FII222) Business case to outline provider collaborative submitted to NHSE.	

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	Q1	Q2	Q3	Q4	Q1
					Y	Y	Y	Y	Y

Positive Assurance

Assurance	Source
- Turnover improved from 16.5% in June 2018 to 10.53% in March 2021. - Trust headcount has increased compared to 12 months ago - Overall statutory and mandatory training performance remains above target (90.0% at June 2021 against target of 85%). - Improved flu uptake (76% in 2020 compared to 61% in 2018) and good Covid vaccine uptake rates. - All staff survey theme scores improved in 2020. - Clinical supervision above trust target	Trust Board Workforce and OD Committee Workforce Insight Report Audit Committee Quality Committee

Negative Assurance

Assurance	Source

- Consultant vacancies remain above target and worse than 12 months ago.
- Some staff have not engaged in the process to have their 3-year DBS renewal.
- 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)	Q1 21-22 Rating	Q2 21-22 Rating	Target	Movement from prev. Quarter
Development of a health and engages 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 – Level of qualified nursing vacancies may impact on the Trust's ability to deliver safe services and have an effective and engaged workforce.**	15	15	10	⟷
	WF04 – 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	⟷
	WF09 – Staff Survey scores for staff with protected characteristics are worse than for staff not declaring a protected characteristic (particularly staff declaring themselves as not heterosexual and/or disabled)	9	9	6	⟷
	WF10 – With current national shortages, the inability to retain Medical staff impacts on the ability to deliver services and/or puts financial pressure through the use of agency staff.	15	15	10	⟷
	WF27 – Risk of increased numbers of "rule breaks" due to pressures on staffing which may impact on the resilience of staff and patient care.	12	12	4	⟷
	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.	20	20	10	⟷
	WF26 – Current GP 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.	8	8	4	⟷
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) (31/03/2022)
(WF10) Lack of career development opportunities indicated through employee exit interviews/questionnaires.	Programme of 6 monthly deep dives into Leaver data to be undertaken and reported into WFOD Committee (31/03/2022)
(WF25) National workforce shortages.	Completion of actions identified as part of Recruitment plan for 'hard to fill' roles (Review at 31/12/2021)

BOARD ASSURANCE FRAMEWORK

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

Positive Assurance

Assurance	Source
- Financial position Month 4 2021/22 – Trust reported a surplus of 0.191m which is in line with the ICS H1 control total of 0.315m. - Trust cash position has stabilised – GBS bank balance at 25.449m - BPPC is cumulatively 90% 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 £2.093m 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
- NHSI Control Total for months 1-6 2021-22 set as a surplus of £0.315m. - Funding position for Months 7-12 not known at this point. - The return to normal commissioning not known at this point.	Trust Board Finance and Investment Committee

Gaps in Assurance

What do we not have

- Funding position for the full year 2021/22 not known.
- Longer term Commissioning Intentions not known.

Objective	Key Risk(s)	Q1 21-22 Rating	Q2 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 Trust Board Reports - Financial Position - Cash
(FII205) Monthly reporting, monitoring and discussion with budget holders.	
(FII205) Financial plan agreed.	
(FII205) BRS reporting to FIC	
(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 (30/09/2021)
(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	Q1	Q2	Q3	Q4	Q1
					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)	Q1 21-22 Rating	Q2 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.**	9	9	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	**No risks identified**				
Embrace and expand our use of volunteers					

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 (Review at 30/09/2021)
(OPS08) Recovery focussed practice still to be fully embedded across the Trust	Delivery of Recovery Strategy implementation plan (31/12/2021)

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 regard 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 24

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting - 29th September 2021</td></tr>
<tr><td>Title of Report:</td><td>Risk Register Update</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 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 June 2021.</td></tr>
<tr><td>Governance:</td><td>
<table>
<tr><th></th><th>Date</th><th></th><th>Date</th></tr>
<tr><td>Audit Committee</td><td>08/ 2021</td><td>Remuneration & Nominations Committee</td><td></td></tr>
<tr><td>Quality Committee</td><td>08/ 2021</td><td>Workforce & Organisational Development Committee</td><td>09/ 2021</td></tr>
<tr><td>Finance & Investment Committee</td><td>08/ 2021</td><td>Executive Management Team</td><td>09/ 2021</td></tr>
<tr><td>Mental Health Legislation Committee</td><td></td><td>Operational Delivery Group</td><td>08/ 2021</td></tr>
<tr><td>Charitable Funds Committee</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 11 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 – Current qualified nursing vacancies 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>
<tr><td>WF10 – With current national shortages, the inability to retain Medical staff 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>

	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**
	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.	**20**	**20**
	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.	**20**	**16**
	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**
	LDC49 – Ongoing pressures within Hull CAMHS Core Team with high acuity of patients and high volumes of referrals resulting in long waiting times.	**16**	**16**
	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**	**16**
	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	**15**	**15**
	SR15 – As a result of current vacancies on Fitzwilliam Ward there may be insufficient qualified staff to manage current patient need, which could result in a delayed response in patient care, reduced quality, and risk to patient safety and reduction in beds to ensure safe patient care.	**16**	**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 **11** 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	Level of qualified nursing vacancies may impact on the Trust's ability to deliver safe services and have an effective and engaged workforce.	**20**	**15**	**10**
WF04	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 Medical staff impacts on the ability to deliver services and/or puts financial pressure through the use of agency staff.	**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**
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.	**20**	**20**	**10**
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.	**20**	**16**	**8**
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**
LDC49	Ongoing pressures within Hull CAMHS Core Team with high acuity of patients and high volumes of referrals resulting in long waiting times.	**16**	**16**	**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**	**16**	**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.	**15**	**15**	**6**
SR15	As a result of current vacancies on Fitzwilliam Ward there may be insufficient qualified staff to manage current patient need, which could result in a delayed response in patient care, reduced quality, and risk to patient safety and reduction in beds to ensure safe patient care.	**16**	**16**	**4**

2. Closed/ De-escalated Trust-wide Risks

There are no risks that were previously held on the Trust-wide risk register which have been closed / de-escalated since last reported to Trust Board in June 2021.

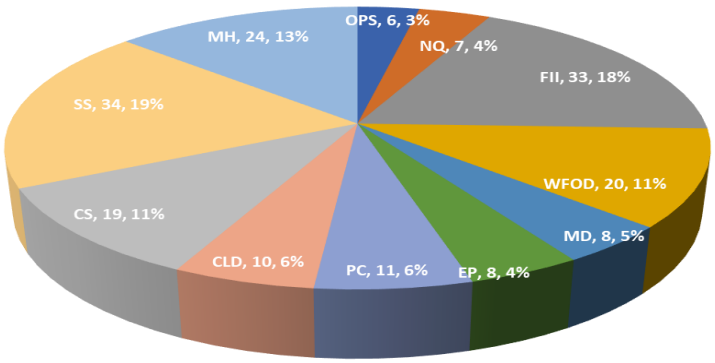
3. Wider Risk Register

There are currently **179** risks held across the Trust's Division, Directorate and project risk registers. The current position represents an overall decrease of **3** risks from the **182** reported to Trust Board in June 2021. The table below shows the current number of risks at each risk rating in comparison to the position presented to the June 2021 Board.

Table 4 - Total Risks by Current Risk level

Current Risk Level	Number of Risks – June 2021	Number of Risks – September 2021
20	1	1
16	2	2
15	4	4
12	55	55
10	6	10
9	44	37
8	27	16
6	36	45
5	1	2
4	2	3
3	4	4
2	0	0
Total Risks	**182**	**179**

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
PC – Primary Care
CLD – Children's and Learning Disabilities
CS – Community Services
SS – Specialist Services
MH – Mental Health Services

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls/ Controls currently failing	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**	Level of qualified nursing vacancies 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	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. 105.4 (FTE) Nursing vacancies as at July 2021 compared with 122.9 (FTE) in July 2020. 2. 10.62% 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) (31/03/2022) 2. Development and expansion of new roles such as Associate Practitioners and Advanced Clinical Practitioner roles (31/12/2021)	Julie Taylor	Hilary Gledhill	WFOD / EMT	Trust Board	Rare	Catastrophic	**10**	**High**
2	**WF04**	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 10.85% as at July 2021(10.88% May / 10.21% June) 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 (31/03/2022) 2. Business Partners to develop bespoke action plans at divisional level based on 6 monthly deep-dive programme analysis (31/03/2022)	Divisional General Managers	Lynn Parkinson	WFOD / EMT	Trust Board	Rare	Catastrophic	**10**	**High**
3	**WF10**	With current national shortages, the inability to retain Medical staff impacts on the ability to deliver services and/or puts financial pressure through the use of agency staff.	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 annual turnover 7.95% as at July 2021 (8.10% May / 9.40% June)	Possible	Catastrophic	**15**	**Significant**	1. HR Business Partners ongoing review of exit questionnaire results to identify any hot spots (31/03/2022) 2. Ongoing PROUD programme implementation plan - ongoing 3 year programme (Review at 31/03/2022) 3. Programme of 6 monthly deep-dives into Leaver data to be undertaken and reported into WFOD Committee (31/03/2022) 4. Business Partners to develop bespoke action plans at divisional level based on 6 monthly deep-dive programme analysis (31/03/2022)	Karen Phillips	Steve McGowan	WFOD / EMT	Trust Board	Rare	Catastrophic	**10**	**High**

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls/ Controls currently failing	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	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.	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 H1 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 (31/03/2022). 2. Detailed budget reduction strategy plans for 2022/23 to be developed (30/09/2021)	Iain Omand	Peter Beckwith	FIC / EMT	Trust Board	Rare	Catastrophic	10	High
5	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.	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. Trust-wide workforce plan. 4. Humbelievable. 5. Medical Director leading recruitment work as part of task and finish group	1. Agency spend considered at Finance and Investment Committee. 2. ODG. 3. EMT. 4. Workforce and OD Committee.	1. National workforce shortages.	1. 16.5 consultant vacancies as of July 2021 (15.9 May / 16.3 May) 2. 25.03% vacancy rate at July 2021 for the consultant workforce	Likely	Catastrophic	20	Significant	1. Completion of actions identified as part of Recruitment plan for 'hard to fill' roles (Review at 31/12/2021)	Karen Phillips	Steve McGowan	WFOD / EMT	Trust Board	Unlikely	Catastrophic	10	High
6	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.	Objectives	Almost Certain	Severe	20	Significant	1. Work underway with Divisions to address three areas of challenges currently (Children's ADHD / ASD, Memory Assessment Service, Department of Psychological Medicine) 2. Local Targets and KPIs. 3. Close contact being maintained with individual service users affected by ongoing issues. 4. Waiting Times Procedure in place 5. Waiting times review is key element of Divisional performance and accountability reviews. 6. Review completed of all services with high levels of waiting times and service-level recovery plans developed.	1. Reports to demonstrate waiting list performance to Trust Board, Quality Committee and Operational Delivery Group. 2. Quality impact on key identified areas monitored via Quality Committee. 3. Weekly divisional meetings with Deputy COO around waiting list performance. 4. Areas of positive improvements	1. Work to understand issues for all services with waiting times issues with some areas breaching 18 weeks and 52 weeks waiting times targets. 2. Process for mitigating risks to individual patients based on length of waits. 3. Waiting times issues for some services have been compounded by Covid-19 situation and associated changes to working arrangements. 4. Issues around monitoring arrangements / governance in terms of performance.	1. Limited historical monitoring arrangements linked to ensuring chronological treatment of patients.	Likely	Severe	16	Significant	1. 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 (Review at 30/09/2021) 2. Introduce waiting list performance dashboard for review as part of Trust accountability review processes (Review at 30/09/2021) 3. Implementation of method for robust oversight of waiting list and patient risks for all Trust service areas (Review at 30/09/2021)	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls/ Controls currently failing	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
7	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.	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. (Review at 31/12/2021)	Claire Jenkinson	Lynn Parkinson	ODG / EMT	Trust Board	Unlikely	Severe	8	High
8	LDC49	Ongoing pressures within Hull CAMHS Core Team with high acuity of patients and high volumes of referrals resulting in long waiting times.	Objectives	Likely	Severe	16	Significant	1. Team are taking on different tasks to support there being no team leader. 2. Work completed around data quality and improving the Lorenzo systems in place to make it clear to see which patient is waiting for what treatment which was not previously visible. 3. All referrals to the team are going through a weekly allocation meeting. 4. Weekly meetings are being held with Deputy COO regarding the waiting list 5. Cases waiting to be allocated to be placed in the team task list. 6. Waiting List Policy and Waiting List Standard Operating Procedure.	1. Complaints 2. FFT 3. Waiting Times Report to the Trust Board.	1. Long waiting times with some up to 2 years for routine appointments. 2. Staff out on secondment to support other areas of the service during Covid has left the team's staffing depleted. 3. Dealing with the increased volume of referrals and high acuity of patients is not happing in a timely manner. 4. Routine referrals put on hold to manage the urgent situation at the beginning of Covid has increased the routine waits. 5. There is no team leader for service as current team leader is on maternity leave.	None identified.	Likely	Severe	16	Significant	1. Team assessment clinics are being looked at to tackle the waiting list (31/10/2021) 2. Conversations with the early intervention service to see if they are able to support to take some of the lower lever longest waits (31/10/2021)	Trish Bailey / Justine Rooke	Lynn Parkinson	Divisional ODG / ODG	Trust Board	Rare	Severe	4	Moderate
9	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.	Objectives	Likely	Severe	16	Significant	1. Team leader has picked up a caseload 2. Clinical lead has taken on more cases, working an additional day and has paused service development work. 3. Training and early intervention work put on hold 4. Staff working additional hours / shifts. 5. Extra visits put into families where needed	1. Complaints 2. FFT 3. Waiting Times Report to the Trust Board.	1. 3 months before Christmas 2020 the team received a years' worth of referrals. 2. Constant issue of trying to find beds for young people that are acutely ill but national lack of appropriate beds. 3. Additional strain on the team as they are having to try to support families and young people that are far too risky to be held in the community. 4. Potential to increase staff sickness or potentially lead to staff leaving the team which is already a hard to recruit to area.	None identified.	Likely	Severe	16	Significant	1. Ongoing communication and escalation to Specialist Commissioning and CCGs. (Review at 31/12/2021)	Trish Bailey / Justine Rooke	Lynn Parkinson	Divisional ODG / ODG	Trust Board	Rare	Severe	4	Moderate

Trust-wide Risk Register 15+

Row	Risk ID	Description of Risk	Impact/ Consequence Type	Likelihood (Initial)	Impact (initial)	Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls/ Controls currently failing	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
10	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.	Objectives	Almost Certain	Moderate	15	Significant	1. Completion of DATIX where unable to deliver care / clinical risks identified. 2. Monitoring of KPIs - review at S&R Business meeting, Divisional Operational meeting, Quality & Performance reviews with NY CCG. 3. Issues highlighted with partner organisations at appropriate forums. 4. Submission of business case and review of outcome. 5. Transformation Plan - Board oversight and workstream action plans.	1. Datix submissions and subsequent investigations, IIRs / SEAs as required. 2. Regular monitoring / discussions / actions planning at identified forums.	1. Acute Trust increases in D2D assess / rapid response need for discharged patients 2. Primary Care increase in nursing referrals following reduction in GP F2F visits, following change to working ways during Covid-19 pandemic 3. NYCC impact of limited community care provision on HTFT community services 4. Palliative patient increases following changes in Saint Catherine's Hospice care provision.	None Identified.	Almost Certain	Moderate	15	Significant	1. Review with Business Team to scope Business case to present to NYCCG for additional funds to supplement workforce, or change in pathways / partner organisation referral models (31/12/2021) 2. Development of One Community Transformation Plan to include review of demand and capacity across all community areas / workforce (31/12/2021)	Helen Cammish / Kerry Brown	Lynn Parkinson	Divisional ODG / ODG	Trust Board	Unlikely	Moderate	6	Moderate
11	SR15	As a result of current vacancies on Fitzwilliam Ward there may be insufficient qualified staff to manage current patient need, which could result in a delayed response in patient care, reduced quality, and risk to patient safety and reduction in beds to ensure safe patient care.	Objectives	Likely	Severe	16	Significant	1. Approval for for RGN Band 5s and Band 6s agency staff - Escalated regarding breaking pay ceiling 2. Recruitment of Pharmacy Technician. 3. Re-modelled team and skill mix (additional B6 and utilising B4). 4. Enhanced advertquality via social media and video to support interest in posts. 5. Fitzwilliam Ward to be involved in pilot for oversea recruitment. 6. Band 6 posts filled on unit	1. Team meetings. 2. Community Services Business meeting. 3. Daily handovers and safety huddles. 4. Complaints 5. FFT	2. Reliance on goodwill of existing staff. 3. Limited local staff on bank - is increasing but still limited 4. Limited staff/CV for suitable agency staff. 5. Current vacancies - 4 RNs	None Identified.	Likely	Severe	16	Significant	1. Registered nursing posts on rolling advert to fill current vacancies (31/03/2022) 2. Competency sign-off for recruited Pharmacy Technician to deliver some RN duties (Review at 31/01/2022)	Helen Cammish / Kerry Brown	Lynn Parkinson	Divisional ODG / ODG	Trust Board	Rare	Severe	4	Moderate

Humber Teaching NHS Foundation Trust

Agenda Item 25

Title of Report:	Guardian of Safe Working - Annual Report September 2021
Author/s:	Name: Dr Mohammed M Qadri Title: Consultant Forensic Psychiatrist & Medical Psychotherapist, Humber Centre - Guardian of Safer Working
Recommendation:	To approve ☐ To receive & note ✓ For information ☐ To ratify ☐
Purpose of Paper:	To inform the Board of rota gaps and vacancies and issues relating to the safe working of junior doctors.
Governance:	

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

Key Issues within the report:	1. Alteration of rota geographical cover reduced traveling for junior doctors when providing on call cover. Contributing to better rest period opportunities. 2. Roll out of electronic prescribing has also significantly contributed to reduction in travelling time and junior doctor fatigue. 3. The provision of adequate rest facilities remains an area of ongoing work.

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	√			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	

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

EXECUTIVE SUMMARY

- There have been progressive improvements with the on call working that have contributed to reduced travel time across sites and thereby providing better opportunity for rest period.
- The roll out of smart phones to junior doctors to ensure safer working has also been a significant change to further improve better safer working environments for junior doctor working on the on-call rota.
- Work is ongoing regarding reviewing the rest and sleep facilities for doctors working on call. The Trust has received money to review these facilities, however, progress was interrupted by the COVID outbreak. This has resumed in close collaboration with the Junior Doctors.

INTRODUCTION

The introduction of the 2016 Terms and Conditions of Service (TCS) has meant clear limits to the number of hours junior doctors can work being set. It has also provided a framework for –

- trainees to be able to report safety concerns in the workplace
- trainees to record if they worked beyond their scheduled hours
- fining departments directly for the most serious breaches of working hours
- providing work schedules to doctors before starting a job and in more detail than previously
- trainees to inform if they are not able to attend education and training opportunities
- the establishment of a junior doctor's forum (JDF) to discusses work and training issues

The contract also requires that every Trust has a Guardian of Safe Working (GoSW), whose responsibilities include ensuring that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and providing assurance to the Board of the employing organisation that doctors' working hours are safe.

Rota Rules Enshrined in the 2016 Contract

- Max 13hr shift length, with no more than 5 consecutive long shifts, or 4 consecutive long evening shifts.
- Max 8 consecutive shifts, with a minimum of 48 hours rest following completion.
- A minimum of 30mins break for 5 hours work and a 2nd 30mins for more than 9 hrs.
- Maximum of 72hrs in 7 consecutive days.
- Maximum of 4 consecutive nights, with a minimum of 46 hours rest when 3 or more night shifts worked.
- Max average of 48 hours/week – can opt out of EWTD allowing 56 hrs.

NROC (Non-resident on call)

- No consecutive on-call periods, except Saturday and Sunday, no more than 3 in 7 consecutive days.
- Day after a NROC must be less than 10hrs, or 5hrs if minimum rest not met.
- Expected rest – 8hrs in 24hrs, with 5hrs continuous between 2200 and 0700

THE ROLE OF THE GUARDIAN OF SAFE WORKING HOURS

The guardian is a senior appointment, and the appointee does not hold any other role within the management structure of Trust. The guardian ensures that issues of compliance with safe working hours are addressed by the junior doctor and/or Trust, as appropriate. The guardian shall provide assurance to the Board that junior doctors' working hours are safe in concordance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 but additional oversight of the working hours of junior doctors still working on the 2002 contract.

The guardian:

- acts as the champion of safe working hours for doctors in approved training programs
- provides assurance to doctors and employers that doctors are safely rostered and enables work hours that are safe and in compliance with Schedules 3, 4 and 5 of the terms and conditions of service
- receives copies of all exception reports in respect of safe working hours. This will allow the guardian to record and monitor compliance with the terms and conditions of service
- escalates issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level
- requires intervention to mitigate any identified risk to doctor or patient safety in a timescale commensurate with the severity of the risk
- requires a work schedule review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed

- has the authority to intervene in any instance where the guardian considers the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily; and
- distributes monies received as a consequence of financial penalties to improve the training and service experience of doctors.

The guardian reports to the Board of the Trust directly or through a committee of the Board, as follows:

- The Board must receive a Guardian of Safe Working Report no less than once per quarter. This report shall also be provided to the Local Negotiating Committee, or equivalent. It will include data on all rota gaps on all shifts.
- A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account, which must be signed off by the trust chief executive. This report shall also be provided to the Local Negotiating Committee, or equivalent.
- Where the guardian has escalated a serious issue and the issue remains unresolved, the guardian must submit an exceptional report to the next meeting of the Board.
- The Board is responsible for providing annual reports to external bodies as defined in these terms and conditions, including Health Education England (Local office), Care Quality Commission, General Medical Council and General Dental Council.

The Guardian and Director of Medical Education have jointly established a Junior Doctors Forum to advise them. This includes junior doctor colleagues from the organisation and includes the relevant junior doctor representatives from the Local Negotiating Committee (LNC) as well as the Chair of the LNC. The guardian attended and consulted with junior doctors regarding their concerns and liaised with supervisors where necessary to explore any issues arising including work on resolving exceptions.

ANNUAL DATA SUMMARY

The rotas were fully covered.

The complement of doctors covering the rota: -

- 5 Foundation year 2 trainees
- 1 (General practitioners' trainee on a 4-month rotation)
- 4 General practitioners' trainees on 6-month placement

- 8 Full time core trainees
- 3 less than full time training (1 x 50%, 1 x 80% - 1 x 60% not on the rota)

- 3 full time Locum Appointment for service (LAS) doctors

There continues to be significant good work being undertaken through medical education and representation on a regional level promoting psychiatry in Humber.

DATA ANALYSIS

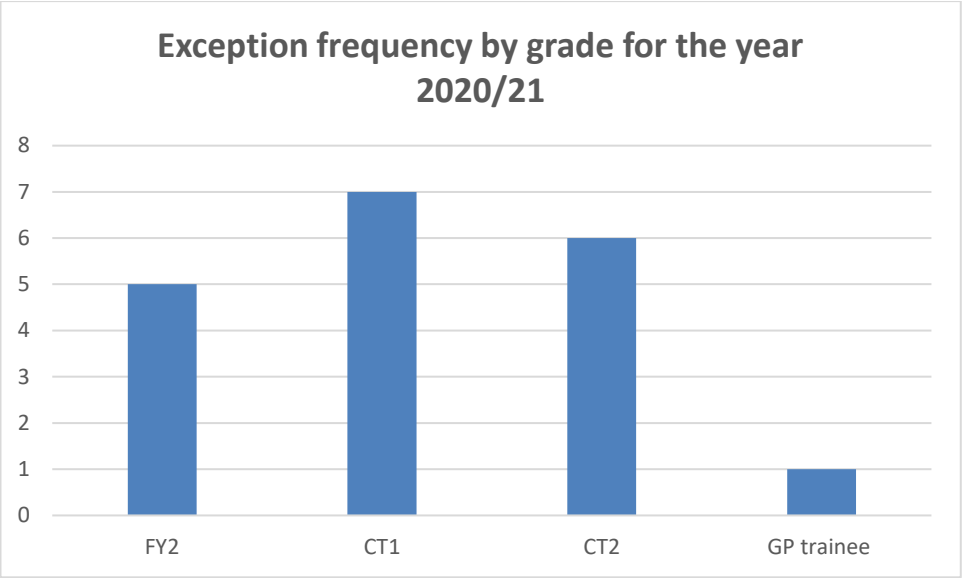


Figure 1. Exception data by grade provided by exception reporting software

Interestingly on the whole it appears GP trainees submit fewer exceptions. The review and feedback of on call work and case presentation can further improve safer working environments and is being highlighted through clinical supervision.

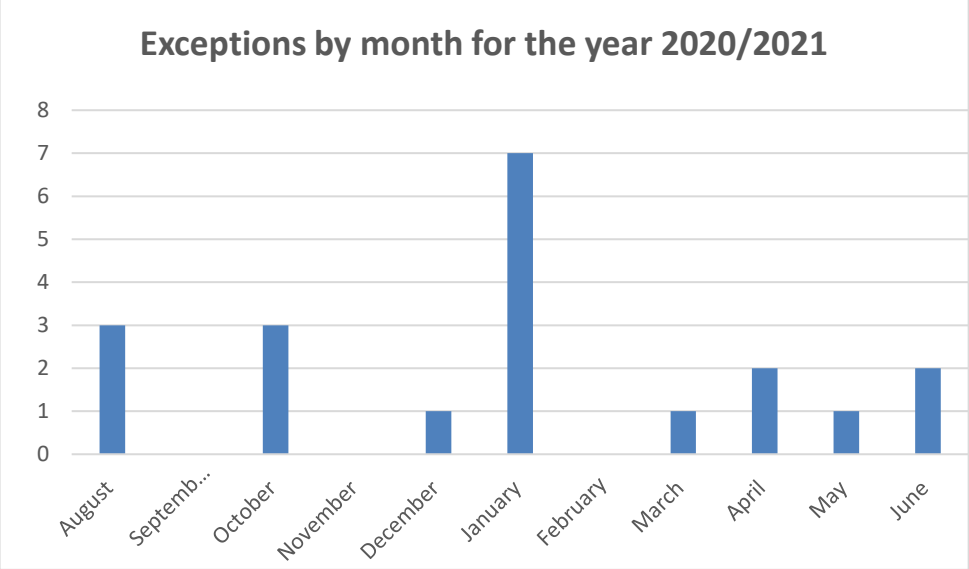


Figure 2. Exception data by month provided by exception reporting software

There are 4 months of no exception reporting. There is also some data to suggest that through bespoke training for specific trainees the number of exceptions would reduce.

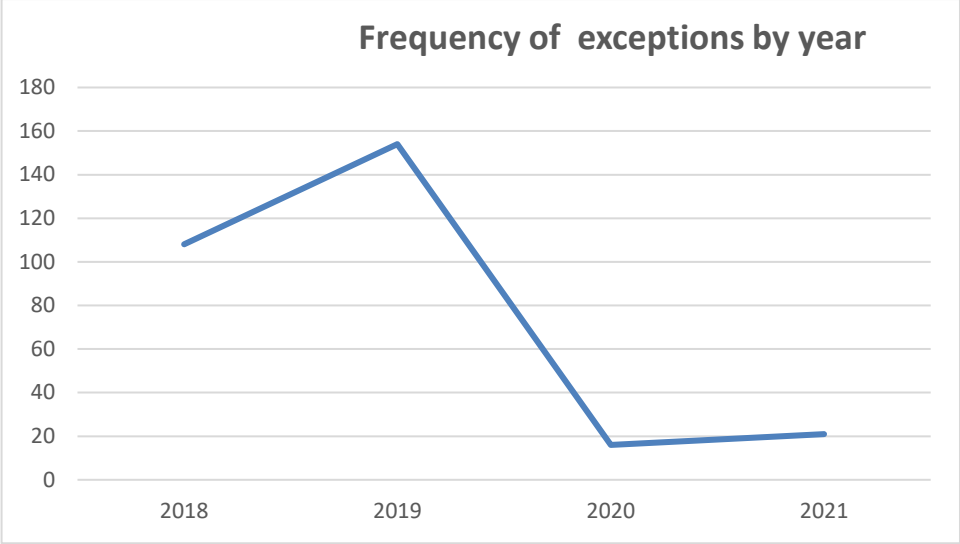


Figure 3. Exception data by year provided by exception reporting software

The data demonstrates that measures implemented in previous years and built up on last year are continuing to contribute to fewer exceptions and better working environments for junior doctors.

The data for the previous year shows no exception reports during the months at the height of the COVID pandemic and lock-down. Interestingly junior doctors reported that on calls were not excessively busy during this period but did begin to pick up in activity levels as lock-down restrictions were eased.

Notably following a monitoring exercise completed in May 2019 a new work schedule was introduced in August 2019. This was very well received by the juniors who reported that it more accurately reflected their work patterns. This is reflected by a marked drop in the number of exception reports since the introduction of the new schedule.

	Previous Work Schedule	New Work Schedule
Weekday Evening (1700-2200)	Rota 1 – 2hrs standard Rota 2 – 2hrs45 standard	3 hours standard
Weekend Day (0900-2200)	Rota 1 – 5 hrs standard Rota 2 7hrs15 standard	10 hours standard
Night (2200-0900)	5hrs45 enhanced	6hrs45 enhanced

The night on call remains as a 3-night weekend and 4-night mid-week pattern. This means the trust is non-compliant with the 2016 TCS which advises against 2 consecutive non resident on calls (NROCS). this, however, this was agreed locally by the junior doctor cohort, who have expressed a preference for maintaining the current 3:4 night on call pattern.

The work that had started last year with regards to adequate rest facilities for junior doctors during on call shift remains a priority, notably factoring in loci of work and access to rest

facilities given the geographical distance covered during emergency cover. A holistic approach of refurbishment of Miranda house and site near Willerby Hill is anticipated to provide real world benefit and reduce travelling times from places of work to places of designated rest space.

The new appointment of workforce lead will also provide greater reassurance to provide junior doctors with work schedules and rota's in advance of rotation start dates.

The rollout of e-prescribing in June 2019 and trust wide adoption in July that same year also contributed to reduce travel time and provided for greater opportunities for rest breaks to be taken.

Change of zonal cover of the rota also reduced travel time for day on call doctors providing for less time travelling between sites and further opportunities for rest.

Peer support has been notable and on-call support via messaging apps has provided support and again reducing time taken to resolve issues arising during emergency cover.

RECOMMENDATIONS

The approach to enhance safer working is to continue to review and improve structural factors such as rota's, rest spaces and proactive recruitment but also to improve processes using technology such as electronic prescribing, smart phone access and promoting reflective education practices through regularly scheduled training spaces for junior doctors

1. Training and teaching programme to continue to provide skillset to help manage on call and emergency cover better. Junior doctor training sessions for of on call scenarios to help manage emergency working better.

2. Continues support for Reflective spaces such as Balint group to allow for development of practice and better workings strategies reducing workload during emergency cover.

3. Continued proactive work to minimize rota gaps by encouraging sustainable recruitment and retention.

4. Ongoing collaborative work with medical staffing GoSW, junior doctors and supervisors to ensure trainees are supported and working in safer environments.

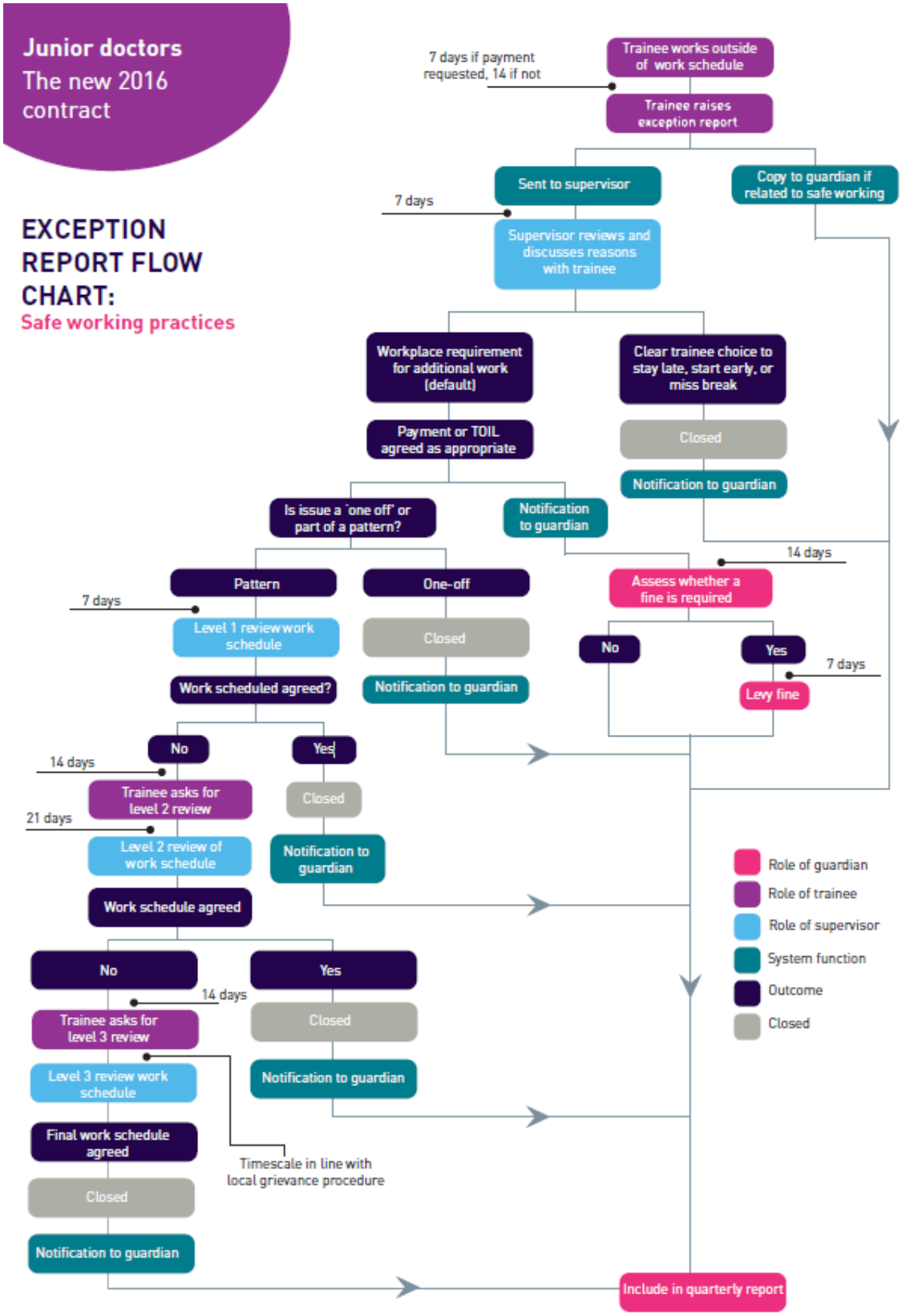
5. Peer support for on call work to be officially recognised as reflective space and training provided regarding reflective working culture.

6. Development of mentor and buddy program to support junior doctors with training and working practices.

7. Junior doctors provided with trust smart phones whilst on call with enabled GPS and SOS (a Morse code distress signal, used internationally) applications given lone working when travelling to sites on night shift including Bluetooth technology to permit calls hands free whilst in the car.

8. The 2016 TCS mandates the provision of adequate rest facilities or alternative arrangements for safe travel home. Miranda House on-call room to be refreshed for effective rest space. With a further view of incorporating potential future rooms in the new campus. There should also be a mechanism where junior doctors that are too tired to drive home after a night on call should have access to a rest facility if none are available then alternative accommodation needs to be considered.

Appendices


Junior doctors
The new 2016 contract
EXCEPTION REPORT FLOW CHART:
Safe working practices
7 days if payment requested, 14 if not
Trainee works outside of work schedule
Trainee raises exception report
Sent to supervisor
Copy to guardian if related to safe working
7 days
Supervisor reviews and discusses reasons with trainee
Workplace requirement for additional work (default)
Clear trainee choice to stay late, start early, or miss break
Payment or TOIL agreed as appropriate
Closed
Notification to guardian
Is issue a 'one off' or part of a pattern?
Notification to guardian
14 days
Pattern
One-off
Assess whether a fine is required
7 days
Level 1 review work schedule
Closed
No
Yes
7 days
Work scheduled agreed?
Notification to guardian
Levy fine
No
Yes
14 days
Trainee asks for level 2 review
Closed
21 days
Level 2 review of work schedule
Notification to guardian
Work schedule agreed
No
Yes
14 days
Trainee asks for level 3 review
Closed
Level 3 review work schedule
Notification to guardian
Final work schedule agreed
Timescale in line with local grievance procedure
Closed
Notification to guardian
Include in quarterly report
Role of guardian
Role of trainee
Role of supervisor
System function
Outcome
Closed

Humber Teaching NHS Foundation Trust

Agenda Item 26

Title & Date of Meeting:	Trust Board Public Meeting - Wednesday 29th September 2021
Title of Report:	Safeguarding Annual Report
Author/s:	**Executive Lead:** Hilary Gledhill Director of Nursing, Allied Health and Social Care Professionals **Authors:** Rachael Sharp, Head of Safeguarding/ Named Practitioner Adults/ Kerry Boughen Named Nurse- Children and Young People.
Recommendation:	To approve: ; To receive & note: ; For information: ; To ratify: X
Purpose of Paper:	To present the Trusts annual safeguarding report to the Trust board for ratification following approval at the August Quality Committee meeting.
Governance: *Please indicate which committee or group this paper has previously been presented to:*	Audit Committee: ; Remuneration & Nominations Committee: ; Quality Committee: August 21; Workforce & Organisational Development Committee: ; Finance & Investment Committee: ; Executive Management Team: ; Mental Health Legislation Committee: ; Operational Delivery Group: ; Charitable Funds Committee: ; Other (please detail):
Key Issues within the report:	The report presents an overview of the Trusts safeguarding activities for 2020-21 and objectives for the year ahead in line with the Trusts statutory safeguarding duties. The main areas covered in the report include information in relation to : Multi agency work Safeguarding training uptake Response to domestic abuse Child neglect work LADO/ Allegations Against Staff concerns

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

Caring, Learning & Growing Together

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	

NHS
Humber Teaching
NHS Foundation Trust

Annual Report

Humber Safeguarding

2020/2021

If you see something, hear something, suspect something – do something

Safeguarding Children and Adults is Everyone's Business

Caring, Learning
& Growing Together

Contents

1.0 Foreword by the Director of Nursing, Allied Health and Social Care Professionals.

It gives me great pleasure to present the safeguarding annual report for 2020-21 which showcases the work done by our safeguarding team and staff to maintain and maximise safeguarding in what has been an extraordinary, unprecedented year for healthcare and the populations we serve as we grappled to deal with a pandemic the like of which we have never experienced before.

Never has safeguarding been of such importance as we went into lockdowns, resulting in significantly reduced patient face to face contact in some services. We have had to develop new ways of working to retain our vigilance in identifying safeguarding issues; recognising that with families `contained' within their homes combined with social support mechanisms being reduced and in some cases severed the likelihood of safeguarding incidents increasing, particularly in relation to domestic abuse and neglect would become a reality.

We responded by ensuring we had a planned approach to raising awareness of domestic abuse and successfully gained accreditation as a 'White Ribbon` organisation demonstrating our commitment to ending male violence against women. Plans to raise awareness, support staff, patients and carers have been developed and implemented during 2020-21 enabling us to maintain a strong focus on this area of safeguarding.

We have developed new ways of delivering safeguarding training using digital platforms to ensure our staff remain skilled in recognising patients and colleagues who are at risk and take appropriate action. As a Trust we have taken on the Board the CQC definition of 'Closed Cultures` with all of our staff being mindful to recognise and report should they have concerns.

The annual report provides information across the range of mandated safeguarding activities and details of improvement initiatives which despite the pandemic we have continued to undertake as well as information in relation to continuous improvement activities to ensure safeguarding awareness remains everyone's business.

The safeguarding team have remained flexible and accessible to our patients, staff and partners throughout the pandemic utilising digital platforms and undertaking site visits as required. We have continued to support the work of our safeguarding partners, sharing our expertise, intelligence and learning to maximise safeguarding in the communities we serve. I am extremely proud of the safeguarding team who lead this agenda for the Trust and the staff across all services who with their commitment and ongoing vigilance ensure safeguarding runs through every contact we make

Hilary Gledhill, Director of Nursing, Allied Health & Social Care Professionals

The Humber Safeguarding Strategy is aligned to the organisation six goals and aims to improve the quality of safeguarding practice and enhance prevention and wellbeing:

Promoting the welfare of all children, young people and adults at risk ensuring this approach is reflected in all areas of the Trust activities and business;	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 2** Enhancing prevention, wellbeing and recovery
Ensuring safeguarding children, young people and adults is undertaken by everyone, supported and governed by the specialist staff employed in dedicated roles and governance structures within the Trust. This provides a framework that supports best practice and allows the Trust to fulfil its key responsibilities;	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 3** Developing an effective and empowered workforce
Ensuring we systematically learn through experience at both an organisational level and team level with continuous improvement to services being made based on learning. Effective horizon scanning and implementation of up-to-date resources is routine to ensure best practice is followed and this enhances the organisational standards;	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 2** Enhancing prevention, wellbeing and recovery **Strategic Goal 6** Maximising an efficient and sustainable organisation
Ensuring staff demonstrate the values and competence required to effectively safeguard working in partnership to promote the welfare of children, young people and adults at risk.	**Strategic Goal 1** Innovating quality and patient safety **Strategic Goal 4** Promoting people, communities and social values **Strategic Goal 5** Fostering integration, partnerships and alliances

2.0 Safeguarding is Everyone's Business

A culture that safeguarding children and adults is everybody's responsibility permeates across all Humber Teaching NHS Foundation Trust teams and the individuals who work in them. The Trust has a clear governance structure in place for safeguarding children and adults. There are individuals with clearly defined leadership roles and a dedicated Safeguarding Team which offers support to a wide range of clinical and non-clinical staff. The Trust holds a statutory responsibility under The Children Act 2004, Working Together to Safeguard Children 2018, Safeguarding Vulnerable People in the NHS, Accountability and Assurance Framework 2018, Children and Social Care Act 2017, the Care Act 2014 along with its accompanying guidance Care and Support Statutory Guidance (DoH 2016).

Humber safeguarding reflects the national priorities for safeguarding in that it seeks to establish a safe environment where staff and patients can recognise, report and prevent safeguarding concerns becoming high risk factors.

3.0 National and Local Context Overview

3.1 Covid-19 – The Pandemic

The year of 2020/ 2021 posed challenges for safeguarding like no other, with the commencement of the 'national lockdown' in March 2020 and the direction to stay at home, this posed profound challenges for health and social care staff delivering and continuing to safeguard the most vulnerable in the community.
The Humber Safeguarding Team continued to deliver a service throughout this challenging period, including the maintenance of providing a safeguarding duty desk. It recognised the importance of moving into providing support through virtual contacts. Initially as services settled into working from home arrangements contacts to safeguarding teams within Humber but also locally and nationally noted a reduction in contacts of safeguarding concerns being raised.

In recognition of this, a drive of raising awareness and ensuring that the safeguarding responsibility of staff continued. The heightened risk of both adults and children being 'hidden` from health professionals, education professionals and communities required working in a creative way. The Humber Safeguarding Team produced five minute focus briefings on safeguarding topics, produced a tool to support staff in identifying safeguarding concerns when undertaking virtual visits, moved to social platforms including Twitter and utilised internal communications platforms to support raising awareness.

3.2 Domestic Abuse

The pandemic provided an opportunity for domestic abuse to flourish, with fear, financial concerns, health, employment all being causal factors to psychological breakdown, stress and violence within families. It also increased the intensity for those suffering in domestic abuse relationships, confining victims for long periods of times with perpetrators under the same roof. Domestic abuse contacts to national helplines locally and nationally increased, with the National Domestic Abuse helpline receiving more than 40,000 calls during the first three months of lockdown.

3.3 Raising awareness of Safeguarding

This is progressing well in all areas, awareness raised through awareness days and additional training. A total of 47 domestic abuse champions are working across the Trust, a second cohort of champion training has commenced from 26th April which has focussed on developing staff safeguarding champions within inpatient settings.
The domestic abuse development plan forms part of the wider Trust safeguarding development plan, the work completed within the White Ribbon action plan informs the updated development plan. There is representation at the East Riding partnership and strategic and operational levels. Domestic abuse remains a priority area across both children's partnership and the safeguarding adult boards (SAB).

The work of the White Ribbon was a feature within the social values report. There has been a positive increase in awareness around domestic abuse across both child and adult

safeguarding concerns through the safeguarding duty desk. Duty enquiries into domestic abuse link strongly to the complexity of coercive control, this is a targeted area for awareness raising through the champion training with shared resources including the Duluth wheel (power and control/equality wheel) and work from Evans Stark to understand the pattern of coercive control, impact upon victims and children.

All three local authority areas provide domestic abuse services; which includes provision of non-convicted perpetrator programmes, details for all services are shared across Humber services to ensure staff are aware of the local service offer

3.4 Children and Young People

The Safeguarding Team has faced unprecedented challenges in supporting and safeguarding children and families during the pandemic. Children with a history of abuse may have found themselves even more vulnerable, both at home and online and may have experienced more frequent and severe acts of violence. Others may have been abused for the first time.

Conflict and violence can escalate when families face increased pressure and stress contributed to by job losses, changes to routines, and the juggling of multiple responsibilities including work, full-time childcare and care for family members who may be shielding or ill. The pandemic has meant that many parents and carers have faced financial insecurity. Hull was previously identified as the 4th most deprived local authority in England out of 317. The NSPCC (2020) recognises the evidence linking these conditions to child maltreatment and the increase in parental negative coping strategies such as alcohol use, drug use or withdrawal behaviours. The exacerbation of existing stressors and introduction of additional ones could increase the risk of physical, emotional, and domestic abuse, neglect, as well as online harm. This is particularly relevant for the Trust as we provide services to families where several family members may be receiving interventions from Humber professionals. Aligning our approaches with the principles of ‘Think Family’ has never been more crucial.

3.5 Neglect

Most of the children supported by Trust services will have experienced a greater level of isolation than what is usual for them which can place children at a greater risk of neglect. This is compounded by the increased economic challenges and poverty that some families may be facing, and the increased exposure of children to neglectful environments as they spend more time in the home.

The Safeguarding Team have continued to promote the risk of neglect in partnership with local Safeguarding Children Partnerships, particularly the East Riding Safeguarding Children (ERSCP) in their relaunch of the Graded Care Profile neglect assessment tool (GCP2). ERSCPs GCP2 multi agency training sessions have been co-facilitated by the Trusts Named Nurse (child) and trainers from the Partnership on several occasions and there are plans in place to co-facilitate additional sessions within the Trust. To enable this, the safeguarding team have a practitioner who is appropriately trained to deliver this and a second Practitioner is due to attend training in May 2021 to enable further roll out of this training to service areas. This will help with the identification and response to child neglect.

3.6 Exploitation and Online Safety

There has been a reported increase in exploitation with increasing numbers of female victims relating to criminal exploitation and county lines. However it is important to acknowledge that exploitation can be identified in many forms. The impact of lockdowns and restrictions has meant that in times of crisis, those who might seek to exploit children and young people can be quick to act and prey on vulnerabilities facing fewer barriers to do so with a reduction in online moderators that work to keep children safe" (Social Care Institute for Excellence 2021).

There is a close association between exploitation and online safety with online social media and gaming sites becoming a lifeline for parents and children adapting to spending more time at home and for addressing social isolation. Not all parents and carers are able to establish clear boundaries and controls which may lead to increased levels of risk for children and young people.

The Safeguarding Team remains committed to the local safeguarding children partnership's approaches to promoting awareness of online safety. All learning, resources and multi-agency training is promoted across the Trust encouraging attendance and participation. There is regular and committed attendance within safeguarding meetings to ensure that as part of a multi-agency framework, the Trust is able to contribute to the risk assessment and management plan of children and young people in our care.

3.7 Adults

Adult safeguarding continues to develop and evolve; the Care Act 2014 continues to drive the agenda along with Chapter 14 of the Care and Support Statutory Guidance (DoH 2016).

3.8 Self-Neglect

There continues to be a national focus on self-neglect and the risk factors associated with this area. The Covid-19 pandemic heightened these risks, specifically in vulnerable groups such as mental health, drug and alcohol dependency and street homeless. The Trust has a Self-Neglect, Neglect and Hoarding Policy that was implemented in 2019/2020 and a dedicated intranet page to support staff in this area. The Trust has also continued to work with Safeguarding Adult Boards and deliver best practice through the Vulnerable Adult Risk Management (VARM) process and safeguarding adult processes. The Humber Safeguarding Team throughout the pandemic has supported staff in attending and facilitating VARM meetings and discussions.

3.9 Financial Abuse

One of the most significant risks associated with vulnerable adults and Covid-19 has been the increased risk of financial abuse. The pandemic has provided perpetrators opportunity's to exploit the most vulnerable, by means of sales of sanitation equipment, financial scams, fake insurance schemes, fake government emails. There has been a drive nationally and locally on raising awareness of financial exploitation in communities, information has been distributed through communications, social media and multi-agency working.

4.0 Safeguarding Governance Arrangements

The statutory safeguarding function for the Trust is held by the Executive Director of Nursing, Allied Health and Social Care Professionals. There is an ongoing and strong commitment to working in partnership with Local Safeguarding Children Partnerships, Local Safeguarding Adult Boards, CCGs and other statutory agencies in delivering the requirements of the Safeguarding Strategy.

The Executive Director of Nursing, Allied Health and Social Care Professionals is the executive member for the Trust at the Hull and East Riding Safeguarding Children Partnerships and Safeguarding Adults Boards. The North Yorkshire Board and Partnership are serviced by the Partnership Commission Unit. The Trust actively participates in the Board, Partnerships and subgroups to ensure appropriate safeguards are in place across all of our health communities.

The safeguarding governance structure is robustly embedded, ensuring that all safeguarding processes are reviewed in Trust risk management processes. An investigation tracker is in situ which incorporates all safeguarding reports; this is reviewed monthly at the Clinical Risk Management Group (CRMG) and updated by the safeguarding leads. Actions and time scales from the safeguarding reports are monitored via the tracker and reviewed at CRMG, attended by a safeguarding representative.

The safeguarding team attend all the Division Clinical Network Meetings to further embed safeguarding governance and information sharing. A safeguarding learning and development meeting occurs six-weekly with Division leads and other key representatives across the Trust to ensure that safeguarding governance and information is embedded.

The safeguarding team has an active role in the patient safety issues, which includes review of all Datix submissions, involvement in Serious Incident investigations and attendance at risk management meetings including the Clinical Risk Management Group, Clinical Advisory Group and the Pressure Ulcer and Review Learning Group (PURL).

The service also forms part of the independent review team for inpatients who are in long term segregation. This enables a safeguarding overview of the rights of the patient, the reasons for segregation, the plans for re-integration and identifies the patient's views and involvement in the process.

The service has a robust safeguarding three-year audit plan in place, approved by the Safeguarding Learning and Development Forum and shared with the audit team. There is a consistent engagement in the Trust's auditing activity and consistent attendance at Safeguarding Board/Partnership meetings and sub-group participation.

The move to audits now being included on My Assure, which is a digital platform for collating audit information, has commenced, further aligning the safeguarding service with Trust auditing processes; this will include the MCA audit and the Early Help and Safeguarding Hub audit regarding children's referrals to Social Care.

5.0 Practice Reviews/ Safeguarding Adults Reviews/ Domestic Homicide Reviews

5.1 Children and Young People

The Named Nurse safeguarding children and the safeguarding practitioners continue to be actively involved in a number of child Safeguarding Practice Reviews and Learning the Lessons Reviews within Hull and East Riding Safeguarding Children Partnerships, at the present time we are not involved with any cases within the North Yorkshire area. The actions resulting from these reviews are included in the Trust`s safeguarding development plan and investigation tracker which are reviewed and quality assured at the Safeguarding Learning and Development Forum and at the safeguarding business meetings.
All learning from cases is shared and explored with the clinician involved with the case and their manager, followed by their team before sharing briefings across the Trust. Learning is also disseminated via 'lunch and learn' sessions, attendance at MDTs, Division Governance meetings, training, supervision, safeguarding newsletters and five minute focus bulletins.

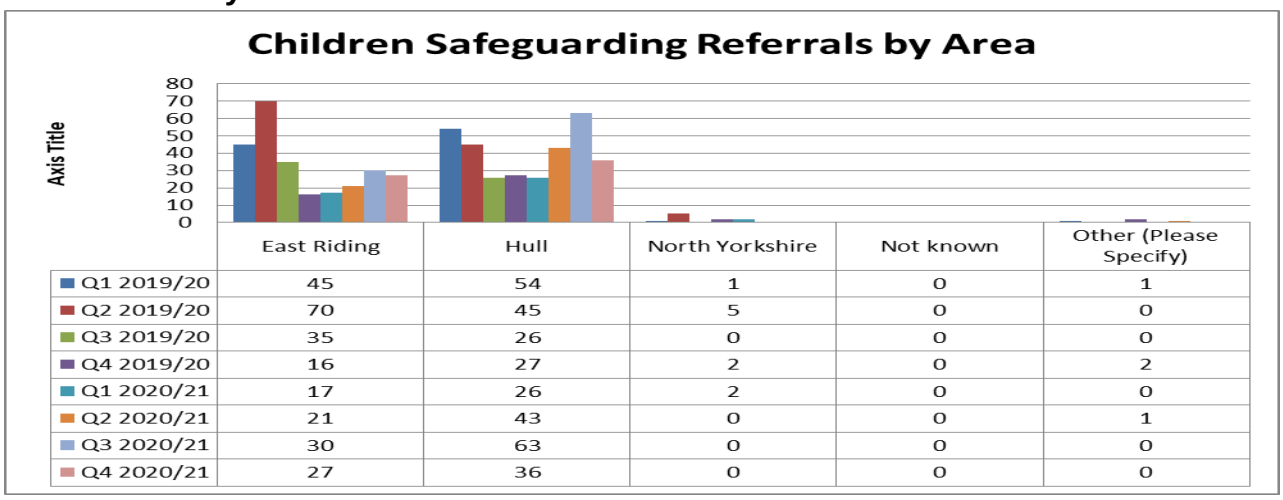
5.2 Adults

The safeguarding team continue to be fully involved in the Safeguarding Adult Review (SAR) process in Hull, East Riding and North Yorkshire. The team have continued to support the Local Authorities to complete comprehensive reports and actions plans. During the first part of 2020 a lot of the working arrangements and meetings had been cancelled to allow time for organisations to work from home. This did not however cease referrals or considerations for Safeguarding Adults Review. A total of four referrals for safeguarding adult reviews have been completed for consideration and involvement in other reviews that are underway have continued.

There have been a number of section 42 enquiries in the Trust requested by the local authorities which have been supported and / or conducted by Humber services. The Trust works closely with Humber staff, service users and local authority services to ensure that the adult at risk is protected and that their outcomes are achieved whenever possible.

6.0 Safeguarding Children Referrals

6.1 Referrals by Area

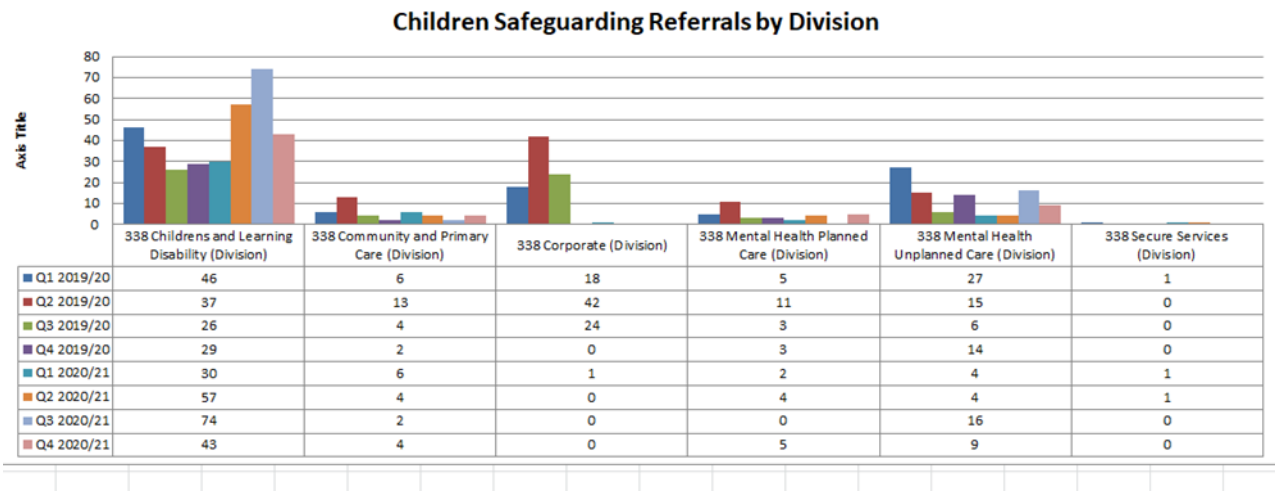


	East Riding	Hull	North Yorkshire	Not known	Other (Please Specify)
Q1 2019/20	45	54	1	0	1
Q2 2019/20	70	45	5	0	0
Q3 2019/20	35	26	0	0	0
Q4 2019/20	16	27	2	0	2
Q1 2020/21	17	26	2	0	0
Q2 2020/21	21	43	0	0	1
Q3 2020/21	30	63	0	0	0
Q4 2020/21	27	36	0	0	0

There have been a total of 266 referrals completed to children's social care in 2020/21. This compares to 329 in the previous year (19/20). A reduction in referrals can be seen at the beginning of Covid-19 (Q1 2020) when we were required to socially isolate and contact with children open to Trust services was affected by restrictions. During this period, many of the contacts that would previously have been undertaken face to face were carried out virtually or over the telephone, limiting direct contact with families and children. This was reflected nationally with Ofsted (2020) reporting that the initial lockdown and reductions in school attendance understandably led to a reduction in referrals by up to a fifth of usual numbers. It appears that referrals are increasing again although this seems to be at a very slow pace.

The safeguarding team are keen to understand the reduction in referrals. Actions have been agreed to explore this further and remind staff of the processes regarding the identification of concerns and submitting safeguarding children referrals. This will be particularly reinforced in North Yorkshire where there have not been any safeguarding children referrals made in the last 3 quarters. These actions will be closely monitored during the safeguarding business meetings and also the Safeguarding Learning and Development Forum, ensuring that all Divisions in the Trust are aware of safeguarding responsibilities.

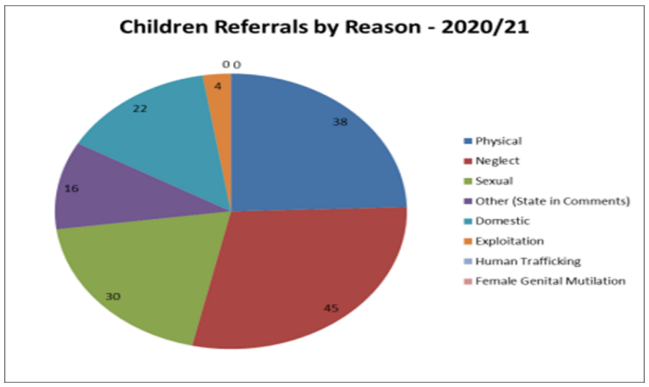
6.2 Referrals by Division



	338 Childrens and Learning Disability (Division)	338 Community and Primary Care (Division)	338 Corporate (Division)	338 Mental Health Planned Care (Division)	338 Mental Health Unplanned Care (Division)	338 Secure Services (Division)
Q1 2019/20	46	6	18	5	27	1
Q2 2019/20	37	13	42	11	15	0
Q3 2019/20	26	4	24	3	6	0
Q4 2019/20	29	2	0	3	14	0
Q1 2020/21	30	6	1	2	4	1
Q2 2020/21	57	4	0	4	4	1
Q3 2020/21	74	2	0	0	16	0
Q4 2020/21	43	4	0	5	9	0

The Division creating the highest number of safeguarding children referrals is Children's and Learning Disability, Q4 in 2019/20 also resulted in the largest number of referrals from this Division although there were fewer referrals made (29 compared to 43 this quarter). The largest reduction identified from the same quarter in 2019/20 is regarding Mental Health Unplanned Care services where referrals have reduced by 5. More significant within the Division is the reduction compared year on year. During 2019/20, a total of 62 referrals were made, during 2020/21, this had reduced to 33. This provides useful information indicating where the increased focus regarding safeguarding children and referral processes (discussed above) is required.

6.3 Reasons for Referrals



Neglect continues to remain the most common reason for safeguarding children referrals. It is anticipated that more cases of neglect are occurring than are identified due to the pandemic and that consequently children have been more invisible than usual. The most significant impact in term of not having needs met was in relation to education. Despite education places remaining available for the most vulnerable children, the uptake of this remained at only 8% nationally (DfE 2020). Children's lives at home have become increasingly difficult as stresses faced by families have been exacerbated by the reduced services available for children and also the increase in the economic and emotional impact of Covid upon families.

Physical abuse has increased over the previous year which possibly reflects the increasing cases of domestic abuse that have been reported to the safeguarding team overall. Calls to The National Domestic Abuse helpline increased by 80% in June 2020. It is likely that this increase has affected the number of referrals made regarding physical abuse.

6.4 Children & Young People Admitted to Adult Units

	Admissions	
Children Admitted to Adult Units	**Q2 2019/20**	6
	Q3 2019/20	2
	Q4 2019/20	7
	Q1 2020/21	0
	Q2 2020/21	2
	Q3 2020/21	1
	Q4 2020/21	0

There is a marked decrease in young people admitted to adult inpatient units. This is likely to be as a result of the Inspire CAMHS service which opened in January 2020. On occasions where an admission to adult units has been necessary is due to a bed not being available at Inspire. At these times, the safeguarding team maintain contact with the admitting unit and support the staff and young person as required.

6.5 Safeguarding Children Supervision

Much work has been undertaken over the previous year to progress safeguarding children supervision from an activity that was possibly perceived as an addition to day to day practice to an activity that is integral to clinical practice. The following actions have been undertaken to date:

- Safeguarding children supervision training is in the process of being integrated with clinical supervision training. As a result, all staff delivering clinical supervision will have the necessary training and skills to deliver safeguarding supervision. This will significantly increase access to safeguarding supervision across the Trust
- The safeguarding children supervision guidance and policy have been merged with the wider Trust clinical supervision policy to ensure that it is seen as relevant and mandatory as clinical supervision
- The SCT 9 form (now ST 9) used to record safeguarding children supervision on Lorenzo has been reviewed and updated to reflect the Signs of Safety model adopted by Hull and East Riding Safeguarding Children Partnerships.
- All CAMHS teams have at least monthly attendance by safeguarding practitioners and the Named Nurse safeguarding children to prompt staff to consider safeguarding supervision and the appropriate recording of this activity.
- Lunch and Learn sessions facilitate by the safeguarding team provide the opportunity for safeguarding supervisors to access support and obtain updates as required

7.0 Looked After Children (LAC)

The year saw the LAC health team move to home working in line with the Trusts response to the pandemic. The team have however been able to fulfil their statutory duties to the children and young people who are looked after by East Riding Local Authority. There are currently 357 children looked after by the local authority with the majority residing in county but with a number living in Hull and some 70 children living away from the East Riding either in foster homes or residential homes. There are currently no young people in secure settings.

2020-2021 saw a decrease in the number of East Riding children and young people who became looked after - with just 99 new referrals, 9 of which ceased care within 20 days (Therefore not counted in the performance figures for Initial health assessments). During the 3 “lockdowns” the numbers of children coming into care were very much reduced from previous years and spikes in the numbers were seen once lockdown restrictions were lifted and schools reopened. However at the time of writing this report the schools had only reopened for just 3 weeks prior to the Easter Holidays and numbers of children becoming looked after continue to remain lower than previous years.

Following NHS England prioritisation matrix over the year statutory health assessments initially moved to a virtual platform. A decision was made with the Designated Doctor and ER CCG that any child who had a virtual medical assessment should be offered a face to face medical appointment within 6 months of becoming looked after. This has been achieved by working with the paediatricians at Hull Teaching Hospital Trust who hold the contract for community paediatrics. 28 children and young people are still to be seen by paediatricians for this follow up appointment.

From February 2021; Dr Cavill (specialist GP for CLA) has now resumed face to face appointments for the Initial health Assessments.

Performance for Initial health assessments was 65%, the majority of reasons for assessments being completed late was down to the correct consent and paperwork being received late from social care. There were also issues with securing interpreters and where children were placed out of county where teams either offered appointments out of statutory timescales or with a nurse rather than a medical practitioner which is deemed as working outside of the statutory guidance on providing care for children looked after.

The LAC health team completed 235 review health assessments with East Riding children(12 fewer than the previous year); again these assessments were completed via a virtual platform from April through to September 2021 when face to face assessments resumed for all children with staff wearing uniform and PPE following Humber Foundation Teaching Trust guidance.

Integrated Public Health Nurses (health visitors) completed 118 assessments (a small increase on the previous year).

Out of area teams completed 31 review health assessments, it should be noted that the East Riding LAC health team are expected to travel to see children and young people placed within a 50 mile radius of the East Riding boundary. These 31 children were placed further afield or within a prospective adoptive placement where it is important that a local health professional complete the assessment with the child.

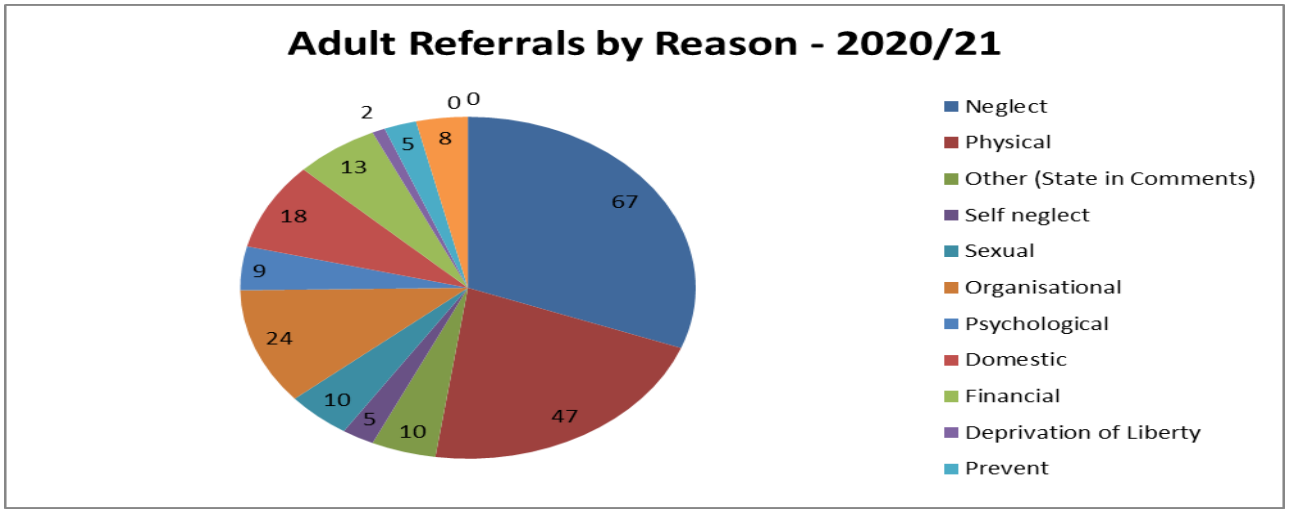
Performance increased to 90% for completion of review health assessments within statutory timescales. It should be noted that the LAC health team were assisted in this excellent performance by members of the ISPHN team in particular school nurses who assisted during the first “lockdown” when there were very limited numbers of children attending education and when both nurses in the LAC health team were on long term sick leave which had left just the Named Nurse for children looked after and the Edge of care nurse in the team.

The East Riding of Yorkshire remains an “importer” of Looked After Children, the majority of whom (160) are placed from the neighbouring Hull City Council. 154 children are placed into the area from other local authorities. The LAC health team completed 95 review health assessments at the request of placing CCG’s (an increase from 73 the previous year) and arranged for 23 children and young people to have their Initial health Assessments completed whilst they resided in the East Riding (an increase from 19 the previous year). A national tariff is charged for the completion of these assessments bringing a small amount of income into the LAC health team.

This year saw 3 Unaccompanied Asylum Seeking Children arriving in the East Riding. One of these was a transfer through Yorkshire Migration directly from Kent who saw large numbers of these young people arrive in the country over the last year, this compared to just 2 young people who arrived in the East Riding by themselves. East Riding Local Authority is expected to take more of these transfers from Kent once they have secured suitable accommodation for the young people. The main issue with working with these very vulnerable young people continues to be the language barrier; many speak dialects of which interpretation services have been extremely difficult to source. This has often leads to a delay in the completion of their Initial Health Assessment.

8.0 Safeguarding Adults

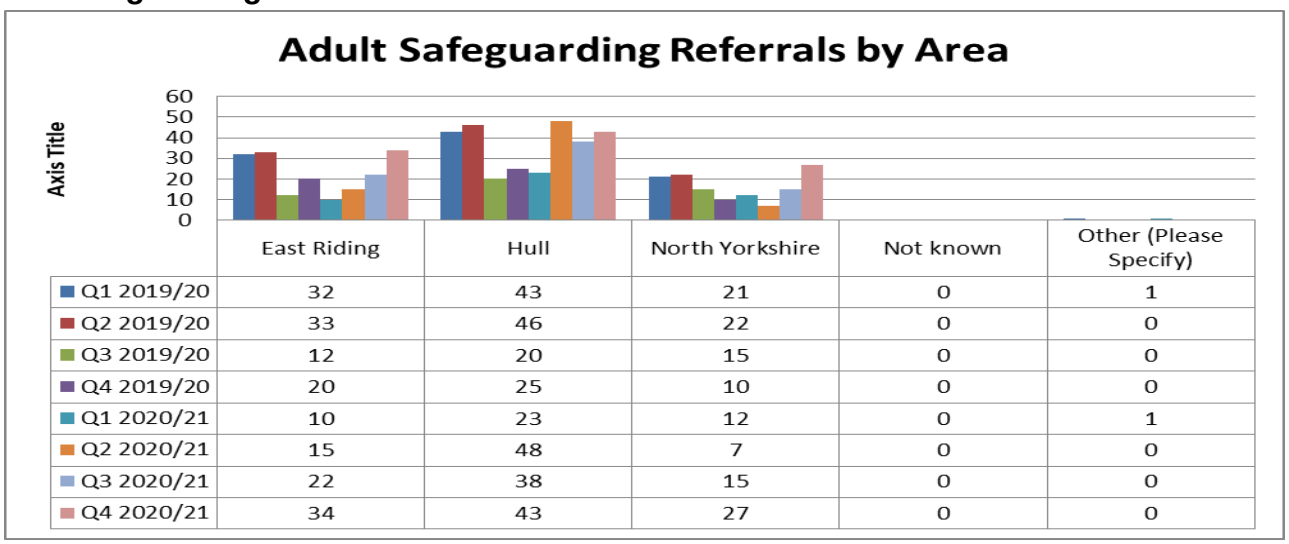
8.1 Referral Reason



Neglect and physical harm have been the highest reporting category of harm during this period. This reflects a similar pattern to the previous year of reporting. It is important to note that this reporting year has seen an increase in reporting of organisational abuse and a decrease in financial abuse.

The national context observed safeguarding concerns dropping markedly during the initial weeks of the COVID-19 lockdown period, only to return to and then exceed normal levels in June 2020.

8.2 Safeguarding Adult Referrals

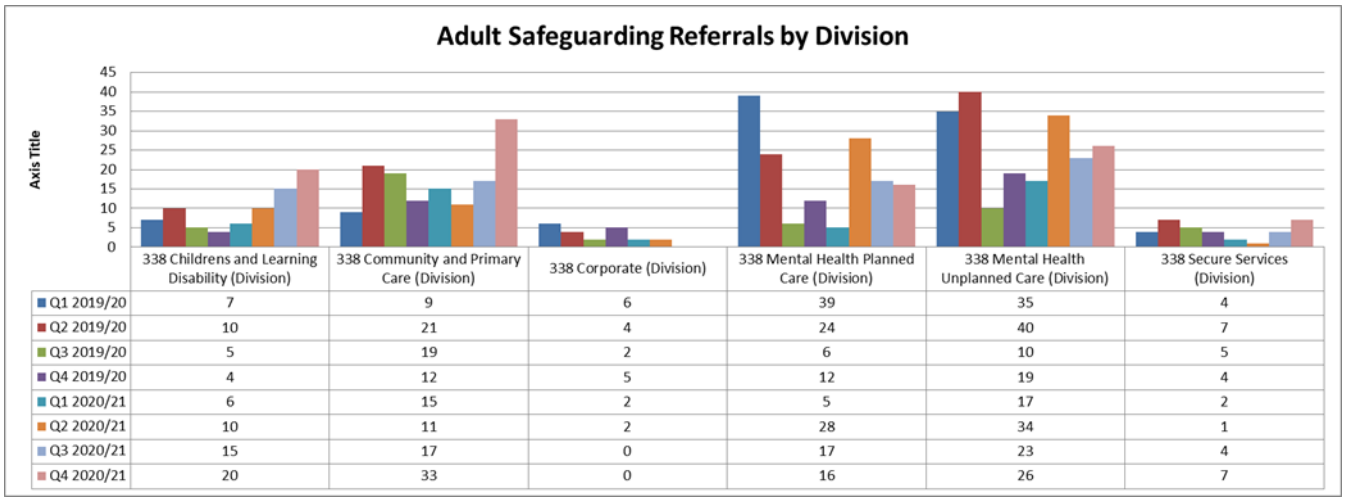


	East Riding	Hull	North Yorkshire	Not known	Other (Please Specify)
Q1 2019/20	32	43	21	0	1
Q2 2019/20	33	46	22	0	0
Q3 2019/20	12	20	15	0	0
Q4 2019/20	20	25	10	0	0
Q1 2020/21	10	23	12	0	1
Q2 2020/21	15	48	7	0	0
Q3 2020/21	22	38	15	0	0
Q4 2020/21	34	43	27	0	0

The chart highlights an increase of referrals over each reporting quarter, which correlates with local and national trends. It highlights a significant increase in reporting in Q4 20/21 compared to Q4 in 2019/20.

A review of safeguarding adults during the Covid-19 pandemic highlighted an overall reduction at the start of the COVID-19 lockdown period in both safeguarding concerns and Section 42 safeguarding enquiries, followed by a renewed increase in safeguarding activity (Local Government Association 2020).

8.3 Referrals by Division



	338 Childrens and Learning Disability (Division)	338 Community and Primary Care (Division)	338 Corporate (Division)	338 Mental Health Planned Care (Division)	338 Mental Health Unplanned Care (Division)	338 Secure Services (Division)
Q1 2019/20	7	9	6	39	35	4
Q2 2019/20	10	21	4	24	40	7
Q3 2019/20	5	19	2	6	10	5
Q4 2019/20	4	12	5	12	19	4
Q1 2020/21	6	15	2	5	17	2
Q2 2020/21	10	11	2	28	34	1
Q3 2020/21	15	17	0	17	23	4
Q4 2020/21	20	33	0	16	26	7

This chart highlights the referrals that have been made by each division within the trust showing the highest reporting division is Mental Health. There has been a slight reduction of 10% from the previous year. This could be as a result of the Covid 19 Pandemic during the initial lockdown period. There is however in Q3 and Q4 20/21 a 74% increase in reporting of safeguarding adult concerns.

The second highest reporting Division is Community and Primary care which incorporates GP's, District Nursing and community wards; there has been a 24% increase since the previous reporting year in this Division. This reflects the increase in activity in the community services, including discharges from the acute trust and people in the community generally requiring more support for their physical health rather than attending hospital settings.

There has been 1 safeguarding adult referral reported and 3 safeguarding children referrals reported by GP practices. Although this appears to be low numbers this is due to how the GP practices are reporting through the Datix system. Monthly drop in sessions have now been arranged with the safeguarding team for supervision and advice on making safeguarding referrals

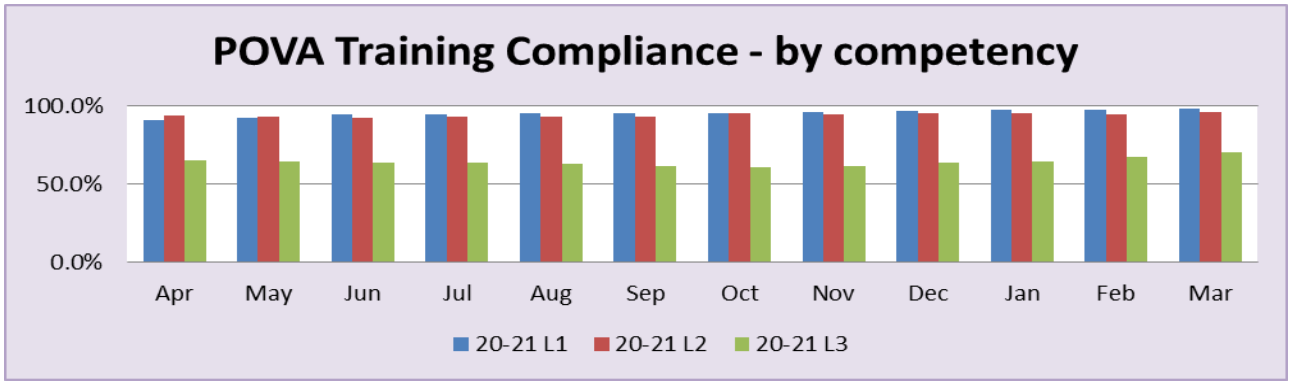
9.0 Safeguarding Training

The previous year has posed challenges with the delivery of training. Face to face sessions were paused for the Safeguarding L3 due to the pandemic. A new package was introduced which included e learning modules and virtual sessions in September 2020.

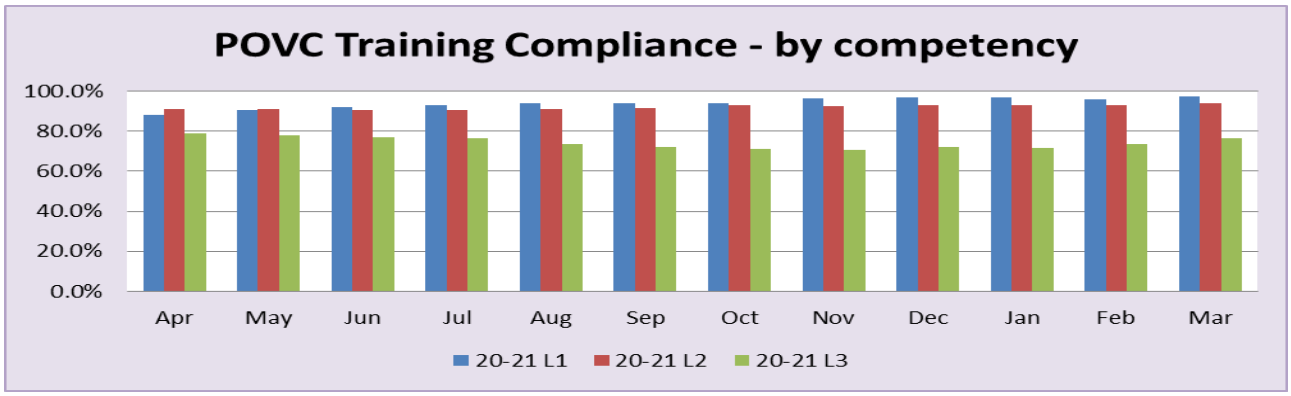
The table below highlights the continued commitment to the delivery and compliance of training. It was expected that Level 3 Safeguarding training would be impacted as a result of having no available sessions for a six month period. However through dedication and an increase in delivery, compliance rates have increased steadily over Q3 and Q4 as outlined below.

9.1 Safeguarding Adults and Children's Training

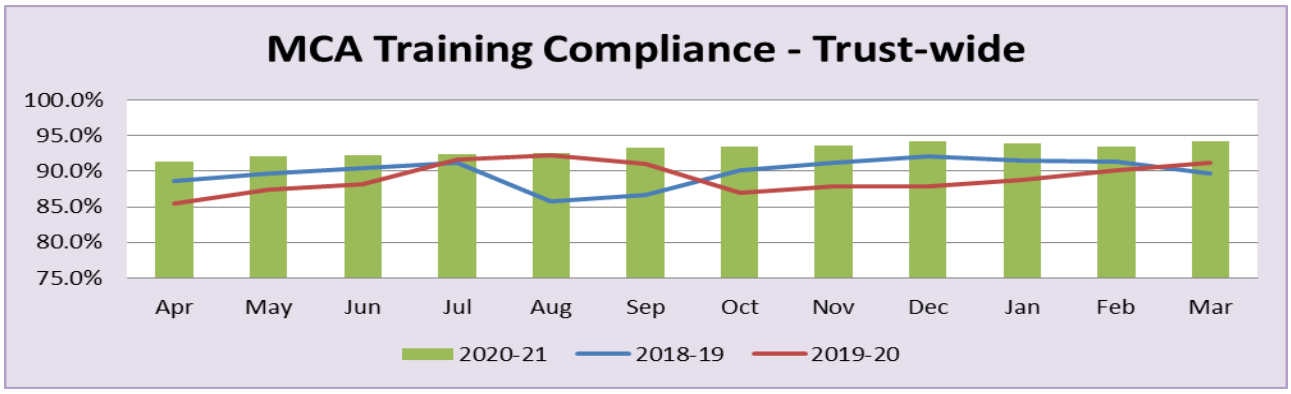
9.1.1 Adults



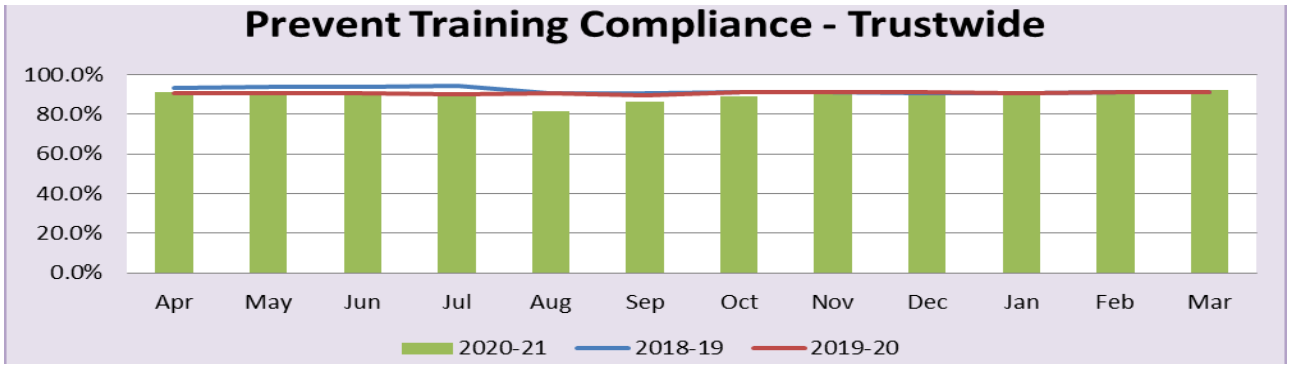
9.1.2 Children



9.1.3 Mental Capacity Act 2005 Training Compliance Trust-wide



9.1.4 Prevent Compliance Trust-wide



10.0 Partnership Working

10.1 Safeguarding Boards and Sub Groups

The Executive Director of Nursing, Allied Health and Social Care Professionals is the executive member for the Trust at the Hull and East Riding Safeguarding Children Partnerships and Safeguarding Adults Boards. The Named Professional for Safeguarding Adults and Named Nurse for Children deputise and attend the safeguarding board and partnership meetings. There is also representation from the safeguarding team at the various sub groups in all three local authority areas to ensure appropriate safeguards are in place across our health communities.

10.2 Local Authority Designated Officer (LADO)

The Trust has a responsibility to provide clear policy and guidance for dealing with allegations against people who work with children and adults with additional needs.

With regards to children, Working Together 2018 identifies how an allegation may relate to a person who works with children who has:

- behaved in a way that has harmed a child, or may have harmed a child
- possibly committed a criminal offence against or related to a child
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children
- behaved or may have behaved in a way that indicates they may not be suitable to work with children

Over the previous year, the Trust has made one referral to the LADO concerning a case in North Yorkshire (Jan 2021), however there have been many cases that the safeguarding team have been made aware of which have been referred by other agencies such as Children's Social Care. The Named Nurse and Named Professional for safeguarding are fully committed to these processes and ensure attendance at all LADO strategy discussions.

Many of the concerns reported to the safeguarding team do not require referrals to the LADO as they don't meet the threshold. It has been observed over the previous year that there appears to be an increase in the number of cases where staff appear to be experiencing the effects of reduced emotional wellbeing, domestic abuse, alcohol use, drug use and marital separations. It is possible that this is the result of the Covid19 restrictions and lockdowns.

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 20201	Mar 2021	Apr 2021
No of cases Identified		**1**		**1**	**4**		**2**	**3**	**1**	**3**			**1**

10.3 Multiagency Risk Assessment Conference (MARAC)

The number of cases discussed at MARAC has increased this year in compared to the previous year, as shown in the table below:

2019/2020	2020/2021
290	402

The cases numbers show an average of 35-45 cases per month, the exceptions identified within the last 9 months are February and March; this correlates with the third lockdown and school closures announced at the beginning of January. As cases are heard at the beginning of the month, this potentially could account for reduced cases heard in February and March. There has been an identified increase in stalking behaviours during lockdown. Data and trends will continue to be reviewed going forwards.

10.4 Multi-agency tasking and coordination (MATAC)

The purpose of the MATAC meeting is as follows:

- To share information to increase the safety, health and well-being of victims- adults and their children;
- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- To reduce repeat victimisation;
- To improve agency accountability; and improve support for staff involved in high risk DV cases.
- The responsibility to take appropriate actions rests with individual agencies; it is not transferred to the MATAC. The role of the MATAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety.

MATAC meetings take place on a monthly basis with usual representation from agencies who attend the MARAC meeting. Each month two further nominals will be included on the agenda. There are no comments at this time in respect of effectiveness or trends associated with MATAC due to its early implementation.

10.5 Multi Agency Child Exploitation (MACE)

A Trust safeguarding practitioner attends all East Riding MACE and Pre MACE meetings.

These monthly meetings bring together all relevant professionals to ensure cases of suspected or actual child exploitation are robustly risk assessed, cases of both child and criminal exploitation are considered.

These meetings are part of the contextual approach to safeguarding; this approach considers the context of the child/young person’s lives and experiences and uses this information to identify appropriate and targeted safeguarding interventions.

This year has seen an increase in the numbers for of very young people becoming involved in criminal exploitation by virtue of being coerced into delivering drugs within their communities. This is being addressed by the Police in order to disrupt this activity and by local services working directly with the young people concerned. There has also been an increase in the number of 'mapping meetings', where the contacts and interrelationships between these young people are explored so that patterns of involvement can be identified early and interventions can be targeted and specific.

The Mace Meeting also works closely with the Organised Crime Group within the Police, to identify individuals and gangs working across Humberside, North and South Yorkshire in order to ensure a coordinated approach to child exploitation.

Between March 2020 and March 2021, the circumstances of approximately 190 children and young people were considered as part of the MACE process. Some of these young people were only briefly involved with MACE; others remained 'open' to MACE oversight for some time.

10.6 Missing

East Yorkshire Missing and Runaway Meeting is held on a 6 weekly basis. Children are discussed over the age of 12 years who have been reported to the Police as missing two or more times, children under the age of 12 years, only need to be reported once to be discussed. The documentation following this meeting has recently been reviewed and streamlined, following the appointment of a new Chair.

Trends are children spending time with older peers, which lead to peer on peer abuse. Children who are Looked After are a vulnerable group who will go missing on numerous occasions. A number of children, who are reported as Missing, also are subject to MACE, therefore MACE Panel have oversight to ensure that Missing meeting do not duplicate any of this work. Statutory guidance for local authorities in England states that on every occasion that a child goes missing, on their return they should be should be offered an independent Return Home Interview (IRHI) by someone who is not involved in caring for the child or young person.

10.7 Prevent

The safeguarding team have continued to share information for the National Prevent duty data set, with the Police and the two Channel Panel chairs for Hull and East Riding of Yorkshire as well as provide a representative on the panels to provide information from the Trust mental health services and ISPHN service.

The Trust has two established Prevent champions and have recently appointed a further two. The safeguarding team has three with experience in covering children and families, learning disability, adult mental health and older adult mental health. The remaining champion works with adult learning disability services.

This year the trust submitted 2 prevent channel panel referrals after the practitioner had discussions with the safeguarding duty desk. The duty desk supported practitioners with identifying possible signs of radicalised behaviours and in making a formal referral to

channel panel. The duty worker also provided advice and support to practitioners on 15 occasions on Prevent concerns when the channel panel referral was not needed.

10.8 Modern Slavery

The trust continues to be a panel member on the Humberside Modern Slavery Partnership and shares resources to the wider trust via the mid- week newsletter and on the dedicated modern slavery page under the safeguarding intranet area.

The Humber Modern Slavery Partnership, has been recognised in this year's iESE Public Sector Transformation Awards, receiving a Certificate of Excellence in the category of 'Working Together' for their work to tackle Modern Slavery and Human Trafficking by prosecuting perpetrators, disrupting identified organised crime and supporting victims.

10.9 Multi Agency Public Protection Arrangements (MAPPA)

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 MAPPA 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 (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.

The Associate Director of Psychology recently had an article published in the MAPPA annual report discussing the effects of the pandemic on work and how staff can self-care effectively.

Training to MAPPA colleagues regarding Mental Health and pathways of referral is due to be delivered on MS Teams by colleagues in Adult Mental Health and MAPPA colleagues have recently provided MS Teams training on MAPPA Awareness.

11.0 Safeguarding Strategy

The Safeguarding Strategy encompasses our joint approach to both adults and children's safeguarding. The strategy is aligned to the organisation's six goals and aims to help improve the quality of safeguarding practice and enhance prevention and wellbeing. It promotes partnership working with patients, staff and safeguarding partners.

Achievements against the Safeguarding Strategy 2020-21

- The Covid-19 pandemic hit the Level 3 Safeguarding training compliance significantly. Face to face training was ceased; however a new format of e learning and virtual sessions was introduced in September 2020, which has supported the trust in compliance figures steadily increasing.
- A review of the MCA 2005 e learning modules was completed and a new package introduced. Bespoke MCA 2005 and Consent sessions have been undertaken with a new face to face package being introduced.
- Section 42 Level 3 training is now available via local authorities Hull and East Riding for all staff. The Safeguarding Team continue to have effective working relationships with all three of the Safeguarding Adults Teams and Boards;
- A multi-agency Making Safeguarding Personal Audit has been completed, with key findings and ways for developing this area across local authorities; this is a piece of work that continues across the safeguarding adult boards.
- The Named Professional for Safeguarding Adults has made links with the three local authority Liberty Protection Safeguard planning groups, and preparation has also begun for implementation into the Trust;
- The Trust has gained White Ribbon Accreditation; the first health trust to have gained this. Domestic abuse training and domestic abuse champions have been introduced.
- A working group has been agreed and provisionally established regarding the development of neglect objectives to drive developments regarding identification and response;
- For the first time, safeguarding children supervision training is to be integrated with clinical supervision training to raise the profile of safeguarding supervision and increase the number of safeguarding supervisors and its availability.
- Raising the profile of safeguarding has continued across the year. Working relationships have been established with the Communications Team and a weekly safeguarding update added to the Midweek mail. A Twitter account has also been raised by the Safeguarding Team and awareness days launched and safeguarding topics and themes.

12.0 Safeguarding Priorities 2021/2022

Trust Strategic Goal	Priorities for 2021-22
Innovating quality and patient safety	To continue to raise awareness of domestic abuse across the Trust, including additional virtual training opportunities for staff To be assured that safeguarding continues to be 'everybody's business' – by completing regular audits via My Assure clinical audit reporting, ensuring ongoing oversight and strengthening links with clinical Divisions and service areas.
Enhancing prevention wellbeing and recovery	To raise awareness of neglect in children, young people and adults at risk through the implementation of neglect assessment tools including the Graded Care Profile 2 and additional virtual training opportunities for staff To promote the safeguarding agenda through the facilitation of virtual forum meetings and lunch and learn sessions and an increased presence via five minute focus briefings, communication notifications and the sharing of resources.
Fostering Integration, partnership and alliance	To maintain positive and collaborative working relationships with internal and external partners To be compliant with safeguarding training. To continue to implement the Integrated Level 3 Safeguarding training through virtual and e Learning sessions To support GP practices in maintaining safeguarding learning and development and improve compliance of mandatory safeguarding training across all practices
Developing an effective and empowered workforce	To be compliant with safeguarding training, MCA and Prevent training Maintain a safeguarding duty desk for support to all staff across the Trust – this will be maintained virtually through email and virtual meetings To continue to raise awareness, plan and implement the Liberty Protection Safeguards Actions and learning from safeguarding investigations and internal incident investigations to be captured and measured, ensuring that learning has been embedded into services Trust wide with a positive outcome for Adults at Risk, children and young people.

Maximising an efficient and sustainable organisation	To ensure the increased availability and appropriate recording of safeguarding children supervision reflected in integrated clinical and safeguarding supervision policy and training The safeguarding team to provide assurances that Trust staff have access to safeguarding supervision in line with policy and guidance. To maintain a link worker with North Yorkshire Services, maintain a presence virtually at operational and strategic clinical and business meetings
Promoting people, communities and social values	To be compliant with safeguarding training, to implement the Integrated Level 3 Safeguarding training through virtual learning and e Learning To consider and reflect the safeguarding transition needs and application of relevant legislation for children and young people in all safeguarding training, policy and processes Making Safeguarding Personal (MSP) to be embedded throughout the Trust and its processes To work and promote the elimination of individual and institutional discrimination, harassment and victimisation across all protected characteristics set out in the Equality Act 2010 which are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

13.0 References

- ADASS (Association of the Directors of Adult social services) - Keep calm and make it personal;
- Care Act 2014;
- Care and Support Statutory Guidance DoH 2016.
- Care Quality Commission: Not seen Not heard;
- Community Care 2016 - The Tension between Human Rights and Self-Neglect Concerns;
- Department for Education (2019) Characteristics of children in need: 2018 to 2019 London;
- Department for Education (2020) Guidance for Schools: coronavirus (Covid-19)
- Her Majesty's Government, 2004. Children Act 2004. London: Her Majesty's stationery office;
- Her Majesty's Government. 2017. Children and Social Work Act 2017. London. Her Majesty's stationary office;
- Home Office – Prevent – Channel Duty Guidance – updated 2019;
- MCA (Amendment) 2019 Liberty Protection Safeguards;
- MCA 2005 and DoLS;
- NHS England (2015) Safeguarding Vulnerable People in the NHS. Accountability and Assurance Framework;
- Ofsted (2020) COVID-19 series: briefing on schools

- Royal College of Paediatrics and Child Health (2019) Safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document;
- Royal College of Nursing (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff London;
- Safeguarding Adults under the Care Act 2014 (2017) Cooper, A and White, E
- The Trussell Trust (2021) https://www.trusselltrust.org/2020/06/03/food-banks-busiest-month/
- Working together to safeguard children 2018. A guide to inter-agency working to safeguard and promote the welfare of children; HM Government (2018);

Humber Teaching NHS Foundation Trust

Agenda Item 28

Title & Date of Meeting:	Trust Board Public Meeting – 29 September 2021
Title of Report:	Standing Orders, Scheme of Delegation and Standing Financial Instructions - Annual Review
Author/s:	Name: Michelle Hughes Pete Beckwith Title: Head of Corporate Affairs Director of Finance
Recommendation:	To approve: x; To receive & note: ; For information: ; To ratify:
Purpose of Paper:	To present amendments for approval following annual review.
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: 13/9; Mental Health Legislation Committee: ; Operational Delivery Group: ; Charitable Funds Committee: ; Other (please detail) Commissioning Committee: 24/8
Key Issues within the report:	The annual review has been brought forward from November to ensure any changes required in relation to the go live date of the Provider Collaborative and Commissioning Committee are reflected. The report summarises the proposed changes.

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	

Annual Review of
Standing Orders, Scheme of Delegation and Standing Financial Instructions

1. Introduction:

An annual review has been undertaken by the Head of Corporate Affairs and Director of Finance. The document was last updated in November 2020 and the review has been brought forward to ensure clear processes are in place for the go live date of the provider collaborative.

2. Proposed Changes:

a) The key changes are additions to the following sections to reflect that the activities via the Provider Collaborative should follow the same principles as the Trusts and who has the overall responsibility and the reporting arrangements – narrative reflected at:

- Page 7 Section A: Interpretation and Definitions for Standing Orders and Standing Financial Instructions: Final paragraph added under 'introduction' ie: These documents apply to all activities of the Trust and specifically including commissioning activities undertaken via the Provider Collaborative which should follow the same principles as the Trust who has the overall responsibility for the reporting arrangements.

- Page 62 Section B: Standing Financial Instructions – final paragraph added to Introduction:- These standing financial instructions (SFIs) refer to both the Trust as provider and any activities the Trust undertakes via the Provider Collaborative. SFIs for the provider collaborative are subject to the same principles as the Trusts as set out in this document.

In addition, references to the Commissioning Committee have been inserted at:

- Page 8/9 Definitions - Commissioning Committee and Provider Collaborative definitions added
- Page 24 section 4.8 Committees Established by the Trust Board – Commissioning Committee included at 4.8.8 – included on contents page too.
- Page 39, Commissioning Committee added to table of committees

b) Page 72 – reference to IR35 included in paragraph

c) A review and update of any minor formatting issues including
   - References to *himself* updated to *himself/herself, him* updated to *him/her*

The updated draft, with the proposed changes highlighted in blue font is attached as Appendix 1.

3. Next Steps:

The Standing Orders, Scheme of Delegation and Standing Financial Instructions is a public document. Subject to approval the changes will take effect from 1st October 2021 and the updated document will be made available on the Trust website.

4. Recommendation:

To approve.

September 2021

Humber Teaching NHS Foundation Trust

Appendix 1
Draft to September 2021 Trust Board

Standing Orders,

Scheme of Delegation and Standing Financial Instructions

~~**November 2020**~~

September 2021

Date Approved: 29 September 2021 - TBC

Review Date: September 2022

Caring, Learning & Growing Together

SECTION A:

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Introduction

Within the Terms of Authorisation issued by the Independent Regulator - NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS foundation trusts - NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2008.

Standing Orders (SOs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated within the Trust's Scheme of Delegation.

These documents, together with Standing Financial Instructions, Standards of Business Conduct and Managing Declarations of Interests Policy for NHS Staff, Budgetary Control Procedures, the Anti Bribery Policy and the procedures for the Declaration of Interest provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation, Standing Financial Instructions and Budget Manual provide a comprehensive business framework that is to be applied to all activities, including those of the Charitable Foundation. Members of the Trust Board and all members of staff should be aware of the existence of and work to these documents.

These documents apply to all activities of the Trust and specifically including commissioning activities undertaken via the Provider Collaborative which should follow the same principles as the Trust who has the overall responsibility for the reporting arrangements.

Interpretation

Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Trust Board).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"Accounting Officer" means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Associate Member" means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.

"Audit Committee" means a Committee whose functions are concerned with the scrutiny and review of Trust systems, risk management and internal control.

"Budget" means a resource, expressed in financial terms, proposed by the Trust Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
"Budget Holder" means the Director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chairman of the Trust Board (or Trust)" is the person appointed to lead the Board and Council of Governors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole.

The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman, if one is appointed, of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the Chief Officer of the Trust.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

"Committee" means a Committee or sub-Committee created and appointed by the Trust Board.

"Commissioning Committee" – means a Committee whose functions are to hold delegated responsibility to provide commissioning leadership and monitoring functions on behalf of the Provider Collaborative.

"Committee members" means persons formally appointed by the Trust Board to sit on or to chair specific Committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Council of Governors" means the body of persons elected and appointed, to fulfil the functions in accordance with the Constitution authorised to be members of the Council of Governors and act in accordance with the Constitution.

"Deputy Chairman" means the Non-Executive Director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.

"Director of Finance" means the Chief Financial Officer of the Trust.

"Finance & Investment Committee" means a Committee whose functions are to monitor, review and support the finance functions of the Trust.

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977.

"**Independent Regulator"** means the regulator for the purpose of Part 1 of the 2003 Act NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS foundation trusts.

"Member" means officer or non-officer member of the Trust Board as the context permits. Member in relation to the Trust Board does not include its Chairman.

"Nominated Officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a Director who is not an officer of the Trust and who has been appointed in accordance with the Constitution. This includes the Chairman member of the Trust of the Trust Board who does not hold an executive office of the Trust.

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"Officer Member" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).

"Provider Collaborative" – A group of providers who have agreed to work together to improve the care pathway for their local population.

"Provider Licence" – replaced the Terms of Authorisation and is how the Independent Regulator regulates providers of NHS Services.

"Quality Committee" means a Committee whose functions are to provide the strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues in the Trust.

"Secretary" means a person appointed by the Trust (the Trust Secretary) to act independently of the Trust Board and Council of Governors and monitor the Trust's compliance with the law, Standing Orders, Department of Health guidance, the Constitution and Provider Licence.

"Senior Employee" means an employee on Very Senior Manager pay and conditions

"Senior Manager" means an employee of band 8c and above.

"SFIs" means Standing Financial Instructions which regulate the conduct of the Trust's financial matters.

"SOs" means Standing Orders.

"Trust" means Humber Teaching NHS Foundation Trust.

"Trust Board" means the Chairman, Chief Executive, Non-Executive Directors and Executive Directors of the Trust collectively as a body.

SECTION B: STANDING ORDERS

1. Introduction

Statutory Framework

Humber Teaching NHS Foundation Trust ("the Trust") came into existence on 1 February 2010 pursuant to authorisation of Monitor under the Health and Social Care (Community Health and Standards) Act 2008 ("the 2008 Act"). Prior to 1st April 2018 the Trust was known as Humber NHS Foundation Trust.

The principal place of business is:-

Trust Headquarters
Willerby Hill,
Beverley Road,
Willerby,
HU10 6ED

NHS Foundation Trusts are governed by the Health and Social Care Act 2012), its Constitution, Provider Licence granted by Monitor (the statutory entity that remains the regulator of NHS foundation trusts), Governors and members.

As a Foundation Trust the Trust has specific powers to contract in its own name and to act as a corporate trustee. It is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

The Code of Accountability requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals. The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

NHS Framework

In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

The Constitution requires that, inter alia, Trust Boards' draw up a Schedule of Matters Reserved to the Trust Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives

The Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Trust also has a Code of Conduct for Directors.

Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make

arrangements for the exercise, on behalf of the Trust of any of their functions by a Committee, sub-Committee or joint Committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Independent Regulator may direct".

2. The Trust

All business shall be conducted in the name of the Trust.

The roles and responsibilities of the Trust Board are set out in Annex 8 of the Constitution

The powers of the Trust established under statute shall be exercised by the Trust Board except as otherwise provided for in Standing Order 4.

Directors acting on behalf of the Trust as corporate trustee of the NHS FT Charitable Funds are accountable for charitable funds held on trust to the Charity Commission.

2.1 Composition of the Membership of the Trust Board

2.1.1 In accordance with the Constitution the composition of the Board shall be:

- The Chairman of the Trust (appointed by the Council of Governors);
- Up to 6 other Non-Executive Directors (appointed by the Council of Governors);
- Up to 6 Executive Directors (but not exceeding the number of non-officer members) including;
    - a Chief Executive
    - a Finance Director
    - a Registered Medical Practitioner
    - a Registered Nurse

The Trust shall have no more than 13 and no less than 8 members

2.2 Appointment of Chairman and Non-Executive Director Members of the Trust Board

2.2.1 The Chairman and Non-Executive Directors shall be appointed and removed by the Council of Governors in accordance with paragraph 26 of the Constitution. The Chief Executive will be appointed and removed in accordance with paragraph 28 of the Constitution.

2.3 Terms of Office of the Chairman

2.3.1 The provisions governing the period of tenure of office of the Chairman and the termination of the office of the Chairman are contained in paragraph 26 of the Constitution. The Chairman and the Non-Executive Directors are to be appointed for a period of office in accordance with the Constitution. The terms and conditions of the office are decided by the Council of Governors at a General Meeting.

2.4 Appointment and Powers of Deputy Chairman

2.4.1 The Council of Governors may appoint a Deputy Chairman in accordance with paragraph 27 of the Constitution.

2.4.2 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman.

2.4.3 Where the Chairman of the Trust has ceased to hold office or has been unable to perform their duties as Chairman owing to absence through illness or any other

cause, shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chairman.

2.5 Appointment of Senior Independent Director

2.5.1 The Trust Board shall, following consultation with the Council of Governors, appoint one of the Non-Executive Directors to be their Senior Independent Director, using the procedure set out in the Constitution.

2.5.2 **Role of Trust Board**

The Board will function as a corporate decision-making body. Executive and Non-Executive Directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.6 Joint Directors

2.6.1 Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directors, those persons shall become appointed as an Executive Director jointly and shall count for the purpose of Standing Orders as one person.

2.6.2 Where a post of Executive Director of the Trust Board is shared jointly by more than one person:

(a) either or both of those persons may attend or take part in meetings of the Trust Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.7 Role of Members

2.7.1 The Trust Board will function as a corporate decision-making body, Executive Directors and Non-Executive Directors will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

2.7.2 **Executive Members**

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

2.7.3 **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

2.7.4 **Director of Finance**

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

2.7.5 **Non-Executive Directors**

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

2.7.6 **Chairman**

The Chairman shall be responsible for the operation of the Trust Board and chair all Trust Board meetings when present. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall liaise with the representatives of the Council of Governors over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Trust Board in a timely manner with all the necessary information and advice being made available to the Trust Board to inform the debate and ultimate resolutions.

2.8 Corporate Role of the Trust Board

2.8.1 All business shall be conducted in the name of the Trust.

2.8.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.8.3 The Trust has the functions conferred on it by the Health and Social Care (Community Health and standards) Act 2003 and by its Provider Licence, which include the Constitution.

2.8.4 The Trust Board shall define and regularly review the functions it exercises on behalf of the Independent Regulator.

2.9 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation

2.9.1 The Trust Board has resolved that certain powers and decisions may only be exercised by the Trust Board in formal session. These powers and decisions are set out in the Schedule of Matters Reserved to the Board in Section B of this document and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.10 Lead Roles for Trust Board Members

2.10.1 The Chairman will ensure that the designation of lead roles or appointments of Board guidance will be made in accordance with that guidance or statutory requirement.

2.11 Relationship between the Trust Board and the Council of Governors

2.11.1 In summary the Trust Board manage the business of the Trust (in accordance with the Constitution) and the Council of Governors conduct a number of tasks amongst them, approving the appointment of Non-Executive Directors and deciding their remuneration, terms and conditions (following recommendations from the Appointments, Terms and Conditions Committee); appointing the external auditors (following recommendations made to the Council of Governors from the Audit and Finance Governor Group); and to review various periodic reports listed in the Constitution, presented to them by the Trust Board. The Council of Governors will represent the views of their constituencies so that the needs of the local health economy are taken into account when deciding the Trust's strategic direction.

2.11.2 In the event of any issues of conflict between the Trust Board and the Council of Governors, this should be raised with the Lead Governor and Senior Independent Director (SID). If a resolution cannot be found, the issue should be escalated to the Chairman whose decision shall normally be final.

3. Meetings of the Trust Board

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Trust Board but shall be required to withdraw upon the Board resolving as follows:

'That representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest' (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).'

The Chairman shall give such direction as seen fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

It was **resolved** that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'in confidence' or minutes and papers headed 'private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

3.1 Calling Meetings

3.1.1 Ordinary meetings of the Trust Board shall be held on a monthly basis at such times and places as the Trust Board may determine. Meetings of the Trust Board will be held in public.

3.1.2 The Chairman of the Trust may call a meeting of the Trust Board at any time.

3.1.3 One third or more of the voting Directors of the Trust Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 Before each meeting of the Trust Board a written notice specifying the business proposed to be transacted shall be delivered to every Director or sent by post to the usual place of residence of each Director, so as to be available to members at least five clear days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting. Details of meetings and the public agenda will be published on the Trust's website.

3.2.2 In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.

3.2.4 A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.5 Before each meeting of the public Trust Board a notice of the time and place of the meeting shall be displayed on the Trust's website at least three clear days before the meeting. The public agenda and papers will be available on the Trust's website.

3.3 Agenda and Supporting Papers

3.3.1 The agenda will be sent to members 5 working days before the meeting and supporting papers, whenever possible, shall accompany the agenda,

3.4 Petitions

3.4.1 Where a petition has been received by the Trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Trust Board wishing to move a motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least 14 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not

prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Trust Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and During a Meeting

3.7.1 i) **Who May Propose**

A motion may be proposed by the Chairman of the meeting or any Director present. It must also be seconded by another Director.

3.7.2 ii) **Contents of Motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Trust Board proceed to next business;
- that the Trust Board adjourn;
- that the question be now put.

3.7.3 iii) **Amendments to Motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Trust Board

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.7.4 iv) **Rights of Reply to Motions**

a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) <u>Substantive/original motion</u>

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.7.5 v) **Withdrawing a Motion**

A motion, or an amendment to a motion, may be withdrawn.

3.7.6 vi) **Motions Once under Debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' Committee to deal with a specific item of business;
- that a /Director be not further heard;

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Trust Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any Director other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of Meeting

3.9.1 At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy-Chairman (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairman and Deputy Chairman are absent, such member (who is not also an Officer Member of the Trust) as the members present shall choose shall preside.

3.10 Chairman's Ruling

3.10.1 The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Board members (including at least one Executive Director and one Non-Executive Director) is present.

3.11.2 An Officer in attendance for an Executive Director (Officer Member) but without formal acting up status may not count towards the quorum.

3.11.3 If the Chairman or another Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chairman of the meeting shall have a second, and casting vote.

3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Director so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director.

3.12.7 A manager attending the Trust Board meeting to represent an Executive Officer during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. A manager's status when attending a meeting shall be recorded in the minutes.

3.12.8 For the voting rules relating to joint directors see Standing Order 2.6.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Trust Board are present (including at least one member who is an Executive Director of the Trust and one member who is a Non-Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board' minutes.

3.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and Directors of the Trust.

3.13.3 No formal business may be transacted while Standing Orders are suspended.

3.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and Amendment of Standing Orders

3.14.1 These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
- that two thirds of the Trust Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Executive Directors vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

3.15.1 The names of the Chairman and Directors/members present at the meeting shall be recorded.

3.16 Minutes

3.16.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.16.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.17 Admission of Public and the Press

3.17.1 Admission and Exclusion on Grounds of Confidentiality of Business to be Transacted

The public and representatives of the press may attend each meeting of the Trust Board, but shall be required to withdraw upon the Trust Board as follows:

It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

The Trust Board meetings shall be held in public, at which members of the public and representatives of the press shall be permitted to attend. Members of the public are not permitted to ask questions during the meeting as it is a meeting held in public, not a public meeting. However, questions can be submitted to the Chairman at the end of a meeting. Responses to the questions may be given at that time or in writing within 5 days of the meeting. Members of the public may be excluded from a meeting for special reasons and having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

3.17.2 General Disturbances

The Chairman (or Deputy Chairman) or the person presiding over the meeting shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as

to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

`*That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'.*

3.17.3 Business Proposed to be Transacted when the Press and Public have been Excluded from a Meeting

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 3.17.1 and 3.17.2 above, shall be confidential to the members of the Trust Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' "private" or minutes headed "strictly confidential, not for wider circulation" outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Trust Board meeting which may take place on such reports or papers.

3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.17.5 Observers at Trust Board Meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

4. Appointment of Committees and Sub-Committees

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by NHS Improvement (NHSI) the organisation that incorporates Monitor, the statutory entity that remains the regulator of NHS foundation trusts, the Trust Board may appoint Committees of the Trust.

4.1.2 The Trust Board shall determine the membership and terms of reference of Committees and Sub-Committees and shall if it requires to, receive and consider reports of such Committees.

4.2 Joint Committees

4.2.1 Joint Committees may be appointed by the Trust Board by joining together with one or more other Trusts, Local Authorities or health service bodies consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.

4.2.2 Any Committee or joint Committee appointed under this Standing Order may, subject to such directions as may be given by the Independent Regulator or the Trust or other health bodies in question, appoint sub-Committees consisting wholly or partly of members of the Committees or joint Committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the Committee of the Trust or health bodies in question.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

4.3.1 The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any Committees established by the Trust. In which case the term "Chairman" is to be read as a reference to the Chairman or other Committee as the context permits, and the term "member" is to be read as a reference to a member or other Committee also as the context permits. There is no requirement to hold meetings of Committees, established by the Trust in public.

4.4 Terms of Reference

4.4.1 Each such Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Trust Board), as the Trust Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Independent Regulator. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of Powers by Committees to Sub-Committees

4.5.1 Where Committees are authorised to establish sub-committees they may not delegate executive powers to the sub-Committee unless expressly authorised by the Trust Board.

4.6 Approval of Appointments to Committees

4.6.1 The Trust Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Trust Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a Committee the terms of such appointment shall be within the powers of the Trust Board as defined by the Independent Regulator. The Trust Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Appointments for Statutory Functions

4.7.1 Where the Trust Board is required to appoint persons to a Committee and/or to undertake statutory functions and where such appointments are to operate independently of the Trust Board such appointment shall be made in accordance with the regulations and directions made with the relevant authority.

4.8 Committees Established by the Trust Board

The Committees, sub-Committees, and joint-Committees established by the Board are:

4.8.1 Audit Committee

In line with the Standing Orders, the NHS Audit Committee Handbook, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the

Independent Regulator, an Audit Committee will be established and constituted to provide the Trust Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Trust Board and are reviewed on a periodic basis.

The Committee will be comprised of a minimum of two Non-Executive Directors, unless the Trust Board decides otherwise, of which one must have significant, recent and relevant financial experience.

4.8.2 Quality Committee

In line with the Standing Orders, a Quality Committee will be established and constituted to provide the Trust Board with a strategic overview of and assurance against clinical and quality governance, clinical risk and patient and carer experience and engagement issues. The terms of reference will be approved by the Trust Board and are reviewed on a periodic basis.

The Committee will be comprised of a minimum of one Non-Executive Director, one Executive Member and one Board Member.

4.8.3 Remuneration and Nominations Committee

In line with Standing Orders, the Audit Code for NHS Foundation Trusts and the Code of Governance issued by the Independent Regulator, a Remuneration and Nomination Committee will be established and constituted.

The Committee will be comprised exclusively of Non-Executive Directors, a minimum of three, who are independent of management.

The Committee will advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, other senior employees on a Very Senior Managers contract and conditions including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms.

The Committee will approve recruitment and retention premia awarded to any member of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants).

4.8.4 Trust and Charitable Funds Committee

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

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

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

Committee will:-

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

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

4.8.5 Mental Health Legislation Committee

The Mental Health Legislation Committee is constituted as a sub-committee of the Trust Board.

The Committee will be comprised of two Non-Executive Directors.

The Committee will provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective Codes of Practice and other mental health related legislation and will;

- monitor, provide challenge and seek assurance of compliance with external standards relating to Mental Health Legislation.
- approve and review mental health legislation policies and protocols.
- promote and encourage joint working arrangements regarding the implementation of Mental Health Legislation with partner organisations including local authorities, clinical commission groups, acute hospital trusts, police and ambulance services.
- receive report regarding inspecting authorities and to monitor the implementation of action plans in response to any recommendations made

4.8.6 Finance and Investment Committee

The Finance and Investment Committee is constituted as a sub-committee of the Trust Board.

The Committee will provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across all financial areas and any potential investment decisions. The primary role of the Committee is to monitor, review and support the Finance Directorate of the Trust, making recommendations to the Board as appropriate and taking actions as required.

The committee is comprised of two Non-Executive Directors. The Committee will;

- Scrutinise, review and endorse all financial plans prior to seeking Board approval.
- Approve the processes and timetable for annual budget setting, and budget management arrangements
- Monitor delivery of Trust's Capital Investment Programme
- Scrutinise all business cases for new business and investment and review all tenders presented to the Committee
- Review and assess business cases to support and govern all investments, contracts and projects as set out in the committee's terms of reference.
- Review the robustness of the risk assessments underpinning financial forecasts
- Monitor delivery of the Trust's budget reduction strategy and other financial savings programmes

4.8.7 Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee exists to provide strategic overview and provide assurance to the Trust Board that there is an effective system of governance and internal control across workforce and organis9ational development that supports the Trust to deliver its strategic objectives and provide high quality care.'

The Committee will be comprised of two Non-Executive Directors.

4.8.8 Provider Collaborative Commissioning Committee

The Trust is the Lead Provider within the Humber Coast and Vale (HCV) Provider Collaborative and will hold the Lead Contract with NHS E/I. The Trust as Lead Provider will sub-contract with a range of healthcare providers in the delivery of:

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

The Commissioning Committee has been established by the Trust as the Lead Provider and holds delegated responsibility to provide commissioning leadership and monitoring functions. On behalf of the Provider Collaborative and Lead Provider the Commissioning Committee will review any significant service proposals to ensure developments are in line with the assessed population needs and can be met from within the resources available within the Provider Collaborative.

The committee is comprised of one Non-Executive Director.

4.8.9 Other Committees

The Trust Board may also establish such other Committees as required to discharge the Trust's responsibilities.

5. Arrangements for the Exercise of Trust Functions by Delegation

5.1 Delegation of Functions to Committees, Officers or Other Bodies

5.1.1 Subject to the Constitution and directions as may be given by the Independent Regulator, the Trust Board may make arrangements for the exercise, on behalf of the Trust Board, or any of its functions

a) by a Committee, sub-Committee appointed by virtue of Standing Order 4, or by an officer of the Trust,

b) or by another body as defined in Standing Order 5.1.2 below,

c) in each case subject to such restrictions and conditions as the Trust thinks fit.

5.1.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to Committees, sub Committees or Officers, the Trust retains full responsibility.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Trust Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive

and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Trust Board shall agree from time to time to the delegation of executive powers to be exercised by other Committees, or sub-Committees, or joint-Committees, which it has formally constituted in accordance with directions issued by the independent regulator. The Constitution and terms of reference of these Committees, or sub-Committees, or joint Committees, and their specific executive powers shall be approved by the Trust Board in respect of its sub-Committees.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Trust Board or delegated to a Committee or sub-Committee or joint-Committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Trust Board subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Trust Board as indicated above.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Trust Board of the Director of Finance to provide information and advise the Board in accordance with statutory or independent regulator requirements. Outside these statutory requirements the roles of the Director of Finance shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust Board and Scheme of Delegation of Powers

5.5.1 The arrangements made by the Board as set out in the "Scheme of Matters Reserved to the Board" in Section C shall have effect as if incorporated in these Standing Orders.

5.6 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

5.6.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Trust Board for action or ratification. All members of the Trust Board, Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Overlap with Other Trust Policy Statements/Procedures, Regulations and Standing Financial Instructions

6.1 Policy Statements: General Principles

6.1.1 The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Humber Teaching NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be

deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy Statements

6.2.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct and Managing Declarations of Interests Policy for NHS Staff
- the staff Disciplinary and Appeals Procedures adopted by the Trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

6.3.1 Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific Guidance

6.4.1 Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Confidentiality: NHS Code of Practice 2003;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. Duties and Obligations of Trust Board Members/Directors and Senior Managers under the Standing Orders

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and Applicability to Trust Board

The Constitution, 2006 Act and the Code of Conduct and Accountability requires Trust Directors to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board Directors should declare such interests. Any Directors appointed subsequently should do so on appointment. It is a condition of employment that those holding director or director-equivalent posts provide confirmation in writing, on appointment and thereafter on demand, of their fitness to hold such posts. Fitness to hold such a post is determined in a number of ways, including (but not exclusively) by the Trust's Provider Licence, the Health & Social Care Act 2012 (Regulated Activities) Regulation, and the Trust's Constitution.

7.1.2 Interests which are Relevant and Material

Interests which should be regarded as "relevant and material" are:

a) Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies);

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;

d) A position of authority in a charity or voluntary organisation in the field of health and social care;

e) Any connection with a voluntary or other organisation contracting for NHS services;

f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to lenders and banks

g) Research funding/grants that may be received by an individual or their department;

h) Interests in pooled funds that are under separate management

Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 and elsewhere) has any pecuniary interest, direct or indirect, the Trust Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Trust Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust, or with the Trust Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in Trust Board Minutes

At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

During the course of a Trust Board meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.1.5 Publication of Declared Interests in Annual Report

Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of Interest which Arise during the Course of a Meeting

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Trust Board. In particular the Register will include

details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both Executive and Non-Executive Trust Board members.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public in accordance with paragraph 34 of the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local population and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest

7.3.1 Definition of Terms used in Interpreting 'Pecuniary' Interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(ii) "contract" shall include any proposed contract or other course of dealing.

(iii) "Pecuniary interest"
Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

For the purpose of this Standing Order the Chairman or a director shall be treated, subject to SO 7.1 as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a) he/she, or a nominee of his/her, is a Director of a company or other body (not being a public body), with which the contract was made, or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration, or

b) he/she is a partner, associate or employee of any person with whom the contract is made or proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

iv) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed

£5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2.

7.3.2 Exclusion in Proceedings of the Trust Board

(i) Subject to the following provisions of this Standing Order, if the Chairman or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(ii) The Board may exclude the Chairman or a Director of the Trust Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.

(iv) Any remuneration, compensation or allowance payable to the Chairman or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

(v) This Standing Order applies to a Committee or sub-Committee and to a joint Committee or sub-Committee as it applies to the Trust and applies to a member of any such Committee or sub-Committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff must comply with the Trust's Standards of Business Conduct and Managing Conflicts of Interest Policy for NHS Staff and the national guidance produced by NHS England on Managing Conflicts of Interest.

7.4.2 Interest of Officers in Contracts

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

i) Canvassing of Members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) A Member shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

iii) Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

7.4.4 Relatives of Members or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

ii) The Chairman and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself/herself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

iii) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust Board whether they are related to any other Director or holder of any office under the Trust.

iv) Where the relationship to a Director of the Trust is disclosed, the Standing Order headed 'Exclusion of Chairman and Members in proceedings on account of pecuniary interest' (SO 7.3) shall apply.

8. Custody of Seal, Sealing of Documents and Signature of Documents

8.1 Custody of Seal

8.1.1 The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him/her in a secure place.

8.2 Sealing of Documents

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

8.3 Register of Sealing

8.3.1 The Chief Executive or another manager authorised by the Chief Executive shall keep a register in which a record of the sealing of every document is entered. A report of all sealings shall be made to the Trust Board on an annual basis.

8.4 Signature of Documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises be signed by the Chief Executive or any Executive Director

In land transactions, the signing of certain supporting documents may be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

8.4.2 Commercial opportunities - for example a joint venture, either contractual or corporate or a subsidiary company shall not be entered into or incorporated unless authorised by the Board.

8.4.3 The Executive Directors are authorised to develop commercial opportunities which may (or may not) lead to the establishment of a joint venture, either contractual or corporate or the formation of a subsidiary company. This includes authority to sign non legally binding documents that may be associated with the development of commercial opportunities prior to Board sign off, where this is required, for example Memorandum of Understanding or Articles of Association. The Executive Directors shall keep the Board apprised of the subject matter and of any non legally binding documents entered into via the Chief Executive (or nominated officer).

9. Miscellaneous

9.1 Joint Finance Arrangements

The Trust Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Trust Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 19.3.

SECTION C:

SCHEME OF MATTERS RESERVED TO THE TRUST BOARD AND DELEGATION

Part A: Decisions Reserved to the Board

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	**General Enabling Provision** The Trust Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers under the 2006 Act, its Constitution and its Provider Licence.
NA	THE BOARD	***Regulations and Control*** 1. Approve Standing Orders (SOs) of the Trust Board a Schedule of Matters Reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders under SO 3.13 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 5. Approve a Scheme of Delegation of powers from the Board to Committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Independent Regulator or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's Committees where the Committees do not have

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for charitable funds held on trust. 13. Establish terms of reference and reporting arrangements of all Committees and sub-Committees that are established by the Trust Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Authorise use of the Trust seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 18. Authorisation of any long term loans to be taken out by the Board within the authorisation limits set out in SFI 20.1.6 19. Approve the formation of any joint venture, either contractual or corporate or a subsidiary company. 20. The granting of loans to any subsidiaries will be subject to approval by the Board regardless of value.
NA	THE BOARD	**Appointments/ Dismissal** 1 Appoint the Senior Independent Director. 2 Subject to the Regulatory Framework, appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 3 Appoint, appraise, discipline and dismiss Executive Directors based on recommendations of the Remuneration and Nomination Committee. (Chief Executive appointment requires Council of Governors approval) 4 Approve proposals of the Remuneration and Nomination Committee regarding Directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration and Nominations Committee.
NA	THE BOARD	***Strategy, Plans and Budgets*** 1. Set and define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		3. Approve strategies covering all key areas of the Trust business. 4. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust. 5. Approve the Trust's Risk Management Strategy policies and procedures for risk management. 6. Approve Outline and Full Business Cases for Capital Investment. 7. Approve budgets. 8. Approve annually the Trust's proposed Organisational Development proposals. 9. Approve the Trust's Organisation Development Strategy and annual plans 10. Approve proposals for acquisition, disposal or change of use of land and/or buildings. 11. Approve Private Finance Initiative (PFI) proposals. 12. Approve the opening of bank accounts. 13. Approve proposals on individual contracts amounting to, or likely to amount to over £500,000 14. Consideration of any proposal not to tender a contract opportunity for a new health care service or a significantly changed health care service. 15. Approve Executive Management Team's proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Trust Board. 16. Approve proposals for action on litigation against or on behalf of the Trust. 17. Review use of NHSLA risk pooling schemes (LTPS/CNST/RPST).
	THE BOARD	**Policy Determination** 1. Ratify management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. 2. Policies will be determined and approved by the relevant Committees of the Board. Exceptionally a policy may be referred to the Board for approval by the Committee, particularly if the issues are novel, contentious, contrary to guidance or breaking new ground.
	THE BOARD	**Audit** 1. Approve the appointment and dismissal of the internal auditors. 2. Approve the appointment and dismissal of External Auditors as appointed by the Council of Governors.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		3. Receive the annual management letter received from the external auditor and taking account of the advice, where appropriate, of the Audit Committee. 4. Receive an annual report from the Internal Auditor and agree necessary actions taking account of advice from the Audit Committee.
NA	THE BOARD	**Annual Reports and Accounts** 1. Receive and approval of the Trust's Annual Report and Annual Accounts. 2. Receive and approval of the Annual Report and Accounts for funds held on trust. 3. Receive and approve the Trust's Annual Quality Accounts
NA	THE BOARD	**Monitoring** 1. Receive such reports as the Board sees fit from Committees in respect of their exercise of powers delegated. 2. Continuously monitor the affairs of the Trust by means of the provision to the Board as the Board may require from Directors, Committees, and officers of the Trust as required. 3. Receive reports from the Director of Finance on financial performance against all internally and externally set targets and standards. 4. Approve and monitor the Board Assurance Framework 5. Approve the Annual Governance Statement based on the Audit Committee's recommendation 6. Approve the Trust's registration with the Care Quality Commission

PART B: DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 11.1.1	AUDIT COMMITTEE	The Committee will: 1. Advise the Trust Board on internal and external audit services; 2. Monitor compliance with Standing Orders and Standing Financial Instructions; 3. Review schedules of losses and compensations and making recommendations to the Board. 4. Review schedules of debtor/creditor balances 5. Review the annual financial statements prior to submission to the Board. 6. Review the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advise the Board accordingly.
	QUALITY COMMITTEE	The Committee will: 1 Provide a strategic overview of Clinical Governance, Risk and Patient Experience to the Trust Board. 2 Co-ordinate all activities relating to Quality, Patient Safety and Patient Experience on behalf of the Trust Board. 3 Provide an assurance to the Trust Board that risk and governance issues of all types are identified, monitored and controlled to an acceptable level. 4 Provide a regularly reviewed and appropriate risk register to the Trust Board identifying risks to achieving the Trust's strategic objectives 5 Ensure all areas/departments of the Trust produce a risk register that relates local risks to achieving the Trust's strategic objectives. 6 Advise the Trust Board on significant risks and governance issues, identifying recommendations, to enable it to take appropriate action. 7 Ensure that there is an effective mechanism for reporting significant risks and governance issues to the Trust Board in a timely manner. 8 Provide a strategic overview of patient and carer experience, regularly reviewing outcomes and satisfaction 9 Oversee the strategic direction of the recovery College 10 Monitor and advise the work of the Research and Development Committee 11 Quality Committee will ensure that there is an integrated approach to quality and effectiveness, and patient and staff safety throughout the Trust.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		12 Ensure that work plans are produced, and a range of actions are undertaken by other committees and meetings, reporting to the Quality Committee to provide assurance to the Trust Board. 13 Monitor trust compliance with the required standards for regulation and registration with the Care Quality Commission and other national guidelines. 14 Implement and monitor any action required to achieve regulatory and registration standards.
	REMUNERATION AND NOMINATION COMMITTEE	The Committee will: 1. Advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors, other senior employees on a Very Senior Managers contract and conditions including: • All aspects of salary (including any performance-related elements/bonuses); • Provisions for other benefits, including pensions and cars; • Arrangements for termination of employment and other contractual terms; 2. Make recommendations to the Trust Board on the remuneration and terms of service of Executive Directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff; 3. Proper calculation and scrutiny of termination payments taking account of such national guidance and as is appropriate advise on and oversee appropriate contractual arrangements for such staff; 4 The Committee shall report in writing to the Trust Board the basis for its recommendations.
	MENTAL HEALTH LEGISLATION COMMITTEE	The Committee will: 1. Provide strategic leadership pertaining to the Mental Health Act, the Mental Capacity Act and their respective Codes of Practice and other mental health related legislation. 2. Monitor, provide challenge and seek assurance of compliance with external standards relating to Mental Health Legislation. 3. Approve and review Mental Health Legislation polices and protocols 4. Promote and encourage joint working arrangements regarding the implementation of Mental Health Legislation with partner organisations including local authorities, clinical commissioning groups, acute hospital trusts, police and ambulance services. 5. Receive reports regarding inspecting authorities and to monitor the implementation of actions plans in response to any recommendations made.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	CHARITABLE FUNDS COMMITTEE	The Committee will; 1. Review administrative arrangements for the investment and use of charitable donations, in particular ensuring that current legislation and guidance is followed and encouraging full use of funds in a reasonable time frame. 2. Ensure that appropriate accounting records and control procedures are maintained and that an Annual Report is produced for consideration by the Trust Board. 3. Review fund-raising and consider and recommend investment policies.
	FINANCE & INVESTMENT COMMITTEE	The Committee will: 1. Scrutinise, review and **e**ndorse all financial plans prior to seeking Board approval. 2. Approve the processes and timetable for annual budget setting, and budget management arrangements 3. Monitor delivery of Trust's Capital Investment Programme 4. Review the robustness of the risk assessments underpinning financial forecasts 5. Monitor delivery of the Trust's budget reduction strategy and other financial savings programmes 6. Review and assess business cases for: • Capital expenditure over £500k • New business development projects with an annual value in excess of £500k in total • Any reconfiguration project which has a financial and/or resource implication over £500k per annum • Leases, contracts or agreements with revenue, capital and/or resource investment/commitment in excess of £500k per annum • The purchase or sale of any property • The purchase or sale of any equipment above £250k • All Borrowing or investment arrangements • Horizon scanning regarding business opportunities. • To periodically consider strategic risks to business and ensure these are reflected and mitigated within any business cases.
	WORKFORCE AND ORGANISATIONAL DEVELOPMENT COMMITTEE	The Committee will: 1. Provide oversight and assurance to the Board in relation to robust processes for the effective management of Workforce and Organisational Development; 2. Be assured on the management of the high operational risks on the corporate risk register which relate to workforce and

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		organisational development and ensure the Board is kept informed of significant risks and mitigation plans, in a timely manner. 3. Be assured of the Trust's response to all relevant Directives, national standard, policies, reports, reviews and best practice as issued by the Department of Health, NHS Improvement and other regulatory bodies / external agencies to gain assurance that they are appropriately reviewed and actions are being undertaken and embedded. 4. To be assured that the views of staff are captured, understood and responded to. 5. Scrutinise the robustness of the arrangements for and assure compliance with the Trust's statutory responsibilities for equality and diversity, staff health and well being, safe working for junior doctors and freedom to speak up.
	COMMISSIONING COMMITTEE	The Committee will: 1. Provide commissioning leadership and monitoring functions 2. Provide assurance to the Board on matters of financial performance 3. Undertake contractual monitoring, financial and performance management of the Provider Collaborative to deliver the HCV aims 4. Monitoring performance including quality assurance on outcomes, experience, safety, activity and finance. 5. Contract management, including quality assurance across NHS and independent sector. 6. Appropriate reporting to Humber Coast and Vale – Specialised Mental Health and Learning Disability - Provider Collaborative Oversight Group and NHSE/I (including nationally required returns)

PART C: SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE	Accountable through NHS FT Accounting Officer to Parliament for stewardship of Trust resources. NHS Foundation Trust Accounting Officer memorandum issued by the Independent Regulator is the reference document.
CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Ensure the accounts of the Trust are prepared under principles and in a format directed by the Independent Regulator. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Trust Board.
CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
CHIEF EXECUTIVE	Ensure effective management systems that safeguard public funds and assist the Trust Chairman to implement requirements of corporate governance including ensuring managers: • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
CHIEF EXECUTIVE	Implement requirements of corporate governance.
CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).
DIRECTOR OF FINANCE	Operational responsibility for effective and sound financial management and information.
CHIEF EXECUTIVE	Primary duty to see that Director of Finance discharges this function.
CHIEF EXECUTIVE	Ensuring that expenditure by the Trust complies with Parliamentary requirements.
CHIEF EXECUTIVE and DIRECTOR OF FINANCE	The Chief Executive, supported by the Director of Finance, to ensure appropriate advice is given to the Trust Board and the Council of Governors on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE	If the Chief Executive considers the Trust Board, the Council of Governors or the Chairman is doing something that might infringe probity or regularity, the Chief Executive should set this out in writing to the Chairman, the Council of Governors and the Trust Board. If the matter is unresolved, the Chief Executive should ask the Audit Committee to inquire and if necessary inform the Independent Regulator of the position, if possible before the decision is taken so that the Independent Regulator can intervene if appropriate.
CHIEF EXECUTIVE	If the Trust Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the Chief Executive's responsibility for value for money, the Chief Executive should draw the relevant factors to the attention of the Trust Board and the Council of Governors. If the outcome is that you are overruled it is normally sufficient to ensure that your advice and the overruling of it are clearly apparent from the papers. Exceptionally, the Chief Executive should inform the Independent Regulator as appropriate. In such cases the Chief Executive should, as a member of the Trust Board, vote against the course of action rather than merely abstain from voting.

PART D: SCHEME OF DELEGATION

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
THE BOARD	Approve procedure for declaration of hospitality and sponsorship.
THE BOARD	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of the NHS Foundation Trust Code of Governance, the Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe to the NHS Foundation Trust Code of Governance and Code of Conduct.
THE BOARD	Board members share corporate responsibility for all decisions of the Trust Board.
CHAIRMAN AND NON-EXECUTIVE MEMBERS	The Chairman and Non-Executive Directors are responsible for monitoring the executive management of the organisation and are responsible to the Independent Regulator for the discharge of those responsibilities.
THE BOARD	The Trust Board has six key functions for which it is held accountable by the Independent Regulator:- 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation, the Council of Governors, members and the local community on its plans and performance and that these are responsive to the community's needs.
THE BOARD	It is the Trust Board's duty to: 1. act within the Regulatory Framework and other statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a Schedule of Decisions Reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish an Audit Committee and Remuneration and Nominations Committee on the basis of formally agreed terms of reference that set out the membership of the sub-Committee, the limit to their powers, and the arrangements for reporting back to the main Board.
CHAIRMAN	It is the Chairman's role to: 1. provide leadership to the Board, the Council of Governors and to ensure the two bodies work effectively together; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally appointed Remuneration and Nominations Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Council of Governors on the performance of Non-Executive Board members via the Appointments, Terms and Conditions Committee
CHIEF EXECUTIVE	The Chief Executive is accountable to the Chairman and Non-Executive Directors of the Trust Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Trust Board. The other duties of the Chief Executive, as Accountable Officer, are laid out in the NHS Foundation Trust Accountable Officer Memorandum.
NON-EXECUTIVE DIRECTORS	Non-Executive Directors are appointed (and removed) by the Council of Governors to bring independent judgement to bear on issues of strategy, performance, key appointments and accountability through the Department of Health to Ministers, the Independent Regulator and to the local community.
CHAIRMAN AND DIRECTORS	Declaration of conflict of interests.

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
THE TRUST BOARD	NHS Boards must comply with legislation and guidance issued by the Independent Regulator and the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

PART E: SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.10	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
2.2	COUNCIL OF GOVERNORS*	Appointment of Chairman and other Non-Executive Directors
2.4	COUNCIL OF GOVERNORS*	Appointment of Deputy Chairman
3.1	CHAIRMAN	Call meetings.
3.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIRMAN	Having a second or casting vote
3.13	BOARD	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD	Variation or amendment of Standing Orders
4.5	BOARD	Formal delegation of powers to sub-committees, joint Committees and approval of their Constitution and terms of reference
4.6	BOARD	Approve appointments to each of the Committees it has formally constituted
5.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chairman and Chief Executive after having consulted at least two Non-Executive Directors.
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	BOARD	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with national guidance contained in *Managing Conflicts of Interest in the NHS - Guidance for staff and organisations"* (Publications Gateway Reference: 06419)
7.4	ALL	Disclose relationship between self and candidate for staff appointment. (Chief Executive to report the disclosure to the Board.)
8.1/8.3	CHIEF EXECUTIVE	Keep Seal in safe place and maintain a register of Sealing.
8.4	CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

**A full list of Statutory Roles and Responsibilities of the Council of Governors is appended to this document.*

PART F: SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS (SFIs)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	DIRECTOR OF FINANCE	Approval of all financial procedures.
10.1.4	DIRECTOR OF FINANCE	Advice on interpretation or application of SFIs.
10.1.5	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
10.2.1	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.2	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.3	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to members of the Board and staff; e) Maintaining such accounts, certificates etc as are required for the Trust to carry out its statutory duties.
10.2.4	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.5	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
10.2.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIRMAN	Raise the matter at the Trust Board meeting where the Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	DIRECTOR OF FINANCE	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.) Ensure the annual report is prepared for consideration by the Audit Committee.
11.2.1	DIRECTOR OF FINANCE	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual Audit Code for NHS Foundation Trusts, NHS Foundation Trust Reporting Manual, the NHS Foundation Trust Accounting Officer Memorandum and best practice.
11.4		Ensure cost-effective External Audit and comply with the Audit Code for NHS Foundation Trusts.
11.5	CHIEF EXECUTIVE & DIRECTOR OF FINANCE	Monitor and ensure compliance with the Audit Code for NHS Foundation Trusts guidance on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management Specialist.
12.1.2 & 12.1.3	DIRECTOR OF FINANCE	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
12.1.6	DIRECTOR OF FINANCE	Ensure adequate training is delivered on an ongoing basis to budget holders.
12.2.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
12.2.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
12.3.1	DIRECTOR OF FINANCE	Devise and maintain systems of budgetary control.
12.3.2	CHIEF EXECUTIVE/ BUDGET HOLDERS	Ensure that a) any likely overspend or reduction of income that cannot be met from virement is incurred without prior consent of the Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within available resources and manpower establishment as approved by the Trust Board
12.3.4	CHIEF EXECUTIVE	Compile and submit to the Trust Board an Annual Plan which takes into account financial targets and forecast limits of available resources. This will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
12.3.4	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Strategic Plan
12.5.1	CHIEF EXECUTIVE	Submit monitoring returns
13.1	DIRECTOR OF FINANCE	Preparation of annual accounts and reports.
14.1	DIRECTOR OF FINANCE	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (The Board approves the arrangements.)
15.	DIRECTOR OF FINANCE	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
15.2.3	ALL EMPLOYEES	Duty to inform Director of Finance of money due from transactions which they initiate/deal with.
16.	CHIEF EXECUTIVE	Tendering and contract procedure.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
16.6.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
16.6.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
16.7.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
16.7.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations dispatched.
16.7.4	CHIEF EXECUTIVE AND DIRECTOR OF FINANCE	Where one tender is received will assess for value for money and fair price.
16.7.7	CHIEF EXECUTIVE CHAIRMAN	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive and Chairman
16.7.11	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
16.7.11	DIRECTOR OF FINANCE	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the Chief Executive.
16.8.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
16.8.4	CHIEF EXECUTIVE or DIRECTOR OF FINANCE	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
16.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
16.10	BOARD	All PFI proposals must be agreed by the Board.
16.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
16.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		employment, regarding staff, agency staff or temporary staff service contracts.
16.17	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
16.17.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
17.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
17.2	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA
18.1.1	BOARD	Establish a Remuneration & Nomination Committee
18.1.2	REMUNERATION & NOMINATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the Chief Executive, Executive members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; Monitor and evaluate the performance of individual senior employees; Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
18.1.3	REMUNERATION & NOMINATION COMMITTEE	Report in writing to the Trust Board its advice and its bases about remuneration and terms of service of Directors and senior employees.
18.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration and Nomination Committee.
18.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
18.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
18.4.1 and 18.4.2	DIRECTOR OF FINANCE/DIRECTOR OF WORKFORCE & ORGANISATIONAL DEVELOPMENT	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 18.4.3).

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
18.4.4	NOMINATED MANAGERS	Submit time records in line with timetable. Submitting termination forms in prescribed form and on time.
18.4.5	DIRECTOR OF FINANCE/DIRECTOR OF WORKFORCE & ORGANISATIONAL DEVELOPMENT	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
18.5	NOMINATED MANAGER	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
19.1.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
19.1.2	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
19.2.1	REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
19.2.2	DIRECTOR OF FINANCE	Shall be responsible for the prompt payment of accounts and claims.
19.2.2.1	DIRECTOR OF FINANCE	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Director of Finance of accounts for payment; provision

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
19.2.3	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
19.2.4	DIRECTOR OF FINANCE	Approve proposed prepayment arrangements.
19.2.5	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform the Director of Finance if problems are encountered).
19.2.6	CHIEF EXECUTIVE/DIRECTOR OF FINANCE	Authorise who may use and be issued with official orders.
19.2.7	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
19.2.8	CHIEF EXECUTIVE DIRECTOR OF FINANCE	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
19.3	DIRECTOR OF FINANCE	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
20.1.1	DIRECTOR OF FINANCE	The Director of Finance will advise the Board on the Trust's ability to pay dividend on PBC, and any proposed borrowing limits set by its Provider Licence and report, periodically, concerning the PDC debt and all loans and overdrafts.
20.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Director of Finance.)
20.1.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.1.5	CHIEF EXECUTIVE OR DIRECTOR OF FINANCE	Be on an authorising panel comprising one other member for short term borrowing approval, following prior agreement of the board
20.2.2	DIRECTOR OF FINANCE	Will advise the Board on investments and report, periodically, on performance of same and report to Monitor on any major investments that will affect the financial risk rating of the Trust.
20.2.3	DIRECTOR OF FINANCE	Prepare detailed procedural instructions on the operation of investments held.
21.1.1	DIRECTOR OF FINANCE	Ensure that Board members are aware of the Financial Framework and ensure compliance
22	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
22.1.2	DIRECTOR OF FINANCE	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
22.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
22.1.4	DIRECTOR OF FINANCE	Assess the requirement for the operation of the construction industry taxation deduction scheme.
22.1.5	DIRECTOR OF FINANCE	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
22.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a Scheme of Delegation for capital investment management.
22.1.7	DIRECTOR OF FINANCE	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
22.2.1	DIRECTOR OF FINANCE	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
22.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
22.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from the Director of Finance).
22.3.5	DIRECTOR OF FINANCE	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
22.3.8	DIRECTOR OF FINANCE	Calculate and pay capital charges in accordance with Monitor requirements.
22.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
22.4.2	DIRECTOR OF FINANCE	Approval of fixed asset control procedures.
22.4.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to the Director of Finance, and reporting losses in accordance with Trust procedure.
23.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to Director of Finance responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
23.2.1	DIRECTOR OF FINANCE	Responsible for systems of control over stores and receipt of goods.
23.2.1	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
23.2.1	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
23.2.2	NOMINATED OFFICERS	Security arrangements and custody of keys
23.2.3	DIRECTOR OF FINANCE	Set out procedures and systems to regulate the stores.
23.2.4	DIRECTOR OF FINANCE	Agree stocktaking arrangements.
23.2.5	DIRECTOR OF FINANCE	Approve alternative arrangements where a complete system of stores control is not justified.
23.2.6	DIRECTOR OF FINANCE	Approve system for review of slow moving and obsolete items and for condemnation, disposal and

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		replacement of all unserviceable items.
23.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to Director of Finance evidence of significant overstocking.
23.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
24.1.1	DIRECTOR OF FINANCE	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
24.2.1	DIRECTOR OF FINANCE	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
24.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Chief Executive and Director of Finance.
24.2.2	DIRECTOR OF FINANCE	Where a criminal offence is suspected, the Director of Finance must inform the police if theft or arson is involved. In cases of fraud and corruption the Director of Finance must inform the relevant LCFS and NHS Counter Fraud Authority.
24.2.2	DIRECTOR OF FINANCE	Notify NHS Counter Fraud Authority and External Audit and the Independent Regulator of all frauds.
24.2.3	DIRECTOR OF FINANCE	Notify the Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
24.2.4	BOARD	Approve write off of losses (within limits delegated by H M Treasury's Managing Public Money).
24.2.6	DIRECTOR OF FINANCE	Consider whether any insurance claim can be made.
24.2.7	DIRECTOR OF FINANCE	Maintain a losses and special payments register.
25.1.1	DIRECTOR OF FINANCE	Responsible for accuracy and security of computerised financial data.
25.1.2	DIRECTOR OF FINANCE	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
25.2.1	RELEVANT OFFICERS	Send details of the outline design of the computer system to the Director of Finance.
25.3	DIRECTOR OF FINANCE	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
25.4	DIRECTOR OF FINANCE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
25.5	DIRECTOR OF FINANCE	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management trail exists; c) Director of Finance and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
25.1.3	DIRECTOR OF NURSING	Shall publish and maintain a Freedom of Information (FOI) Scheme.
26.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
26.3	DIRECTOR OF FINANCE	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
26.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
27.1	DIRECTOR OF FINANCE	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
28	CHIEF EXECUTIVE	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		staff
29	CHIEF EXECUTIVE	Ensure retention of document procedures in accordance with NHS Records Management: Code of Practice
30.1	CHIEF EXECUTIVE	Ensure a Risk Management programme is in place
30.1	BOARD	Approve and monitor Risk Management programme.
30.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
30.4.1	DIRECTOR OF FINANCE	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
30.4.1	DIRECTOR OF FINANCE	Ensure documented procedures cover management of claims and payments below the deductible.

PART G: SCHEME OF BUDGETARY DELEGATION

Quotation, Tendering and Control Procedures				
Goods and Services including Estates and Maintenance *(where this relates to contracts over more than one year, the annual value is delegated as per below)*				
Value (excluding VAT)	**Minimum No**	**Opened by**	**Adjudicated by**	**Authorised by**
Up to £9,999	At discretion of budget holder/Purchasing officer	Any Officer	Purchasing Officer or budget holder	Budget holder
£10,000 to £49,999	3 or more quotes	Any Senior Manager	Purchasing Officer or budget holder	Director
£50,000-£99,999	3 or more competitive tenders	Any Senior Manager	Head of Procurement/+1 Director	Director of Finance
£100,000 to £249,999	3 or more competitive tenders	2 Senior Managers/Directors not from originating department	Head of Procurement/+ 1 Director	Chief Executive
£250,000- £499,999	5 or more competitive tenders	2 Senior Managers/Directors not from originating department	Director of Finance + 1 other Director	Chief Executive
Over £500,000	6 or more competitive tenders	2 Senior Manager/Directors not from originating department	Director of Finance + 1 other Director	Trust Board

All contracts for goods, services, works and subsequent variations to contracts
Values as in table above – *Quotation, Tendering and Control Procedures*

Non-Pay Revenue and Capital Expenditure/Requisitioning/Ordering/Payment Of Goods. Contracts and Non Pay Revenue. Stock/Non-stock requisitions	
Financial Limit *(where this relates to contracts over more than one year, the annual value is delegated as per below)*	Delegated to
Up to £9,999	Senior Manager/other staff on authorised signatory list up to their delegated limit
£10,000 to £24,999	Divisional General Manager
£25,000 to £49,999	Director subject to quotes
£50,000-£99,999	Director of Finance subject to quotes
£100,000 to £249,999	Chief Executive subject to tenders
All other invoices over £250,000 relating to approved capital projects and approved NHS creditors	Trust Board
All invoices over £250,000	Trust Board

Authorisation of Losses and Special Payments		
Delegated Matter	Up to £5,000	£5,000 to £49,999
Losses of cash	Director of Finance or Trust Secretary	Chief Executive and Director of Finance

Drawing Down of Pre-Arranged Loans		
	1st Signatory	**2nd Signatory**
Any pre-arranged loan	Chief Executive or Director of Finance (or person acting up*)	Deputy Director of Finance or Executive Director

Short term loans		
Short term borrowing up to £499,000	With the authority of two members of an authorised panel, one of which must be the Chief Executive or Director of Finance	The Board must be made aware of all short term borrowings at the next Board meeting.

Expenditure on Charitable and Endowment Funds	
Up to £1000	Fund Manager, Health Stars Charity/Fundraising Manager
£1000 - £4,999	Fund Manager, Director of Finance
Over £5,000* *Any expenditure over £5,000 is subject to procurement rules and budgetary delegation set out above and elsewhere in the SFIs	Fund Manager, Director of Finance and Charitable Funds Committee
Over £25,000	Fund Manager, Director of Finance and Charitable Funds Committee (reported to Trust Board for information within Chairs Assurance Report)
Over £100,000	Trust Board as Corporate Trustees

Humber Teaching NHS Foundation Trust

SECTION D –

STANDING FINANCIAL INSTRUCTIONS

SECTION D - STANDING FINANCIAL INSTRUCTIONS

10. INTRODUCTION

These standing financial instructions (SFIs) refer to both the Trust as provider and any activities the Trust undertakes via the Provider Collaborative. SFIs for the provider collaborative are subject to the same principles as the Trusts as set out in this document.

10.1 General

10.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its Directors and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

10.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with the requirements of the Independent Regulator in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Matters Reserved to the Trust Board and the Scheme of Delegation adopted by the Trust.

10.1.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

10.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

10.1.5 The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

10.1.6 The Trust is considered as a commercial organisation under the terms of the Bribery Act 2010. As such all employees of the Trust are required to comply with these SFIs.

10.1.7 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All Directors of the Trust Board and officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

10.2 Responsibilities and Delegation

10.2.1 The Board

The Board exercises financial supervision and control by:

(a) approving the financial strategy; following formulation by the Finance & Investment Committee
(b) requiring the submission and approval of budgets within approved allocations/overall income;
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
(d) defining specific responsibilities placed on Board members and employees as indicated in the Scheme of Delegation

10.2.1.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in a formal session. These are set out in the Scheme of Matters Reserved to the Trust Board document. All other powers have been delegated to such other Committees as the Trust has established.

10.2.2 The Chief Executive and Director of Finance

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Independent Regulator, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

10.2.2.1 It is a duty of the Chief Executive to ensure that Directors, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

10.2.3 The Director of Finance

The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

10.2.4 Board Members and Employees

All Board members and officers, individually and collectively, are responsible for:

(a) the security of the property of the Trust;
(b) avoiding loss;
(c) exercising economy and efficiency in the use of resources;
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

10.2.5 Contractors and their Employees

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

10.2.6 For Board members and any officers employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board members and officers discharge their duties must be to the satisfaction of the Director of Finance.

11. Audit

11.1 Audit Committee

11.1.1 In accordance with Standing Orders, the Constitution, the 2006 Act (and as set out in the Audit Code for NHS Foundation Trusts, issued by the Independent Regulator) the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2014), which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments.

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

(d) monitoring compliance with Standing Orders and Standing Financial Instructions;

(e) reviewing schedules of losses and compensations and making recommendations to the Board;

(f) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

The Audit Committee can delegate some of their detailed responsibilities to the but they remain accountable for the independent and objective view of all internal controls.

11.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health. In the first instance this should be referred to the Director of Finance

11.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

11.2 Director of Finance

11.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

11.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or Board members or officer of the Trust;

(c) the production of any cash, stores or other property of the Trust under a Board member and or an officer's control; and

(d) explanations concerning any matter under investigation.

11.3 Role of Internal Audit

11.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other in scope management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and the Constitution, the 2006 Act (and as set out in the Audit Code for NHS Foundation Trusts, issued by the Independent Regulator)

11.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

11.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

11.3.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

11.4 External Audit

11.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

11.5 Fraud and Corruption

11.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

11.5.2 The Director of Finance shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

11.5.3 The Local Counter Fraud Specialist shall report to the Trust's Director of Finance and shall work with staff in NHS Counter Fraud Authority and the Regional Counter Fraud Specialist in accordance with the Department of Health Fraud and Corruption Manual.

11.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

11.6 Security Management

11.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

11.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

11.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

11.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

12. Allocations, Planning, Budgets, Budgetary Control and Monitoring

12.1 Preparation and Approval of Plans and Budgets

12.1.1 The Chief Executive will compile and submit to the Board an annual budget which takes into account financial targets and forecast limits of available resources. The Strategic Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;
(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

12.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Plan
(b) accord with workload and manpower plans;
(c) be produced following discussion with appropriate budget holders;
(d) be prepared within the limits of available funds;
(e) identify potential risks.

12.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

12.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

12.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

12.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

12.2 Budgetary Delegation

12.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

12.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

12.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

12.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

12.3 Budgetary Control and Reporting

12.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working capital;

(iii) movements in cash and capital;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

12.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board.

12.3.3 (a) Where an employee has more than one post with Humber Teaching NHS Foundation Trust then for the purposes of approval of expenses on-line the budget holder for the primary post will be the person designated to approve expenses claims for all posts held by the individual staff member.

12.3.4 The Chief Executive is responsible for ensuring the Trust identifies and implements cost improvements and income generation initiatives in accordance with the requirements of the Strategic Plan and a balanced budget.

12.4 Capital Expenditure

12.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure.

12.5 Monitoring Returns

12.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

13. Annual Accounts and Reports

13.1 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by Monitor, the Trust's accounting policies, and generally accepted accounting practice;

(b) prepare and submit annual financial reports to Monitor certified in accordance with current guidelines;

(c) submit financial returns to the Independent Regulator for each financial year in accordance with the timetable prescribed by the Independent Regulator.

13.2 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented to the Board for approval and received at a public meeting of the Council of Governors.

13.3 The Trust will publish an annual report, in accordance with the Constitution and present it to the Council of Governors. The document will comply with the Independent Regulator's Annual Report Guidance for NHS Foundation Trusts

14. Bank Accounts

14.1 General

14.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the Monitor. In line with 'Cash Management in the NHS' the Trust's banking arrangements should be in line with the guidelines set out in the Trust's Treasury Management policy.

14.1.2 The Board shall approve the banking arrangements.

14.2 Bank Accounts

14.2.1 The Director of Finance is responsible for:

a) the control and internal administration of the Trust's bank accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with Department of Health guidance on the level of cleared funds.

14.3 Banking Procedures

14.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts which must include:

(a) the conditions under which each bank account is to be operated.

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

14.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

14.4 Tendering and Review

14.4.1 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

14.4.2 The results of the tendering exercise should be reported to the Board. This review is not necessary for Government Banking Service accounts.

15. Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

15.1 Income Systems

15.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

15.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

15.2 Fees and Charges

15.2.1 The Trust shall follow the Department of Health's advice in the "Costing Manual" in setting prices for NHS service agreements.

15.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Trust's Standards of Business and Managing Conflicts of Interest Policy for NHS Staff shall be followed.

15.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

15.3 Debt Recovery

15.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

15.3.2 Income not received should be dealt with in accordance with losses procedures.

15.3.3 Controls should be in place to prevent overpayments arising. If there are incidences of such overpayments there need to be controls and processes in place to detect them and to initiate recovery.

15.4 Security of Cash, Cheques and other Negotiable Instruments

15.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

15.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

15.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

15.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

16. TENDERING AND CONTRACTING PROCEDURE

This procedure is used for when the Trust is procuring goods and services

16.1 Duty to Comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Financial Instructions (except where SO 3.13 is applied).

16.2 Legislation Governing Public Procurement

(a) The Trust shall comply with the Public Contracts Regulations 2006 (the "Regulations") and any EU Directives relating to EU procurement law having direct effect in England (the "Directives") and any other duties derived from the EU Treaty ("Treaty Obligations") and any duties derived from the UK common law ("Common Law Duties") (the Regulations, Directives, Treaty Obligations and Common Law Duties together are referred to elsewhere in these SFIs as "Procurement Legislation"). The Procurement Legislation as from time to time amended shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

(b) The Trust should consider obtaining support from any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures.

(c) The Trust shall consider the application of any applicable duty to consult or engage the public or any relevant Overview and Scrutiny Committee of a Local Authority prior to commencing any procurement process for a contract opportunity.

16.3 Guidance on Public Procurement and Commissioning

a. The Trust should have regard to all relevant guidance issued by the Department of Health in relation to the conduct of procurement practice and the commissioning of health care services, including but not limited to:

b. All off payroll engagements of more than six months in duration, for more than a daily rate of £220 should be referred to the Trust Procurement department before commitment to contract is given. This is to ensure contractual provisions are explicit that allow the Trust to seek assurance regarding the income tax and NICS obligations and IR35 of the engage – and to terminate the contract if that assurance is not provided. The general provision in relation to tendering 16.6.1 and quotations 16.8.1 also apply in addition to this requirement

16.4 Decision to Tender and Exceptions to Requirement to Tender

16.4.1 Presumption to Tender

Where:

(a) a contract opportunity that is required to be tendered under the Regulations

(i.e. the contract opportunity is governed by the Regulations and the value of the contract opportunity as calculated pursuant to the Regulations exceeds the relevant financial threshold excluding VAT for the requirement to run a formal tender process; then subject to SFI 16.7.5 the Trust shall ensure that contract opportunities with the Trust are advertised in accordance with SFI 16.6.9 and where more than one response is received that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services;

- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- subject to SFI 16.16 for disposals.

16.5 Capital Investment Manual and Other Department of Health Guidance

The Trust shall comply with the requirements of the Department of Health's Capital Investment Manual and Estatecode in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply with the Independent Regulator's Management Consultancy spending approval process

16.6 Formal Competitive Tendering

16.6.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;

- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health);

- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

16.6.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with SFI 17.

16.6.3 Exceptions and Instances where Formal Tendering Need Not be Applied

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the threshold for tendering as set out in the Scheme of Delegation;

(b) where the supply is proposed under special arrangements negotiated by the Department of Health in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI 24;

d**)** the Trust is entitled to call off from a Framework Agreement and the requirements of SFI 21.1.2 (Use of Framework Agreements) have been followed and have been approved in accordance with the Scheme of Delegation

(e) for a contract opportunity for goods and services that it is not reasonably expected to exceed £49,999 as requirements of SFI 16.8 Quotations: Competitive and Non-Competitive thence apply;

Formal tendering procedures **may be waived** in the following circumstances:

f) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(g) where the requirement is covered by an existing contract;

(h) where a Consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the Consortium members;

(i) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(j) where specialist expertise is required and is available from only one source;

(k) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

when the goods required by the Trust are a partial replacement for, or in addition to, existing goods and to obtain the goods from a supplier other than the supplier who supplied the existing goods would oblige the Trust to acquire goods with different technical characteristics and this would result in:

- incompatibility with the existing goods; or
- disproportionate technical difficulty in the operation and maintenance of the existing goods;

but no such contract may be entered in for a duration of more than three years;

(l) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

when works or services required by the Trust are additional to works or services already contracted for but for unforeseen circumstances such additional works or services have become necessary and that such additional works or services:

- cannot for technical or economic reasons be carried out separately from the works or services under the original contract without major inconvenience to the Trust; or

- can be carried out or provided separately from the works or services under the original contract but are strictly necessary to the latest stages of performance of the original contract; provided that the value of such additional works or services does not exceed 50% of the value of the original contract.

(m) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(n) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded on a Tender waiver form which must be completed by Procurement, signed by the Chief Executive and reported to the Audit Committee at each meeting.

(o) Where subcontracting arrangements arise following successful joint tender applications with partner organisations or where contracting arrangements/requirements are inherited under a Lead Provider arrangement.

16.6.4 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 16.1 and 16.8.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate having regard to their capacity to supply the goods or materials or to undertake the services or works required. The appropriate numbers are set out in the Scheme of Delegation

16.6.5 Equality of Treatment

The Trust shall ensure that no sector of any market (public, private, third sector/social enterprise is given an unfair advantage in the design or conduct of any tender process.

16.6.6 Non-Discrimination

(a) The subject matter and the scope of the contract opportunity should be described in a non-discriminatory manner. The Trust should utilise generic and/or descriptive terms, rather than the trade names of particular products or processes or their manufacturers or their suppliers.

(b) All participants in a tender process should be treated equally and all rules governing a tender process must apply equally to all participants.

16.6.7 Building and Engineering Construction Works

The Trust shall ensure that firms/individuals invited to tender for building and engineering construction work, where this is not contrary to the Directives by the Council of the European Union (see Scheme of Delegation) are among those on approved lists or have been openly advertised in accordance with EU Procurement and UK legislation.

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

16.6.8 Items which Subsequently Breach Thresholds after Original Approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

16.6.9 Advertisement of Contract Opportunities

Where a formal tender process is required under SFI 16.4 then:

(a) where a contract opportunity falls within the Regulations and a process compliant with the Regulations is required, an OJEU Notice should be utilised; or

(b) Where a contract opportunity does not fall within the Regulations the Trust shall utilise a form of advertising for such contract opportunity that is sufficient to enable potential providers (including providers in member states of the EU other than the UK) to access appropriate information about the contract opportunity so as to be in a position to express an interest; and

16.6.10 Choice of Procedure

(a) Where a contract opportunity falls within the Regulations and a process compliant with the Regulations is required then the Trust shall utilise an available tender procedure under the Regulations.

(b) In all other cases the Trust shall utilise a tender procedure proportionate to the value, complexity and risk of the contract opportunity and shall ensure that invitations to tender are sent to a sufficient number of providers to provide fair and adequate competition (in any event no less than two).

16.7 Contracting/Tendering Procedure

16.7.1 Invitation to Tender

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) or are submitted electronically through the appropriate process using the Trust's e-tendering service, as instructed within the tender documentation;

(c) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

Every invitation to tender must require each bidder to give a written undertaking not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered.

(d) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

16.7.2 Receipt and Safe Custody of Tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

16.7.3 Opening Tenders and Register of Tenders

(a) Tenders are received electronically and the Procurement team will be responsible for the unlocking of the e-tendering portal to allow bids to be opened with an audit trail kept on the accessing of the electronic tender submissions.

(b) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 16.7.5 below).

16.7.4 Admissibility of Tenders

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are

insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

16.7.5 Late Tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. dispatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

16.7.6 Accountability where In-house Bid

(a) In all cases where the Trust determine that in-house services (which term includes Trust community services) should be subject to competitive tendering the following groups shall be set up:

- Specification group, comprising the Chief Executive or nominated officer/s and specialist officer whose function shall be to draw up the specification of the service to be tendered.
- In-house tender group, comprising a nominee of the Chief Executive and technical support to draw up and submit the in-house tender submission.
- Evaluation group, comprising normally a specialist officer, a supplies or commissioning officer and a Director of Finance representative whose function is to shortlist expressions of interest received and evaluate tenders received. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team.

(b) No officer or employee of the Trust directly engaged or responsible for the provision of the in-house service subject to competitive tendering may be a member of any of the specification or evaluation group established under SFI 16.7.12(a) but the specification group may consult with and take into account information received from such officers or employees in drawing up the Trust's specification subject at all times to observing the duty of non-discrimination at SFI 16.7.6. No member of the in-house tender group may participate in the evaluation of tenders.

(c) The evaluation group shall make recommendations to the Board.

(d) The Chief Executive shall nominate an officer to oversee and manage the contract awarded on behalf of the Trust.

16.7.7 Acceptance of Formal Tenders (See overlap with SFI No. 16.7)

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(b) Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders (see SFI 16.7.5 above).

(c) Where examination of tenders reveals errors which would affect the tender figure, the tenderer may be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

(d) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;

(ii) understanding of client's needs;

(iii) feasibility and credibility of proposed approach;

(iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(e) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(i) No tender shall be accepted by the Trust which is obtained contrary to these SFIs except with the authorisation of the Chief Executive or Director of Finance.

(ii) All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be kept confidential and should be retained for 12 months from the date set for the receipt of tenders for inspection.

(f) The use of these procedures must demonstrate that the award of the contract was:

(i) not in excess of the going market rate / price current at the time the contract was awarded;

(ii) that best value for money was achieved.

(g) All tenders should be treated as confidential and should be retained for inspection.

(h) All tendering activity carried out through e-tendering should be compliant with Trust policies and procedures. Issue of all tender documentation will be done electronically through a secure website with controlled access using secure login, authentication and viewing rules. All tenders will be received into a secure vault so that they cannot be accessed until an agreed opening time.

16.7.8 Tender Reports to the Board

Reports to the Board will be made on an exceptional circumstance basis only.

16.7.9 Monitoring and Audit of Decision to Tender

(a) The waiving of competitive tendering procedures should not be used with the object of avoiding competition or solely for administrative convenience or subject to SFIs 16.8.2 to award further work to a provider originally appointed through a competitive procedure.

(b) Where it is decided that competitive tendering need not be applied or should be waived, the fact of the non application or waiver and the reasons for it should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

(c) Where the Trust proposes not to conduct a tender process in relation to a contract opportunity for a new health care service or a significantly changed health care service then the Trust shall consider such proposal at a meeting of the Board as recommended by the Trust Procurement Guide

16.7.10 List of Approved Firms for Building and Engineering Construction Works

The Trust does not hold a physical approved contractors list as it uses general open tendering principles the same as for all other tenders created. Where relevant the Trust may use the services of construction industry standards such as Constructionline or YORBuild to pre approve contractors to bid for work.

16.7.11 Checks to be Undertaken When Not Using Approved Lists

Where a contract (and where appropriate a quote) is to be awarded to a contractor who is not on an approved list there should be appropriate checks to ensure that the Contractor is technically competent, financially secure and where appropriate that they comply with any appropriate equalities and health and safety legislation.

16.7.12 Contracts for Building or Engineering Works

(a) Subject to SFIs 16.7.9(b) inclusive, every contract for building or engineering works shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode.

(b) When the content of the work is primarily engineering every contract shall embody or be in the terms of:

- the General Conditions of Contract recommended by the Institution of Mechanical Engineers; and/or
- the Association for Consultancy and Engineering (Form A);

(c) In the case of civil engineering work every contract shall embody or be in the terms of the General Conditions of Contract recommended by:

- the Institution of Civil Engineers; and/or

- the Association for Consultancy and Engineering; and/or
- the Civil Engineering Contractors Association.

(d) Each of the documents referred to in SFI 16.7.12 (a) to (c) inclusive may be modified and/or amplified to accord with Department of Health guidance and, with appropriate professional advice (including legal advice if necessary), to cover special features of individual projects.

16.8 Quotations: Competitive and Non-Competitive

16.8.1 General Position on Quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds the threshold set out in the Scheme of Delegation.

16.8.2 Competitive Quotations

(a) Quotations should be obtained from up to 5 firms/individuals based on Scheme of Delegation prepared by the Trust.

(b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

16.8.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.

16.8.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

16.9 Evaluation of Tenders and Quotations

16.9.1 Overriding Duty to Achieve Best Value

The Trust shall ensure that it seeks to obtain best value for each contract opportunity.

16.9.2 Choice of Evaluation Methodology

The Trust must for each contract opportunity which is subject to a tender or a competitive quotation choose to adopt evaluation criteria based on either:

(a) the lowest price; or

(b) the most economically advantageous tender, based on criteria linked to the subject matter of the contract opportunity including but not limited to some or all of:

- quality;
- price;
- technical merit;
- aesthetic and functional characteristics;
- environmental characteristics;
- running costs;
- cost effectiveness;
- after sales service;
- technical assistance;
- delivery date;
- delivery period; and/or
- period of completion

c) Each invitation to tender or invitation to supply a competitive quotation must state the evaluation criteria to be used to evaluate the tender or quotation and the relative weightings of each such criteria.

16.9.3 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract will be decided as specified in Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Board this shall be recorded in their minutes.

16.9.4 Form of Contract: General

Subject to the remainder of SFI 16.9.5 below the Trust shall consider the most applicable form of contract for each contract opportunity (including to the extent appropriate any NHS Standard Contract Conditions available) and should consider obtaining support from a suitably qualified professional advisor (including where appropriate legal advisors).

16.9.5 Statutory Requirements

The Trust must ensure that all contracts that are governed by mandatory statutory requirements (whether contained in Statute, Regulations or directions) comply with such requirements. Such contracts include, but may not be limited to:

(a) GMS contracts;
(b) PMS agreements;
(c) SPMS contracts;
(d) APMS contracts;
(e) PCTMS contracts;

(f) PDS agreements;
(g) PCTDS contracts;
(h) GDS contracts;
(i) GOS contracts (mandatory and/or additional services contract)

16.10 Private Finance for Capital Procurement (See also SFI 22.2)

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Trust Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

16.11 Compliance Requirements for All Contracts

The Trust Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

(h) In all contracts made by the Trust, the tendered value of the winning contract should not be exceeded. If, in the course of the contract, the tendered value is required to be exceeded then, prior to any agreement to vary the value, authorisation must be obtained by the relevant Director in charge of the business area. In the case of a capital contract, this agreement must be provided from the Capital and Redesign Group prior to any agreement being made. In all instances this agreement should only be sought when all other mitigating options have been explored.

16.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

16.13 Health Care Services Agreements (See overlap with SFI No. 17)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

16.14 Contracts for Health Care Services

Where a mandatory requirement of the Department of Health, the Trust shall utilise the most relevant NHS commissioning contract for the commissioning of health care services, or where a mandatory requirement of the Department of Health include standard provisions.

Health Care Services are classed as Light Touch under the Regulations. The Light touch regime applies to health care, social care, education, cultural and certain other services defined in the regulations. The Trust can design its own procedure for light touch regime procurements provided it complies with the Public Contract Regulations 2015 and follows its principles of equal treatment, transparency and setting time limits that are reasonable and proportionate. Contract opportunities should be advertised when/as required by SFI 16.6.9.

16.15 Commissioning Health Care Services: Decision to Tender

Health Care Services are classed as Part B Services under the Regulations. As such, no requirement to advertise arises by virtue of SFI 16.12 above, but may do under SFI 16.13 and each contract opportunity should be assessed against the Cross Border Test.

16.16 Disposals (See overlap with SFI 24)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value below the threshold detailed in Scheme of Delegation;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.

16.17 In-house Services

16.17.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

16.17.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000 a Non-Executive Trust Board member should be a member of the evaluation team.

16.17.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

16.17.4 The evaluation team shall make recommendations to the Board.

16.17.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

16.18 Applicability of SFIs on Tendering and Contracting to Funds Held in Trust (see also SFI 27)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

17. NHS Service Agreements for Provision of Services (see also SFI 16.13).

17.1 Service Level Agreements (SLAs)

17.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

17.1.2 All SLAs should aim to implement the agreed priorities contained within the Annual Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

- that SLA's are based on dialogue with clinicians, users, carers, public health professionals and managers

- that the SLA should apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this thus ensuring that the Trust jointly manages risk with all interested parties

17.2 Reports to Trust Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

18. Terms of Service, Allowances and Payment of Members of the Board and Employees

18.1 Remuneration and Terms of Service (see also SO 4)

18.1.1 In accordance with Standing Orders the Board shall establish a Remuneration and Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

18.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust, and other senior employees (if any) as it is designated to consider, including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of Executive Trust Board members (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such Board members and staff where appropriate;

(c) ensure in consultation with the Chief Executive, that the performance of individual Executive Directors is regularly monitored and evaluated

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

18.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

18.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

18.1.5 The Trust will pay allowances to the Chairman and Non-Executive Directors in accordance with instructions issued by the Council of Governors.

18.1.6 The Committee will approve recruitment and retention premia awarded to any member of staff not covered by Agenda for Change where there are national recruitment and retention pressures (for example medical consultants).

18.2 Funded Establishment

18.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

18.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

18.3 Staff Appointments

18.3.1 No Trust Board member or officer may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive

(b) within approved Scheme of Delegation

18.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

18.4 Processing Payroll

18.4.1 The Director of Workforce and Organisational Development is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

18.4.2 The Director of Workforce and Organisational Development will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employees;

(h) procedures for payment by cheque, bank credit, or cash to employees, liaising as necessary with the Finance Directorate;

(i) procedures for the recall of cheques and bank credits, liaising as necessary with the Finance Directorate;

(j) pay advances and their recovery, liaising as necessary with the Finance Directorate;

(k) separation of duties of preparing records and handling cash;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

18.4.3 The Director of Finance will issue instructions regarding maintenance of regular and independent reconciliation of pay control accounts

18.4.4 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

18.4.5 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

18.5 Contracts of Employment

18.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

19. Non Pay Expenditure

19.1 Delegation of Authority

19.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

19.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

19.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

19.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (See also SFI 16)

19.2.1 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement department should be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

19.2.2 System of Payment and Payment Verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

19.2.2.1 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Financial Instructions and regularly reviewed

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of officers and Board members (including specimens of their signatures) authorised to certify invoices should be submitted to Finance and Purchasing by each Business Unit/HQ Directorate. It is the responsibility of the Assistant or Deputy Director /Departmental Director to re-submit specimen signatures where staff changes occur.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

- Email authorisation of invoices is allowable up to the thresholds within the Scheme of Delegation

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 19.2.4 below.

19.2.3 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

19.2.4 **Official Orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised under the Scheme of Delegation

19.2.5 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement; (current thresholds are detailed in the Scheme of Delegation)

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health (The Procurement and Management of Consultants within the NHS)

(d) where the item being procured is a capital investment or an estate or property transactions, the procurement must be in accordance with guidance issued by the Department of Health (Capital Investment Manual and Estatecode)

(e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with SO 7 and 7.4.1)

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(g) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or purchases made using the Trust purchasing card process ;

(h) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of officers authorised to certify invoices are notified to the Director of Finance ;

(l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance ;

(m) petty cash records are maintained in a form as determined by the Director of Finance .

19.2.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Concode and Estatecode. The technical audit of these contracts shall be the responsibility of the relevant Director.

19.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

19.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See also SO 9.1)

20. External Borrowing

20.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

20.1.2 The Board will agree the list of officers (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

20.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

20.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money, and comply with the latest guidance from the Department of Health.

20.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

20.1.6 All long-term borrowing must be consistent with the plans outlined in the current Strategic Plan and be approved by the Board.

20.2 Investments

20.2.1 Temporary cash surpluses must be held only in such public or private sector investments in accordance with the conditions set out in the Trust's Treasury Management Policy and the Independent Regulator's guidance "Managing Operating Cash in NHS Foundation Trusts"

20.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

20.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained The Trust will comply with all the relevant guidance published in relation to investments.

21. Financial Framework

21.1.1 The Director of Finance should ensure that Board members are aware of the Financial Framework. This document contains directions which the Trust must follow. The Director of Finance should also ensure that the direction and guidance in the framework is followed by the Trust.

. The Board will ensure that funds are available for short term cashflow management and this maybe by negotiating an irrevocable working capital facility. The value of this facility shall not exceed 30 days worth of normal operating expenditure.

21.1.2 Use of Framework Agreements

The Trust may utilise any available framework agreement to satisfy its requirements for works, services or goods but only if it complies with the requirements of Procurement Legislation in doing so, which include (but are not limited to) ensuring that:

(a) the framework agreement was procured on its behalf. The Trust should satisfy itself that the original procurement process included the Trust within its scope;

(b) the framework agreement includes the Trust's requirement within its scope. The Trust should satisfy itself that this is the case;

(c) where the framework agreement is a multi-operator framework agreement, the process for the selection of providers to be awarded call-off contracts under the framework agreement is followed; and

(d) the call-off contract entered into with the provider contains the contractual terms set out by the framework agreement.

22. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

22.1 Capital Investment

22.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

22.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

22.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Estatecode.

22.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

22.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

22.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see also SFI 16.9);

(c) approval to accept a successful tender (see also SFI 16.9).

The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with Estatecode guidance and the Trust's Standing Orders.

22.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

22.2 Private Finance (See also SFI 16.10)

22.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

22.3 Asset Registers

22.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

22.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual or later guidance as issued by the Department of Health.

22.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

22.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

22.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

22.3.6 All assets are initially measured at cost and subsequently at fair value. For specialised buildings this involves a valuation based on modern equivalent assets (see accounting policies)

22.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Independent Regulator‘s Financial Reporting Manual and IFRS.

22.3.8 The Director of Finance of the Trust shall calculate and pay capital charges as specified in the Capital Accounting Manual issued by the Department of Health.

22.4 Security of Assets

22.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

22.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

22.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

22.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

22.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

22.4.6 Where practical, assets should be marked as Trust property.

23. Stores and Receipt of Goods

23.1 General Position

23.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

23.2 Control of Stores, Stocktaking, Condemnations and Disposal

23.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an officer by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

23.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

23.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

23.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

23.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

23.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also SFI 23). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

23.3 Goods Supplied by NHS Supply Chain

23.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

24. Disposals and Condemnations, Losses and Special Payments

24.1 Disposals and Condemnations

24.1.1 **Procedures**

The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

24.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

24.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

24.1.4 The Condemning Officer shall satisfy himself/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

24.2 Losses and Special Payments

24.2.1 Procedures

The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

24.2.2 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved if this has not already been done. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and NHS Counter Fraud Authority Regional team

The Director of Finance must notify NHS Counter Fraud Authority, the External Auditor and the Independent Regulator of all frauds.

24.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

24.2.4 Within limits delegated to it by the Managing Public Money guidance the Board shall approve the writing-off of losses.

24.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

24.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

24.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

24.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

24.2.9 All losses and special payments must be reported to the Audit Committee annually

25. Information Technology

25.1 Responsibilities and Duties of the Director of Finance

25.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

25.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

25.1.3 The Director of Nursing shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the

information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

25.2 Responsibilities and Duties of Other Directors and Officers in Relation to Computer Systems of a General Application

25.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance :

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

25.3 Contracts for Computer Services with Other Health Bodies or Outside Agencies

The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

25.4 Risk Assessment

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

25.5 Requirements for Computer Systems which have an Impact on Corporate Financial Systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

26. Patients' Property

26.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as property) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

26.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

a) notices and information booklets;

b) hospital admission documentation and property records;

c) the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

26.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

26.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

26.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

26.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

26.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

27. Funds Held on Trust

27.1 Corporate Trustee

a) SO 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SO 4.8.4 that defines the need for compliance with Charities Commission latest guidance and best practice.

b) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

c) The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

27.2 Accountability to Charity Commission and Secretary of State for Health

(a) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(b) The Schedule of Matters Reserved to the Trust Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust Officers must take account of that guidance before taking action.

27.3 Applicability of Standing Financial Instructions to Funds held on Trust

a) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. See also SFI No 16.18).

b) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

28. Acceptance of Gifts by Staff and Link to Standards of Business Conduct (See also SO 6 and SO 7.4.1)

The Director of Finance shall ensure that all officers are made aware of the Trust's Standards of Business and Managing Conflicts of Interest policy for NHS Staff on acceptance of gifts and other benefits in kind by officers. This policy follows the guidance published by NHS England) and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

29. Retention of Records

29.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

29.2 The records held in archives shall be capable of retrieval by authorised persons.

29.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

30. Risk Management and Insurance

30.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current Monitor guidance.

30.2 Insurance: Risk Pooling Schemes Administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

30.3 Insurance Arrangements with Commercial Insurers

30.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(a) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(b) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(c) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

30.4.1 Arrangements to be Followed by the Trust Board in Agreeing Insurance Cover

(a) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

(b) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Trust Board is informed

of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(c) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Statutory Roles and Responsibilities of the Council of Governors

Subject always to provisions of the Constitution, the Governors shall have the following statutory roles and responsibilities:-

- Appoint and, if appropriate, remove the chair (Constitution paragraph 26);
- Appoint and, if appropriate, remove the other non-executive directors (Constitution paragraph 26);
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors (Constitution paragraph 33);
- Approve (or not) the appointment of the chief executive (Constitution paragraph 28);
- Appoint and, if appropriate, remove the NHS foundation trust's auditor (Constitution paragraph 38);
- Receive the NHS foundation trust's annual accounts, any report of the auditor on them and the annual report at a general meeting of the Council of Governors (Constitution paragraph 44);
- Hold the non-executive directors, individually and collectively, to account for the performance of the Trust Board (Constitution paragraph 16);
- Represent the interests of the members of the Trust as a whole and the interests of the public (Constitution paragraph 12);
- Approve 'significant transactions' (Constitution paragraph 46);
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution (Constitution paragraph 46);
- Decide whether the Trust's non-NHS work would significantly interfere with its principle purpose, which is to provide goods and services for the health service in England or performing its other functions (Constitution paragraph 41);
- Approve amendments to the Trust's constitution (Constitution paragraph 44).

Agenda Item 28

Title & Date of Meeting:	Trust Board Public Meeting 29 September 2021
Title of Report:	'A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance'
Author:	Name: Dr John Byrne Title: Executive Medical Director & Responsible Officer (RO)
Recommendation	

To approve	x	To receive & note	
For information		To ratify	

Purpose of Paper:	This report summaries activity relating to appraisal and revalidation processes for 2020/2021 The Annual Organisation Audit (AOA) data is also attached for information. If the committee are satisfied the Chief Executive is required to sign the statement of compliance.
Governance	

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

Key Issues within the report:	A note needs to be added to the attached Assurance Report to Board to confirm the following '*The Medical Director has received confirmation from NHSE that they are satisfied with regard to governing the process via the Workforce & OD Committee'.*

Monitoring and assurance framework summary:

Links to Strategic Goals	
√	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 been considered?	**Yes**	**Yes** Detail in report	**N/A**	**Comment**
		Any Action Required?		
Risk			X	To be advised of any
Legal	√			To be advised of any future implications reports as and when future implications by Lead Directors through Board required
Compliance	√			
Communication			X	
Financial	√			
Human Resources	√			
IM&T			X	
Users and Carers			X	
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Title of Report

Body of report

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: The Revalidation Team continues to attend updates/refresher training as part of the RO Network 2020/21. Comments: In full compliance with the regulations, Dr John Byrne, Medical Director, has been the Responsible Officer for revalidation since 1st April 2018, following completion of training. He is also a member of the Regional Responsible Officers network. Dr Byrne himself is compliant in relation to appraisal. Action for next year: No new action for 2021/2022 – Retained action from 2018/18 i.e. continue to attend any updates/refresher training as part of the RO Network.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: Continue to utilise all resources effectively to ensure the RO is able to carry out the responsibilities of the role fully. Comments: The Appraisal Lead was appointed in April 2018; the post holder receives 1PA remuneration for the role. The Appraisal Lead and Responsible Officer are supported by a part time Revalidation Officer and also by The Medical Directorate & Medical Education Manager (MDEM). The Trust currently has 7 trained appraisers; this ensures that all doctors receive an annual appraisal (where appropriate). The L2P system is fully implemented in the Trust; this system supports doctors to collect all required and supporting information for appraisal and ensures sufficient time to participate in annual appraisal effectively. Action for next year: Retained action from 2018/19 - Continue to utilise all resources effectively to ensure the RO is able to carry out the responsibilities of his role fully.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Continue to update and maintain information systems as necessary. Comments: The L2P system is fully implemented across the Trust and this system is used effectively to record appraisal compliance (including engagement/completion of 360 Multisource appraisals), individual doctor's details in relation to their continuing professional development (CPD), preparation for, and completion of, appraisal and any issues or concerns raised during the appraisal process. This system is maintained by the Revalidation Officer. Action for next year: Retained action from 2020/2021 - Continue to update and maintain information systems as necessary.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Next formal review is due in January 2023. It is accepted that the policy may require an earlier review in line with any local or national changes in policy and/or guidance. Comments: The Trust Medical Revalidation and Appraisal Policy is designed to incorporate the principles outlined in the NHS England Revalidation Policy, National Guidance and guidance from the GMC. This policy also complies with equality and diversity legislation Action for next year: Retained action from 2020/2021

5. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: 2020/2021- The Trust will request that all long term locums will confirm that they have had the necessary appraisal and share that with us. Information sharing process about the Agency Locum doctor's appraisal between both Responsible Officers will be reviewed. Comments: All doctors employed by the Trust on either a substantive or fixed term basis are expected to comply with the local Medical and National Revalidation Policy. Short term doctors are treated in exactly the same way as permanent medical staff in relation to expectations about appraisal and revalidation. Agency Locum doctors (not employed by the Trust but working in the Trust) are supported to meet their CPD requirements and attend the weekly Postgraduate Teaching Programme and peer group meetings, however, their responsible officer requirement sits with their agency Responsible Officer. We requested the Locum Doctors share with the Revalidation Team their most recent appraisal in PDF Format.

Action for next year: Retained action from 2020/2021 – The Trust will continue to request that all long term locums will confirm that they have had a necessary appraisal and continue sharing their appraisals with us.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: 2019/2020: Maintain existing standards to comply with the Trust 'Medical Revalidation and Appraisal' Policy. The external peer review process will be used to provide quality assurance.

Comments: Appraisal 2020 model has been implemented during the Covid-19 pandemic and a flexible approach to appraisals has been adopted. Appraisals were reinstated by 1st October 2020.

In compliance with the local 'Medical Revalidation and Appraisal' Policy all doctors, prior to their appraisal are provided with pertinent information from the Risk Management Department relating to Serious Incidents (SI's)/significant events/clinical incidents and complaints in which they have been named. A reflection regarding wellbeing during the pandemic is included in their appraisals. The focus is mainly on discussion in the appraisal meeting even if there is minimum supporting information submitted by the appraisee. This information is included within the appraisal and reviewed by the appraiser.

Action for next year: 2021/2022 – Continue to use Appraisal 2020 model. To maintain existing standards to comply with Medical Revalidation and Appraisal Policy. The external peer review process will be used to provide quality assurance.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: Not Applicable – See response to Question 1 above.

Action for next year: N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Conduct policy review as/when necessary. The next policy will be reviewed in 2023.

Comments: The Trust Medical Revalidation and Appraisal Policy is designed to incorporate the principles outlined in the NHS England Revalidation Policy, national guidance and guidance from the GMC. The policy is reviewed and updated at specified intervals. All medical policies are ratified through the Local Negotiating Committee (LNC) and signed off by the Executive Management Team (EMT). Following an internal audit which was carried out as part of the Audit Committee Annual Audit Plan the Trust 'Medical Revalidation and Appraisal Policy' was reviewed and updated. The policy was ratified though the Local Negotiating Committee (LNC) and Executive Management Team (EMT). All actions from that audit have been completed.

Action for next year: Retained action from 2019/2020 - Next formal policy review is due in January 2023, however it is accepted that the policy may require earlier review in line with any local or national changes in policy and/or guidance.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continue to ensure appraisals are completed in a timely manner and maintain/increase number of qualified Appraisers.

Comments: Medical Appraisers are recruited and selected by the Trust in accordance with national guidance. The Revalidation Team has recruited an extra 1 appraiser. Therefore, we have 7 trained appointed appraisers to meet the need and this ensures that all doctors receive an annual appraisal (where appropriate) in a timely manner. Appraiser allocation takes place on an annual basis; this is led by the Appraisal Lead and ensures adequate notice for Appraisees.

Action for next year: Retained action from 2020/2021.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Action from last year: RO, Appraisal Lead, Medical Education Manager and Revalidation Officer regularly attend regional network meetings.

Comments: RO, Appraisal Lead, Medical Education Manager and Revalidation Officer regularly attend regional network meetings and disseminate relevant information through local Appraiser meetings to facilitate personal development of the appraisers and maintain the standards of the appraisal process. All Medical appraisers have completed a suitable training programme before undertaking any appraisals. All Appraisers have access to medical leadership and support, and the Trust operates a regular Appraiser meeting which allows peer review and learning to take place. There is a system in place to obtain feedback for Appraisers on the appraisal process; the Appraisal Lead facilitates this process and gives the feedback to the appraisers.

Action for next year: Retained action from 2020/2021 and continue to maintain and expand on existing good practice.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continue to maintain and build on local appraisal quality assurance processes and ensure the dissemination of learning.

Comments: Actions completed include: Appraisal Summary Review Audit, Appraisee Feedback Questionnaire Audit, Appraiser Review Meeting between Appraisal Lead and Appraisers, Patient Satisfaction Survey and second Appraisal Forum (CPD event) completed by the Appraisal Lead in 2020/2021

Action for next year: Retained action from 2020/2021 - Continue to maintain and build on local appraisal quality assurance processes and ensure the dissemination of learning.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Humber Teaching NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	47
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	36
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	3
Total number of agreed exceptions	8

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Continue to maintain standards of good practice and remain compliant.

Comments: The RO makes timely recommendations to the GMC as required in line with protocol. The RO ensures that the Trust Board (through the Workforce & OD Committee) are informed/advised of any late or missed recommendations with an explanation and reasons for any deferral submissions.

Action for next year: Retained action from 2020/2021- Continue to maintain standards of good practice and remain compliant.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue to maintain standards of good practice.

Comments: All recommendations made to the GMC are confirmed in a timely manner with the doctor along with the reason/s for the recommendation. Discussion is held with individual doctor/s before the submission of a recommendation as required.

Action for next year: Retained action from 2020/2021 - Continue to maintain standards of good practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: No actions for 2020/2021 as no changes anticipated.

Comments: For appraisal doctors are routinely provided with information regarding complaints, SI's, etc. in which they have been named and a reflection is included in the appraisal. The Responsible Officer has quarterly booked meetings with the employer liaison adviser (ELA) for the GMC which discusses ongoing development s and challenges

Action for next year: No changes anticipated for 2021/2022

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: 2020/2021 - Due to Covid-19 Restrictions the following action was unable to be achieved - An external peer review will be conducted in the next 12 months to provide assurance with regard to the quality of Trust appraisal processes and documentation.

Comments: The performance of all doctors is monitored as part of the annual job planning process. Systems are in place to monitor the fitness to practice of doctors working in the Trust. Relevant information is also shared with other organisations in which a doctor works, where necessary. The Trust also has a system in place to link complaints, SI's, incidents etc. to individual doctors and appraisees are provided with this information for appraisal. Appraisal reviews and re-audits have been completed by the Appraisal Lead in the Trust. This will be expanded moving forward to include peer review. This has been interrupted due to lack of availability and COVID 19 restrictions.

Action for next year: Retained action from 2020/2021 Implement peer review process.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Conduct policy update and review as required.

Comments: The local Medical Disciplinary Policy is in line with, and based on, Maintaining High Professional Standards in the Modern NHS (MHPS). This policy outlines the process by which to respond to concerns relating to fitness to practice and includes process arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns. The policy has been ratified through the Local Negotiating Committee (LNC) and by Executive Management Team (EMT). Links with the National Clinical Assessment Service (NCAS) are well established and regular meetings take place between the Medical Director and the GMC Employer Liaison Adviser (ELA). Trust policy ensures there is a formal procedure in place which allows colleagues to raise concerns. Following audit and scrutiny over the last 12 months the local policy was reviewed and updated. The final document was ratified though the Local Negotiating Committee (LNC) and Executive Management Team (EMT).

Action for next year: Retained action 2020/2021 – Next formal policy review is due January 2023. It is accepted that the policy may require earlier review in line with any local or national changes in policy and/or guidance.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Continue to maintain existing standards or practice

Comments: In relation to concerns relating to a doctor/s the Medical Director provides an annual report to the Trust Board (through the Workforce & OD Committee or through part 2 monthly board reportable log where necessary), detailing number of concerns, types of concern and outcome from previous year. Information relating to numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors is the responsibility of the HR Department who have recently appointed a lead for E&D.

Action for next year: Retained action 2020/2021 – Continue to maintain existing standards of practice.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue to maintain good practice, the Directorate will continue to work with the Primary Care group to ensure similar standards are maintained across the organisation for either locums or trust salaried GP's (these have a different RO network as they are on the Performers list which is a distinct entity for General Practitioners).

Comments: All Consultant and SAS doctor appointments are subject to pre-employment checks in line with the NHS Employment Check Standards. As part of these checks the Trust insists on a sharing of the doctor's appraisal history and portfolio from the previous RO and the completion of transfer of appraisal information form (MPIT form). All conditional employment offer letters request that the prospective employee provides contact details of their RO. In the case of Agency doctors, feedback is provided to their RO in the form of an exit form once their placement with the Trust ends.

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Retained action from 2020/2021 - Continue to maintain good practice, the Directorate will continue to work with the Primary Care group to ensure similar standards are maintained across the organisation for either locums or trust salaried GP's (these have a different RO network as they are on the Performers list which is a distinct entity for General Practitioners)

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: No action from 2020/2021

Comments: The Medical Revalidation and Appraisal Policy and the Medical Disciplinary and other Trust policies are subject to Equality Impact Assessment (EIA). Policies contain the right of appeal where relevant. Advice on cases relating practice concerns are discussed with NCAS and with the GMC ELA as required and in line with policy.

Action for next year: No action for 2021/2022

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Maintain compliance and standards of good practice. Comments: All Trust doctor appointments, substantive or temporary, are made in line with the NHS Employment Check Standards, this includes checks relating to qualifications and experience, reference checks (including information relating to local investigations and management of concerns), identity and right to work checks, etc. GMC registration is also verified and GMC information relating to fitness to practice, conditions/restrictions/ revalidation and doctor history is checked. A Disclosure and Barring Service (DBS) check is conducted for new starters. Action for next year: Retained action from 2020/2021 – Maintain compliance and standards of good practice.

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- General review of last year's actions – Appraisal 2020 model has been implemented during the Covid-19 pandemic and a flexible approach to appraisals has been adopted. Appraisals were reinstated by 1st October 2020.There were no other major actions arising in 2020/2021 except actions around the maintenance standards and good practice, and compliance with policy and quality assurance process.

- There are three outstanding appraisals at the end of March 2021 (all with valid reasons), which have now all been completed.

- As part of the Trusts internal audit plan the Medical Revalidation and Appraisal Policy was subject to internal process and all the audit actions have been completed.

- The Trust Appraisal Lead has provided first appraisal training for the new appraisees and a review of all Patient Feedback data which has been completed by doctors over the past 5 years. This data is very positive, has been shared with the Medical Network and has also been shared with the Head of Patient and Carer Experience. We are planning to increase the time for the doctors to collect the 360 Patient Feedback to ensure adequate number of patients are giving their feedback.

- We will continue to have regular Revalidation/Appraisal meetings, Appraisal Forums and continue to organise training courses.

- Actions still outstanding – The peer review process needs to be implemented which has been interrupted due to COVID 19 restrictions.

- Current Issues – No current issues

- New Actions: No significant new actions, mainly retention of existing actions which mainly relate to standards of good practice.

Overall conclusion: The Trust continues to strive to create and maintain a supportive environment and promote a culture of continuous improvement and learning. There are clear lines of accountability within the organisation which actively supports doctor's personal and professional development.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Humber Teaching
NHS Foundation Trust

Agenda Item 29

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting 29 September 2021</td></tr>
<tr><td>Title of Report:</td><td>Winter Plan – 2021/22</td></tr>
<tr><td>Author/s:</td><td>Name: Claire Jenkinson
Title: Deputy Chief Operating Officer</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 winter plan for 2021/22 has been developed and formulated based on what worked well during the winter of 2020/21 and within the context of the ongoing expectation that the Covid-19 pandemic will continue throughout the winter months.

This plan is overseen by our Emergency Preparedness, Resilience and Response (EPRR) command arrangements and the remit of our command structure has been expanded to include winter planning due to the interdependencies between our ongoing response to Covid- 19 and winter pressures.

The purpose of this paper is to provide assurance that the critical issues that impact our ability to maintain our services robustly during winter have been taken into account.</td></tr>
<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>Other (please detail)</td><td></td></tr>
</table></td></tr>
<tr><td>Key Issues within the report:</td><td>In setting out the plan and undertaking our preparations for winter this has been undertaken in the context of the ongoing impact of the Covid- 19 pandemic and the following factors:

• Contingencies in the event of a serious flu outbreak

• Sustaining our trajectories to meet service demand effectively and achieve/maintain access and waiting time requirements.

• Adverse Weather

• Focus on workforce

• Systemwide engagement, collaboration and escalation</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	

Humber Teaching NHS Foundation Trust

Winter Plan – 2021/2022

1. Introduction

The winter plan for 2021/22 has been developed and formulated based on what worked well during the winter of 2020/21 and within the context of the ongoing expectation that the Covid-19 pandemic will continue throughout the winter months. The following principles have been considered in all plans:

- Systems should plan for COVID as part of Business As Usual arrangements
- System resilience is 365 days of the year
- Review command and control arrangements to support system escalation
- Staff Support and Wellbeing arrangements should be in place to enable a resilient workforce
- Evaluation of system wide learning from the previous winter to inform future planning including Operational Pressures Escalation Levels Framework (OPEL)
- Escalate early in anticipation of demand surges, not in response to them. (Collaboration with ambulance services and primary care to monitor illness, patterns in the local community and weather changes that may affect specific patient cohorts)
- Early identification of winter schemes through winter learning
- Consideration of the impact of wider transformational schemes on system plans
- System wide clinical engagement and leadership in the ongoing development of plans and oversight of them
- Development of communication plans with system partners and the public to influence behaviour
- Health Inequalities integral to all plans

Additionally, the following considerations have been taken into account following the Trusts learning from Covid:

- **IPC management**. Plans need to ensure the impact of infection outbreaks is minimised and managed. Regional learning to be shared with systems; consideration of cohorting and social distancing requirements
- **Vaccination** – to build upon success of last year's flu campaign and covid vaccination roll out and plan for any future covid booster requirements
- **Robust testing -** Including routine staff and inpatient testing and sufficient rapid point of care testing within ED
- **Recovery -** Resilience plans needs to be aligned with recovery and restoration plans.
- **Surge and escalation –** Resilience plans must be inclusive of organisation, system and feed into ICS plans

Our Winter Plan is overseen by our Emergency Preparedness, Resilience and Response (EPRR) command arrangements and the remit of our command structure continues to be expanded to include winter planning due to the interdependencies between our ongoing response to Covid-19 and winter pressures.

In setting out the plan and undertaking our preparations for winter, other factors have also been taken into account:

- Contingencies in the event of a serious flu outbreak
- Sustaining our trajectories to meet service demand effectively and achieve access and waiting time requirements.
- Adverse Weather

The Trust will continue to work with our mental health partners, utilising agreed,standard Opel reporting protocols and agreed system triggers to determine when mutual aid and joint working arrangements will come into effect. The Trust continues to work closely with our wider system partners across a wide range of forums and the work is focussed on ensuring robust joint working and communication methods are in place to respond to system surge and complex case needs as we enter the winter period. Specific system recovery workshops and planning sessions have been held at HCV Partnership and subsystem levels, the Trust has participated and shaped the plans that have been developed to date. Recent focus within these forums has also been placed on stress testing the winter pressures component of the plans and other EPRR and system wide scenario planning events are taking place between now and the end of October to further assess the readiness of the plans to respond to the system pressures

This report will set out a summary of the key elements that have informed our planning and preparedness, that our approach to planning for the coming winter is robust, however that the complexities of planning for an ongoing pandemic and winter seasonal pressures make this winter likely to be more challenging than the previous year.

2. Emergency Preparedness, Resilience and Response (EPRR)

A key element of our winter planning in previous years has always been to ensure that our service business continuity plans are robust and fit for purpose, this year the Covid-19 emergency has already provided significant opportunity to actively test and refine them. These plans are in place for all of our clinical and corporate areas. Currently through our EPRR arrangements these plans are being reviewed to ensure that they accurately reflect the learning that has taken place since the pandemic commenced and that they are ready for the anticipated ongoing impact due to Covid-19 and winter pressures. This review and assurance process will commence in October 2021 and is being led by the EPRR team. Some of our on-call managers have recently undertaken additional EPRR training based on the JESIP principles, this equips them to use a recognised framework to support effective and safe decision making in the context of responding to emergencies.

3. Performance, Demand and Activity

In developing the Winter Plan, the Trust has worked closely with Hull, East Riding and North Yorkshire commissioners and our system partners to consider and respond to the anticipated /predicted demands expected over Winter 2021/22. The objectives of the Winter Plan and the associated actions are focussed on the following objectives agreed across the system:

- Mental health acute care pathway including adult and older people's beds, mental health response service and the mental health liaison service.
- Community Mental Health Teams (CMHT) and Improving Access to Psychological Therapies (IAPT)
- Children and Adolescent Service (CAMHS) acute and Learning Disability Pathways
- Community Beds and Community (Physical Service) services
- Primary Care

Each area of service has developed detailed draft plans and these will be subject to review and challenge prior to final submission to be incorporated into the systemwide Winter Plans. The following sections provide an overview of the key issues, the plans in place and being developed to address and mitigate where possible the impact of winter and the expected additional pressures

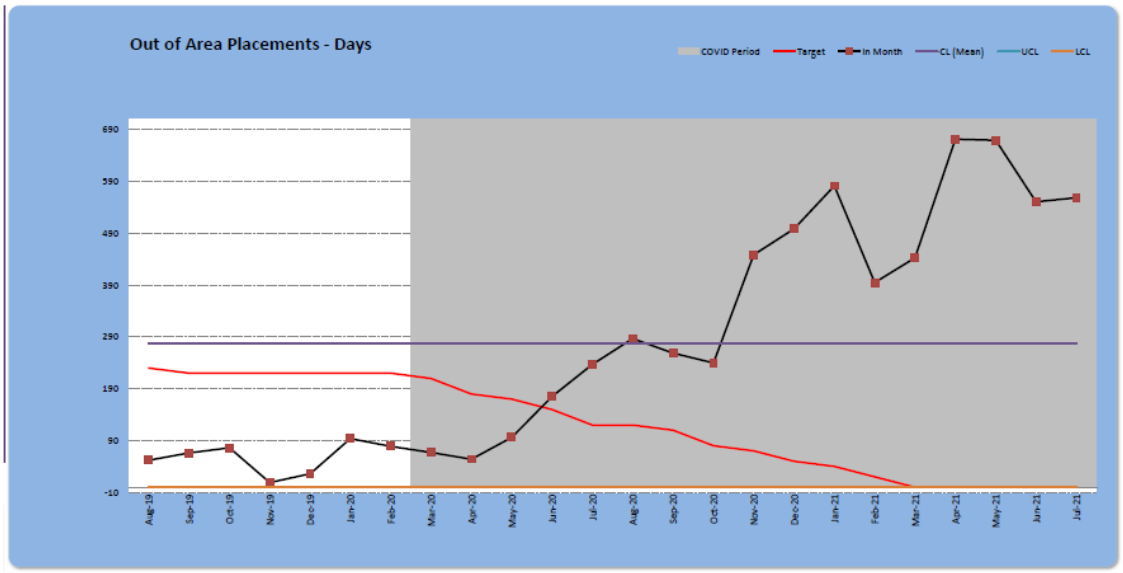
Mental health acute care pathway

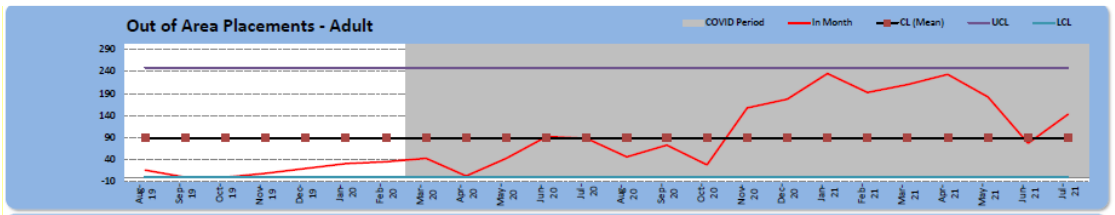
Key to our planning is working closely with our system partners to maintain patient flow through the acute care pathway. These services performed well last winter whilst working through the first winter also affected by the Covid 19 pandemic, significant to this was:

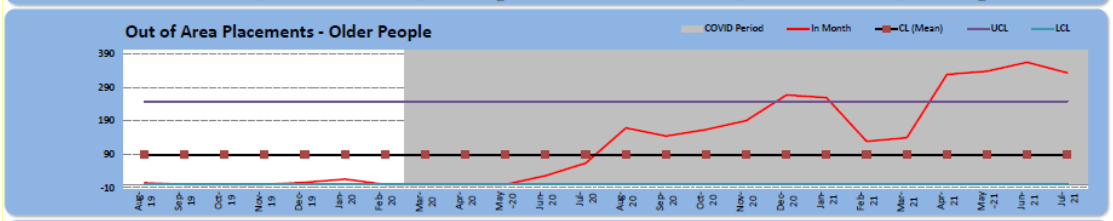
- Bed occupancy has been good
- Length of stay in beds has been stable
- Block purchase of out of area beds to mitigate bed reduction
- Improved levels of Delayed Transfers of Care (DTOC)

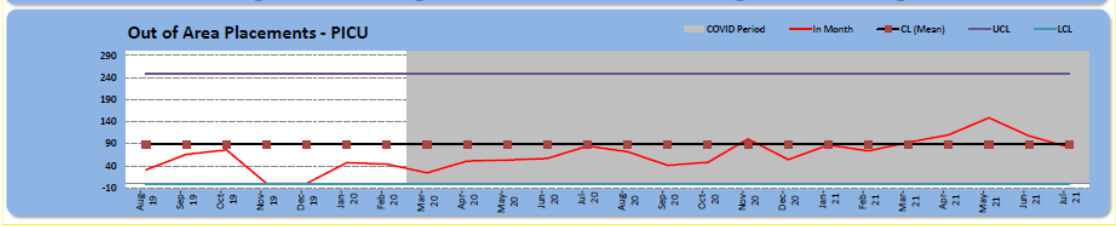
The actions to achieve this will continue including a) daily review of DToC patients, b) daily meetings with the bed management team, c) utilisation of step down beds, d) review of bed capacity requirements over and above those available.

In order to support our winter planning and the impact that continued covid safe working requirements/cohort beds has affected bed capacity, the planning this year is focussing on the reviewing of infection prevention on the bed reduction and the opening of additional older adult beds where our greatest reliance has been on out of area placements. Demand for beds has continued to be high and this has resulted in a continued rise in the use of out of area placements as the chart below demonstrates.





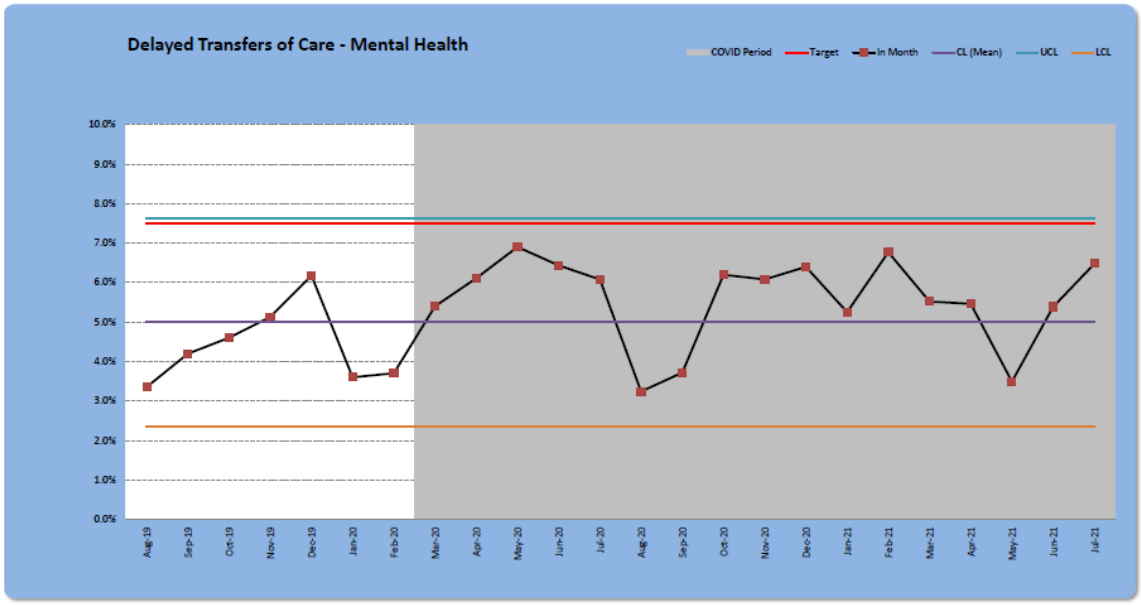




This increase is due primarily to a rise in demand for functional older people's mental health beds. Analysis of our acute bed flow continues to demonstrate that this is not due to delays in discharges or deterioration of length of stay but a rise in acuity of need which has been evident throughout the pandemic. The service have monitored the needs closely and developed a series of plans to reduce the reliance on Out of Area Placements. These included the development of a business case to increase the older peoples bed provision by a further 5 beds, which has been approved through the capital programme group and the beds will begin to open from October. The review of the infection prevention measures to reopen a range of beds closed to support social distancing, has enabled a further 2 adult beds to reopen on Millview Court.

The Divisional have also introduced an older peoples acute community service which will serve as a new alternative to hospital admission.

Work undertaken with our local authority partners has continued to ensure timely discharge is maintained (see chart below), this remains an area of focus with the local authority this winter to ensure access to care homes to aid timely discharge is maintained. This will be supported with the introduction of weekend RC capacity to facilitate weekend discharges. It is acknowledged that there are increased pressures in local authorities to provide community packages, but there is a fragility to this provider market.



The mental health response service and mental health acute hospital liaison service are key in addressing the demand for acute mental health care. Due to the ongoing increase in demand and presenting complexity for adult and older peoples mental health services and the challenging issue of achieving a consistent timely response to the crisis and single point of access telephone number, the Trust implemented a service change to further enhance and refine the service already in place in order to address this increased demand and to improve both the service user and referrer experience.

The Mental Health and Crisis Line for Humber Teaching NHS Foundation Trust changed and is now called the Mental Health Advice and Support Line. The new line is available 24 hours a day, 7 days a week and is free to access for anyone over the age of 16 who lives in Hull and the East Riding of Yorkshire (ERY). The Trust has extended its well-established partnership with Hull and East Yorkshire Mind to achieve this change and implemented a new team who are integrated with our existing Mental Health Response Service who will be answering the calls.

In addition to this change, urgent and crisis referrals from primary care now have dedicated numbers to refer adults and older people (these numbers are not available to the public). These numbers are responded to by our crisis team in order that they get an immediate response. A dedicated number also remains in place for other emergency services i.e. Humberside Police and Yorkshire Ambulance Service.

For all adult and older people's routine referrals, primary care via the Primary Care Network Clinical Directors and the Clinical Commissioning Groups, have agreed to use the new electronic referral system (e-RS). Every Primary Care Network (PCN) have access to direct bookable triage slots via the referral form on e-RS. This allows general practice to have full access and control, to view and book a triage slot on behalf of a patient. In addition to the existing availability of Primary Care Mental Health clinicians, we have introduced bookable advice, guidance and discussion slots across all PCNs. These slots are available via e-RS and are open to professionals only to have a direct discussion with a mental health professional including a consultant psychiatrist.

Changes were made during the first phase of Covid-19 to stream mental health patients away from the hospital emergency department to Miranda House and this will continue. This arrangement will be sustained through winter and we are evaluating options with Hull University Teaching Hospital (HUTH) to secure additional accommodation to ensure that there is sufficient capacity to achieve the access and performance targets required by this service. The mental health response service will remain focussed on timely response to crisis and urgent care need and providing effective alternative support to hospital admission through home based treatment where this is safe and appropriate.

Community Mental Health Teams (CMHT) and Improving Access to Psychological Therapies (IAPT)

Maintaining timely access to community mental health teams is required to reduce increased demand on the mental health acute care pathway. We have now achieved the full role out of the new primary mental health care service to all PCNs which supports the capacity in Community Mental Health Teams to support those with moderate to severe illness and needs.

The service have consistently maintained good waiting times over the past 12 months by introducing a digital offer and this will be maintained over the winter period. The service will continue to promote the pathway to increase the number of patients entering for treatment.

Children and Adolescent Mental Health Service (CAMHS) and Learning Disability Services.

Planning for the forthcoming winter includes the following:

Preventing admissions into Tier 4 CAMHS with funding from the HCV ICS

The service continues to work hard to reduce the need for an in-patient admission providing intensive intervention to the young person, supporting parents and other agencies involved including social care, education and acute hospital settings.

The service has developed a small home treatment offer over the past 7 months with winter pressure money. Additional non-recurrent money is to be invested to enhance this home treatment service across Hull and East Riding of Yorkshire. This work has helped shape what a comprehensive service offer needs to look like to support local young people, working closely with the Core CAMHS services to ensure smooth transitions for young people and working closely with partner agencies to ensure services compliment the overall offer for a young person and family.

The inpatient unit, Inspire, opened a 4 bedded PICU (Psychiatric Intensive Care Unit), to supplement the existing general adolescent inpatient provision. Only 2 of these beds are currently open, with the remaining 2 planned to be opened by December 2021. Responsibility for commissioning inpatient CAMHS will transfer from NHS England to the Humber Coast and Vale mental provider collaborative in October 2021.

A safe space to prevent inappropriate admissions has been developed, this new service which will open in quarter 3 of this year to provide a place of safety and sanctuary for Children and Young People (CYP) experiencing acute emotional distress/crisis. The service is proposed to be a partnership with an independent third sector provider and the Trust. It will provide a safe and welcoming environment where one to one support can be delivered out of hours by appropriately skilled and trained staff experienced in managing emotional distress and mental health crisis in children and young people. The service will be co-located with the CAMHS Crisis team and the newly established Home Intensive Treatment Team. This is to offer a cohesive and aligned service with other community mental health services.

Additionally, the service will offer in reach into HUTH to support CYP admitted with physical health needs and who are requiring detention under MHA or mental health support during admission.

Plans are currently being progressed to explore the viability of developing a short stay unit.

Avoid an increase in waiting lists across Children's and Learning Disability (LD) services

CAMHS is continuing to see higher numbers of urgent referrals with noticeably greater acuity and complexity, and a high proportion of these have significant safeguarding and/or social issues which cannot be resolved without support from social care services. Bi-weekly systems calls are in operation to provide a forum for the discussion of cases which need escalation between health and social care agencies.

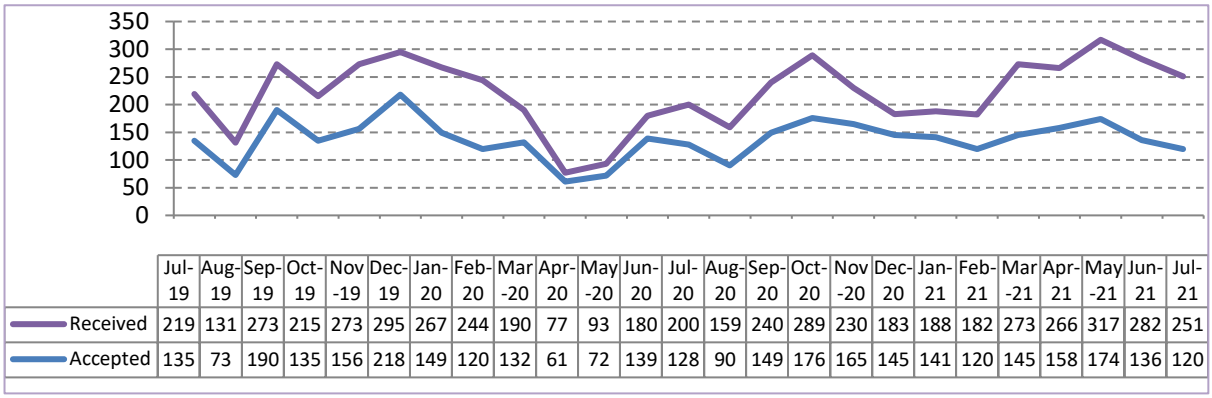
Caseloads in core CAMHS are regularly reviewed with the potential that some cases will need to be placed on hold for more urgent cases to be seen if deemed clinically appropriate to do so and some cases may need escalation for a more urgent response.

A programme of transformation has commenced which will change the current diagnostic pathway of assessment of neuro diverse conditions such as autistic spectrum condition (ASC), attention deficit hyperactivity disorder (ADHD) and learning disability into a needs-led service model which includes increased support for CYP and families. A new specification will include:

- A single point of access
- Increased support for children and their families from the point of access
- A named lead worker care co-ordination role (Key worker).

The new multi-disciplinary team model aims to ensure all referrals are triaged and directed to appropriate professionals who undertake a needs-led assessment of the CYP. This will reduce the lengthy waits for different types of assessment and the need to be re directed to different pathways.

The table below demonstrates the levels of referrals being received.



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Received	219	131	273	215	273	295	267	244	190	77	93	180	200	159	240	289	230	183	188	182	273	266	317	282	251
Accepted	135	73	190	135	156	218	149	120	132	61	72	139	128	90	149	176	165	145	141	120	145	158	174	136	120

Work will continue with multi agency partners to support children presenting with emotional health issues. Contact Point, neuro waiting lists, 0-19 services awareness of Eating Disorders. The division will continue with its digital approach if unable to see people in venues although not necessarily digital first, each case will be risk stratified.
Robust duty systems will be maintained for 0-19 SPOC, neuro duty line and CAMHS duty to ensure the service is responsive.

Managing Demands in Children's and LD services

The Division will continue with internal communication forums which provide support to Service Managers and Team Leaders on managing demands as well as attendance at cross organisational forums to monitor service pressures and understand the demands of the services effecting CYP and LD.

Additionally, CYP will continue to support home working and online service offers when weather adverse to travel.

Implement an effective real time view of system pressure

The General Manager has worked with EPRR to refresh OPEL guidance for CYP/LD teams and to have clearer trigger points for escalation. The opel reporting will be maintained to ensure a daily temperature check of service pressures and delivery.

<u>Community Beds and Community (Physical Service) services</u>

Admission/conveyance avoidance

The Division have identified and will introduce a range of services to prevent acute admission. These include:

- Embed Hospital Discharge Service (HDS) – 7 days per week
- Access to 7-day senior support / triage
- Introduction 7-day therapy (Pocklington/Whitby)
- Review utilisation of diversionary pathways – strengthen pathways and rapid access
- The introduction of the UTC at Whitby which is already affecting the flow of patients into the acute provider Emergency Department

Optimise patient flow & discharge

In order to maintain patient flow and to support timely discharge a number of initiatives have been implemented including a daily review of Delayed Transfers of Care patients; the introduction of admission and discharges taking place on the community wards 7 days a week. To support this, discharge guidance has been implemented to ensure a consistent approach is in place.

The Hospital Discharge Service has been introduced 7 days a week to aid patient step down into community beds and, whilst an inpatient, all patients will receive therapy 7 days a week to aid early discharge. To further support timely and effective patient discharge, the inpatient wards with adopt the 5 elements of the SAFER patient flow bundle to aid reduced length of stay, this will be implemented with the Red and Green days approach, which evaluates whether the patient's planned day is adding value to the patients care. To support this efficient discharge, the implementation of the Trusted assessor or D2A model will be put in place to avoid duplication of assessments and improve the patient experience.

Support to Care Homes

There is increased support into nursing homes with the alignment of named District Nursing and Therapist into the care home and the implementation of an MDT/virtual ward round with primary care.

The use of pharmacists will be extended into care homes to ensure the effective administration of medicines and their management.

The offer of additional training to care home staff will continue to maximise the level of care the home is able to provide to residents and patients in order to support ongoing demand.

The Division will also implement the Nourish to Flourish initiative to provide support for patients with eating disorders which is an area of growing demand.

Managing Demand

A review of the Malton ward covid safe environment has taken place to increase the bed base back to 18 to enable greater numbers of patients to be discharged to community beds, this is subject to staffing initiatives coming to fruition to support the agreed bed base.

The implementation of complex caseload managers across Scarborough & Ryedale will be supported by total triage, e consultations where appropriate, direct booking into primary care for MSK service and all staff training in Validation of Death (VOD) to further support primary care and GP out of hours.

Primary Care

The pressures across Primary Care remain high and to ensure the services remain responsive to these pressure, the clinical leadership is being strengthened to drive forward changes and support the efforts to recruit GPs into vacant posts.

The team are focussing on utilising workforce better across practices by creating a Centre of Excellence within the Practices which will support satellite Practices with training and governance.

The Division are currently working with GPs to increase the face to face appointment offers to patients when requested, whilst also reviewing the digital offer to include video consultations to compliment the current telephone appointment offers in place.

4. Vaccinations

Protecting our work force and our patients from the impact of seasonal flu and Covid 19 has been a priority for the Trust over recent years. The vaccination programme of 2020/21 saw the highest uptake of flu and the programme will be repeated this year, where it is expected that the uptake will surpass last years levels as the peer vaccinator model becomes embedded and our data recording much improved. Planning for the flu roll out commenced in Quarter 1 in readiness for the vaccination anticipated arrival in September 2021.

The staff uptake of the Covid 19 vaccination neared 90% in the first half of this year. The Trust will embark on a Booster campaign expected to commence in October 2021 to further protect the workforce. The model of delivery will be via the Humber Vaccination Centre and Peer vaccinators. The Trust will roll out weekly LAMP testing, in replacement of lateral flow testing which takes place twice a week. The LAMP test is a non-invasive test which provides an accurate weekly result which has a level of accuracy of the PCR test. This was piloted in the East Riding CMHT and will be rolled out across the Trust from late September.

5. Workforce

Critical to both our Covid-19 planning and our winter plan is the availability of our staff to achieve safe staffing levels. Our ongoing plan to recruit to our hard to fill posts is actively being supported by our “Humbelievable” campaign. Work has also been undertaken to address the demand for flexible/bank staff as part of the winter preparedness process. The Divisions are working closely with the flexible workforce team to enhance bank staffing levels in areas of demand. Consideration is being given to enhancing the recruitment team to further enhance the timeframe for the recruitment and onboarding of new personnel.

The health and wellbeing offer to our staff has been significantly enhanced, however, they continue to report that they are fatigued. The risk of staff absence during winter due to Covid-19, seasonal flu and other sickness related absence remains extremely high and this is reflected in our risk register and mitigated by enhancing bank staffing levels where possible. The Trust has maintained agile/remote working where possible to support both staff wellbeing by reducing infection risk.

6. Adverse Weather

Adverse weather has been considered as part of our winter planning. Our Severe Weather and Winter Plan remains in place and will be reviewed by the end of October 2021 considering lessons learnt from the Covid-19 emergency. Significant benefit has been achieved by equipping our staff and services to work remotely and this will enhance considerably our ability to mitigate the risk adverse weather poses to travel.

7. Conclusion

Winter 2021/22 is predicted to be very challenging; all system partners will be expected to maximise opportunities to support the NHS recovery programme whilst ensuring the continued reliable application of the recommendations in the UK Infection Prevention and Control guidance to prevent and control COVID-19 infection. Whilst vaccination has proven its effectiveness at reducing deaths, there are still high levels of covid within the community with the removal of public restrictions. There is an expectation that flu will be circulated at higher levels than the previous year and that respiratory virus will be high. Our Winter Plan has considered these points when being produced.

The position that we face continues to be challenging, managing winter pressures in the context of an ongoing pandemic is going to be extremely challenging for our staff, our patients and their families. Our planning for the Winter of 20/21 proved effective, and we have continuously reviewed and identified lessons learnt from this and taken those forward into this year’s winter planning preparation processes. We will maintain our daily sitrep in order to identify and respond to pressures quickly and as effectively as we can.