NHS
Humber Teaching
NHS Foundation Trust

Trust Board Meeting 26 October 2022
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 26 October 2022, via Microsoft Teams

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence	CF	To note	verbal
2.	Declarations of Interest	CF	For information/to note	√
3.	Minutes of the Meeting held on 28 September 2022	CF	To approve	√
4.	Action Log and Matters Arising	CF	To receive & discuss	√
5.	Staff Story – Clinical Leadership in Primary Care	LP	For information/to note	√
6.	Chair's Report	CF	For information/to note	verbal
7.	Chief Executives Report	MM	For information/to note	√
8.	Publications and Highlights Report	MM	For information/to note	√
	Performance & Finance			
9.	Performance Report	PBec	For information/to note	√
10.	Finance Report	PBec	For information/to note	√
11.	NHS England Operating Framework	PBec	For information/to note	√
	Quality			
12.	Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services- Humber Teaching NHSFT response to Panorama Expose on Edenfield Secure Services	HG	For information/to note	√
13.	Infection Prevention and Control Annual Report 2021/22 – Debbie Davis, Lead Nurse Infection Prevention Control attending	HG	To ratify	√
	Strategy			

	No items this meeting			
	Corporate			
14.	Trust Behavioural Standards Refresh	SMcG	For information/to note	√
15.	Emergency Preparedness Resilience and Response (EPRR) Assurance Process 2022-23	LP	To approve	√
16.	Workforce Disability Equality Scheme (WDES) Annual Report 2022	SMcG	For information/to note	√
17.	Workforce Race Equality Scheme (WRES) Annual Report 2022	SMcG	For information/to note	√
18.	Council of Governors Public Meeting Minutes 14 July 2022	CF	For information/to note	√
19.	Humber, North Yorkshire, York Integrated Care Board (ICB) Update	MM	For information/to note	√
	Assurance Committee Reports			
20.	Finance & Investment Committee Assurance Report	FP	To receive & discuss	√
21.	Collaborative Committee Assurance Report	SMcKE	For information/to note	√
22.	Workforce & Organisational Development Committee Assurance Reports & 13 July 2022 Minutes	DR	For information/to note	√
23.	Quality Committee Assurance Report & 3 August 2022 Minutes	PE	For information/to note	√
24.	Items for Escalation	All	To note	verbal
25.	**Any Other Business**			
26.	**Exclusion of Members of the Public from the Part II Meeting**			
27.	**Date, Time and Venue of Next Meeting** Wednesday 30 November 2022, 9.30am by Microsoft Teams			

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Agenda Item 2

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Declarations of Interest
Author/s:	Caroline Flint Chair
Recommendation:	

To approve		To receive & discuss	
For information/To note	✓	To ratify	

Purpose of Paper:
Please make any decisions required of Board clear in this section:

The report provides the Board with a list of current Executive Directors and Non-Executive Directors interests.

- The declarations for Dr Kwame Fofie have been added
- Declarations for Dr Dasari Michael have been removed

Declarations for Mike Smith have been amended to remove

- Non-Executive Director for The Rotherham NHS Foundation Trust
- Chair of Charitable Funds Committee at The Rotherham NHS Foundation Trust

The declaration for Peter Beckwith has been updated to remove :

- Sister is a Social Worker for East Riding of Yorkshire Council

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:
- No issues to note

Key Actions Commissioned/Work Underway:
- N/A

Positive Assurances to Provide:
- Updated declarations

Decisions Made:
- N/A

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

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

Caring, Learning
& Growing Together

presented to:				Organisational Development Committee	
	Finance & Investment Committee			Executive Management Team	
	Mental Health Legislation Committee			Operational Delivery Group	
	Charitable Funds Committee			Collaborative Committee	
				Other (please detail) Monthly Board report	✓

Monitoring and assurance framework summary:

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

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

Directors' Declaration of Interests

Name	Declaration of Interest
Executive / Directors	
Ms Michele Moran Chief Executive (Voting Member)	• Appointed as a Trustee for the RSPCA Leeds and Wakefield branch • Chair of Yorkshire & Humber Clinical Research Network • SRO Mental Health/Learning Disabilities Collaborative Programme. • HCV CEO lead for Provider Collaboratives • IMAS partner • Humber and North Yorkshire ICB Board Member
Mr Peter Beckwith, Director of Finance (Voting Member)	• Son is a Student at Hull York Medical School
Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care Professionals (Voting Member)	No interests declared
Dr Kwame Opoku-Fofie, Medical Director (Voting member)	• Director of Bluewaters Healthcare Limited, (not actively trading) • Spouse Mrs Marian Opoku-Fofie is the Deputy Chief Pharmacist of Humber Teaching NHS Foundation Trust
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	No interests declared
Mr Steve McGowan, Director of Workforce and Organisational Development (Non-Voting member)	No interests declared
Non Executive Directors	
Rt Hon Caroline Flint – Chair (Voting Member)	• Husband is a member of Doncaster MBC Councillor and Cabinet member • Brother-in-law works at Sandwell and West Midlands NHS Trust as the Senior Consultant for Ophthalmology at the Birmingham and Midland Eye Centre in City Hospital. He is also Professor of Ophthalmology at Aston University and Hon Consultant at Birmingham Children's Hospital. • Chair of the Committee on Fuel Poverty which is an advisory non-departmental public body sponsored by the Department for Business, Energy and Industrial Strategy • Member of UK Commission on Covid Commemoration (21.7.22 – 31.3.23)
Mr Mike Smith, Non-Executive Director (Voting Member)	• Director Magna Trust • Director, Magna Enterprises Ltd • Associate Hospital Manager RDaSH • Associate Hospital Manager John Munroe Group, Leek • Trustee - The Rotherham Minster Development Trust
Mr Francis Patton, Non-Executive Director (Voting Member)	• Non-Executive Chair, The Cask Marque Trust • Treasurer, All Party Parliamentary Beer Group • Industry Advisor The BII (British Institute of

	Innkeeping) • Managing Director, Patton Consultancy • Non Executive Director of SIBA and Chair of SIBA Commercial, The Society of Independent Brewers • Appointed to Baxi Partnership Limited as a Trustee • Appointed as a Trustee to the Spirit Pension Trust
Mr Dean Royles, Non-Executive Director (Voting Member)	• Director Dean Royles Ltd • President Health People Managers Association (HPMA) • Owner Dean Royles Ltd • Advisory Board of Sheffield Business School • Associate for KPMG
Mr Hanif Malik, Associate Non-Executive Director (Non-Voting Member)	• Non-Executive Director, Karbon Homes
Mr Stuart McKinnon-Evans, Non-Executive Director (Voting Member)	• Wife is employed by Carers' Resource, which may supply services to the NHS in West and North Yorkshire.
Dr Phillip Earnshaw, Non-Executive Director (Voting Member)	• Director of Conexus GP Federation • Vice Chair of Wakefield District Housing • FMC Health Solutions Ltd – Director and Shareholder • Health Care First Partnership – Senior Partner • Phillip Earnshaw Ltd – Director & Majority Shareholder • Trustee of Prince of Wales Hospice

Humber Teaching NHS Foundation Trust

Item 3

Trust Board Meeting
Minutes of the Public Trust Board Meeting held on Wednesday 28 September 2022 via Microsoft Teams

Present:

Rt Hon Caroline Flint, Chair
Mrs Michele Moran, Chief Executive
Dr Phillip Earnshaw, Non-Executive Director
Mr Hanif Malik OBE, Associate Non-Executive Director
Mr Stuart McKinnon-Evans, Non-Executive Director
Mr Francis Patton, Non-Executive Director
Mr Dean Royles, Non-Executive Director
Mr Mike Smith, Non-Executive Director
Professionals
Mr Peter Beckwith, Director of Finance
Mr Steve McGowan, Director of Workforce and Organisational Development
Dr Dasari Michael, Interim Medical Director
Mrs Lynn Parkinson, Chief Operating Officer

In Attendance:

Mrs Tracy Flanagan, Deputy Director of Nursing
Ms Donna Groke, International Nurse Recruitment & Education Lead and Mr Thomas Tinashe-Tom, Practice Nurse (for item 165/22)
Mrs Mandy Dawley, Assistant Director of Patient and Carer Experience and Engagement and Mrs Lorna Barrett Patient and Carer Experience Manager (for item 173/22)
Oliver Sims, Corporate Risk & Compliance Manager (for items 178/22 & 179/22)
Ms Kiza Ishemo, Workforce Equality, Diversity and Inclusion Lead (for item 180/22)
Dr Mo Quadri Guardian of Safeworking (for item 181/22)
Rosie O'Connell Head of Safeguarding (for item 182/22)
Mrs Jenny Jones, Trust Secretary (minutes)

Apologies:

Mrs Hilary Gledhill, Director of Nursing, Allied Health and Social Care
Mrs Michelle Hughes, Head of Corporate Affairs

Board papers are 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.

162/22	**Declarations of Interest** The declarations were noted. Any further changes to declarations should be notified to the Trust Secretary. The Chair requested that if any items on the agenda presented anyone with a potential conflict of interest, they declare their interest and remove

	themselves from the meeting for that item. The Chief Executive and the Director of Finance have a standing declaration of interest in items relation to the Collaborative Committee.
163/22	**Minutes of the Meeting held 27 July 2022** The minutes of the meeting held on 27 July were agreed as a correct record
164/22	**Matters Arising and Actions Log** The action log and work plan were noted.
165/22	**Staff Story – Overseas Nurses** The Chair welcomed Donna Groke and Thomas Tinashe-Tom to the Board meeting to share their experiences. Thomas was one of the Trust's first international nurse recruits who came to the Trust from Namibia in September 2021. Donna supports the recruitment of international nurses working collaboratively with the divisions to establish a process for successful, sustainable international nurse recruitment, in line with the national landscape Thomas told Board members about his experiences working in the organisation and sharing his reflections of the Humber recruitment and re-settlement process. Thomas was selected by the NHS International Recruitment Team to share his story in London which also involved a photoshoot. Since coming to the Trust he has been able to use his working knowledge and experience from Namibia to become a Practice Nurse at the King Street Medical Centre. He was grateful for the opportunity to work in the UK and that he had a team to work with. It was difficult coming to a new country, however the Trust assisted with accommodation and for him to get the right qualifications for working here. Board members asked Thomas questions about his general experience and if he had any suggestions on how improvements could be made based on his previous experience. Thomas' responses were in relation to evidence of qualifications and how GP appointments were arranged with a focus on urgent appointments slots. The enthusiasm and ambition of Thomas was welcomed by the Board. It was recognised that by tailoring his skills and knowledge to a particular role had been beneficial to the organisation and Thomas. The Deputy Director of Nursing, Mrs Flanagan explained that with the diverseness of the Trust there are a range of opportunities to offer to international recruits. The importance of pastoral care support was recognised and Thomas feeling that he had a family in his work colleagues was great to hear. The Chief Executive commented that Continuous Professional Development (CPD) is important and encouraged Thomas to continue to be ambitious in his career path. The Chair asked if there are any national issues with regards to international recruiting that the Board should be aware of. Mrs Flanagan said that NHS England has done work around visas and the use of agencies for recruiting and having a process in place to ensure that this was not creating anxieties or delays for recruiting. As recruitment comes from different areas different considerations have come from each area. Mr McGowan reported that the recruitment process has become better in recent years with the help of NHS England. There is an ethical caveat about where nurses are taken

	from so as not to create issues elsewhere. The Trust works with partners to ensure this is taken into account when recruiting. Thomas and Donna were thanked for attending the meeting.
166/22	**Chair's Report** The Chair provided a verbal update on activity she has been involved with since the last meeting that included: - • A visit to Newbridges inpatient unit where it was a chance to meet staff and patients • The long service awards took place at Whitby Hospital where the Chair and Chief Executive were delighted to present certificates to members of staff • A Governor Development Day was held recently. The Chair thanked Board members who supported the event which included a focus on how the Trust audits itself and the Collaborative Committee. A question and answer session on the issues around waiting times for children and young people for autism and ADHD was also held. • A series of events are taking place for National Inclusion Week which is this week. These are accessible by clicking on links. The Chief Executive and the Chair have been involved creating a video and blog for sharing. Mr Smith recently attended a visit to Maister Court with the Deputy Director of Nursing. He suggested that when visits have been undertaken by Non-Executive Directors that these are highlighted as part of the chair's update. The Chair confirmed that she would be happy to include these in her updates. A report was also presented on proposed changes to Committee membership for Non-Executive Directors which has been discussed with the Chief Executive and the Non-Executive Directors. The new membership will be effective from October subject to any conflicts of dates with new members to Committees. The changes will be fully in place by January 2023. Mr Smith referred to the Mental Health Legislation Committee and asked for the number of Non-Executive Directors to be reviewed. This will be discussed outside the meeting **Resolved:** The update and the proposed changes to the Committee membership were noted.
167/22	**Chief Executive's Report** The report provided updates from each of the Directors along with a summary of activities undertaken by the Chief Executive. Of particular note were: - • In person and virtual visits continue to be held. • The Chief Executive has been asked to present at the HSJ integrated Care Summit and NHS Providers over the next few weeks. • An update on winter pressures and Covid was included in the report. • The Director of Nursing update included the new framework for safety responses and highlighting a number of significant changes to the reporting of serious incident in the future. This outcome of the work will go to the Quality Committee with the final detail coming to the Board. • Governors are involved in the Patient Led Assessments of the Care Environment

inspections with the work concluding around November.

- The Annual Members Meeting is taking place on 6 October
- The Communications update provided detail on the Whitby Hospital opening event on 3 October.
- Whitby Bricks are still available to purchase, details were included in the Health Stars update.

In relation to the Operational and Covid update, Mrs Parkinson reported an upturn in Covid infection rates. Currently there are nine positive patients in inpatient beds and staff positive numbers are also rising. A further rise in infection rates is expected at the end of October/early November. The situation is being monitored to minimise any impact on services.

An update was included in the report on the Humber Youth Action Group work on the Child and Adolescent Mental Health Services (CAMHS) transition and passport which has been co-produced with the group.

Mr Patton asked about the uptake for the Shiny Minds app. This information was not available at the meeting and Mr McGowan will provide a post meeting note with the detail.

In response to a question around the increase in pension contributions due to the recent pay award, Mr Beckwith explained that staff affected have been written to make them aware of the impact and have been offered an advance of pay to mitigate the impact in September, which is repayable over the remainder of the year. Responses received are in mostly positive.

CAMHS demand for referrals has plateaued however there is an increase in acuity and complexity of the groups that are being seen. The introduction of home based treatment service into CAMHS, the crisis service and the imminent opening of Children Safe Space should help to manage the complexity and avoid hospital admission where appropriate. The demand and complexity is a direct consequential impact of Covid. There is still a lot of work that needs to be done and it is being prioritised in the system. The provider market in this area is difficult and there is more work to do with other colleagues to improve this element of care to support children and young people before they reach a crisis position.

Mr Smith asked if CPD funding was given to the individual and whether it was successfully spent. Mrs Flanagan reported that there are a number of caveats around the Health Education England (HEE) funding and returns have to be provided on an individual level. Creative use of the funding has been made to give opportunity for it to be used collaboratively. Mel Barnard in the team works with HEE to ensure that the appropriate evidence is provided and demonstrates that best use of the funding is being made. Mr Smith was pleased that it was a positive position as in his experience some organisations find it difficult.

Dr Earnshaw queried if the approach for having separate Senior Responsible Owners (SRO) for Flu and Covid programmes was appropriate. Dr Michael provided assurance that there is close working between the SROs to ensure they are appropriately covered. Dr Earnshaw also commented that it was difficult to see on the website any recruitment of GP jobs and that information was not easily found and suggested the use of visuals or it being in a more prominent position. The Chief Executive explained that this was a valid point and there are separate sections under the Humberleivable campaign. The

	Chief Executive will ask the Clinical Lead for primary care and the Communications Team to review and the HR team will look at the recruitment section. The Safeguarding Children Policy was ratified by the Board ratification and approval given for the proposed change to the Sub Committee Terms of Reference in line with internal audit recommendations. **Resolved:** The report and updates were noted. Mr McGowan will provide a post meeting note on the uptake for the Shiny Minds app **Action SMcG**
168/22	**Publications and Highlights Report** The report provided an update on recent publications and policy with updates provided by the Lead Executives. **Resolved:** The report was noted.
169/22	**Performance Report** Mr Beckwith presented the report relating to the current levels of performance as at the end of August 2022. Areas brought to the Board's attention included:- • An appendix to the report provided an update on waiting times. A more detailed report is due with the October report. • Safer Staffing Dashboard - The thresholds for CHPPDs have been revised upwards based on the latest model health system data and this accounts for the increased number of units flagging at red. Mrs Flanagan commented that it was important to note that the organisation has been higher than the national and regional average. The Trust has some diverse services which was not necessarily reflected in the original thresholds. Work is underway to refresh the dashboard and some training with NHSE is planned around the optimisation tool. Mr Smith appreciated the update and he felt that the Board needed at some stage to see this in writing and for the benefit of the public. • After reducing to zero for a short period in the summer, the number of out of area placements is beginning to increase as a direct result of the increasing number of patients whose discharge is delayed due to available social care packages or specialised hospital placements. • Statutory and mandatory training overall remains above the Trust target of 85%, currently at 91%. Mr McKinnon-Evans asked how delayed transfers of care issues linked into risk assessments as he was not able to see this in the risk register. Mrs Parkinson explained that the increase in delayed transfers of care is affecting performance in service areas. She assured him that the risks have been drafted and should be coming through in the future. The risk is not only to patient flow but also patient quality of care. A composite Trustwide risk has also been scoped and drafted and is in development as we go into winter. A zero position was reached for out of area placements in July, but delayed transfers of care have a direct impact on the use of out of area beds. At the

	moment there are 21 patients delayed across Adult and Older People beds. There are also delays in children and secure mental health beds and the overall position is rising. Also contributing to this for Older People services is the service users with complex dementia requiring identified nursing care home support and access to these is being affected by the market. This is at a system level and an escalation mechanism is in place with weekly meetings held. Adult mental health delays are due to complex needs where community accommodation is required for specialised and bespoke placements. Out of the 99 operational beds the Trust has, 21 is a high number that is taken up with delayed transfers of care. Mr McKinnon-Evans appreciated the update. The Chair felt it was helpful to have this detail for other HNY ICS meetings. Mr Patton asked how the system is helping with delayed transfers of care as it is due to the lack of social care packages and out of area placements. Mrs Parkinson reported that the issue has been escalated and there are regular meetings with senior leaders, but an outcome is awaited. The lack of availability of community-based packages and workforce challenges is causing problems and the Trust is doing all it can in support of this for example, the Learning Disability Services are providing significant intensive input to support other partners staff to ensure service users are in a stable position. The focus over the coming months is to manage demand and flow which is a big task. Dr Earnshaw stated that a key tool to manage mild/moderate mental illness is Talking Therapies and only half of the patients have been seen in six weeks. He asked if there is an improvement trajectory plan for this area. Mrs Parkinson confirmed this is an area of focus and a recovery plan is in place. It is expected that this will come to fruition in the next 2-3 months. The Trust works with sub contractor providers and arrangements in place to monitor activity. As with the organisation some of the contractors have staffing issues. There are vacancies in the service and plans on how recruitment will be progressed. **Resolved:** The report and verbal updates were noted
170/22	**Finance Report** The finance report as at the end of June 2022 was presented to the Board. The following areas were highlighted: The Trust recorded an overall financial position consistent with the Trust's planning target. Agency costs continue to rise and a recovery plan has been developed aimed at reducing the level of agency costs and of recruiting to permanent medical consultancy posts. A further discussion will take place at the October Board Time Out The cash balance at the end of Month 5 was £29.862m of which £3.734m relates to the Provider Collaborative. The Better Payment Practice Code figures show achievement of 90.6% for Non NHS invoices and 93.2% for NHS invoices, work continues to maintain/improve the position **Resolved:** The Board noted the Finance report for August 2022
171/22	**Use of Force Act – Update Report** From 31 March 2022, new statutory obligations aimed at preventing inappropriate use of force applied to organisations providing inpatient mental health units, including NHS Trusts and independent sector organisations that provide NHS-funded care. The Act (known as 'Seni's law) placed new duties on hospitals in relation to the use of

	force (e.g. record keeping, training and investigations) and requires police officers visiting mental health units to wear body cameras. A different level of data is required and the first iteration of this will be in the next report to the Mental Health Legislation Committee. Progress is being made with these important areas of work and ensuring that staff are aware of the new requirements. **Resolved:** The report was noted.
172/22	**Suicide and Self Harm Strategic Plan 2022-2025** The Suicide and Self-harm strategic plan 2022-2025 represented a refreshed and updated approach by the Trust utilising the latest available evidence. The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) toolkit has been adopted which is based on a 10 way approach to safer care. The plan outlined how the 5 strategic priorities have been developed and aligned to the Trust strategic goals. It also provided a position in relation to the work already completed and being delivered in relation to suicide and self harm prevention. A short presentation was shared with the Board and highlighted the key areas of the plan. Mr McKinnon-Evans referred to lower staff turnover and asked whether there is a proposed number identified. He was informed that there is no specific target set but it would be within the regional and national target. Initiatives around nursing turnover are being looked at as part of the implementation of the priority. This would likely be a reduction by 5%. The Chair asked for more detail to be provided to the Board outside the meeting. Mr Malik expected to see reference to stakeholders and external agencies given the organisation works with partners. He asked if this was a gap in the strategy. Mrs Flanagan said there is focus at a system level and multi-agency level to reduce suicide and self harm. The Trust works alongside partners including the Crisis Care Concordat. The strategy looks at a specific way to the organisation as an individual provider. To reduce the overall suicide rates required work as a system and the Trust's strategy will be knitted in at a system level. The Chair agreed with Mr Malik's point and felt there should be some mention. The strategy should stand on its own as well as being part of the system and the emphasis on family and friends is important to the strategy. Mr Malik said work with drug and substance misuse partners and additional agencies has been critical in some cases. Mr Royles suggested that 8,4 and 8.4.2 overlapped with the second part of year 1 and there was an opportunity to accelerate this with the ICB. In terms of turnover, deep dives of leavers are undertaken at the Workforce & Organisational Development Committee, and he suggested that this is an area of work the Committee could look at. The Chair supported this idea which will be taken away and an update reported back to the Board. Mr McGowan felt that turnover was nurse focussed and the plan and strategy is across all posts in the organisation. It was clear that some actions in the patient strategy etc read across and there is more that could be done with this priority. He suggested expanding this priority to impact across the organisation and pick up with the work that is done at the Committee on targets. This is the Trust's strategy and Dr Michael affirmed that as a provider it would dovetail

	into the wider ICS strategy. The individual providers strategies will compliment each other. There will be a model for others to use and the ICS has there will be mandatory suicide prevention training for all staff across the board. What the organisation set out to do has been achieved. The Chair acknowledged the comments which were well made and need to be taken away including reference to what we do and how we engage with other sectors for example, ICS, voluntary service groups and other services. Any work with the police should also be reflected in the strategy. As a general point, the Chair recognised the differing font sizes in the document and also the way that coloured boxes have been used making it difficult for the reader to see. Some other points will be shared with the authors. Summarising the discussions, the Chair recognised the huge amount of work that has gone into the Strategy. The was delighted to see the foreword from Anthony Houfe who is also a Service User and Carer Governor and appreciated his input into the strategy. **Resolved:** The Trust Board noted the Suicide and Self harm strategic plan More detail on the nursing turnover initiative to be provided to Board members **Action TF** The Workforce & Organisational Development Committee to look at turnover and provide an update to the Board **Action SMcG**
173/22	**Patient & Carer Experience Annual Report 21/22** The Patient and Carer Experience Annual Report) including Complaints and Feedback (2021/22) was presented. A short film that has been produced with highlights from the report was played at the meeting which Board members felt was easy to understand, with animations and was a fair and balanced representation. Mrs Dawley highlighted primary care as an area of focus. A number of comments are received from members of the public in relation to access to GP services, including getting an appointment in the way they want and when they want. Mrs Dawley attended QPAS to share some of the findings of complaints, compliments and friends and family information. Away from the appointment's issues, comments were that staff were kind, friendly and caring. Primary care is the only area that does not have an Engagement Lead and information is collated by the PACE team. Outcomes are shared on the website and there is a "You said, we did" section on practice noticeboards. Patient Participation Groups (PPGs) have been successful in some practices but not in others. These are now set up in every practice the Trust has and there is a framework to follow so all of the groups have the same approach across the organisation. Mr McKinnon-Evans asked if there are any groups that are not being heard from that would be expected to have a voice. He was informed that primary care has had the biggest voice over the last couple of years. Groups have been set up across all Divisions and people do have the opportunity to voice their opinions. There is an Engagement Lead to drive the aspects of the Patient & Carer Experience agenda and an opportunity for people to come and have a voice across mental health, secure services, children and young people and primary care. Mr Malik suggested that with the cost of living and NHS pressures that some impact may be seen going forward for complaints. He suggested forward planning a trajectory

	to ensure there are adequate resources in place in to respond in this area. Mrs Dawley thanked him for the suggestion which will be considered. She assured the Board that although it is a small team it is perfectly formed and team members have vast experience. It is difficult to predict what complaints may come in the future. Recently the Mental Health Division has produced an animated film for staff to watch to help them respond to any complaints informally and this will be rolled out to other services. When Covid hit system changes and processes were changed to triage complaints and any that could be escalated to the team to contact the patient within 24/48 hours which can often pacify a complainant. Dr Michael thanked Mrs Dawley and her team for producing the report and for being innovative with information and presentation of it. The Complaints/PALS team should be congratulated on their work and all they have done to keep people updated. Mrs Parkinson endorsed the work done around the GP survey results. The work is led by the Clinical Lead and overseen by Operations and the action plan reports into the Operational Delivery Group (ODG) and the Executive Management Team (EMT). The Chief Executive thanked the team for their work and for their work in primary care. It was recognised that there has been significant improvement in performance over the last few years under Mrs Dawley's leadership. The Chief Executive felt it would have been helpful if the report and data had been via EMT to ensure that there is regular monitoring of the primary care information in particular. She suggested that EMT discuss the complaints information as there has been a slight increase since last year. The report has been to the Quality Committee to look at the operational aspects. The Chair referred to the data on page 7 of the report that showed the improvements made, the number of people turning up to appointments, people being able to contact the practice 24/7 and Did Not Attends (DNAs) that are published on the website. She wondered whether as well as the number of DNAs whether the number of cancelled appointments or changed time appointments by the practices would be worthwhile including. EMT will consider this going forward. **Resolved:** The report was noted. Complaint's data to be discussed at EMT **Action DM**
174/22	**Winter Planning** The report provided a summary of the winter planning process undertaken, the key issues that are likely to impact on our operational response and the plans developed to mitigate the service pressures and risks anticipated for the Winter 2022/23. Details of the range of work in place and underway to address the impact of winter 2022/3 on the operational delivery of services was also included. Mrs Parkinson reported that the pressures since Covid have not abated over the year. It is important that a robust operational plan is in place for the winter. The plan is predicated on the ICB and what the organisation may need to respond to. Infection prevention control remains key not just in relation to Covid, but for flu and other infections associated with winter. Any risks such as industrial action, cost of living pressures, surge and escalation and adverse weather has been included. The plan has been discussed at the Executive Management Team and operational mechanisms are in place and regularly monitored.

	Mr Patton referred to the Emergency Planning, Risk and Resilience update asked how the desktop exercised went. He was informed this was around secure services and evacuation planning. It went well and any learning from the exercise will be progressed. Following a question from Mr Patton, Mrs Parkinson reported that the crisis line response times are closely managed in conjunction with Mind colleagues. The Board was informed that the support vehicle with the Ambulance service was predicated on pilot work which was already in place. All have mental health specialist on board the ambulance. However, given the pressures on the Ambulance service there is the potential for the vehicle to be diverted and used for category one cases. The situation is being monitored and the Chief Executive said that good results are being seen. The business continuity plans are being linked into the wider system to give a more joined up approach across the system. The system business continuity plans will come to the Board for mental health and community services **Resolved:** The report was noted The system business continuity plans will come to the Board for Mental Health and Community services **Action MM**
175/22	**Covid-19 Booster Vaccination Programme 2022** The report provided an update on plans for the 2022 Autumn Covid-19 Booster Programme for Staff The plan is to deliver the Covid-19 vaccination autumn boosters in according with the NHSE standards and requirements. The plan has operational capacity to deliver Covid booster vaccines, in addition to co-administration of the Flu vaccine to all Humber Teaching NHS Foundation Trust staff. The Team is largely made up of members who delivered the successful first two Covid vaccinations and first booster dose programme **Resolved:** The Board noted the report
176/22	**Cost of Living and Support Report** The Chief Executive presented the report which identified a number of national and international factors that have affected the cost of living and it is well recognised that many people and families are finding it difficult to afford day to day necessities which is placing a lot of pressure on households. As a local employer the Trust has worked with staff colleagues and patients to provide support where possible and to keep the range of support, we offer under review to ensure we are doing all we can to support people during this particularly difficult financial time. In addition, working with our partners in the system, we continue to review the impact and support available. Regular discussions take place at the Executive Management Team as to any other support that can be offered. Mrs Parkinson is the chair of the Staff Health and Wellbeing Group and is aware of issues raised. It was suggested that this report is taken to a development session when there is more time for in depth discussion

	Resolved: The Board noted the report The report to be discussed at a future Board Time Out **Action MM**
177/22	**Formal Board Meetings, Strategic Discussions and Board Development Sessions** The Trust commissioned an external governance review in 2021 to comply with NHSI guidance 'developmental reviews of leadership and governance using the well-led framework' and the final report was received earlier this year, in April. The report provided external validation on work to progress governance within the organisation and it was noted that the organisation had been transformed since it's 2017 assessment. Building from a position of strength, at the July Board time out session it was agreed further consideration would be given to the frequency of formal Board meetings alongside the need for strategic board discussions and board development. It is proposed that six formal Board meetings be held next year and six strategic Board sessions. Anything urgent for the Board that falls out with the Board meeting will be dealt with at the strategic Board session. A review will take place after six months to ensure that the process is working adequately. The dates for Board meetings will remain the same and Sub Committee chairs will ensure that reports feed into an appropriate Board meeting. **Resolved:** The Board approved the proposals outlined in the report to commence in January 2023.
178/22	**Board Assurance Framework** The report provided the Trust Board with the Q2 2022/23 version of the Board Assurance Framework (BAF). Following approval of the refreshed Trust Strategy in July, the Board Assurance Framework document has been updated to reflect the newly approved strategic goals and their underlying strategic objectives. The existing risks referenced in the Board Assurance Framework document for the previous quarter have been reviewed and aligned to the new strategic objectives where applicable and this work has been considered and agreed by the Executive Management Team. Mr Patton highlighted that strategic goal 5 says "maximising" and should be "optimising". This will be rectified. Mr McKinnon-Evans reiterated his previous comment about delayed transfers of care and that consideration may be needed as to how it could affect this document. **Resolved**: The Board noted the report.
179/22	**Risk Register** 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 2022 was presented by Mr Sims. Work is underway to risk assess the objectives in the refreshed trust strategy. Once assessed the risks will be included on the respective risk register with any risks scoring 15 or higher included on the trust wide register. There are currently **6** risks held on the Trust-wide Risk Register. The current risks held on the Trust-wide risk register and an

	update on each of the risks was provided in the report. An error was contained in the report that there are three risks with a score of 15 and three with a 16 score. The Chair thanked Mr Sims for the update and thought the detail on the front sheet was helpful. Mr Patton commented that the actions taken for some risks did not address the gaps in control. His comment will be taken back to the relevant risk lead and an update provided in the next report. **Resolved:** The risk register was noted.
180/22	**Annual Equality, Diversity & Inclusion Report 2022- 2023** The Trust has a duty to create a comprehensive annual report on equality, diversity and inclusion in line with the Equality Act 2010 and the Public Sector Equality Duty (Equality Act 2010 s.49). This report is drafted collaboratively and details progress against workforce and PACE equality objectives. The EDI Annual report has been discussed at both the Workforce & OD Committee (July) and Quality Committee (August)s, as well as being consulted upon with the EDI Working group and networks. It informed the Board of the work taking place across the Trust to support the EDI agenda and to provide insight into the progress against EDI objectives in line with the various national EDI reports. Ms Kiza Ishemo is the new Workforce Equality, Diversity and Inclusion Lead and joined the meeting for this item. She explained that her focus is on building the staff networks and for National Inclusion week which is this week. She sees this work being successful if there is collaboration and for the staff networks to provide the forums to contribute to the way forward. They are in a good position, but more work is needed to gain traction and momentum. Awareness is a good vehicle to start conversations and to weave together the organisation to have inclusion at the forefront of everyone's mind. Mr Malik commented that it is good to see the metrics and milestones, but that the real change has to be in the culture. He asked as a Board member if there is anything else that can be done to move this forward. Kiza appreciated the support that she has received and felt that if the Board continued to promote the culture change that would be helpful. The report has been to the Quality Committee and Workforce & Organisational Development Committee, and it covered both the aspirations of staff represented and service delivery. Work is underway on a Respect report that the Chief Executive will bring to a future Board meeting. Mr McGowan thanked Kiza for the work she has done and for making an impact since she came to the organisation. **Resolved:** The report was approved
181/22	**Guardian of Safeworking Annual Report** Dr Mo Qadri attended to present the report which showed any rota gaps and vacancies and issues relating to the safe working of junior doctors. A number of positive changes were referred to in the report including:-

	• Maintained lowered numbers of exceptions being raised by trainees for past three years • No SIs pertaining to trainees • Proactive and collaborative medical education department • Good rest facilities available for trainees on call • Effective communication links established with freedom to speak up guardian and recovery tutor Weekly training sessions are held with on call scenarios around specific topics to provide more information and alleviate anxiety of the junior doctors. It also helps with any call outs as junior doctors have the training to deal with these issues Dr Qadri commented on the delay in the rota being issued for junior doctors. Mr Royles confirmed that the Workforce & Organisational Development Committee received regular updates on the work that is done and the approach that is taken. Positive discussions are held at the LNC meeting to resolve issues which are being highlighted at an early stage to prevent them escalating **Resolved:** The report was noted
182/22	**Safeguarding Annual Report** the Safeguarding Annual Report 2021/22 which presents the annual work of the Trust Safeguarding Team, including changes to team structure, key achievements, performance across the Trust and priorities for 2022/23. The report was approved by the Quality Committee at its meeting in August and has also been through the Executive Management Team. Areas highlighted from the report included:- • Increasing demand on Safeguarding Team this (duty desk, increasing numbers being referred to multi-agency meetings such as MACE (Multi Agency Child Exploitation) and Prevent, commissioning of new services) • Impact of Covid-19 on child and adult mental health can lead to increased risk of harm or abuse. • Safeguarding Training compliance for Level 3 remains under 85% however following a review we have seen these rates increase month by month • An increase in demand is being seen and the team has been attending safeguarding meetings which could contribute to the increased requests for support. • Modern Slavery element – as a consequence of the Ukraine/Russian war the team has been more involved with Local Authority partners providing information and support. • White Ribbon Accreditation – the Trust moved into its second year of White Ribbon accreditation status, and with that significant progress made with the safeguarding team's domestic abuse workstream. • Focus on child neglect – with the cost of living crisis a rise in this area is anticipated. Mr Royles noted that the training compliance was above target. This is an area discussed at the Workforce & Organisational Development Committee and was pleased to see the update. He referred to the increased number of referrals coming through for safeguarding and the cost of living impact and wondered whether the Chair/Chief Executive should write to MPs as a responsible partner, to highlight this and to give an

	opportunity for something to be done at source. The Chair and Chief Executive will discuss this suggestion. Mr McGowan highlighted that the increased training figures are going in the right direction which is positive. In regard to domestic abuse, he suggested contacting Gary Jennison to link into the staff Health & Wellbeing Group so that staff are aware of support available. The Chief Executive noted the increase in demand and conveyed her thanks to the team for the work they are doing and the difference they are making **Resolved:** The Board ratified the annual report
183/22	**A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance** This report summarised activity relating to appraisal and revalidation processes for 2021/22. The Annual Organisation Audit (AOA) data is also attached for information. It has also been approved by the Executive Management Team. Mr McGowan suggested that the Workforce & Organisational Development Committee see the report in the future for information. **Resolved:** The report was noted and the Chief Executive will sign the statement of compliance.
184/22	**Humber and North Yorkshire Integrated Care System – Mental Health and Learning Disabilities Collaborative Programme Update** An update was presented on the work of the H&NY collaborative programme which is overseen by the H&NY ICB Board and the H&NY Mental Health, Learning Disabilities and Autism Strategic Executive Leadership Group. Workplans are delivered and monitored regularly by the MH LDA Operational Leadership Group. **Resolved:** The update was noted.
185/22	**Charitable Funds Committee Assurance Reports from 2 August & 6 September 2022*** These reports were presented to the Board as Corporate Trustee and related to the meetings held in August and September 2022. The minutes from the 15 March and 2 August 2022 were provided for information. Constructive discussions were held with Fund Zone Managers around the use of funds raised. A working list of potential fund campaigns is being produced. **Resolved:** The reports were noted.
186/22	**Health Stars Key Performance Indicators (KPIs) 2022/23*** The Charitable Fund Committee discusses and agrees KPIs for Smile Health Stars on an annual basis as part of the contract for managing the Trust's Charitable Funds. The Board requested a review of the KPIs be undertaken. The Committee felt that the time to do this was linked into the confidential discussions that are being progressed. A recommendation is made that the KPIs remain as they are and be reviewed early in the New Year. Any comments already received on KPIS will be fed into the review.

	Resolved: The Board ratified the recommendation that the existing KPIs continue to be used for 2022/23, pending the options appraisal work.
187/22	**Quality Committee Assurance Report & 4 May 2022 Minutes** The report provided a summary of discussions held at the meeting on 3 August 2022 with a summary of key issues for the Board to note. The approved minutes of the meeting held on 4 May 2022 were presented for information. Discussions included the number of policies and procedures that have been through the Committee and the Quality Improvement work undertaken to look at these across the Divisions. . **Resolved:** The report was noted
188/22	**Mental Health Legislation Committee Assurance Report** The report provided assurance to the Board with regard to the agenda issues covered in the Committee meeting held on 4 August 2022. Mr Smith reported that the Task and Finish Group looking at the diversity of Associate Hospital Managers has met once, and a further meeting is planned in October. **Resolved:** The assurance report was noted
189/22	**Audit Committee Assurance Report** The report following the meeting held on 8 August was presented to the Board. A deep dive into the Children's & Primary Care risk register was on the agenda and there is good evidence that risk management is embedded in the operations. Some national level work about the financial health of the NHS has been requested which may need some amendment to the audit plan. **Resolved:** The report was noted
190/22	**Collaborative Committee Assurance Report** An executive summary of discussions held at the meeting on Friday 5 August 2022 was presented. Mr McKinnon-Evans reported that a decision has been taken to meet less frequently to give more streamlined reporting and to avoid duplication. A key issue discussed was delayed transfers of care. Each of the workstreams continues to mature and learning from the Shoen Clinic are being taken forward **Resolved:** The Board noted the report.
191/22	**Items for Escalation** No items were raised.
192/22	**Any Other Business** **Retirement** Michelle Hughes, Head of Corporate Affairs retires from the Trust in October. The Board thanked her for her help, support and advice over the years and her work on the External Well Led Review which she led.

	The Board wished her a Happy Retirement.
193/22	**Exclusion of Members of the Public from the Part II Meeting** It was resolved that members of the public would be excluded from the second part of the meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.
194/22	**Date and Time of Next Meeting** Wednesday 26 October 2022, 9.30am via Microsoft Teams

Signed …… Date …….
Chair

Humber Teaching NHS Foundation Trust

Agenda Item 4

Action Log:
Actions Arising from Public Trust Board Meetings

Summary of actions from September 2022 Board meeting and update report on earlier actions due for delivery in October 2022 *Rows greyed out indicate action closed and update provided here*						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
28.9.22	167/22	Chief Executive's Report	Mr McGowan will provide a post meeting note on the uptake for the Shiny Minds app	Director of Workforce & Organisational Development	October 2022	Post meeting note sent out 20.10.22
28.9.22	172/22(a)	Suicide and Self Harm Strategic Plan 2022-2025	More detail on the nursing turnover initiative to be provided to Board members	Deputy Director of Nursing	October 2022	E mailed to Board members 14.10.22
28.9.22	172/22(b)	Suicide and Self Harm Strategic Plan 2022-2025	The Workforce & Organisational Development Committee to look at turnover and provide an update to the Board	Director of Workforce & Organisational Development	October 2022	Contained within the Workforce and OD Committee assurance report.
28.9.22	173/22	Patient & Carer Experience Annual Report 21/22 (incl Complaints and	Complaint's data to be discussed at EMT	Medical Director	November 2022	Item not yet due

		PALs)				
28.9.22	174/22	Winter Planning	The system business continuity plans will come to the Board for Mental Health and Community services	Chief Executive	November 2022	Item not yet due
28.9.22	176/22	Cost of Living and Support Report	The report to be discussed at a future Board Time Out	Chief Executive	December 2022	Item not yet due
Outstanding Actions Arising from Previous Board meetings for feedback to a later Board meeting						
Date of Board	**Minute No**	**Agenda Item**	**Action**	**Lead**	**Timescale**	**Update Report**
27.4.22	81/22	Freedom to Speak Up (FTSU) Annual Report 2021/22	The next report will break down the data by ethnic group and gender	FTSU Guardian	April 2023 (Date changed to align with next annual report)	Item not yet due
22.6.22	122/22	Summary Briefing – Independent report – Leadership for a Collaborative and Inclusive Future	Further discussion to take place at a future Board Time Out	Director of Workforce & Organisational Development	October 2022	On agenda for 11 October Board Time Out
22.6.22	129/22	Equality Delivery System (EDS2) 2022	Consideration of leads for the work to come to the Board and provide more detail on the process	Director of Workforce & Organisational Development/Medical Director	TBC	**Update 15/9/22.** To be picked up when the ED&I Annual Report is presented in September. The lead for the workforce side of this

						work has left the Trust. An appointment has been made and the discussion at Board is being arranged.
27.7.22	150/22	External Review of Governance Action Plan Update	A review of embeddedness will be undertaken in quarter 3 (Oct-Dec) and reported to Board.	Chief Executive	January 2023	Not yet yet due

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

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Board Public Workplan 2022/2023 – *(no August or December meeting) (v2r)*

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

Board Dates:- / Reports:	Strategic Headings	LEAD	27 Apr 2022	18 May 2022	22 June 2022	27 Jul 2022	28 Sep 2022	26 Oct 2022	30 Nov 2022	25 Jan 2023	29 Mar 2023
Standing Items - monthly											
Minutes of the Last Meeting	Corporate	CF	x	x	x	x	x	x	x	x	x
Actions Log	Corporate	CF	x	x	x	x	x	x	x	x	x
Chair's Report	Corporate	CF	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
Publications and Highlights Report	Corporate	MM	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
Finance Report	Perf & Del	PBec	x	x	x	x	x	x	x	x	x
Head of Corporate Affairs' Report	Corporate	SJ							X	X	x
Quarterly Items											
Finance & Investment Committee Assurance Report	Committees	FP	x			x		x		x	
Charitable Funds Committee Assurance Report	Committees	SMcKE			x		x			x	x
Workforce & Organisational Development Committee	Committees	DR	x			x		x		x	
Quality Committee Assurance Report	Committees	MS		x			x		x		x
Mental Health Legislation Committee Assurance Report	Committees	MS		x			x		x		x
Audit Committee Assurance Report	Committees	SMcKE		x			x		x		x
Collaborative Committee Report moved to bi-monthly	Committees	SMcKE	x	x	x	x		x		x	x
Board Assurance Framework	Corporate	MM			X		x		x		x
Risk Register	Corporate	HG			X		x		x		x
HCV Update	Corporate	MM		x			x		x		x
6 Monthly items											
Trust Strategy Refresh/Update due to July Board	Strategy	MM			X to July	x					x
Freedom to Speak Up Report	Quality & ClinGov	MM	X A/R					x			
MAPPA Strategic Management Board Report inc in CE report	Strategy	LP					x				x
Safer Staffing 6 Monthly Report	Quality & ClinGov	HG				x				x	
Research & Development Report	Quality & ClinGov	KF				x				x	
Annual Agenda Items											
Review of Strategic Suicide Prevention Strategy	Strategy	KF/HG	X def			X					

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Board Dates:- Reports:	Strategic Headings	LEAD	27 Apr 2022	18 May 2022	22 June 2022	27 Jul 2022	28 Sep 2022	26 Oct 2022	30 Nov 2022	25 Jan 2023	29 Mar 2023
Recovery Strategy Update	Strategy	LP	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	KF			x						
Presentation of Annual Community Survey – Quality Health	Quality &ClinGov	KF								x	
Guardian of Safeworking Annual Report	Quality &ClinGov	KF					x				
Patient & Carer Experience (incl Complaints and PALs) Annual Report	Quality &ClinGov	KF					x				
Quality Accounts	Reg.Comp	HG			x						
Risk Management Strategy Update	Strategy	HG	x								
Infection Control Strategy – not due until March 23 moved from Sept 22	Strategy	HG									x
Infection Prevention Control Annual Report moved to Oct to go through Quality Committee	Quality &ClinGov	HG					X def	x			
Safeguarding Annual Report	Quality &ClinGov	HG					X				
Annual EPRR Assurance Report	Quality &ClinGov	LP	x								
EPRR Core Standards moved to Oct	Corporate	LP						X			
Patient Led Assessment of the Care Environment (PLACE) Update –	Quality &ClinGov	LP					x				
Health Stars Strategy Annual Review	Strategy	SMcG		x							
Health Stars Operations Plan Update (moved to May from April)	Perf & Delivery	SMcG		x							
Annual Operating Plan	Strategy	MM									x
Report on the use of the Trust Seal	Corporate	MM	x								
Review of Standing Orders, Scheme of Delegation and Standing Financial Instructions	Corporate	SJ		x							
Annual Non Clinical Safety Report - moved to July for review by FIC	Corporate	PBec			X moved to July	x					
Annual Declarations Report	Corporate	SJ		x							
Charitable Funds Annual Accounts	Corporate	PBec						X moved to Dec		x	
Equality Delivery Scheme Self Assessment moved to June from May	Corporate	SMcG			x						
Gender Pay Gap	Corporate	SMcG				x					
WDES Report — reports into Workforce & Organisational Development Committee , but separate report to the Board moved from July to October to meet Committee requirements	Reg. Compl	SMcG						x			
WRES Report reports into Workforce Committee with report to Board moved from July to October to meet Committee requirements	Corporate	SMcG						x			

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

Humber Teaching NHS Foundation Trust

Agenda Item 5

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Staff Story – Clinical Leadership in Primary Care
Author/s:	Dr Iqbal Hussain, Clinical Lead for Primary Care & Community Services, GP Lead for the Community & Primary Care Division & GP Research Lead for Primary Care
Recommendation:	

To approve		To receive & discuss	
For information/To note	x	To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	Clinical leadership is key to the successful development and transformation of services. The Trust has continued to focus on developing and expanding senior and other clinical leadership roles in all divisions. Dr Iqbal Hussain will share his story of developing from a general practitioner to the GP lead for Primary Care and more latterly the Clinical Lead for the Primary Care and Community Division (a job share with Kerry Brown). Importantly he also provides a key role as the GP research lead for Primary Care. Dr Hussain will share his experience of clinical leadership in Primary Care, he will focus on some key developments and changes taking place, including the recently announced plans for primary care in Bridlington and will reflect on some of the current clinical challenges and opportunities for the future.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • Our primary care services are experiencing challenges in recruitment (in line with the national position). Dr Hussain will consider current and future opportunities to address this.	**Key Actions Commissioned/Work Underway:** • Further work is underway to consider new roles and skill mix in primary care to address some of the current workforce challenges.
Positive Assurances to Provide: • The Trust participates in a range of mechanisms at place and system level to address the current and future development of primary care. • A project approach led by East Riding Place has been established to progress and	**Decisions Made:** • NA.

oversee the proposed changes to primary care in Bridlington., the Trust is represented at senior level.	

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

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

Monitoring and assurance framework summary:

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

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

Agenda Item 7

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Chief Executive's Report
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	

To approve		To receive & discuss	
For information/To note	x	To ratify	

Purpose of Paper:	To provide the Board with an update on local, regional and national issues.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: Nothing this month	**Key Actions Commissioned/Work Underway:** • As per the detail in the relevant sections
Positive Assurances to Provide: Depth and scope of work. Link to Trust strategy and risk register where relevant	**Decisions Made:** None 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		Operational Delivery Group	

	Committee			
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail) Monthly report to Board	✓

Monitoring and assurance framework summary:

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

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

Chief Executive's Report

1 Items for Approval

There are no items that require approval.

1.1 Trust Policies

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

2 Around the Trust

2.1 Recruitment Work

We have been approached by the Healthcare Financial Management Association (HFMA) to speak on our recruitment work due to our HSJ shortlist.

2.2 Flu Update

Flu vaccinations have commenced in earnest, more detail is contained withing this report alongside our Covid vaccination update.

2.3 Events

It has been another busy month with visits and celebrations for staff, Whitby, Inclusion week and Black History Month, alongside during the month holding our Annual Members Meeting.

It was also an honour to support our first Allied Health Professionals Day and presenting at the National Stammering event at Hull Minister.

2.4 "My Stammering Child" Film

Following the success of the award nominated film 'My Stammering Tap', Humber Teaching NHS Foundation Trust Speech and Language Therapists, in partnership with Action for Stammering Children and My Pockets Films, are proud to be premiering their latest film 'My Stammering Child'.

The new film focuses on the concerns of parents with stammering children and puts their unique role in supporting those young people in the spotlight. The goal when creating this film was to help others going through what can be an anxious and challenging time.

Created together with people with lived experience of stammering, this unique project aims to raise awareness of stammering and gives a voice to just some of the people that have been on this journey before and want to share their thoughts to help others.

The film is set to be premiered at an event on Friday 21 October, at Hull Minster.

2.5 International Recruitment Work

Dr Kwame Opoku-Fofie, and Dr Michael Dasari are travelling to India on Saturday 19th November 2022 in order to progress our international recruitment work with Keeler in India. A full report will be presented to the Board via the Workforce & Organisational Development Committee.

2.5 Freedom to Speak Up Update

There has been new guidance recently released by the National Guardians office which the Board have recently reviewed. Our FTSU Strategy and policy is currently being reviewed. We will be holding a series of focus meetings with staff to develop our speaking up strategy. The completed self assessment, policy refresh and strategy will be shared with the Workforce Committee.

We have recently participated in the National Guardians Office (NGO) annual initiative during October – speak up month. During this time we have held virtual pop in sessions for staff to find out more about speaking up and also shared regular communications on the importance of speaking up.

We were delighted to welcome Karen Beal, our new Freedom to Speak Up Ambassador for our mental health services and we will continue to seek more ambassadors across our other services.

The Chair and Senior Independent Non-Executive Director continue to meet with myself as the Executive Lead for speaking up and the Freedom to Speak Up Guardian on a regular basis to review concerns raised in detail.

3 Around the Integrated Care System (ICS)

3.1 ICS Roles

Phil Mettam has taken up a role, reporting into the ICS CEO, to provide support and oversight to the Humber Acute Services review and associated developments. Phil was previously the Accountable Officer at the Vale of York Clinical Commissioning Group (CCG), and he is an experienced NHS Leader, having previously worked in the East Midlands and South Yorkshire

Simon Bell has taken on the position of the Interim NHS Place Director for York whilst recruitment is underway for a permanent appointment. Simon previously held the role of Chief Financial Officer for Vale of York CCG and has worked in the NHS for more than twenty years across a number of provider and commissioning organisations.

Jack Lewis will take up this role on 1 October 2022 having previously held the position of Inequalities Lead for the North East and Yorkshire COVID-19 vaccination programme. Jack will work with Directors of Public Health and other consultant colleagues across the Partnership to lead on improving the health and wellbeing of the ICS population. This will include developing system wide population health management approaches and focussing on addressing health inequalities.

4 National

4.1 Covid 19 Independent Inquiry

Some key points of the inquiry are below:

- Inquiry to take a modular approach
- Preliminary hearing held (delayed due to Queen's death)
- Module 3 will be the key one for organisations as it will look at the impact of Covid on healthcare systems –hospitals, primary care, impact of backlogs etc

- In addition to modules there will be a 'listening exercise' to gather experiences to understand what the public have to save – so this isn't for organisations
- Interim reports will be issued after each module with one complete report at the end. No timescales as yet. Organisations will be expected to act on learning as interim reports are issued and not wait for final report.
- Core participant status will be for e.g. NHSE, DoH and status will relate to how direct and significant the role was (and not necessarily for individual organisations)
- Frontline staff unlikely to be directly involved in inquiry and
- Highly unlikely all Trusts will be asked for information on everything they hold – an example where an individual Trust is if for example where it was an outlier in some area and so may be asked something.
- Freedom of Information (FOIs) if prepared for inquiry will be public documents – FOI requests need to be considered on an individual basis – Caldicott Guardians should have processes in place.

4.2 Government Health Policy

The latest Government policy has been published by Secretary of State. The new policy for patients puts patients at the centre of the policy making.

The ABCD plan:

- Ambulances supported to operate more effectively more focus on Category one category two incident times.
- Backlogs continue with the elective recovery plan including maximising the use of the independent sector and accelerating the hospital building program.
- Care launching a £500 million adult social care discharge fund and also a national recruitment campaign to encourage more people to join social care will start of winter.
- Doctors and dentists the policy sets out an expectation about who needs an appoint with GP practice within two weeks should get one, urgent cases to be seen within the same day there is also time and access regarding Dentistry services,
- The policy notes about government enabling delivery and incentivising recruiting more people.
- It goes on to note that Providers will ensure they meet their statutory responsibilities for the delivery of safe, effective, efficient, high-quality services, both now and longer term. They will be responsible for their contribution to effective system working and delivery of ICS strategies and plans.
- Providers will also be responsible for meeting the financial and performance requirements set out in NHS planning guidance and complying with their provider licence and Care Quality Commission (CQC) standards. Providers will be expected to reduce unwarranted variation, for example through their participation in provider collaboratives.

The framework does not contain all the answers at this point.

The newly published operation report is presented on the Board Agenda.

4.3 Winter NHSE Plans Update

Highlights include:

- Better support people in the community – reducing pressures on general practice and social care, and reducing admissions to hospital by:

- Putting in place a community-based falls response service in all systems for people who have fallen at home including care homes
- Maximising the use of virtual wards, and actively considering establishing an Acute Respiratory Infection (ARI) hub to support same day assessment
- Providing additional support for care homes through reducing unwarranted variation in ambulance conveyance rates

- Deliver on our ambitions to maximise bed capacity and support ambulance services
- Bed occupancy continues to be at all-time highs, and we need to take all opportunities to make maximum use of physical and virtual ward capacity to increase resilience and reduce delays elsewhere in the system. This includes:

  - Supporting delivery of additional beds including previously moth-balled beds
  - All systems setting up a 24/7 System Control Centre to support system oversight and decision making based on demand and capacity across sites and settings
  - Ensuring all ambulance services deploy 24/7 mental health professionals in emergency operation centres and on-scene

- Ensure timely discharge and support people to leave hospital when clinically appropriate – more than 10,000 people a day are clinically ready to leave hospital but can't be discharged, and this causes significant and fundamental issues for patient flow. In addition to maintaining focus on the high impact actions from the 100 day challenge, the Government recently announced £500m to support social care to speed up discharge across mental and physical health pathways. More details about distribution of this fund will be shared with you when available
- Continuing to support elective activity
- Infection prevention and control (IPC) measures and testing
- Existing UKHSA guidance on the management of COVID-19 patients remains in place, along with the appropriate IPC measures detailed in the IPC Manual. Ahead of winter, providers should self-assess their compliance with this guidance using the IPC board assurance
- Staff Vaccination - It is important that health and social care workers receive both the COVID-19 and flu vaccine
- Oversight and incident management arrangements - NHSE will work with ICBs to ensure that oversight arrangements and associated support are appropriately focused on winter resilience and the delivery of elective recovery, including cancer, as set out above. This includes updating the NHS Oversight Framework metrics to reflect those set out in the Board Assurance Framework.

  The NHS continues to operate at Level 3 Incident Response.

5 Operational & Covid Update – October 2022

This update provides an overview of the operational and covid position across our clinical services and the arrangements and continuing work in place in the Trust and with partner organisations to manage operational pressures and ongoing impact of the Covid-19 emergency.

Operational focus this month has been on working with our system partners to reach a final version of our Winter Plan for 2022/20-23. The plan has been reviewed by the Executive Management Team (EMT) and demonstrates that our approach to planning for the coming winter is robust. The plan recognises that the complexities of planning for a

winter when system pressures have remained very high throughout the year and with the lasting impact of the pandemic still evident, the seasonal pressures make this winter likely to be particularly challenging. Integrated Care Boards are tasked to maximise the benefits of system working. A lack of capacity across the NHS and social care has an impact on all areas of the system and it is essential that access to primary care, community health services, mental health and learning disability services for urgent patients is sufficient to ensure patients do not need to present to emergency services when alternatives are available. In developing the Trusts Winter Plan, the following Integrated Care Board (ICB) objectives were considered and incorporated into our planning:

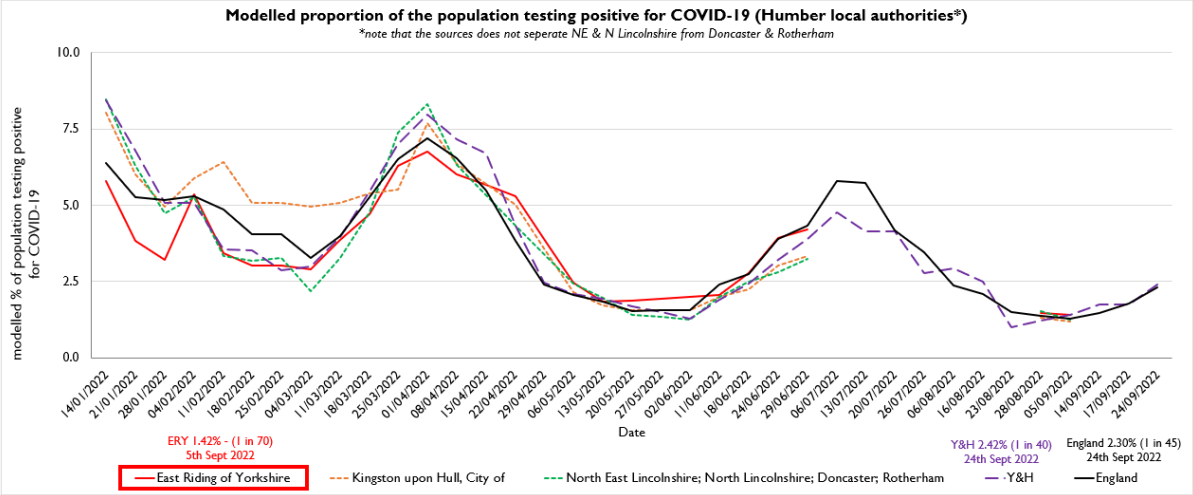
- Prepare for variants of COVID-19 and respiratory challenges, including an integrated COVID-19 and flu vaccination programme.
- Increase capacity outside acute trusts, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
- Increase resilience in NHS 111 and 999 services, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
- Target Category 2 response times and ambulance handover delays, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
- Reduce crowding in A&E departments and target the longest waits in ED, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
- Reduce hospital occupancy, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
- Ensure timely discharge, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100-day challenge’.
- Provide better support for people at home, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

Our Winter Plan is being monitored through our daily sitrep reporting processes to identify and respond to pressures quickly across services, ensuring we are clear what our level of pressures are, allowing us to communicate these to the wider system effectively and either respond with or receive mutual aid as necessary.

NHS England and Improvement raised the national incident alert level from 3 to level 4 on 13th December in recognition of the impact of the Omicron variant on the NHS of both supporting the increase in the vaccination programme and preparing for a potentially significant increase in Covid-19 cases. On 19th May 2022 the national incident level was reclassified to a Level 3 (regional incident) this was due to community and hospital case numbers declining and the success of the winter and spring vaccination programmes.

As of the week ending 24th September, the cases of Covid-19 for Yorkshire and the Humber are:

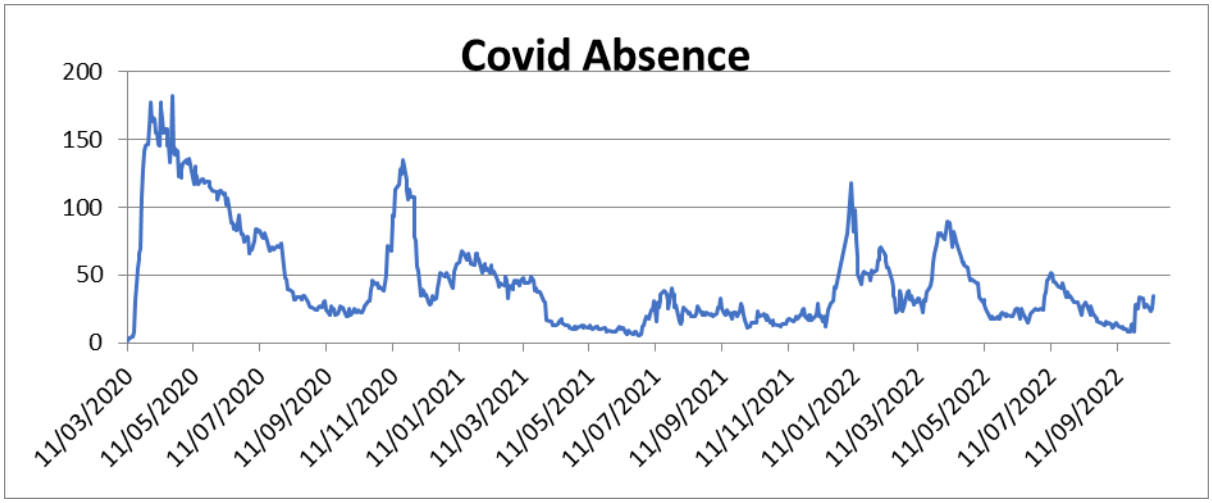
Humber ONS infection survey sub-regional estimate, Yorkshire and Humber: 2022



As of the 8th October the 7-day rate per 100,000 population for Scarborough is 102.8, for Ryedale is 176.3 and Hambleton is 129.0. The overall 7- day rate for North Yorkshire is 127.9

As of 14th October 2022, there have been 2,020 hospital deaths related to COVID-19 across the Humber area. This includes 1,301 deaths registered by HUTH, 689 deaths registered by NLAG, 27 deaths registered by CHCP (East Riding Community Hospital) and 3 deaths registered by HTFT.

The Trust recorded an increase in the number of Covid-19 positive inpatients during late September and early October reaching a daily high of 12 cases in total, this has now reduced to one case currently.
Staff sickness absence related to Covid increased in late September and early October to reach a daily high of 35 cases. When combined with non-covid related sickness the overall absence position is currently at 6.77%.



The Trust's emergency planning command arrangements related to covid were stood down on 31st January 2022. Twice weekly Sitrep reporting remains in place to monitor operational pressures and the ongoing impact of the pandemic on our services. The command arrangements will remain under close monitoring and will be stood up again as necessary. System emergency planning arrangements have remained in place. The

Covid- 19 task group chaired by the Deputy Chief Operating Officer continues to meet to ensure that any changed requirement in relation to Covid are responded to and addressed.

Operational service pressures improved in some areas in the Trust in late September and early October. The highest pressures were seen in our community services in Scarborough and Ryedale due to ongoing high demand from the acute hospitals for discharges and increasing delays in discharging patients from our community beds. The Trusts overall operational pressure in the last month have been at escalation levels (OPEL) 2 (moderate pressure) predominantly.

Child and Adolescent Mental Health (CAMHS) services are continuing to experience high demand for both community and inpatient services in line with the national surge due to the direct impact of the pandemic on children, young people and their families. Demand has continued to plateau during September early October with presenting needs continuing to be of high levels of acuity and complexity. Breakdown of placements for young people in residential care continues to lead to urgent and crisis admissions to mental health and acute hospital beds. High demand for young people experiencing complex eating disorders has led to pressure on CAMHS beds locally and nationally leading to admissions to acute hospital beds. System and ICS work is ongoing to enhance provision to support out of hospital care for children and young people including those with eating disorders. A proposal has been developed and now supported to establish a new eating disorder day treatment service. Focus continues on reducing waiting times in these services, particularly in relation to autism and attention deficit hyperactivity disorder diagnosis.

Nationally requirements are in place to eradicate the use of out of area mental health beds and our services are implementing plans to achieve this. Our out of area bed use has reduced but after recording zero bed days for a short period in July it has risen slightly over the last month due to a further significant increase in the number of delayed transfers of care. Our overall bed occupancy has remained high in September and early October with the pressures especially high for mental health, learning disability beds and our community beds at Malton and Whitby Hospitals, it has been between 79.1– 86.5%.

Delayed transfers of care from our community and mental health beds have unfortunately risen during the last month. Patients are waiting predominantly for specialised hospital placements with other NHS providers or local authority provided residential placements. Escalation mechanisms are in place with partner agencies to take action to resolve the delayed transfers and discharges that our patients are experiencing.

System pressures have remained very high in North Yorkshire and York and in the Humber areas in September and early October for both health and social care, system command arrangements remain in place. Acute hospital partners in all parts of our area have reported pressures at OPEL 4 predominately during the last month. Hull and the East Riding of Yorkshire stood up gold command arrangements for a period due to a further escalation in pressures. Local authorities have also seen their pressures remain very high due to staff availability and the national requirement that all patients who do not meet the criteria to reside in an acute hospital should be discharged. Ambulance services have continued to experience pressures and delays in handover times at acute hospitals resulting in decreased call response times. The combined impact of these pressures has seen system pressures remain at overall OPEL 3. System work has continued to focus on reducing the number of patients in the acute hospitals who do not meet the criteria to

reside in order to improve patient flow, reduce ambulance handover times and to recover elective activity.

Ongoing work has been taking place by our recruitment team to increase the number of staff available to us on our bank, recruitment campaigns focussed on specific clinical areas e.g., CAMHS have had some success. Effort is taking place to reduce the number of health care assistant vacancies to reduce reliance on agency use.

Testing, Infection Prevention and Control Requirements and Isolation Arrangements
The Trust continues to follow the nationally updated infection prevention and control (IPC) guidance which uses a risk-based approach. Monitoring of community prevalence of COVID and seasonal flu and their impact on services will continue to be led by matrons and the infection control team, overseen by the Director of Nursing and the Chief Operating Officer. Increased use of PPE and staff and patient testing for COVID has resumed for our inpatient services in late September and early October due to the rise in infection prevalence and outbreaks in order to maintain patient, staff safety and sustainability of services. The position remains under constant review.

Covid-19 Vaccine
A national Autumn vaccination programme has now commenced and both our staff covid booster and flu campaigns are underway. Our SRO for the flu vaccine remains our Director of Workforce and OD. The SRO for the covid vaccine is our medical director.

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

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, the supplies of PPE remain at good levels.

Staff Health and Wellbeing
We continue to recognise that for all 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 and Wellbeing Group. Feedback from our staff continues to be positive and they value the support that has been provided. 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 and North Yorkshire Resilience Hub to support frontline staff remains operational and providing an increased offer of psychological and emotional wellbeing support for our staff.

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

Focus has been maintained on those groups of staff that are more vulnerable to Covid-19. The guidance requires managers to liaise frequently with staff in any of the increased risk groups to support them and to consider if adaptations are needed to their roles. Support remains in place for our staff who are experiencing long covid.

Clinical Advisory Group

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

- Ensuring that covid related changes and interventions do not increase restrictive practices.
- Maintaining focus on developing further use of digital clinical interventions.

Operational Planning and Winter Planning

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

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

The Trust continues to effectively manage the impact of Covid-19 and winter within its ongoing arrangements. The ICB Mental Health, Learning Disability and Autism collaborative continues to maintain focus on delivering the ambitions within the long-term plan and particularly those areas with increased clinical challenges including CAMHS and Learning Disabilities.

6 Director's Updates

6.1 Chief Operating Officer Update

6.1.1 Community Transformation – "One Community" Model

Historically our community services in Scarborough, Ryedale, Whitby and Pocklington have been commissioned at different times with different commissioners which led to variation in specifications, models and structures. Merger of commissioning arrangements has enabled work to take place incrementally over the last two years to optimise the

clinical and services models. This work has included changes to the operational, clinical and administration structures within Community Services. This transformation work has been undertaken with a high level of engagement with our staff and wider stakeholders with the aim to create a 'One Community' approach delivering quality, efficient, dynamic services to the population of our whole geographical area.

Key changes within the scope of the new model are:

- **Single Point of Contact (SPOC) -** the creation of one single point of contact (SPOC) for all Community Services, operating 7 days per week 8am – 6pm as a minimum, with the inclusion of clinical triage and coordination at the point of referral.
- Development of a **Core Unit** which will support the SPOC comprising of Urgent Crisis Response, Intermediate Care, Community Nursing**,** Physiotherapy, Occupational Therapy**,** Pharmacy and Tissue Viability Services.
- Development of a **Specialist Unit** will include Musculoskeletal service (MSK), Stroke Services, Continence Services**,** Dietetics**,** Speech and Language Therapy, Heart Failure**,** Cardiac Management Rehabilitation**,** Diabetes**,** Respiratory Services inc. Home Oxygen and Pulmonary Rehabilitation.

Key national drivers underpinning these changes have been the need to improve the responsiveness of community services to address pressures and improve patient flow in the acute hospitals. These included the development of an Urgent 2-hour Community Response (UCR) for all adults within their homes or usual place of residence, including care homes operating over 7 days (this has been operational since the end of March 2022) and the Virtual Ward which will be operational in the Scarborough area in December (with future consideration being given by Humber and North Yorkshire ICB to future expansion to other areas).

The community in-patient units in Whitby Hospital and Malton Hospital will continue to play a vital role as part of the pathways with the new service model by supporting step-up referrals and continuing to support step down / discharge to assess referrals from the acute Trust. The transformation programme is being delivered in two phases, phase 1 is nearly completed and phase 2 will continue until the year end, focussing on the specialist services and delivery of the Virtual Ward.

This work is being supported by significant development of the electronic patient record (SystmOne). The Trust is also taking the lead in the development of a technological solution for the roll out of Virtual Wards across the Humber and North Yorkshire Integrated Care System. The virtual ward development in Scarborough is one of three sites chose to pilot the new technology due to our readiness for the new service to “go live”.

6.1.2 Proposed changes to Bridlington Primary Care Practices

A proposal has been made by East Riding Place and recently supported by the Humber and North Yorkshire Integrated Care Board to make changes to Primary Care Practices in Bridlington. The Trust is working in partnership with East Riding and Bridlington Primary Care Network to develop and support the proposal to ensure the ongoing delivery of high quality primary care to the population of Bridlington.

In Bridlington, there are currently five GP practices caring for around 42,000 registered patients who live in and around the local area. These are:

- Field House Surgery which is run by Humber Teaching NHS Foundation Trust (HTFT).
- Humber Primary Care (previously Manor House and Practice 2) which is run by Humber Teaching NHS Foundation Trust (HTFT).
- Practice One which is currently being run by Practice Three acting in a caretaker capacity.
- Practice Three which is run by Drs Nunn, Reddy & Reddy.
- Wolds View which is run by City Health Care Partnership CIC (CHCP)

Most GP practices operate under nationally agreed General Medical Services (GMS) or Personal Medical Services (PMS) arrangements which do not have a contract end date. However, three of the practices in Bridlington are operating under Alternative Provider Medical Services (aPMS) arrangements which are agreed more locally and must be reviewed in accordance with the terms of the individual contract. These aPMS contracts are due to end on 31 March 2023 and will not be renewed. This follows feedback from current providers, experience from previous market engagement and an options appraisal, from which it is considered that a managed change process would create a more sustainable Primary Care service in Bridlington leading to better patient care.

Therefore, as a Health and Care Partnership together with the Bridlington Primary Care Network (PCN), discussions are now underway with all the GP practices in Bridlington to safely manage the successful transfer of patient care from the aPMS contract holders to the GMS or PMS GP practices and to ensure continuity of care for patients.

It is recognised that some patients and staff may naturally be concerned when hearing this news. However, the consensus from clinicians involved is that this is in line with the national direction of travel to create larger practices enabling greater provision of proactive, personalised, coordinated and more integrated health and social care for people, stabilising and securing the future of general practice in Bridlington.

A project approach led by East Riding Place has been established to progress and oversee the proposed changes and the Trust is represented at senior level. It is vital that our patients and staff impacted by this change are fully engaged and plans are in place to do this.

6.2 Director of Nursing, Allied Health and Social Care Professionals

6.2.1 The Oliver McGowan Mandatory Training in Learning Disability & Autism

From 1 July 2022, all registered health and social care providers must ensure that their staff receive training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This should be at a level appropriate to their role. This is to ensure health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. This requirement is set out in the Health and Care Act 2022.

The Oliver McGowan training which ensures staff working in health and social care receive learning disability and autism training at the right level for their role is the nationally mandated training and will be rolled out nationally commencing November 2022. The training is named after Oliver McGowan, whose tragic death in 2016 highlighted the need for better training for health and social care staff when interacting with autistic people and people with a learning disability.

Roll out will be led by the ICS. The training aims to ensure staff have a better understanding of people's needs, resulting in better services and improved health and wellbeing outcomes.

The training is as follows:

Tier 1- designed for those who require a general awareness. It is delivered by a 90-minute eLearning session followed by a 60-minute interactive online session. The session is delivered by experts by experience supported by a facilitator. Tier 1 will be ready for roll out from November 2022.

Tier 2- designed for those who may provide care and support for people with a learning disability and autistic people. It will consist of the 90-minute online session followed by a 1 day face to face session co facilitated by experts by experience and a subject matter expert. Tier 2 training will be available early 2023

The tiers are not expected to deliver training for all of the requirements of a role, and it is expected that additional training will continue to be requires dependent upon the individual's needs. In line with our Autism strategy we have been undertaking work to ensure all of our staff can access training in autism and learning disability commensurate with their role and as a result we already have a range of training available to suit all needs.

Health Education England are required to work with ICBs to mobilise the training to provide the delivery infrastructure across systems. This work has commenced, and we have been asked for provisional numbers of staff that will require training.

6.2.2 Clinical Competency Framework Update

The Clinical Competency Programme Manager is a relatively new role for the Trust with responsibility for leading on the development and rollout of the trusts approved clinical competency framework, developed to outline the essential training and assessment requirements ensuring that nursing and allied health professional (AHP) staff have the required level of knowledge and skill, enabling the delivery of safe and effective care. This is a standardised approach that includes core and role specific clinical competencies.

The core clinical competencies have been rolled out and assessors are in place in almost all of the Trust's clinical teams that include qualified and non-qualified nurses and AHP's. The competency areas include recognising the deteriorating patient, falls assessment, nutrition and hydration, and pressure ulcer prevention and management. This has been well received and staff have given positive feedback about their understanding and learning across these four key areas. The role specific competencies are developed alongside training packages, policy and procedure reviews and to enhance learning within the teams. A system of recording these on ESR has been created which will enable managers to report compliance which now includes medicines optimisation and hand hygiene and use of PPE. The competencies will be available to staff on the intranet.

The aim is to have a library of clinical competencies relevant to all divisions which will increase patient safety, quality and staff development, and encourage staff to be involved in quality improvement. The creation of competencies for development roles is underway which will be key in contributing to the retention of staff providing them with a pathway to

develop their skills and knowledge in relevant clinical skills and investing in their development, ensuring that the national standards are being met.

The role has been key in the development and coordination of work involving quality improvement, practice development and patient safety. The next steps are to address the continuing development of various clinical competencies and improving learning and support to staff, and to develop a work-based induction framework for clinical staff which has been identified. This would create an approved structure for clinical staff to work through during their probationary period, with recommended training and resources, agreed core and role specific competencies, and clinical supervision to support the practitioner and aid staff retention. Joint work with the educational team, preceptorship academy and learning centre will allow the progression of this with the support of the matrons to develop a framework for each area.

6.2.3 International Nurse Recruitment – Update

In 2021 it was agreed by the Trust Hard to Recruit Task and Finish group and EMT to support international nurse recruitment.

In September 2021 we welcomed the first cohort of 7 registered nurses. To date we have recruited 18 nurses and 17 have successfully completed the OSCE exam and are on the NMC register. The table below illustrates where these nurses are placed in the Trust.

Division	Ward/Team	Number of INR in post
Community & Primary Care	Malton	8
	Whitby	3
	Primary Care	1
Adult Mental Heath	In patients	2 (one in OSCE stage)
Forensic services	Humber centre	3
CAMHS and LD	Granville	1

The table below illustrates how many INR have been successfully interviewed and are currently in various stages of the recruitment process and the division where they will work. Allocation of team/ ward is agreed once an arrival date is known.

Division	Number of INR in post
Community & Primary Care	3
Adult Mental Heath	8

NHSE have informed Trusts of further funding being available to support international recruitment in Jan- March 2023. Trusts are required to submit bids. EMT have supported a bid to enable us to secure a further 15 nurses using Trust monies topped up with NHSE monies. We are waiting to hear if our bid has been successful.

6.3 Medical Director Updates

6.3.1 COVID-19 Booster Vaccination Programme

The COVID-19 Booster vaccination programme is currently underway with opportunity for all our staff to get vaccinated to protect themselves, their families and their patients. We are vaccinating with Pfizer Bivalent COVID-19 Booster vaccine at six planned clinics at Trust HQ during October 2022. We have the capacity to vaccinate all our staff, partners

and patients in our long stay wards. The plan has also included the co-administration of the Covid booster vaccine with the Flu vaccine.

6.3.2 Research Conference

Bookings for our Trust annual research conference taking place on 3 Nov now stand at over 400. This is our sixth research conference and every year the audience has grown. It's a great opportunity for us to showcase some of the novel research we are participating in across our services and the exciting opportunities this creates for our staff and wider community. Like last year's conference, this will be a blended event, with some people attending virtually and some in person (subject to infection control guidance as may be appropriate). As well as presentations by research-active clinicians in the Trust, the programme also includes high-profile speakers from across the country, as well as people with lived experience sharing how research has changed their lives. The final programme is available at Humber Teaching NHS Foundation Trust - Annual Research Conference VI Registration, Thu 3 Nov 2022 at 09:00 | Eventbrite and people can still register to attend online. All those registering also get access to a recording of the conference afterwards, meaning even those that can't join on the day, can still hear about all the great research going on in our Trust.

6.3.3 2023 Community Mental Health (CMH) Service User Survey

During 2021 a pilot was conducted to analyse the feasibility of transitioning the CMH service user survey to a mixed-mode methodology (in previous years the methodology was paper only). Service users were offered the option of completing the questionnaire either online or by paper. Text message (SMS) reminders were sent containing a direct link to the online survey. As a result of the pilot, the 2023 CMH service user survey will be implementing a push-to-web mixed-mode methodology.

Changing the way we ask for patient feedback will change the way people respond and will make results from the 2023 survey incomparable to previous years. Therefore, this is providing an opportunity for the Centre to review all aspects of the way the survey is run and the questionnaire will be undergoing significant revision this year. Timeframes are also changing (and are subject to change). At present, key dates are likely to move to :

- Sample period – March to May 2023
- Sampling – July to August 2023
- Fieldwork – August to November 2023 (in previous years fieldwork took place between the months of February to June)

CQC are currently working with Ipsos MORI and all approved contractors to finalise the methodology. Preparations for delivering the survey using this new push-to-web approach have begun.

CQC are currently working with Ipsos MORI and all approved contractors to finalise the methodology. Preparations for delivering the survey using this new push-to-web approach have begun.

6.3.4 International Recruitment Event

We are delighted to be part of an Integrated Care Board (ICB) organised careers festival that will be taking place on 21st November to 25th November 2022 in India.
Dr Fofie and Dr Michael will be attending the fair to represent Humber. It is our hope that this collaboration with our ICB partners will lead to the further recruitment of high calibre Doctors, Nurses and AHPs to the trust and region.

6.4 Director of Workforce & Organisational Development Updates

6.4.1 Staff Side Chair

Staff Side have agreed for Ian Somerville of UNISON to take up the Chair role until elections in March 2023. Ian replaces Sarah Mellor who was successful getting a job in the new ICB.

This move sees UNISON back in Staff Side after their decision to withdraw earlier in the year.

6.4.2 Flu Vaccination Programme

At the time of writing after two weeks (17/10/22) 706 (28.8%) of front line staff have had the vaccine.

Roll out continues through October, November and December.

The Trust were invited by NHSI to speak to a national audience on how we have been successful in increasing and maintaining a high rate of flu vaccinations.

6.4.3 LGBTQ Staff Network

The Rainbow Alliance, the Trust LGBTQ staff network, elected a new chair in September. Lynsey Foston has taken up the role from October.

6.4.4 Respect Campaign

The Trust has contracted with the Centre for Diversity to :-

1. Review our approaches to anti-harassment and violence
2. Scope out, devise and deliver a FREDIE campaign across the Trust.
3. Scope out what a RESPECT campaign will look like in the Trust.

Work will commence in November and a more detailed report will come back to the November meeting.

6.4.5 National Staff Survey

The staff survey was sent out to our staff on Monday 3rd October 2022. As at Friday 14th October (end of week 2) we have had 385 responses which is 12%. We have also had 30 bank staff responses which is 11%. The closing date is 25th November 2022. Ongoing communications will continue to encourage staff to complete their survey.

6.4.6 HOPE (Hospitals of Europe) European exchange programme- applications open until 31st October 2022

The HOPE European Exchange programme is a unique and exciting opportunity to understand the challenges of a healthcare system outside of the UK. The benefits are personal as well as professional, as it leads to seeing the NHS in a whole new light. HOPE stands for Hospitals of EurOPE. The exchange programme offers those with managerial responsibilities across the healthcare system a unique opportunity to exchange time with another EU member state for four weeks, followed by an international meeting for all participants.

The programme has been promoted to staff across the Trust via global comms.

6.5 Director of Finance Update

6.5.1 Cyber Security Updates

There are two types of CareCert notifications,

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

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

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

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

In terms of CareCerts

- CareCERT notices issued during 2022: 174 (Inc. 22 in September)
- High Priority CareCERT notices Issued during 2022: 8 (1 issued in September)

September Statistics

- CareCERT Notices with patch(s) NOT approved for deployment: 0
- CareCERT notices with patch(s) applied to all devices: 15
- CareCERT notices with devices still to check in to patch: 7

Workstations update:

- Total workstations detected 3,380 (2,848 are laptops, 46 are servers)
- Workstations non seen in last 60 days (36)
- Workstations non seen in last 90 days (22)

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

6.5.2 New Trust HQ Project

Works to form the new Trust HQ are now complete, service orientation days currently taking place

6.5.3 Humber Centre – Phase 2 (Reception / Airlock re-configuration; Health Garage refurb)

Contract for the phase 2 works at the Humber Centre has been awarded. This includes works to; improve the reception, form a new staff airlock, improve the back office support area, formation of a new patient ‘Bank’, and refurbishment of the Health Garage.

Works are programmed to commence on 7 November, with a completion at the end of January 2023

6.5.4 Salix Submission

An application was made on 14 October for the latest round of Salix grants, which is in

support of the Trust's Green Plan and associated carbon reduction strategy.
The application covers projects that can be delivered over a three year period, updates will be provided on the outcome of submissions when known.

6.5.5 PLACE

PLACE inspections are continuing across the inpatient estate. These have been modified to recognise access restrictions that have been implemented across the wards.

The deadline for submission of PLACE have been extended until the end of November, in recognition of the challenges nationally.

7 Communications Update

Quarterly Communications Update

HSJ Awards 2022

The judging panel for the Communication's Initiative of the Year award was held earlier this month. The panel noted how impressive the campaign was to have been delivered in house and commended the use of data in the presentation. The awards are held on 17th November.

Health Care Financial Management Association Conference

Rachel Kirby was invited to present the Humbelievable marketing campaign at the annual mental health providers conference.

World Mental Health Day 2022

Westlands' creation with the arts and crafts package

This year our annual World Mental Health Day (10/10/22) campaign has centred upon the importance of taking a moment to reflect and check in with yourself, to understand how you might be feeling and whether you may need additional support. The aim is to raise awareness of self-referral.

We worked with Art Therapists across the Trust to convey the research and evidence behind getting creative for your mental health. We produced graphics and information with a seasonal theme to encourage people to do things that can help them to feel brighter, even when the days are getting darker, which can influence your mood.

To engage with patients, we partnered with Health Stars and local charity Hull Scrapstore, to produce 14 arts and crafts boxes, which were delivered to each of our inpatient wards. These boxes included materials to create autumnal wellbeing crafts. Digital version of the pack were also created for staff and the public.

This project has been well-received on social media with visits to the webpage for mental health advice increasing by 80% compared to the previous week. Full data will be shared in the next report as the campaign is still live.

The project received media coverage across local channels including BBC Radio Humberside.

Theme 1: Promoting people, communities, and social values

- **Brand Activity**

The new brand portal launches this month with new assets for staff to use including new design templates such as PowerPoint templates, Microsoft Teams backgrounds, leaflet and booklet designs, as well as a LinkedIn header for staff to use to increase our brand presence across the platform.

The team has worked on the 'customer journey' of portal, researching the most frequently asked questions and the most requested designs, in order to create a new system so busy staff can find their brand solutions faster. This will help direct enquiries better and encourage use and understanding of the brand portal. The portal can be viewed at https://brand.humber.nhs.uk/

- **Health Stars**

This month we have worked together with Health Stars across a number of campaigns, including:

- Buy a Brick for the Whitby Hospital Appeal
- Whitby Hospital Opening
- Stand Up for Comedy Night at Hull Truck Theatre
- World Mental Health Day Scrapstore Hull Collaboration

- **Social Media Content**

Following the pause in output due to the official mourning period of Her Majesty the Queen, this has been an exceptionally busy period on our social channels.

The Annual Members Meeting achieved over 350 views on the Trust YouTube channel. We used an integrated approach to drive people to the live coverage.

- **Awareness Days**

In the last month, we continue to support a high volume of awareness days and create impactful campaigns in collaboration with our diverse services across the Trust.

Key dates of note this month were:

- World Suicide Prevention Day
- World Patient Safety Day
- World Alzheimer's Day
- World Sepsis Day
- Youth Mental Health Day
- National Inclusion Week
- Domestic Violence Awareness Week
- Speak Up Month
- Black History Month

- Stoptober
- World Mental Healthy Day
- Baby Loss Awareness Week
- AHP Day
- Global Handwashing Day

The days generate content across our social media channels supporting our performance on these channels as well as giving us opportunities for positive media coverage. Interviews were put forward for as Speak Up Month, Domestic Violence Support and Baby Loss Support Awareness Week.

- **Media Coverage**

A total of 13 positive stories were published on our Trust website news page this month. The top three performing stories over the period were:

1. **World Mental Health Day**, published in Hull Is This, BBC Radio Humberside, Greatest Hits Radio Yorkshire Coast and That's TV Humber.
2. **Annual Members' Meeting**, published in the Hull Daily Mail, That's TV Humber and BBC Radio Humberside
3. **Stoptober**, published in Hull Is This, That's TV Humber, Greatest Hits Radio Yorkshire Coast, BBC Radio Humberside, and the Scarborough News

Media coverage has been exceptionally high this month. Despite stories following an inquest, we have offset this with an outstanding 26 positive publications across local media outlets and channels.

KPI	Measure of success by 2025	Benchmark	This month	Progress to target
Positive Media Stories published	Positive vs negative coverage maintained at 5:1	5 stories covered by media per month	13 unique stories 26 publications total	100%
Visits to Brand Portal	Up 20%	Average visits per month since Sept 2021 -1461	1461	20% - 1753
Facebook engagement rate	2%	2%	5.06% HTN-FT FB page 10.82% Join Humber Account	3.6% above target 8.82% above target
Twitter engagement rate	2%	2%	1.9%	0.1% needed

LinkedIn follower growth	+ 15%	Need to reach at least 2872 followers with a 15% increase	2738 followers – 10.1% increase on last month, 98 additional followers	4.9% - 2872 followers

Theme 2: Enhancing prevention, wellbeing and recovery

Notice Boards Project
We are working with clinical teams to scope out a project to standardise patient facing notice boards. A plan will be shared with ODG to support the roll out and ensure out face to face communications matches the style and quality of our other communications channels.

Theme 3: Developing an effective and empowered workforce

- **Humbelievable Marketing Recruitment**

This month we created an enhanced focus on GP recruitment with our primary care colleagues. In addition to agreeing to fund rolling bi-weekly adverts on our channels, we are looking at the Unique Selling Points (USPs) of being a GP at Humber and how we can use these points to influence our messages.

We have further supported Primary Care with a detailed 'Writing a GP job vacancy' guidance sheet to help these messages translate directly into the Trac adverts.

- **Flu and Covid-19 Booster Campaign**

Our flu vaccination and Covid-19 Booster campaign launched this month. We have worked hard to maintain a strong individual message whilst ensuring the importance of both vaccines has been made clear. Updated intranet pages have been created with clear booking information and question and answers to support staff to make an informed decision.

As part of this campaign, we have interviewed peer vaccinators from across the Trust to learn about why they chose to become a peer vaccinator, to dispel myths and to encourage others to either consider becoming a peer vaccinator for their service or to simply get the jab themselves.

We continue to monitor the campaign response and support the teams to spread the message.

- **Staff Survey 2022 Promotion**

Our Staff Survey campaign is now live. We have personalised national promotional materials to ask staff, 'What's your Humber like?'.

As part of the campaign, we have worked with eight different areas of the Trust to find out how past surveys have had a real impact on them. These articles will be cascaded to staff

on a weekly basis throughout the two-month campaign, to demonstrate how making their voice heard is truly beneficial to them as an employee.

KPI	Measure of success by 2025	Benchmark	Progress to date (average since Sept 22)	This month	Progress to target
Intranet bounce rate reduced	< 50%	57%	57.13%	56.62%	-6.62%
Intranet visits maintain at current level	7,300 visits p/m	4293	7065	6728	-7.84%
Global click through rate (CTR) increase	7%	4.6%	6.37%	12.75%	+5.75%

Theme 4: Fostering integration, partnerships, and alliances

- **Wellbeing Recovery Employment Service (WRES)**

We have been working with this new service to ensure that the launch of their initiative externally is well-received by our local communities. The service supports people who ae facing barriers of getting into work and education and is free to refer if you are living in Hull or the East Riding.

Media interest was high with interviews on several local radio stations, including BBC Radio Humberside, and That's TV Humber.

- **Humber and North Yorkshire Health and Care Partnership**

As pressures on primary care services continue to rise, we have used our social media channels to support Humber and North Yorkshire Health and Care Partnership to encourage patients to choose the correct source of treatment if a condition is not serious or life-threatening, rather than adding unnecessary pressure to urgent care.

- **Stoptober – NHSE and Health Trainers**

The team has used national assets to support the Stoptober campaign, sharing posts from Healthtrainers and encouraging people to seek support from them to quit smoking

- **My Stammering Child, Film Premiere**

The team has supported the organising and publicity for the upcoming national launch of a new film (21/10/22) created by our Speech and Language Therapists in partnership with national charity, Action for Stammering Children.

This new film looks at the concerns of parents and puts their unique role in supporting children and young people in the spotlight with the aim of helping others going through what can be an anxious time. The launch includes several high profile guests including Nick Hewer (BBC Apprentice/C4 Countdown), Luke Ayling (Leeds FC) and has been supported by a video message from Sir Michael Palin.

We have supported media management, printed materials, video, streaming the event live and will support with social media coverage and photography on the day.

Theme 5: Innovating for quality and patient safety

- **Events**

Whitby Opening

A Thank You and Celebration Event (3/10/22) to mark the end of work on site at Whitby Hospital was attended by more than 60 staff and The event took place across two sites at Whitby Hospital and Whitby Pavilion with a live streamed tree planting and speeches from the Trust and stakeholders. The live stream has been watched by 937 people as of 13 October 2022. The event was covered by BBC Radio Tees, Yorkshire Coast Radio and the Whitby Gazette.

Annual Members' Meeting

The team delivered the Annual Members' Meeting at the MKM Stadium in Hull (6/10/22), in-person and online for the second time. The market stall display from fifteen trust teams was attended by 40 guests and over 350 watched the stream of the event on our Youtube channel.

- **Awards Update**

Elvis Jerimiah, a social Worker at Townend Court has been nominated for a national award for Mental Health Social Worker of the Year. This was covered in local media outlets to celebrate the achievement.

The rescheduled HSJ Patient Safety Awards Ceremony will take place on 24 October. The team are attending to support with social media coverage for our Addictions Service who are shortlisted for 'Improving Health Outcomes for Minority Ethnic Communities'.

- **Research Team Support**

We continue to support the Research and Development team to promote their upcoming Annual Research Conference in November. This includes weekly adverts on our social media channels and in the Global. We are pleased to hear that in-person tickets have been popular and are now sold out, with waitlists being devised to ensure those who really wish to attend still have a chance to do so.

KPI	Measure of success by 2025	Benchmark	This month	Progress to target
Annual number of awards nominations	2 local and 4 national shortlists p/a	4 national p/a	4 submissions this quarter 3 local, 4 national shortlists	**100%** Achieved measure of success following successful submissions to HSJ awards

Theme 6: Optimising an efficient and sustainable organisation

KPI	Measure of success by 2025	Bench mark	This month	Progress to target
Reduce homepage bounce rate	Over 50%	64.9% (2021/ 22 avg)	67.16 %	+2.26%
Increase average page visits per session	Over 2 per visitor	2	1.3	-0.7
Increase average dwell time	Over one minute	1m28s	1m31s	+31s

Trust Strategy

The Trust Strategy was launched at the Annual Members Meeting. The roll out that followed including a launch video and a LinkedIn-led social media campaign. The Strategy webpage has seen a 260% increase in views following the campaign.

8 Health Stars Update

Forthcoming Fundraising Events

The Stand Up for Health Stars Comedy Night, will take place at Hull Truck Theatre on the 4th November 2022. Ticket sales have continued to sell steadily and both Health Stars and the Comms Team are supporting with raising the profile of the event on social media. Health Stars will be supporting at the event together with a team of volunteers from the Trust.

The Whitby Bricks Appeal continues and following a fresh media push in August/September we received an increase in sign ups and donations. We still have a long way to go to reach the first phase target of 250 so are continuing to look for new opportunities to share and cascade the appeal.

Wishes

We are continuing to receive plenty of Wishes for a wide range of resources, equipment and projects. We recently visited the Avondale Assessment Unit, as Health Stars had supported several Wishes from them over the last year. Wishes were granted for a range of things to improve the unit, such as wall murals, therapy equipment and gardening resources and plants.

In addition, we have recently been successful in obtaining funding from the League of Friends (Malton) to purchase a new Gait Trainer for the Physiotherapy Unit at Malton Hospital.

Christmas

The deadline for Christmas Wishes is 30th November 2022 and this information has been circulated to all staff.

Health Stars Golf Day 2023
The provisional date for the rescheduled 2022 event is 14th April 2023.

Staff Changes:
Victoria Winterton, Head of Smile Health, has now started her Maternity Leave and we are delighted to have Clare Woodard covering the role for the duration.

Michele Moran
Chief Executive
October 2022

NHS
Humber Teaching
NHS Foundation Trust

Agenda Item 8

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Publications and Policy Highlights
Author/s:	Name: Michele Moran Title: Chief Executive
Recommendation:	To approve [ ] To receive & note [/] For information [ ] To ratify [ ]
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	To inform and update the Trust Board on recent publications and policy since the September Board: I. Covid-19 Public Inquiry II. NHS England external freedom to speak up policy for NHS workers III. Long COVID: A framework for nursing, midwifery, and care staff IV. Statutory transactions

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No issues identified.	**Key Actions Commissioned/Work Underway:** • n/a
Positive Assurances to Provide: • n/a	**Decisions Made:** • n/a

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	12/10/22
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

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

Caring, Learning & Growing Together

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

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

Publications and Policy Highlights

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

1. Covid-19 Public Inquiry

The independent public inquiry set up to examine the UK's response to and impact of the Covid-19 pandemic, and learn lessons for the future has begun.

The inquiry will be broken down into three modules with teams set up across the UK to investigate and report on each module, followed by public hearings chaired by Baroness Hallett. The third and final module will examine the impact on the health sector including the impact of COVID-19 and of the governmental and societal responses to it, on healthcare systems and patients, hospital and other healthcare workers and staff. Among other issues, it will investigate healthcare systems and governance, hospitals, primary care, the impact on NHS backlogs and non-COVID treatment, the effects on healthcare provision of vaccination programmes, and long COVID diagnosis and support. UK Covid-19 Inquiry (covid19.public-inquiry.uk)

Lead: Chief Executive

The Trust has clear Gold and Silver Command corporate records. However, it is not expected that individual Trusts will be core participants. Interim reports will be issued after each module with one complete report at the end of the inquiry. No timescales have been confirmed but organisations will be expected to act on learning as interim reports are issued and not wait for final report. Board will be kept updated on the key points from the inquiry and actions to address any learning.

2. **NHS England external freedom to speak up policy for NHS workers** Care Quality Commission 4 October 2022

This policy provides information on how NHS workers can speak up to NHS England in our role as a prescribed body. NHS workers can speak up to us about any matters which relate to the role of NHS England.

This policy replaces the previous NHS Improvement and NHS England freedom to speak up policies for NHS workers. https://www.england.nhs.uk/long-read/external-freedom-to-speak-up-policy-for-nhs-workers/

Lead: Chief Executive

The Board received a detail update at this month's Board Development Session. Work continues on the self-assessment, review of FTSU policy in light of national changes and our revised strategy is in hand

3. **Long COVID: A framework for nursing, midwifery, and care staff** CQC 4 October 2022

This framework supports nurses, midwives and care staff in ensuring our care remains at a high standard, as well as demonstrating our significant contribution to the long COVID response. It gives us the opportunity to embrace our collective leadership in supporting the people and communities we serve and showcase good practice as it emerges across England. https://www.england.nhs.uk/wp-content/uploads/2022/09/C1474-long-covid-a-framework-for-nursing-midwifery-and-care-staff.pdf

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

A good information resource for all clinicians who are providing services for patients who may have symptoms of long COVID. The resource has been shared widely across our clinical services via clinical leads.

4. Statutory transactions NHS England 11 October 2022

NHS England is responsible for approving statutory transactions having first been satisfied that the transacting trusts have taken the necessary steps to prepare for the transaction. We aim to ensure that the proposed transaction is the right solution to the issues it is attempting to address and that the intended benefits will be delivered.

Statutory transactions are those governed by the NHS Act 2006 (the Act) and incorporate:

- Mergers (section 56)
- Acquisitions (section 56A)
- Dissolutions (NHS trusts – schedule 4; foundation trusts – section 57A)
- Separations (section 56B)
- Transfer schemes (section 69A)

All statutory transactions are reportable, regardless of their size. We will apply our risk assessment framework to each transaction to determine the level of risk and therefore the extent of assurance work required. We will classify transactions as either 'material' (lower risk) or 'significant' (higher risk).
https://www.england.nhs.uk/wp-content/uploads/2022/10/B1464_i_revising-NHS-transactions-guidance-for-trusts-consultation-response-1.pdf

Lead: Director of Finance

This guidance reflects the new NHS architecture and has come into immediate effect. NHSE are preparing training programmes to support implementation of the new guidance and will consider transactional arrangements on a case by case basis.

Statutory transactions are those governed by the NHS Act 2006 (the Act) and incorporate:

- **Mergers (section 56)**
- **Acquisitions (section 56A)**
- **Dissolutions (NHS trusts – schedule 4; foundation trusts – section 57A)**
- **Separations (section 56B)**
- **Transfer schemes (section 69A)**

All statutory transactions are reportable, regardless of their size.

The Trust doesn't currently have any transactions

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Agenda Item 9

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 26 October 2022</td></tr>
<tr><td>Title of Report:</td><td>Performance Report September 2022</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 & discuss</td><td></td></tr>
<tr><td>For information/To note</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 September 2022.

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 colspan="2">Key Issues within the report:</td></tr>
<tr><td>Matters of Concern or Key Risks to Escalate:

• Waiting Times - Appendix B provides a review of current waiting times performance.

• The performance for Care Programme Approach (CPA) reviews has slightly improved but remains below the target. Recovery plans are in place with robust monitoring within planned services within the Mental Health Division (the area with the highest number of reviews below the target) and all other service areas that are lower than target. Weekly reports are available to managers to ensure the position is being monitored very closely to enable them to raise the position with individual care coordinators.</td><td>Key Actions Commissioned/Work Underway:

• Analysis of the spike in staff turnover has been undertaken, this has identified the increase in September is influenced by ending of Psychology student placements at the Trust.</td></tr>
</table>

Caring, Learning
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- After reducing to zero for a short period the number of ***out of area placements*** is beginning to increase as a direct result of the increasing number of patients whose discharge is delayed due to available social care packages or specialised hospital placements. The bed management team continue to review bed demand and reconfigure ward arrangements to meet the changing demand for male or female beds.

    - The number of **delayed transfers of care** has risen further in the last month above the upper control limit and means that of the available beds a significant number are now occupied by a patient who is ready to be discharged. These patients are waiting predominantly for specialised hospital placements with other NHS providers or local authority provided residential placements. System escalation mechanisms are in place to address this overseen by the Chief Operating Officer. Focus will be maintained on improving this position in order to achieve the best outcomes for our patients and to ensure it does not adversely impact on the improved position we have achieved in reducing out of area placements. The ICB and Provider Collaboratives are escalating DTOCs as an issue requiring more action particularly as we enter the Winter period. The position does vary but the current number of patients delayed by bed type is set out below.

	No. of patients delayed	% of available beds delayed
Learning Disability beds	3	42%
Secure beds	3	5.5%
Adult Mental Health beds	17	17%
CAMHS Beds	2	22%
Community Beds (North Yorkshire)	10	27%

Positive Assurances to Provide:

- Statutory and mandatory training overall remains above the Trust target of 85%, currently at 91.2%.

Decisions Made:

- n/a – report to note.

Governance:

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	Sept 2022
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

Monitoring and assurance framework summary:

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

	Developing an effective and empowered workforce
	Maximising an efficient and sustainable organisation
	Promoting people, communities and social values

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

Financial Year
2022-23

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TRUST PERFORMANCE REPORT

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

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

Chief Executive: Michele Moran

Prepared by: Business Intelligence Team

Reporting Month:
Sep-22

Humber Teaching NHS Foundation Trust
Trust Performance Report

For the period ending:	Sep 2022

Purpose	This paper provides a summary on the progress being made against a basket of NHS performance indicators together with executive summary and underpin the Trust's Strategy 2017-2022. A sample of the strategic goals are represented in this report. Particular attention is drawn to the new format and the use of Statistical Process Control (SPC) in the following charts. SPC charts contain upper and lower control limits which are based on 2 standard deviation points above and below the 2 yearly average.
What are SPCs?	Statistical process control (SPC) charts can help us understand the scale of any problem, gather information and identify possible causes when used in conjunction with other investigative tools such as process mapping. SPC tells us about the variation that exists in the systems that we are looking to improve: S – statistical, because we use some statistical concepts to help us understand processes. P – process, because we deliver our work through processes ie how we do things. C – control, by this we mean predictable. SPC should be used to help to get a baseline and evaluate how we are currently operating. SPC will also help us to assess whether service changes have made a sustainable difference. They give an indication as to whether there is relatively stable variation over time or whether there are special causes creating exceptional variance. This is done by analysing the chart looking at how the values fall around the average and between or outside the control limits. The average and control limits do not indicate whether the indicator is achieving the target that has been set, but they allow us to better understand how stable the performance is and whether or not it is changing.

Strategic Goal 1	Innovating Quality and Patient Safety	**Strategic Goal 4**	Developing an effective and empowered workforce
Strategic Goal 2	Enhancing prevention, wellbeing and recovery	**Strategic Goal 5**	Maximising an efficient and sustainable organisation
Strategic Goal 3	Fostering integration, partnership and alliances	**Strategic Goal 6**	Promoting people, communities and social values

Key Indicators The following is a list of indicators highlighted within this report and the Goal to which they are set against. Other than the Safer Staffing dashboard, each indicator uses SPC charts

Dashboard	Safer Staffing	A dashboard to provide overview on a number of clinical indicators for the Trust's inpatient units across all services
Dashboard	Mortality	Learning from Mortality Reviews
Goal 1	Mandatory Training	A percentage compliance for all mandatory and statutory courses
Goal 1	Vacancies	Proportion of posts vacant when compared to the budgeted establishment. This information is taken from the Trust financial ledger.
Goal 1	Number of Incidents per 10,000 Contacts	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)
Goal 1	Clinical Supervision	Percentage of staff with appropriate clinical supervision taken place within the last 4-6 weeks
Goal 1	FFT - Patient Recommendation	Results where patients would recommend the Trust 's services to their family and friends
Goal 2	FFT - Patient Involvement	Results where patients felt they were involved in their care
Goal 2	72 hour follow ups	Percentage of patients who had a follow up within 72 hours (3 days) of discharge from hospital
Goal 2	CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months

For the period ending:	Sep 2022

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

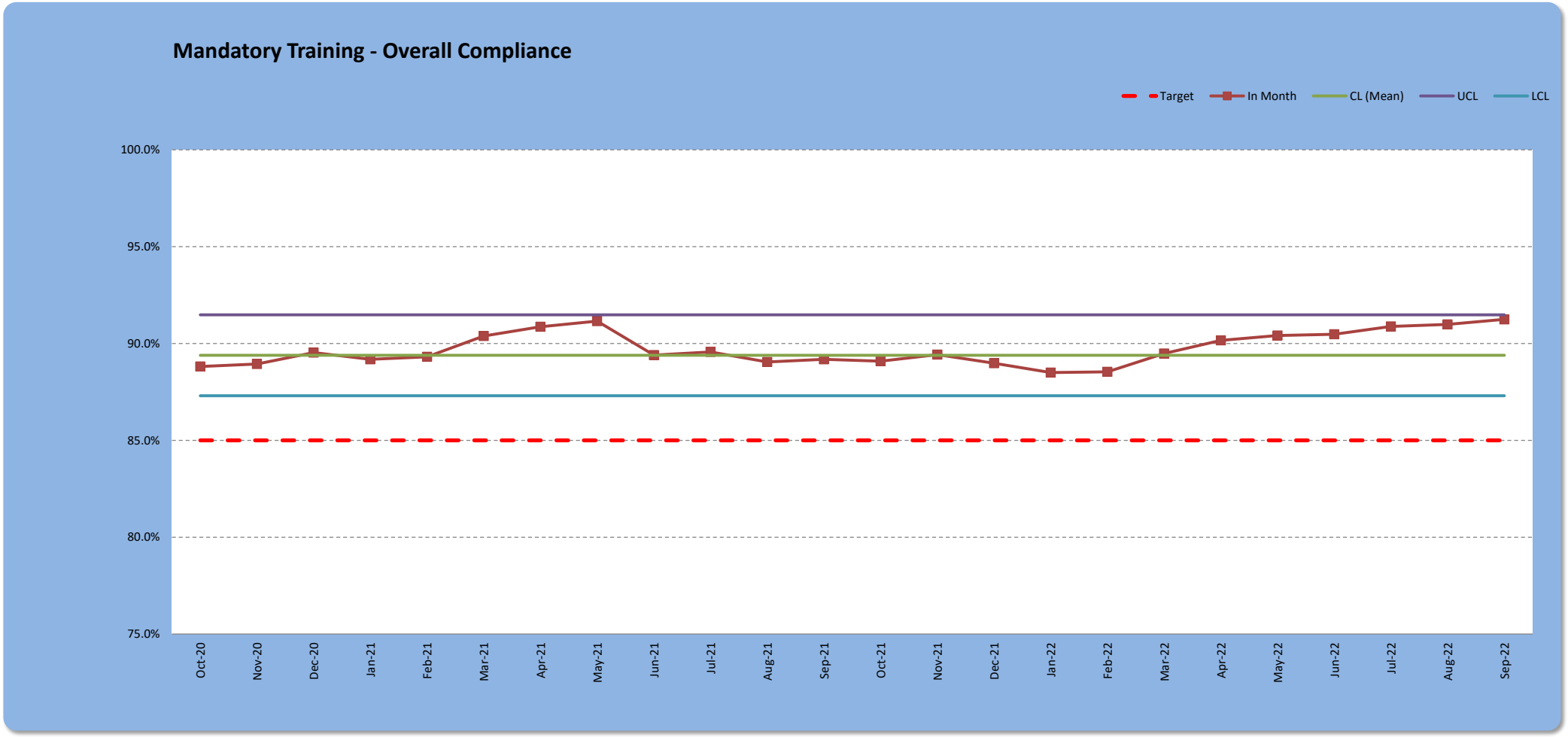
PI RETURN FORM 2022-23

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
85%	80%	91.2%

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



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

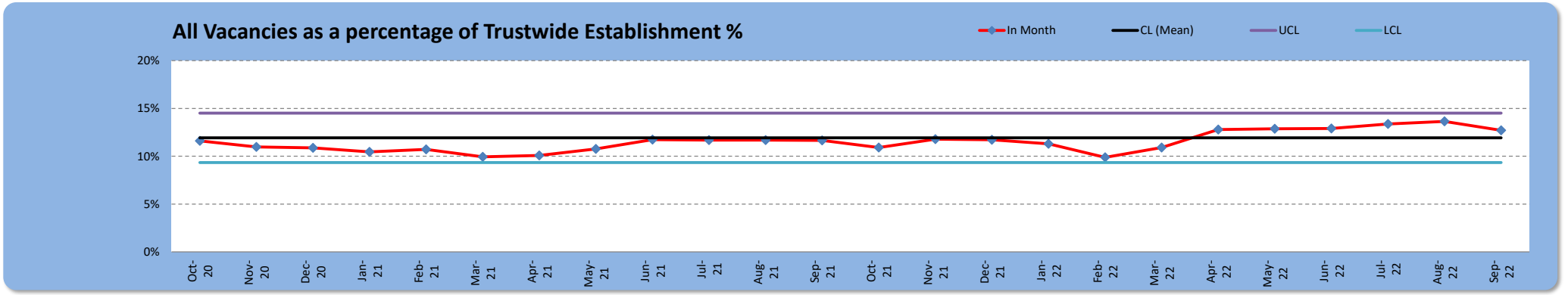
PI RETURN FORM 2022-23

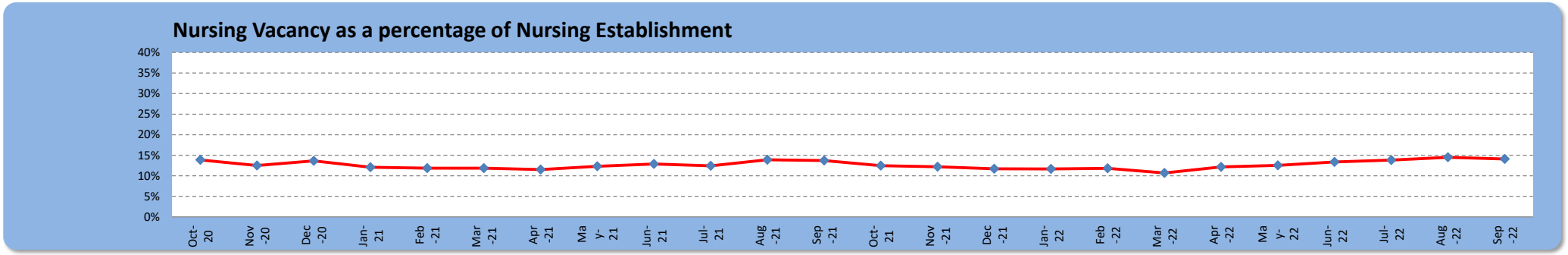
Target:	Amber:	Current month stands at:
85%	80%	12.7%

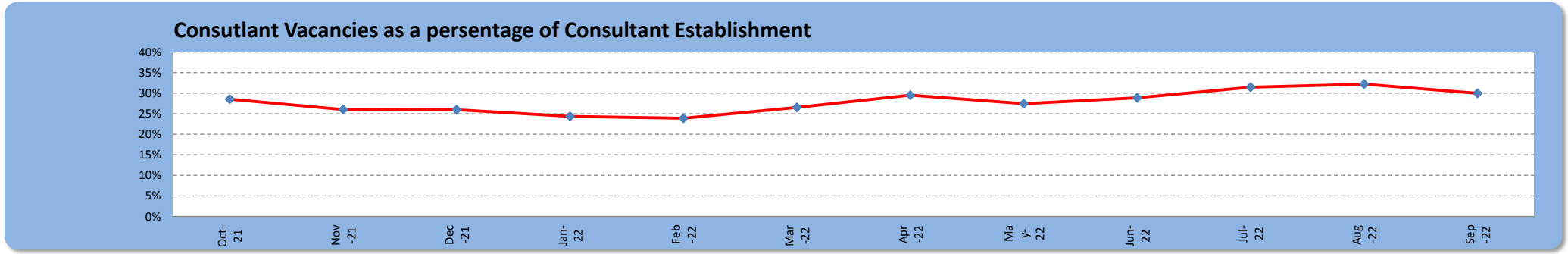
Goal 1 : Innovating Quality and Patient Safety

For the period ending: Sep 2022

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







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

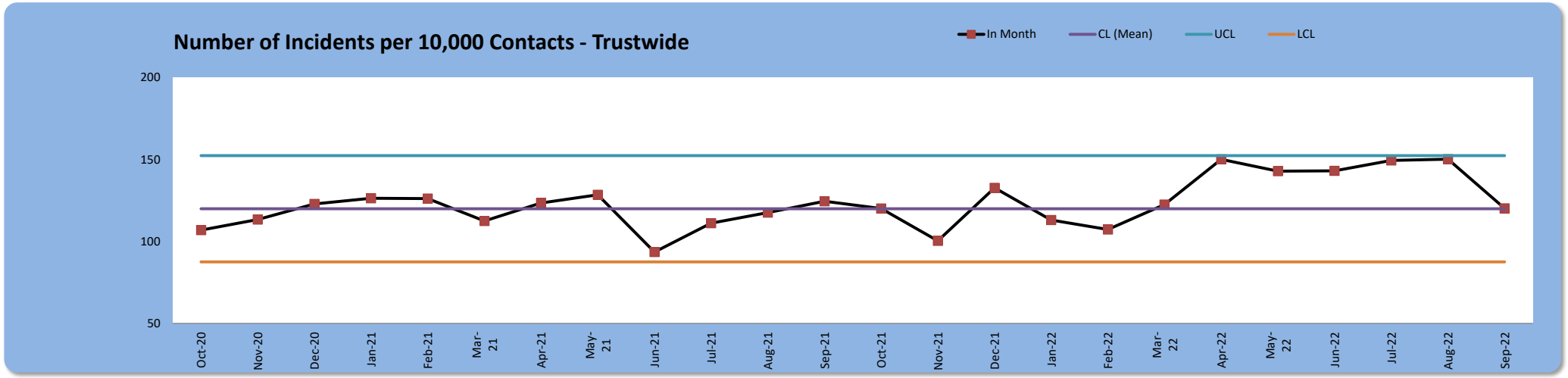
PI RETURN FORM 2022-23

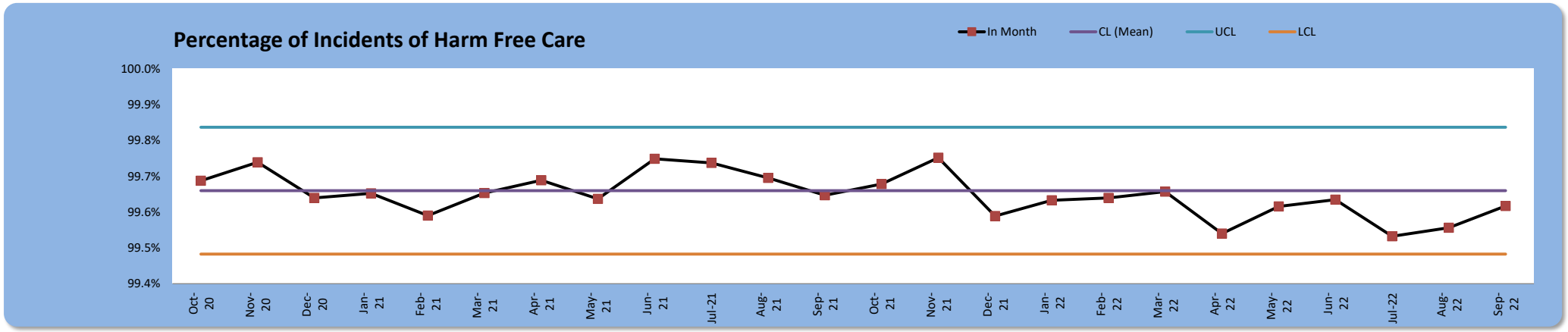
Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Sep 2022**

Target:	Amber:	Trustwide current month stands at:
0	0	120

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





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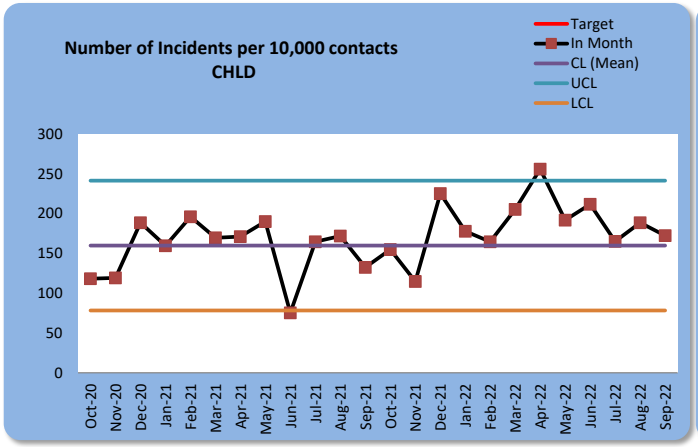
PI RETURN FORM 2022-23

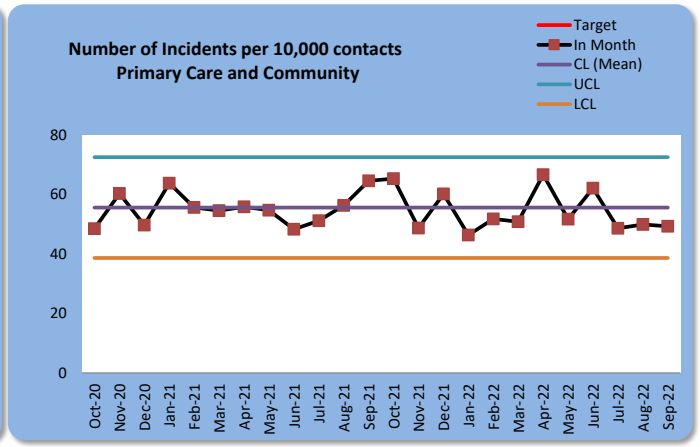
Goal 1 : Innovating Quality and Patient Safety

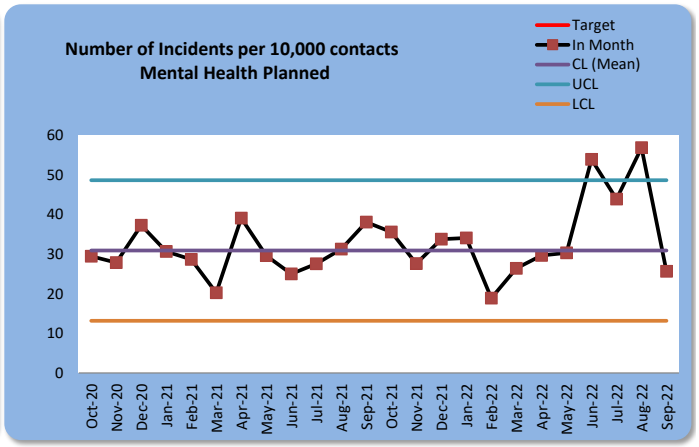
For the period ending: **Sep 2022**

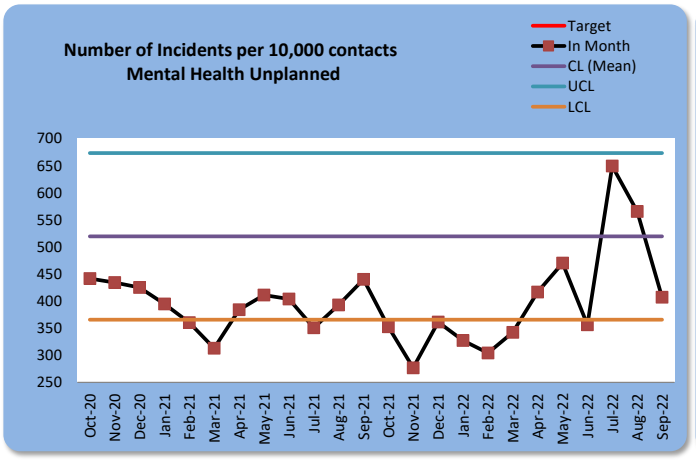
Target:	Amber:	Trustwide current month stands at:
0	0	120

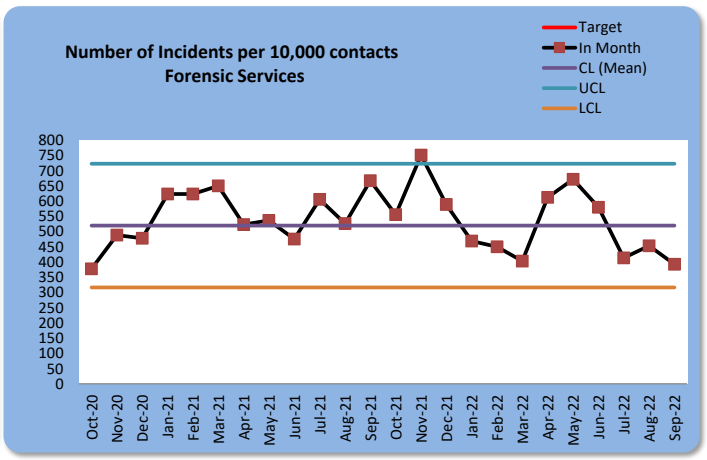
Indicator Title	Description/Rationale	Executive Lead	KPI Type
Incidents	Number of Incidents per 10,000 Contacts (based on contacts and occupied bed days)	Hilary Gledhill	IA_TW











Current Month per Division

Children and Learning Disability	172
Primary Care and Community	49
Mental Health Planned	26
Mental Health Unplanned	407
Forensic Services	393

Incident Analysis

	Aug-22	Sep-22
Never Events	0	0
% of Harm Free Care	99.6%	99.6%
% of Incidents reported in Severe Harm or Death	0.5%	0.5%

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

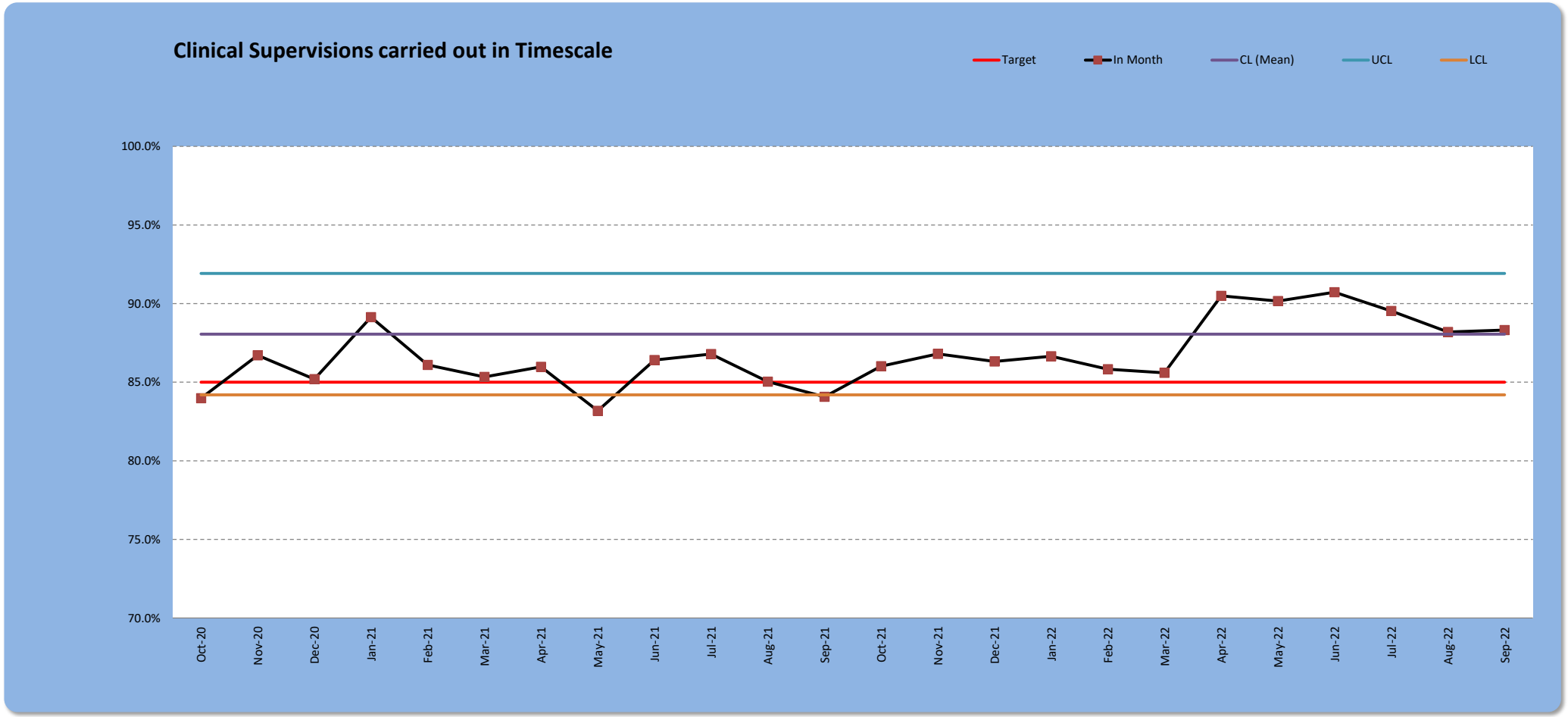
PI RETURN FORM 2022-23

Target:	Amber:	Current month stands at:
85%	80%	88.3%

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Sep 2022**

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



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

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

Staffing and Quality Indicators

Contract Period: 2022-23

Reporting Month: Aug-22

NHS Humber Teaching NHS Foundation Trust

Shown one month in arrears

Units						Bank/Agency Hours				Average Safer Staffing Fill Rates				High Level Indicators															
										Day		Night		QUALITY INDICATORS (Year to Date)														Indicator Totals	
Speciality	Ward	Speciality	WTE	OBDs (inc leave)	CHPPD Hours (Nurse)	Bank % Filled	Improvement	Agency % Filled	Improvement	Registered	Un Registered	Registered	Un Registered	Staffing Incidents (Poor Staffing Levels)	Incidents of Physical Violence / Aggression	Complaints (Upheld/ partly upheld)	Failed S17 Leave	Clinical Supervision	Mandatory Training (ALL)	Mandatory Training (ILS)	Mandatory Training (BLS)	Sickness Levels (clinical)	WTE Vacancies (RNs only)	Jul-22	Aug-22
Adult MH	Avondale	Adult MH Assessment	26.8	78%	10.9	29.4%	↓	9.0%	↑	84%	81%	87%	108%	2	14	8	0	88.5%	92.3%	91.7%	66.7%	7.2%	4.0	1	1
Adult MH	New Bridges	Adult MH Treatment (M)	39.4	110%	7.90	6.5%	↑	5.3%	↑	80%	93%	94%	108%	0	28	2	0	82.9%	93.9%	94.1%	76.0%	5.9%	1.6	3	3
Adult MH	Westlands	Adult MH Treatment (F)	34.0	95%	8.77	21.9%	↓	20.4%	↓	92%	78%	97%	121%	1	27	2	0	90.0%	91.7%	100.0%	70.0%	4.5%	2.4	3	2
Adult MH	Mill View Court	Adult MH Treatment	24.3	91%	8.37	25.3%	↓	20.1%	↓	76%	83%	80%	116%	3	6	0	0	83.3%	93.4%	80.0%	66.7%	2.3%	4.6	2	1
Adult MH	STARS	Adult MH Rehabilitation	39.6	99%	23.64	23.3%	↓	0.3%	↓	61%	167%	101%	100%	0	1	0	0	78.6%	94.4%	84.6%	81.5%	3.8%	0.5	3	2
Adult MH	PICU	Adult MH Acute Intensive	31.9	78%	20.53	29.3%	↓	17.5%	↑	79%	115%	90%	136%	1	55	0	0	100.0%	77.4%	85.7%	82.4%	9.3%	4.0	1	1
OP MH	Maister Lodge	Older People Dementia Treatment	31.2	81%	13.44	20.3%	↑	6.4%	↑	90%	106%	101%	101%	0	38	0	0	96.9%	93.8%	100.0%	95.7%	5.1%	1.0	0	0
OP MH	Mill View Lodge	Older People Treatment	23.1	112%	15.56	17.3%	↑	28.0%	↑	74%	113%	101%	185%	0	27	0	0	80.0%	92.5%	100.0%	78.6%	12.8%	2.8	2	3
	Maister Court	Older People Treatment	17.4	94%	15.63	25.9%	↓	12.6%	↑	90%	86%	103%	98%	0	1	0	0	100.0%	92.7%	85.7%	90.9%	0.0%	0.8	0	1
	Pine View	Forensic Low Secure	31.2	82%	8.53	13.0%	↑	0.0%	→	87%	96%	58%	94%	1	6	0	19	100.0%	95.5%	91.7%	85.0%	6.5%	0.2	2	2
	Derwent	Forensic Medium Secure	26.1	98%	11.87	25.9%	↓	0.0%	→	97%	91%	79%	117%	0	6	1	0	92.0%	94.1%	87.5%	88.9%	5.8%	0.8	2	2
	Ouse	Forensic Medium Secure	23.9	85%	8.54	18.4%	↓	0.0%	→	95%	95%	120%	127%	3	3	1	5	76.0%	92.8%	100.0%	82.4%	6.0%	1.6	2	2
	Swale	Personality Disorder Medium Secure	26.2	93%	9.55	32.6%	↑	0.0%	→	89%	108%	100%	91%	0	5	6	11	88.0%	96.8%	100.0%	83.3%	3.5%	2.2	4	1
	Ullswater	Learning Disability Medium Secure	27.7	58%	16.74	18.9%	↓	0.0%	→	84%	123%	91%	123%	0	8	0	9	85.7%	94.2%	100.0%	95.0%	7.3%	1.6	1	1
Child & LD	Townend Court	Learning Disability	39.6	71%	30.29	22.7%	↑	0.0%	↑	40%	80%	82%	113%	3	66	1	2	63.6%	89.7%	91.7%	60.0%	11.0%	3.0	4	4
Child & LD	Inspire	CAMHS	49.8	73%	27.15	0.0%	↑	20.6%	↓	43%	87%	63%	94%	5	0	0	0	No Ret	86.9%	77.8%	67.7%	11.3%	5.2	4	4
Child & LD	Granville Court	Learning Disability Nursing Care	48.5	83%	17.56	22.7%	↑	12.9%	↓	102%	85%	103%	90%	0	4	0	0	88.9%	89.2%	100.0%	90.9%	3.1%	0.0	1	0
CH	Whitby Hospital	Physical Health Community Hospital	45.8	94%	7.99	1.3%	↑	0.8%	↑	92%	79%	100%	98%	0	0	0	0	85.7%	91.6%	90.0%	65.2%	5.3%	-1.4	4	3
CH	Malton Hospital	Physical Health Community Hospital	32.1	88%	7.14	Not on eRoster	↓	Not on eRoster	↓	106%	79%	106%	94%	2	1	0	0	100.0%	83.2%	100.0%	77.8%	5.0%	-1.6	3	1

HUMBER TEACHING NHS FOUNDATION TRUST
SAFER STAFFING INPATIENT DASHBOARD

	Staffing and Quality Indicators
Contract Period:	2022-23
Reporting Month:	Aug-22

Humber Teaching NHS Foundation Trust

Exception Reporting and Operational Commentary

Safer Staffing Dashboard Narrative : August

The thresholds for CHPPDs have been revised upwards based on the latest model health system data and this accounts for the increased number of units flagging at red. Four wards continue to have below target levels of fill rates on days. In most instances this is due to having only 1 RN on duty instead of 2. The registered fill rates on nights are all above the threshold with the exception of Pine view which is showing fill rates of 60% due to frequently only having 1 registered nurse on nights. The fill rates on Inspire are based on an incorrect demand template which has now been corrected.

ILS compliance has improved to 88% overall in September and Whitby and Ullswater are now at 100%. BLS at TEC has improved to 60% in September and Inspire has continued to improve to 67.7%.

Supervision is above target for all units with the exception of TEC which has dropped since July due to sickness and high clinical acuity. However 3 units have failed to return data for August which has been addressed with the Matrons and through the AMH accountability review.

Sickness remains a significant concern but has improved slightly from July. Overall there is an improved picture from July with 9 wards now flagging green.

The CHPPD RAG ratings are based on the Organisational National Average Benchmark as at March 2022

For all MH units other than Pine View/Ouse the RAGs are set at: >10.3 = Green, 9.3 to 10.3 = Amber, < 9.3 = Red.
Pine View/Ouse ratings are set as: >6.3 = Green, 5.8 to 6.3 = Amber, < 5.8 = Red
Community Hospitals are RAG rated based on Model Hospital national average: > 9.07 = Green, 9.07 to 8.07 = Amber, < 8.07 = Red
We are now collecting Occupied Bed Days for Granville Court. However as this is a nursing home and not MH unit. As such the fill rate and CHPPD is not RAG rated

OBD RAG ratings for Safer Staffing (exc Forensics) are: < 87% = Green, 87% to 92% = Amber, > 92% = Red
OBD RAG ratings for Safer Staffing for Forensics are: < 50% = Red and > 50% = Green

Registered Nurse Vacancy Rates (Rolling 12 months)

Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
11.20%	8.70%	10.90%	10.30%	10.50%	8.80%	7.20%	13.90%	13.80%	14.90%	15.27%	15.00%

Slips/Trips and Falls (Rolling 3 months)

	Jun-22	Jul-22	Aug-22
Maister Lodge	9	12	7
Millview Lodge	3	2	5
Malton IPU	6	6	7
Whitby IPU	5	0	1

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

Quality Dashboard

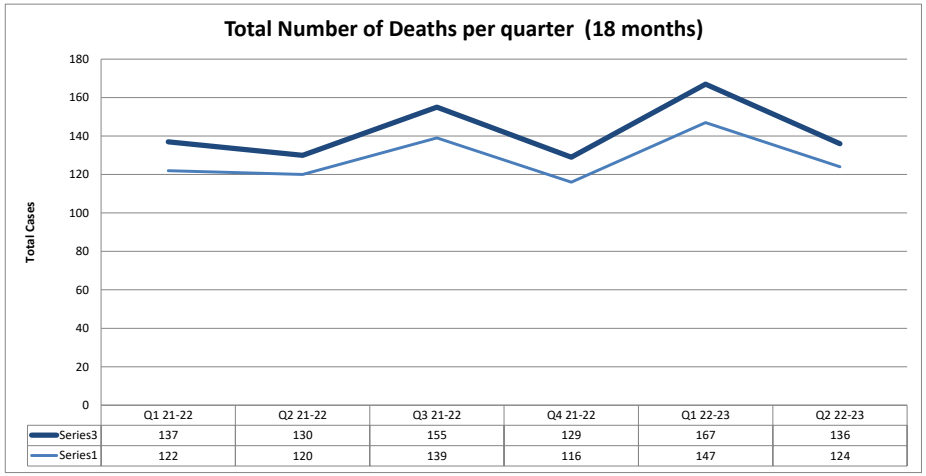
Section 2.2	Mortality Dashboard	Quality Dashboard

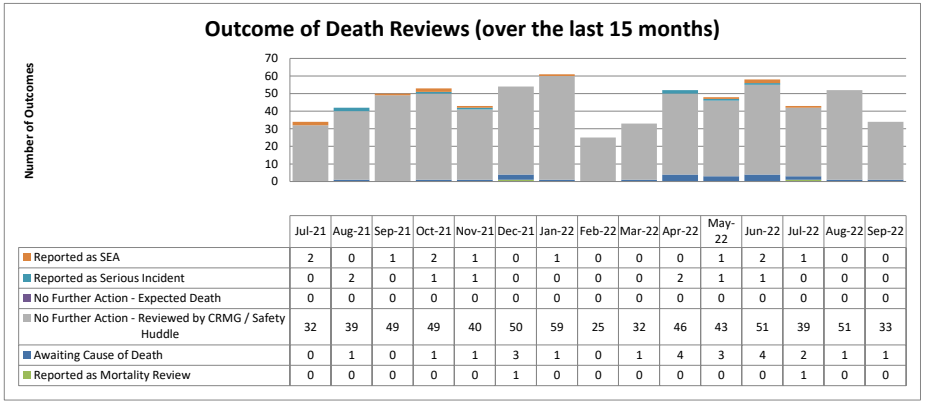
Description : Learning from Mortality Reviews

Summary of total number of deaths and total number of cases reviewed under the SI (Serious Incident) Framework or Mortality Review

Total Number of Deaths and Deaths Reviewed
(does not include patients with identified Learning Disabilities)

	Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Last 12 months
Total Number of Deaths	130	155	129	167	136	587
Total Number of Natural Deaths	120	139	116	147	124	526
Proportion of Natural Deaths	92.3%	89.7%	89.9%	88.0%	91.2%	89.6%
Total Number of Deaths - Community Hospitals	6	9	9	8	3	29
Total Number of Deaths - MH Inpatients	2	1	1	0	1	3
Total Number of Deaths - LD Inpatients	0	0	0	0	0	0
Total Number of Deaths - Forensics Inpatients	0	0	0	0	0	0
Total Number of Deaths - All Community excl. MH	54	74	60	75	54	263
Total Number of Deaths - Addictions	10	8	5	11	4	28
Total Number of Deaths - MH Community	58	64	49	76	70	259
Review Process						
Reported as Mortality Review	0	1	0	0	1	2
No Further Action - Reviewed by CRMG / Safety Huddle	120	139	116	140	123	518
No Further Action - Expected Death	0	0	0	0	0	0
Reported as Serious Incident	2	2	0	4	0	6
Reported as SEA	3	3	1	3	1	8
Child Death Review	0	0	0	0	0	0
Statements Being Produced For Coroners	0	0	0	0	2	2
Total Deaths Reviewed	125	145	117	147	127	536
Awaiting Cause of Death	1	5	2	11	4	22
Not Yet Reported	4	5	10	9	5	29





	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Reported as SEA	2	0	1	2	1	0	1	0	0	0	1	2	1	0	0
Reported as Serious Incident	0	2	0	1	1	0	0	0	0	2	1	1	0	0	0
No Further Action - Expected Death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No Further Action - Reviewed by CRMG / Safety Huddle	32	39	49	49	40	50	59	25	32	46	43	51	39	51	33
Awaiting Cause of Death	0	1	0	1	1	3	1	0	1	4	3	4	2	1	1
Reported as Mortality Review	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0

Summary of total number of Learning Disability deaths and total number of cases reviewed under the LeDeR Review methodology

Total Number of Deaths, Deaths reviewed and Deaths Deemed Avoidable for patients with identified Learning Disabilities)

	Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Last 12 months
Number of LD Deaths in Inpatients	3	0	0	2	3	5

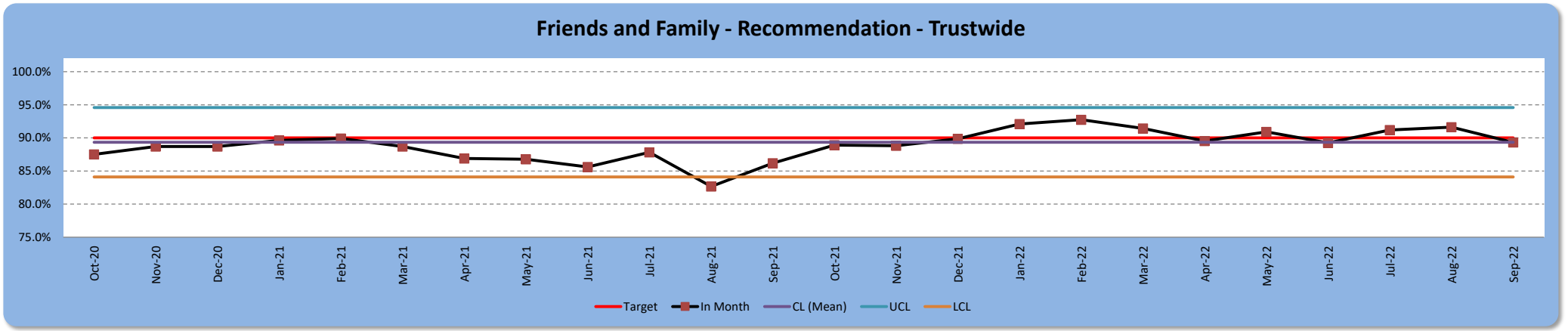
PI RETURN FORM 2022-23

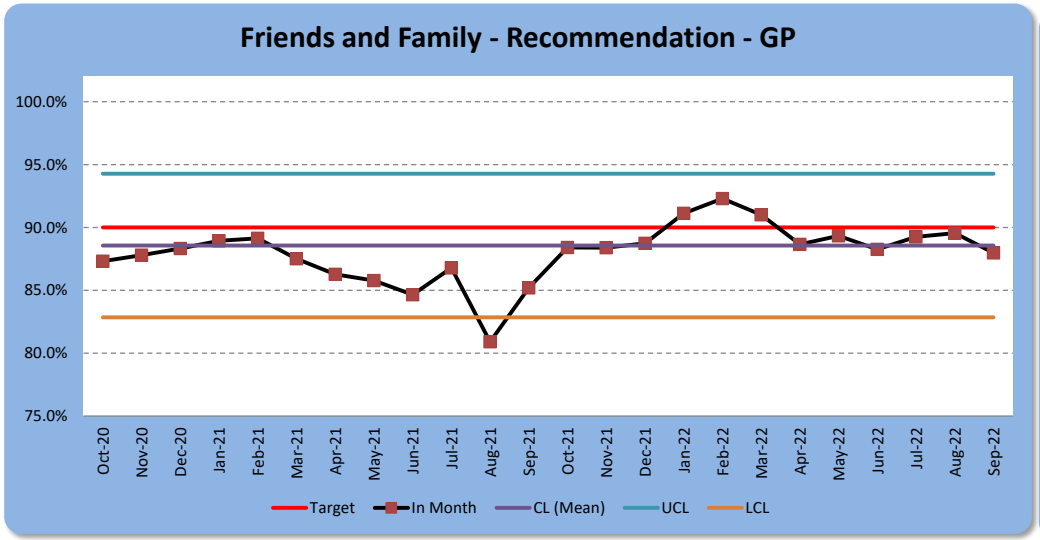
Goal 1 : Innovating Quality and Patient Safety

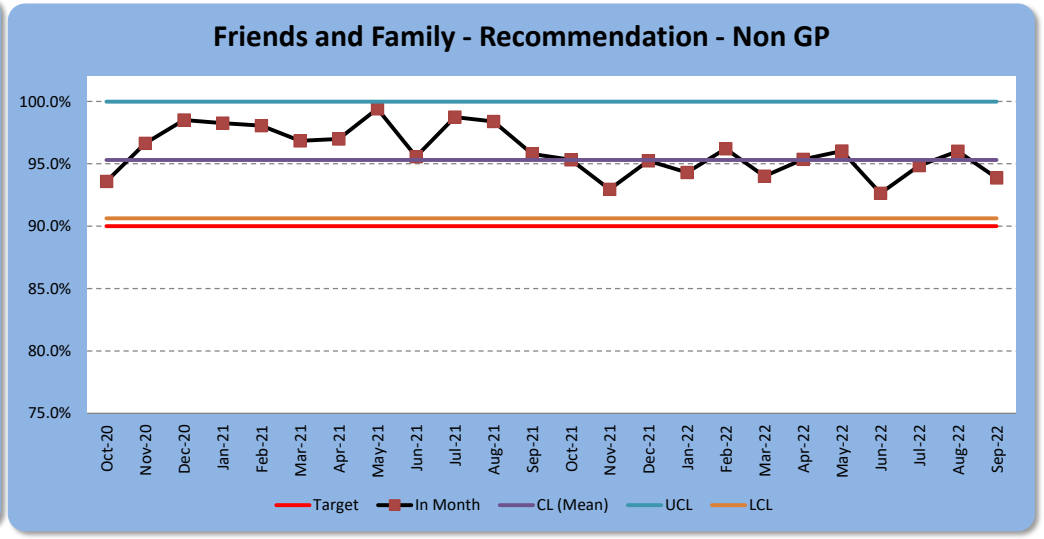
Target:	Amber:	Current month stands at:
90%	80%	89.3%

For the period ending: **Sep 2022**

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







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

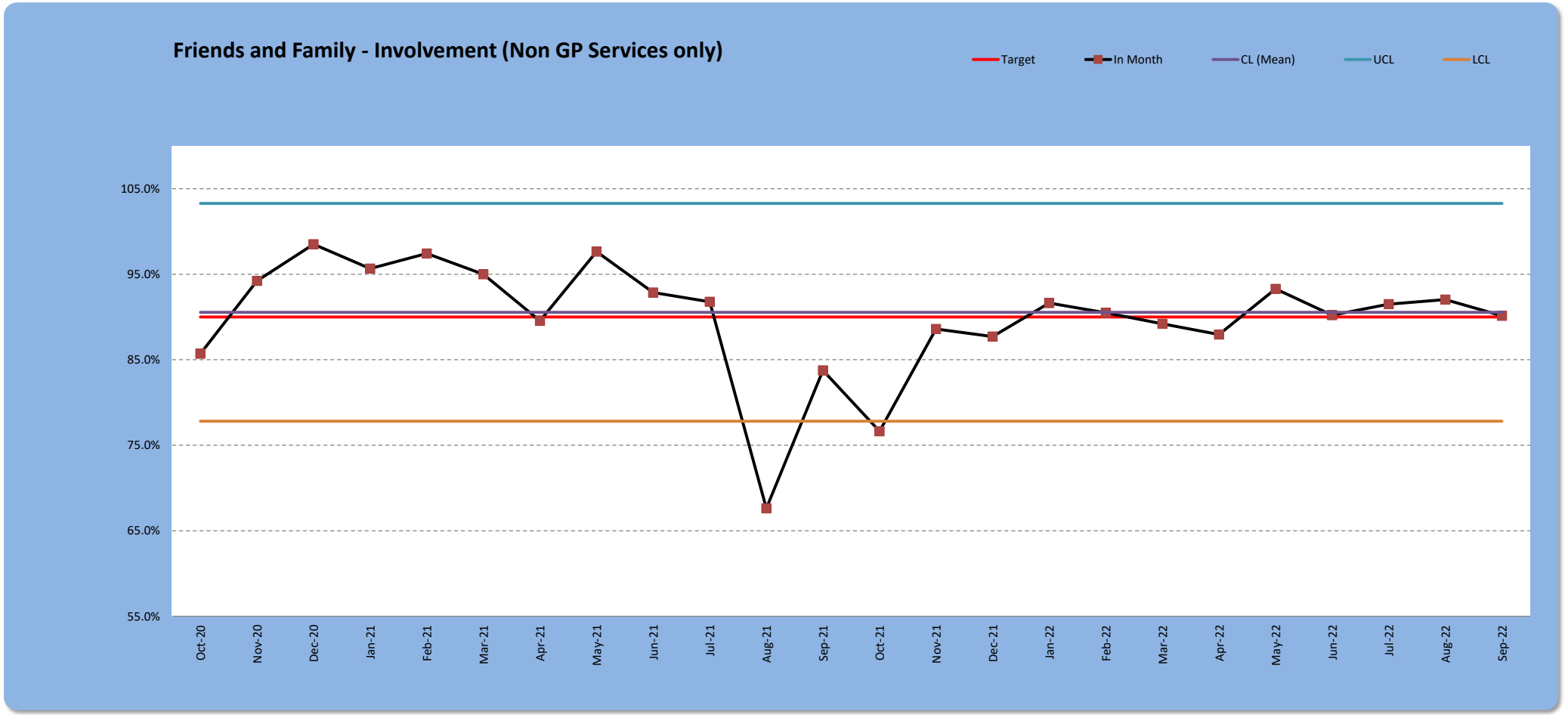
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
90%	80%	90.1%

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 %



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

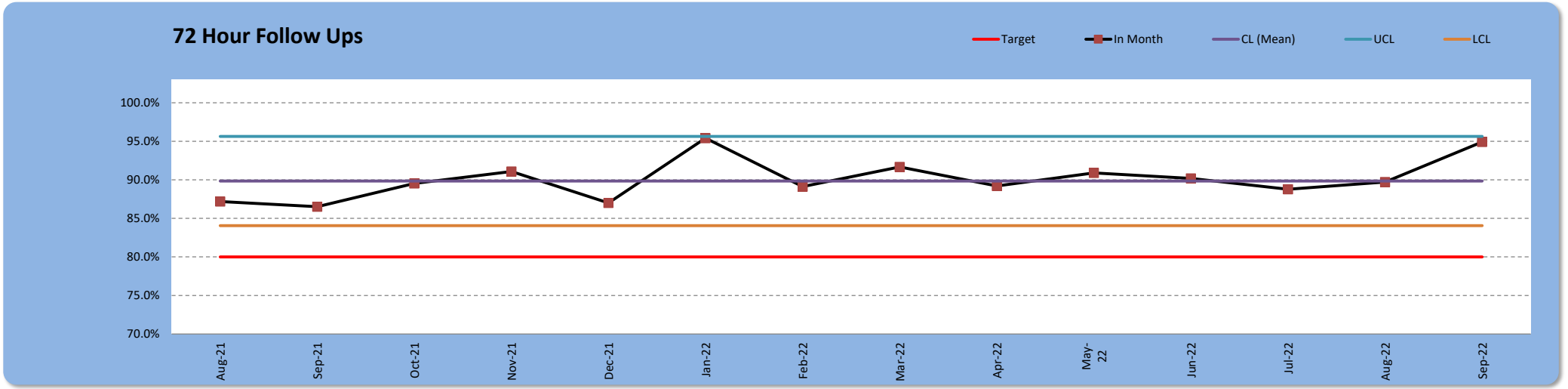
PI RETURN FORM 2022-23

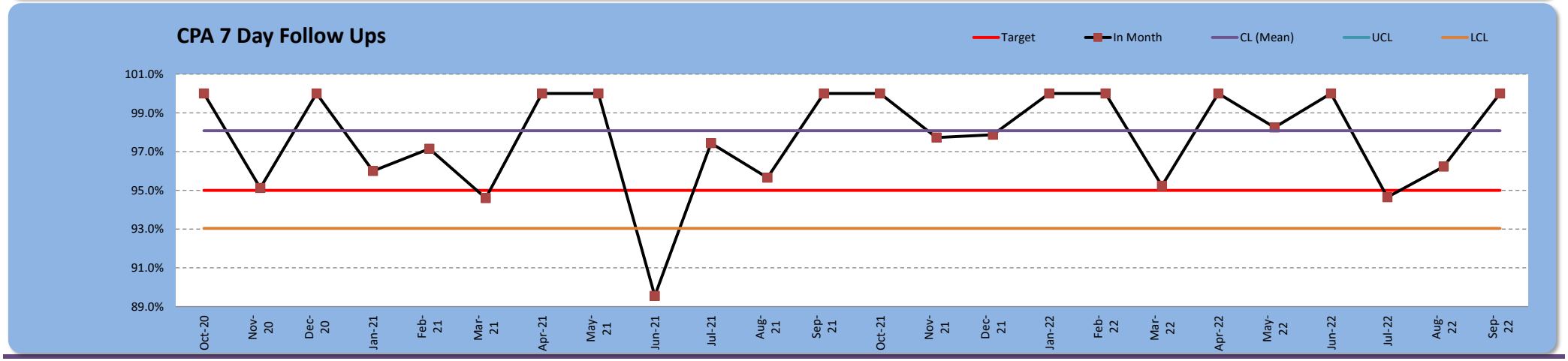
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month for 72 hour stands at:
80%	60%	94.9%

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





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

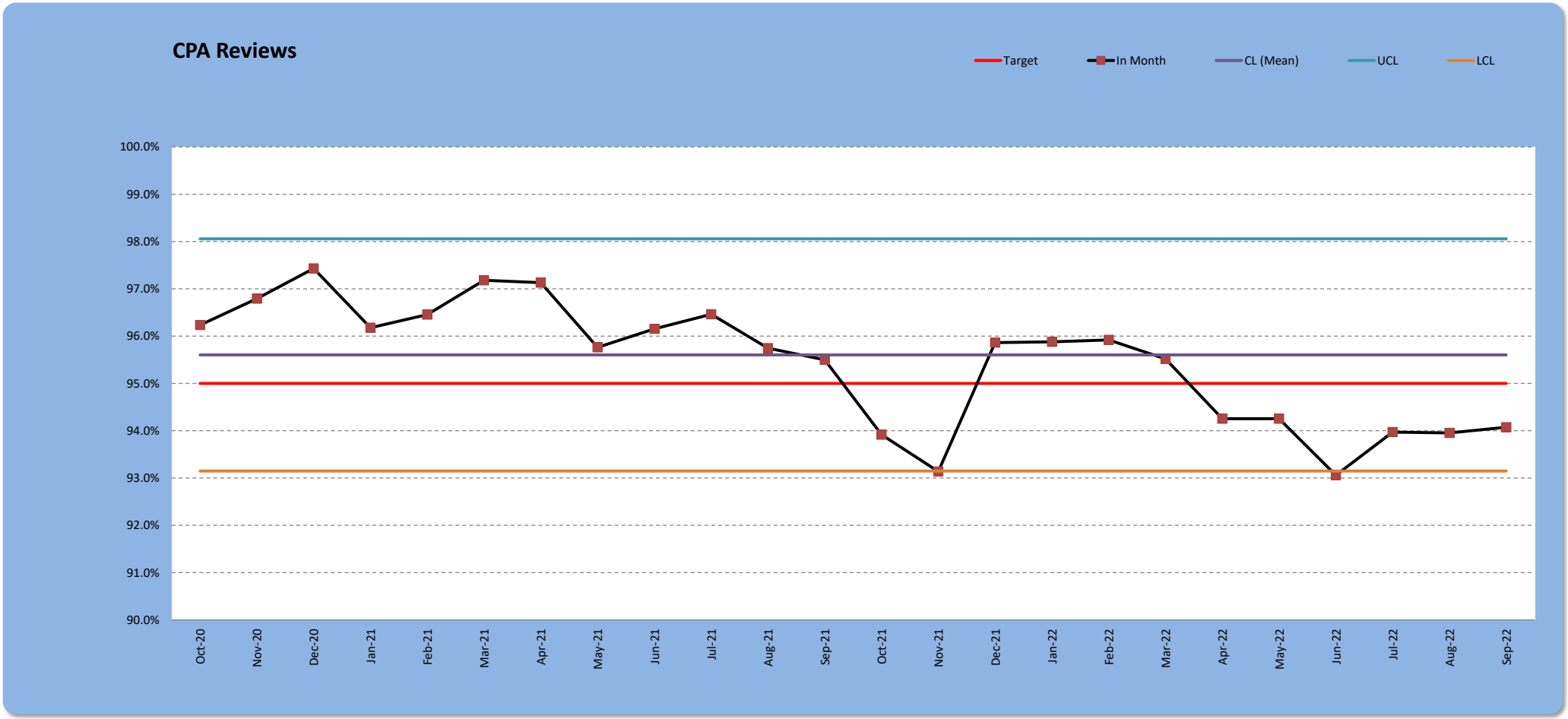
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
95%	85%	94.1%

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



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

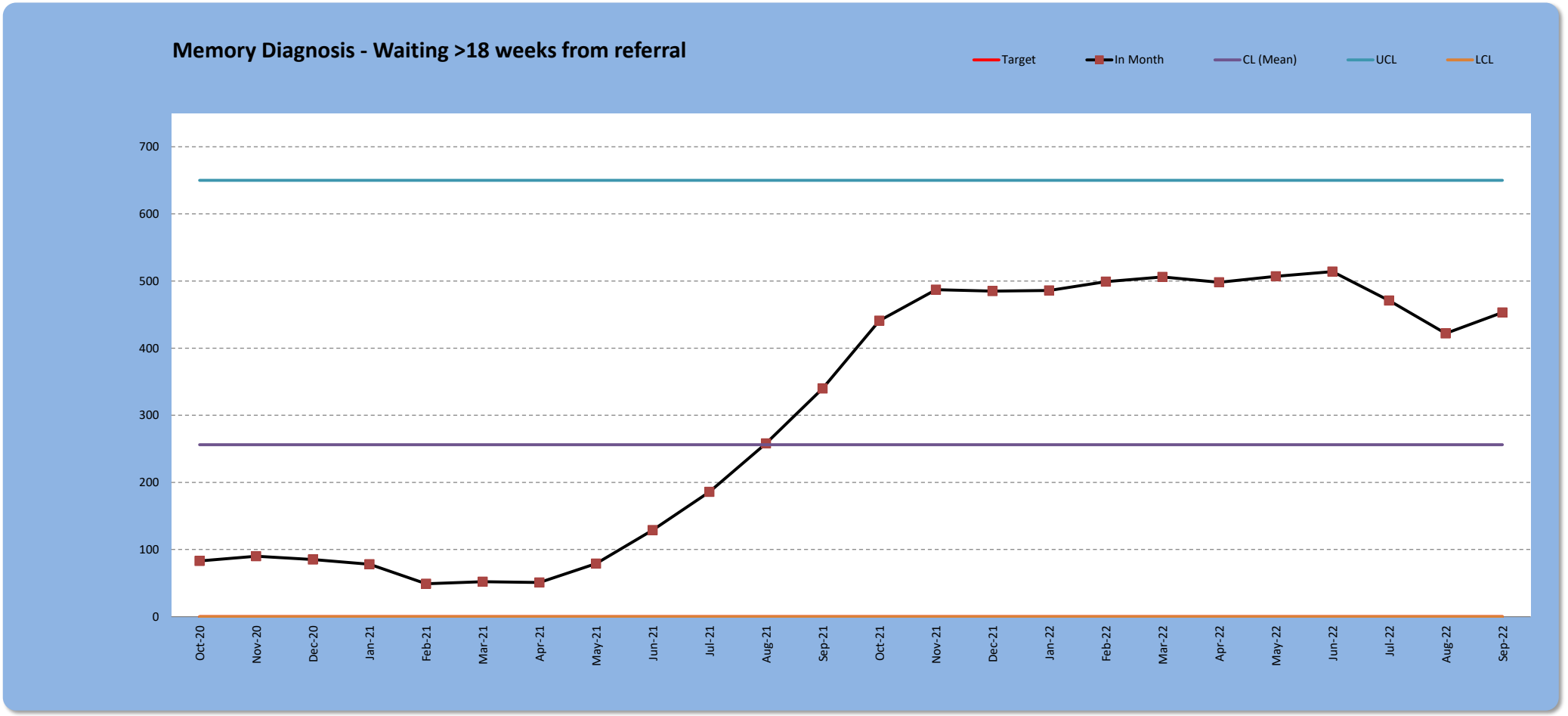
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
n/a	n/a	453

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



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

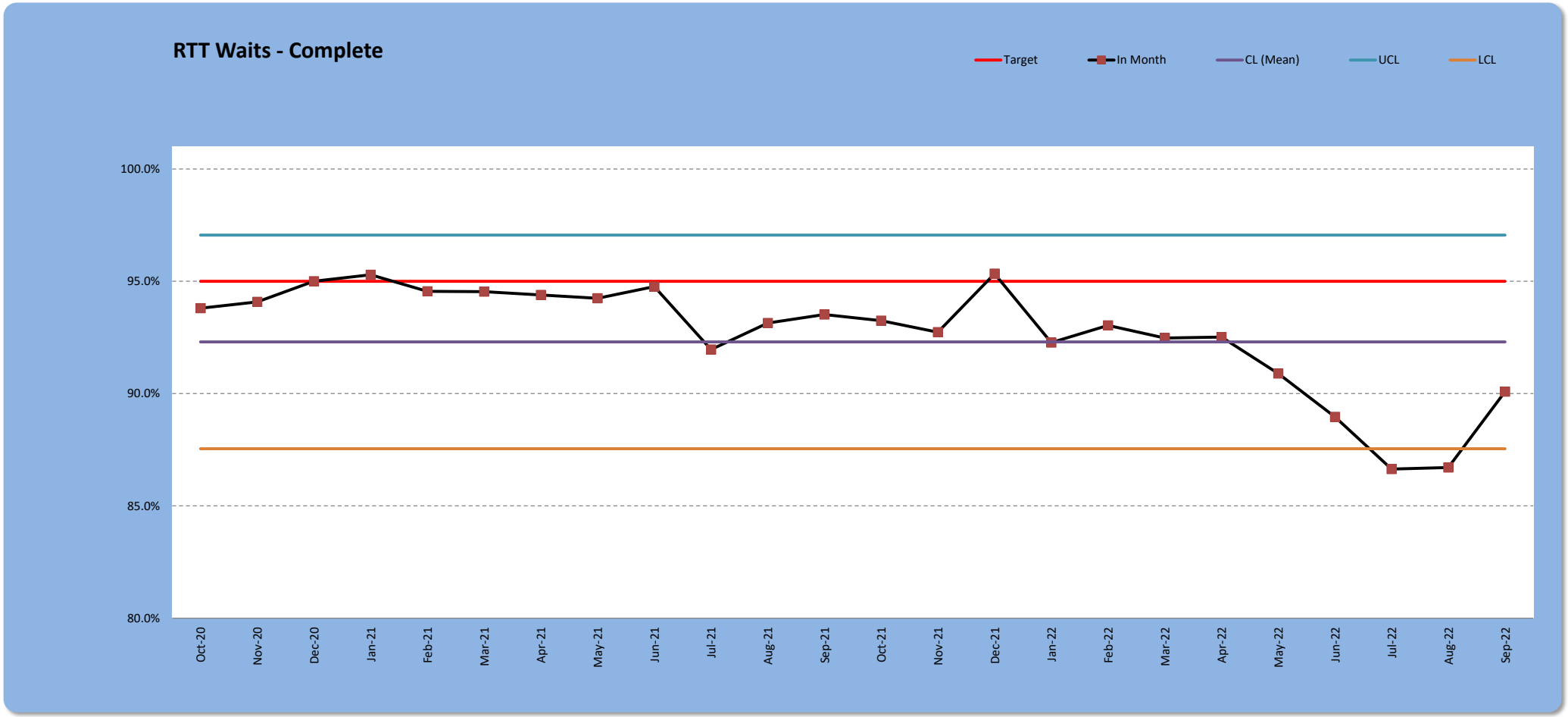
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
95%	85%	90.1%

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



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

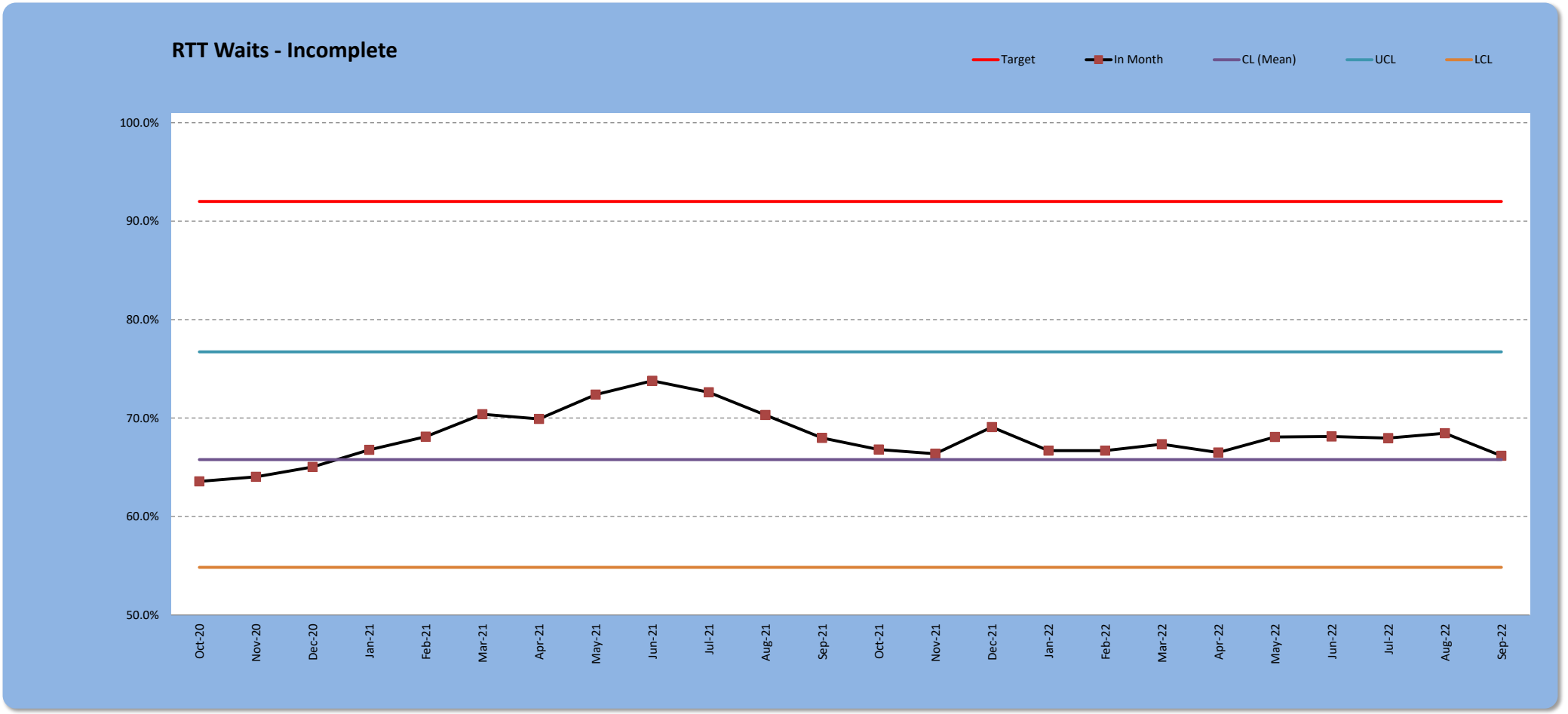
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
92%	85%	66.2%

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



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

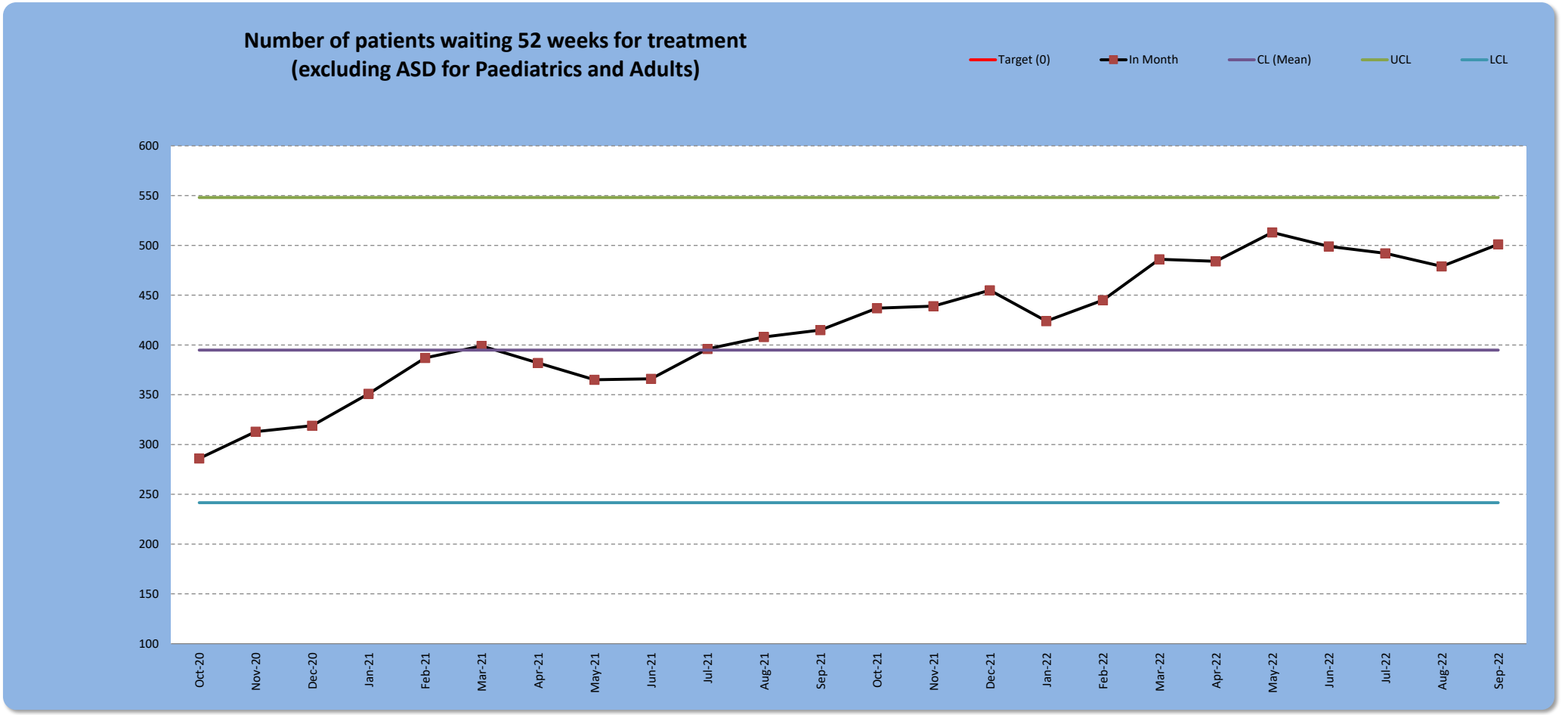
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
0	0	501

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



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

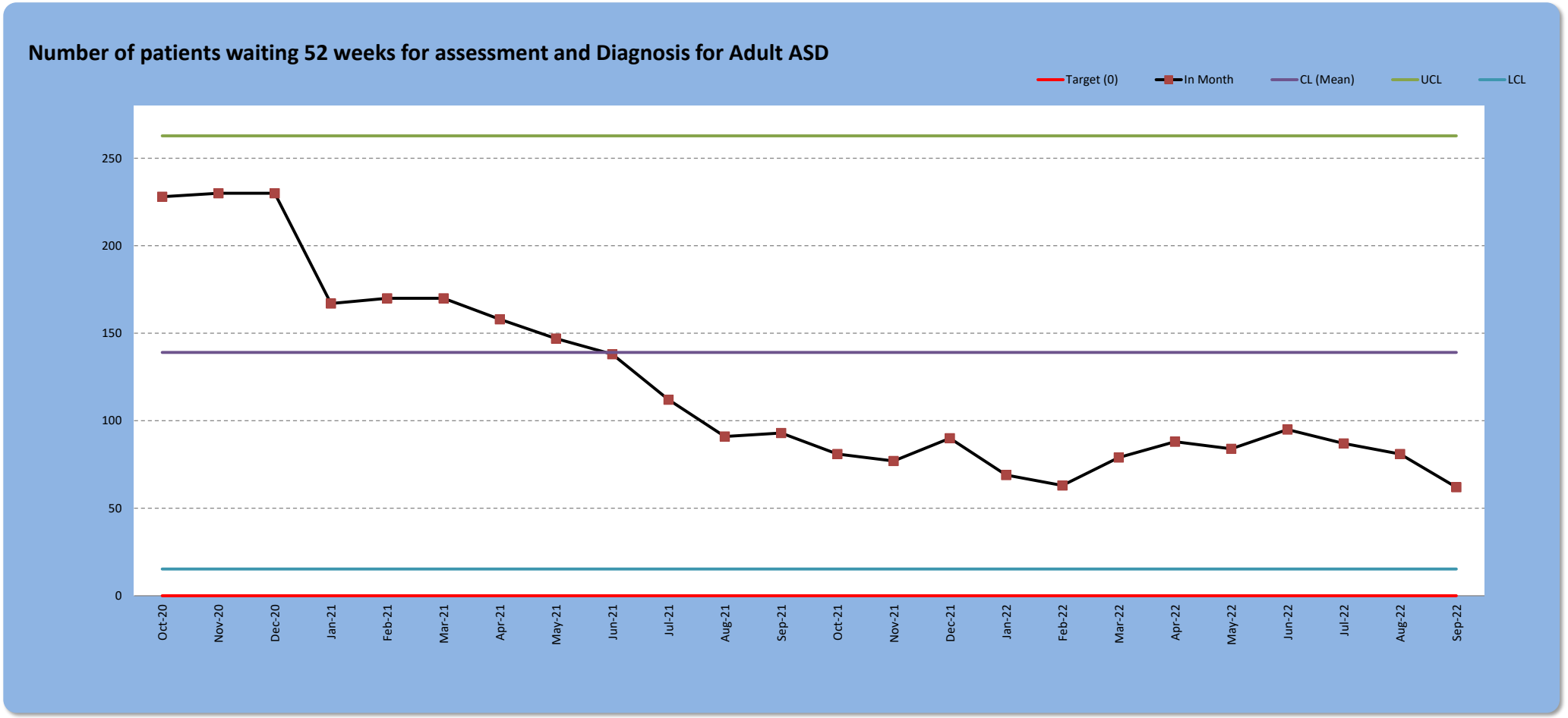
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	62

For the period ending: **Sep 2022**

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



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

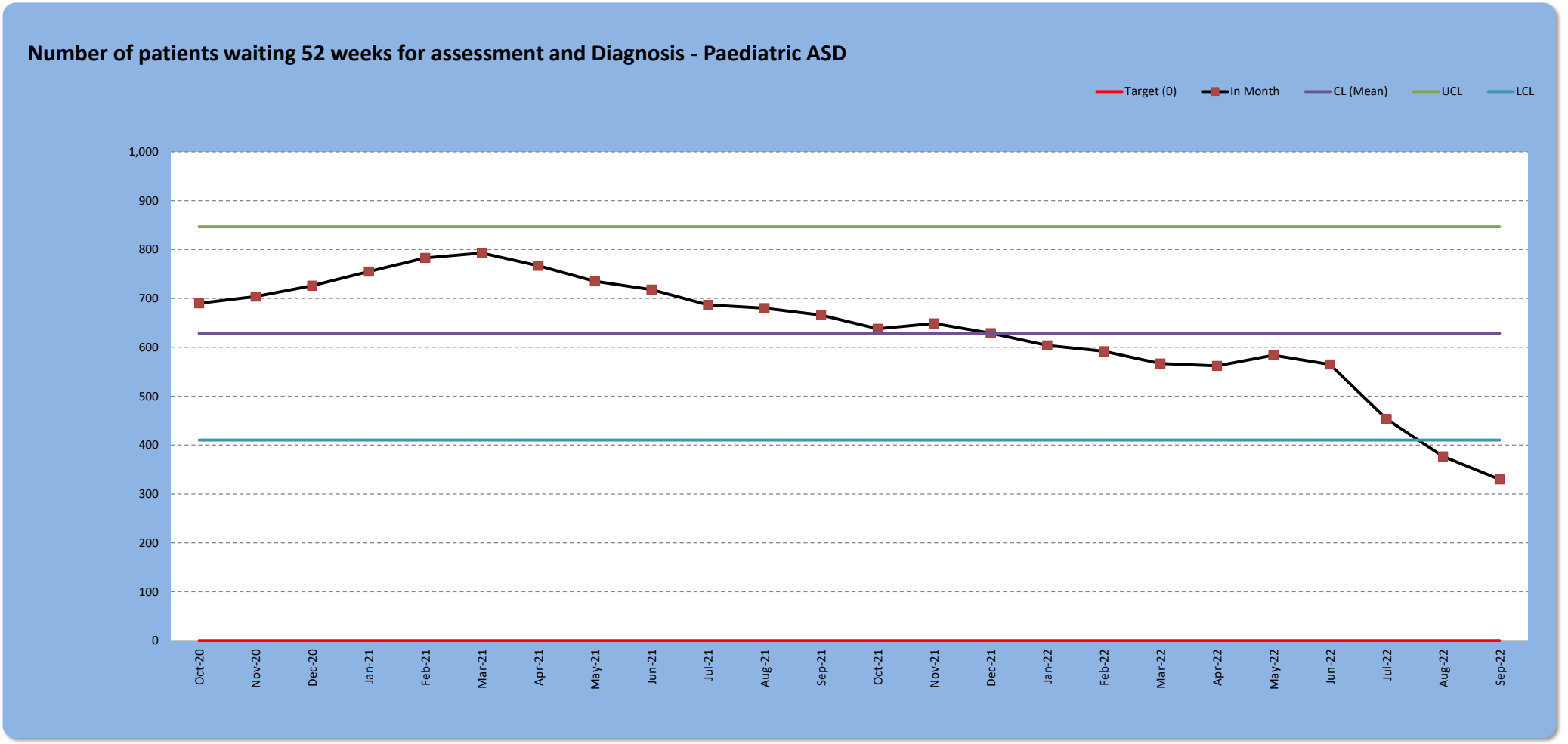
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
0	0	330

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



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

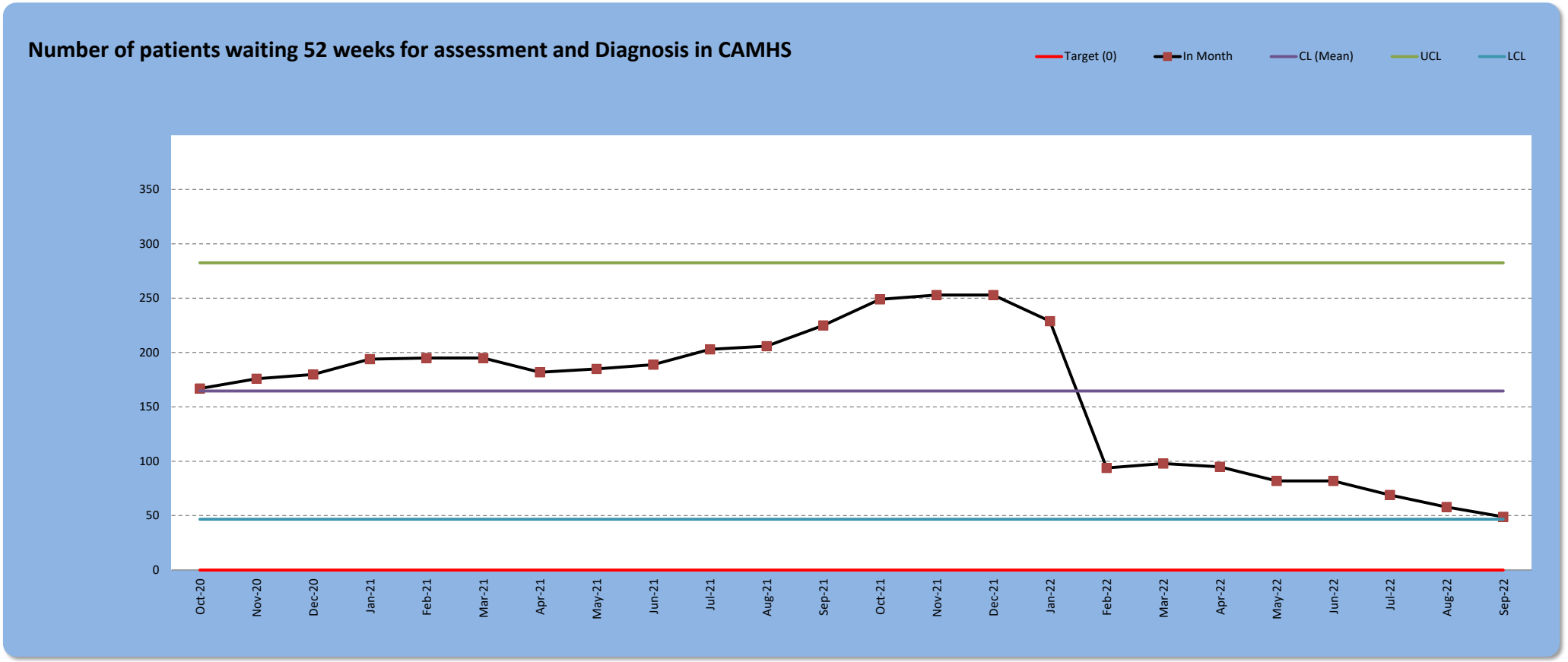
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
0	0	49

For the period ending: **Sep 2022**

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



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

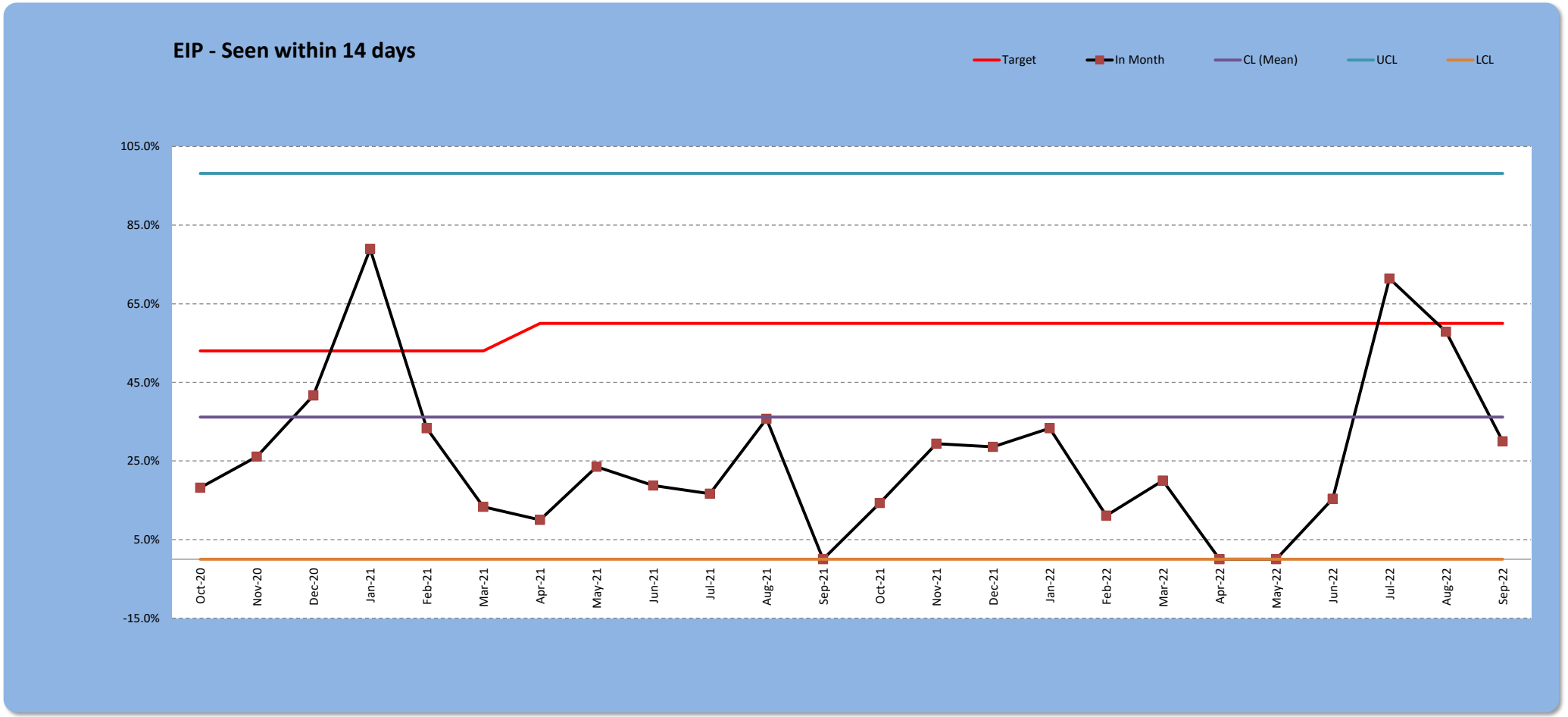
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
60%	55%	30.0%

For the period ending: **Sep 2022**

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



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

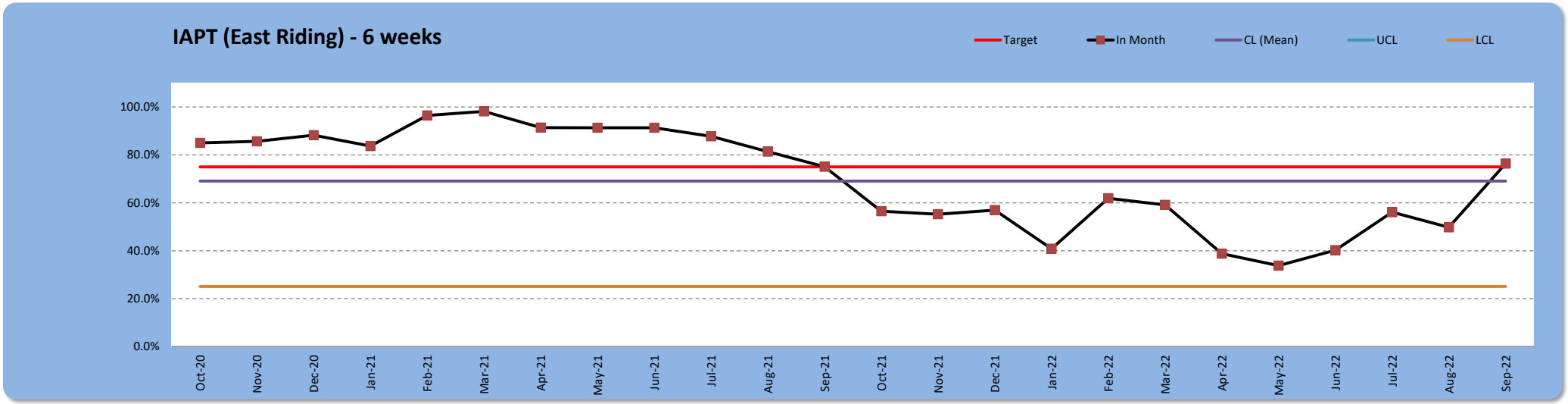
PI RETURN FORM 2022-23

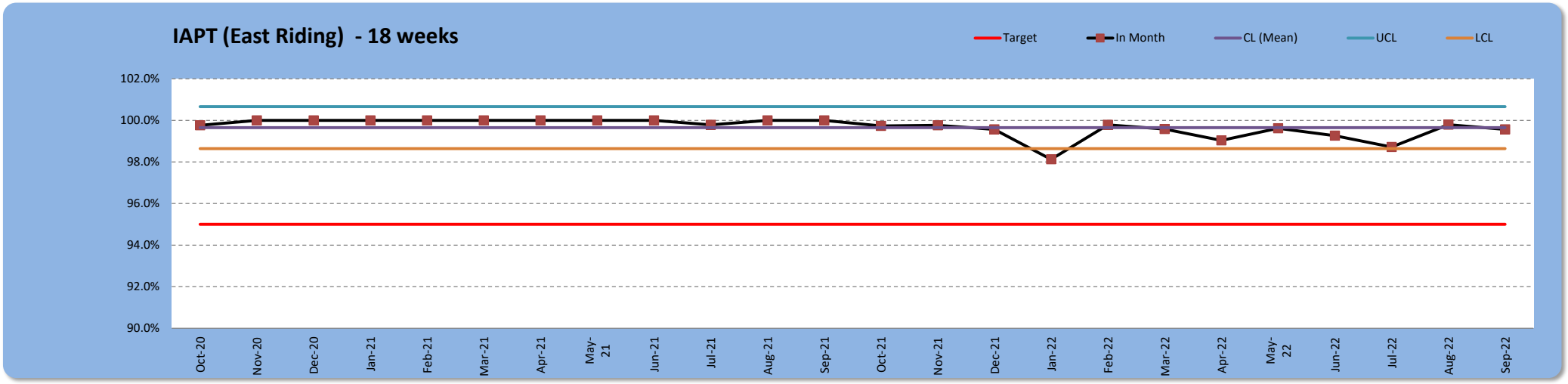
Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Sep 2022**

Target:	Amber:	Current month 6 weeks stands at:	Target:	Amber:	Current month 18 weeks stands at:
75%	70%	76.4%	95%	85%	99.6%

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





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

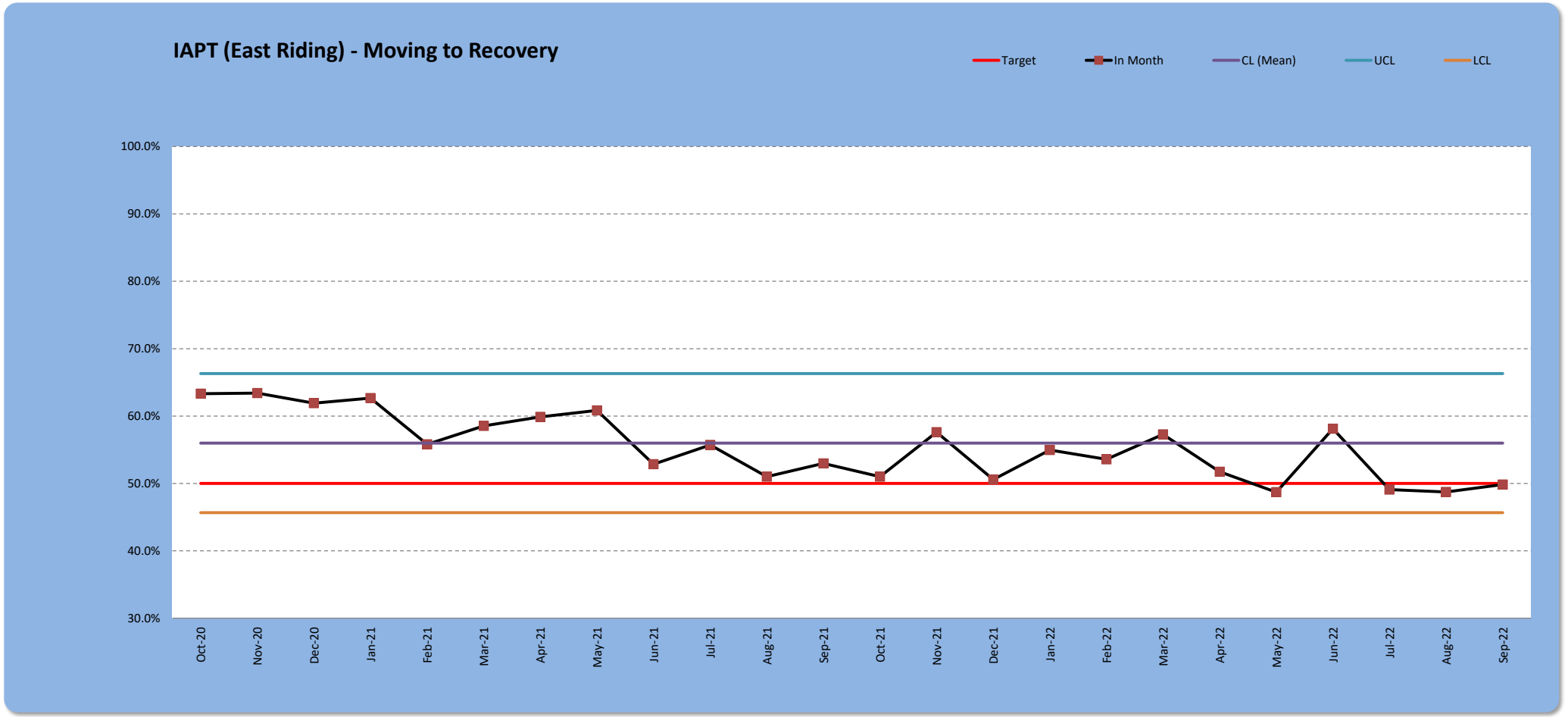
PI RETURN FORM 2022-23

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

Target:	Amber:	Current month stands at:
50%	45%	49.8%

For the period ending: **Sep 2022**

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



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

PI RETURN FORM 2022-23

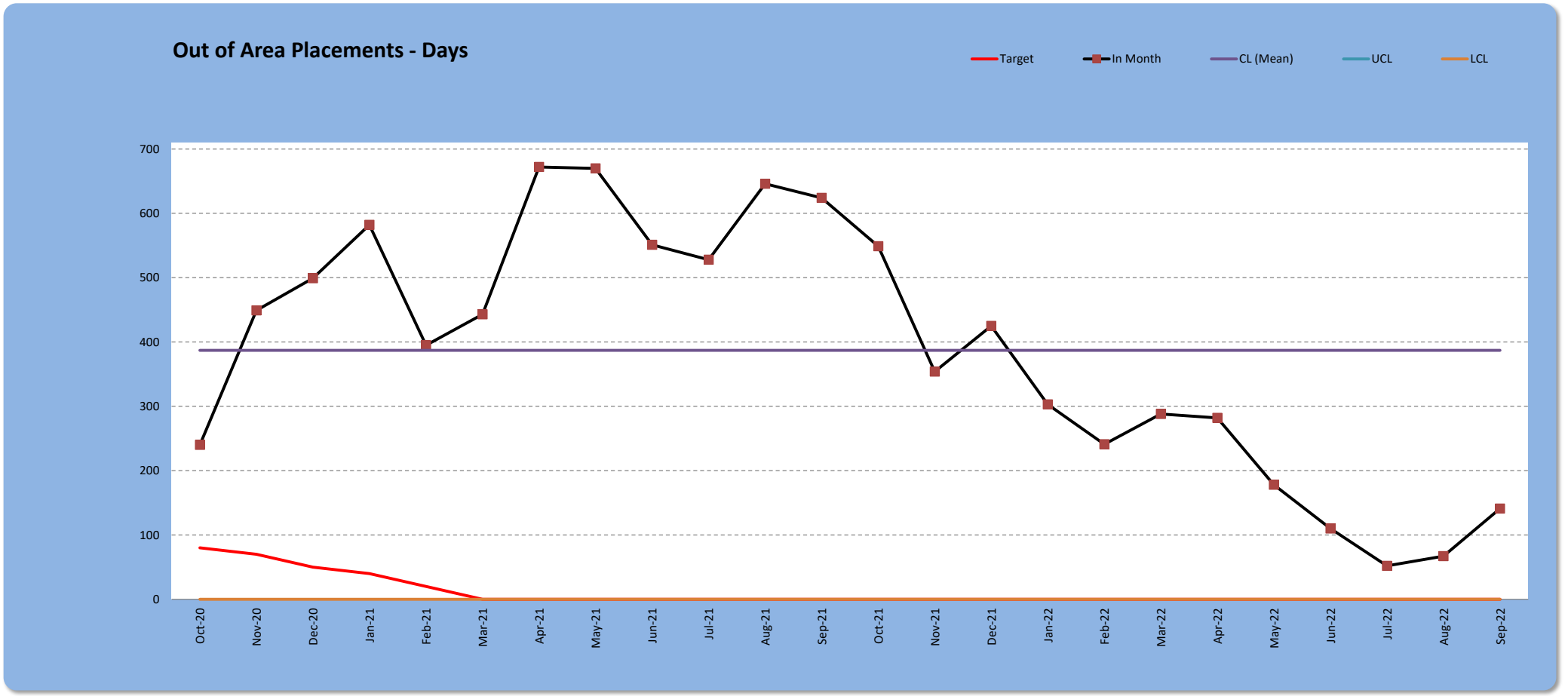
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Sep 2022**

Target:	Amber:	Patients OoA within month:
0	0	7

Split:	# days	# patients
Adult	63	3
OP	77	3
PICU	1	1

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



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

PI RETURN FORM 2022-23

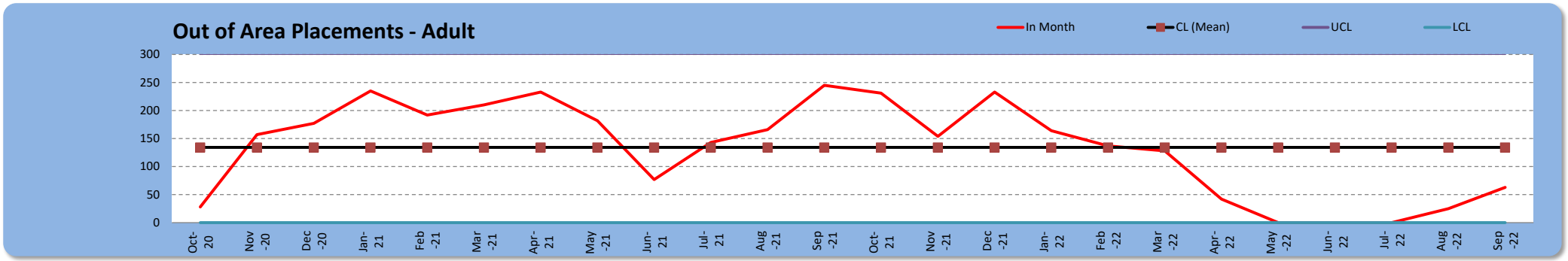
Goal 3 : Fostering Integration, Partnership and Alliances

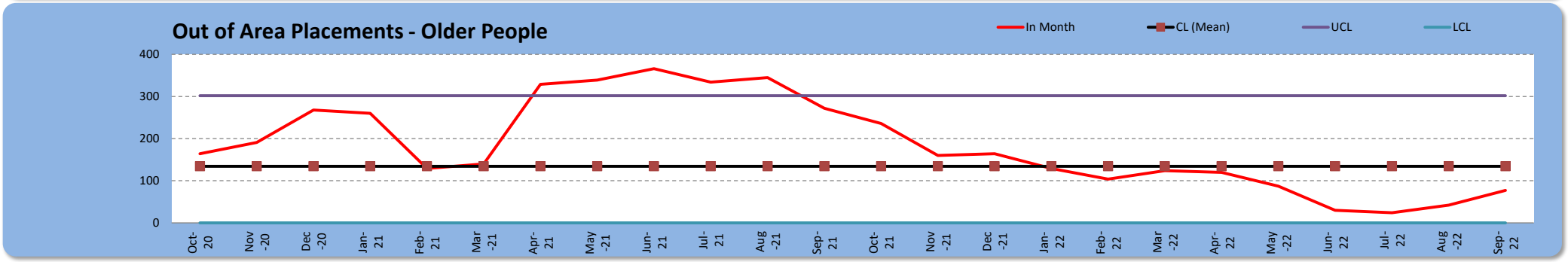
For the period ending: **Sep 2022**

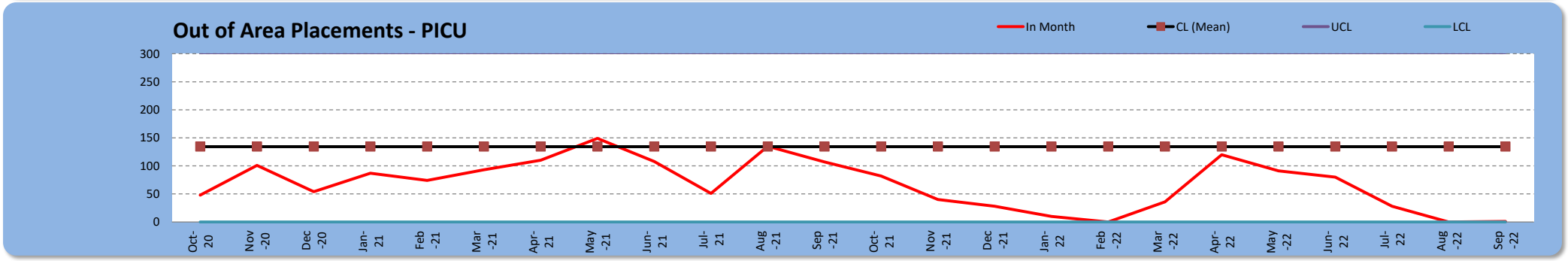
Split for Current month:

Sep-22	
63	Adult
77	OP
1	PICU
141	Total

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







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

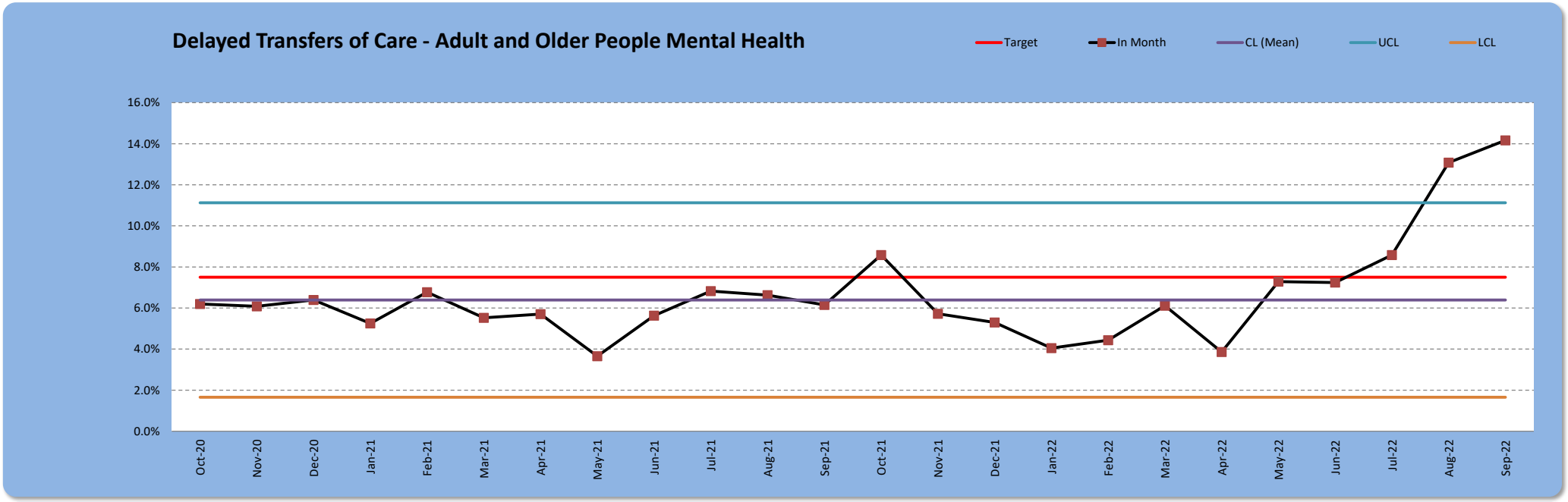
PI RETURN FORM 2022-23

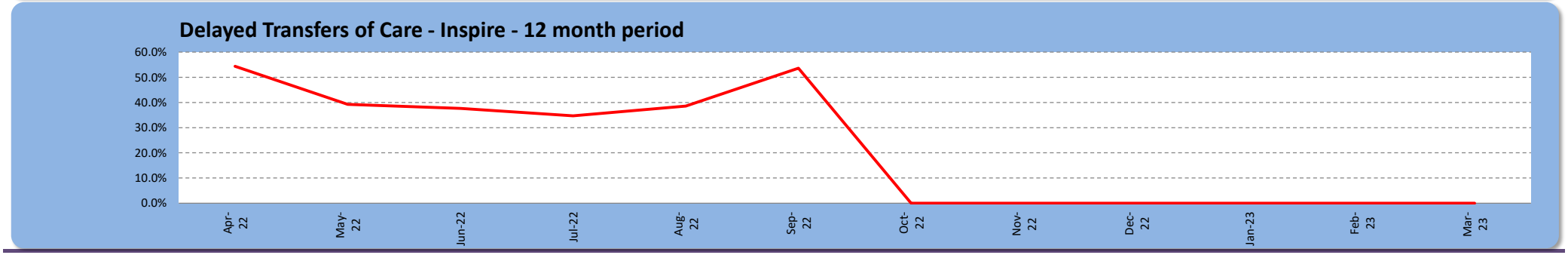
Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
7.5%	7.0%	14.2%

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





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

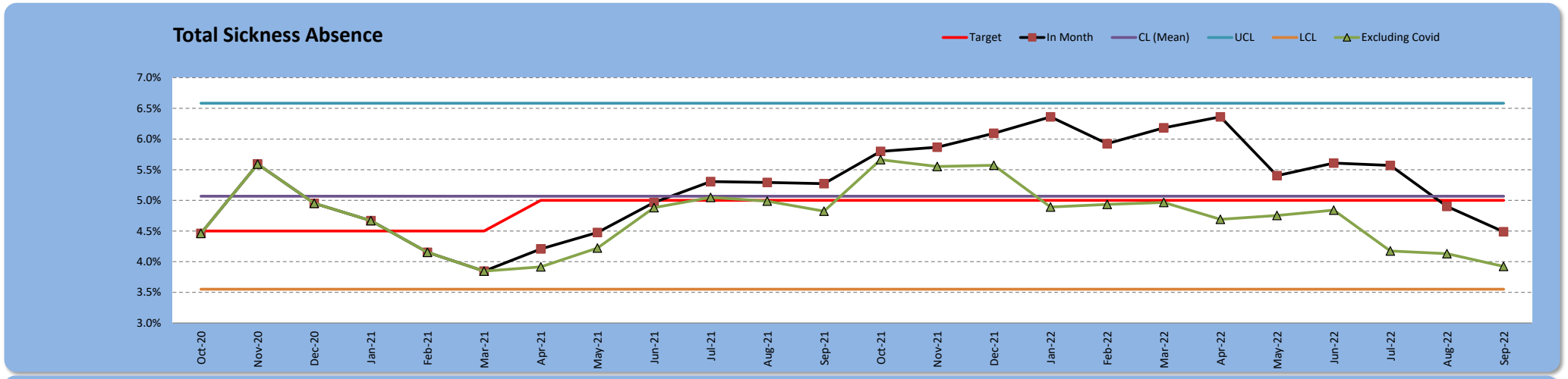
PI RETURN FORM 2022-23

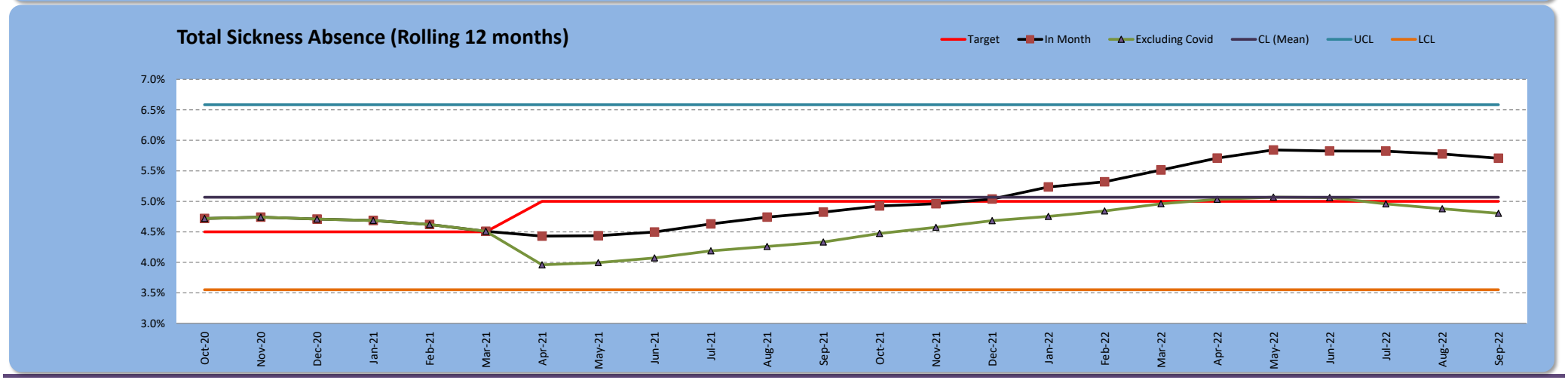
Goal 4 : Developing an Effective and Empowered Workforce

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

For the period ending: **Sep 2022**

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





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

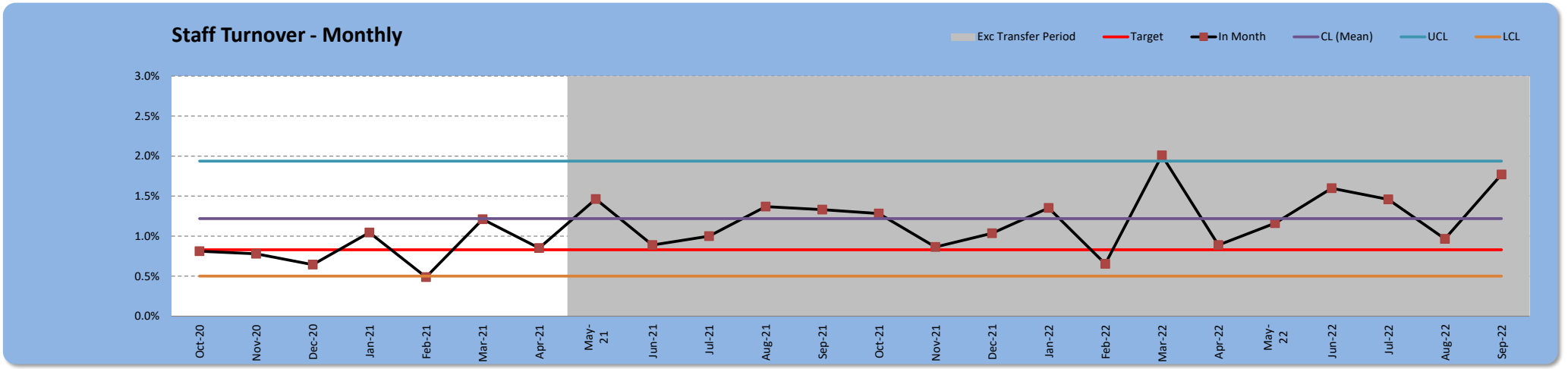
PI RETURN FORM 2022-23

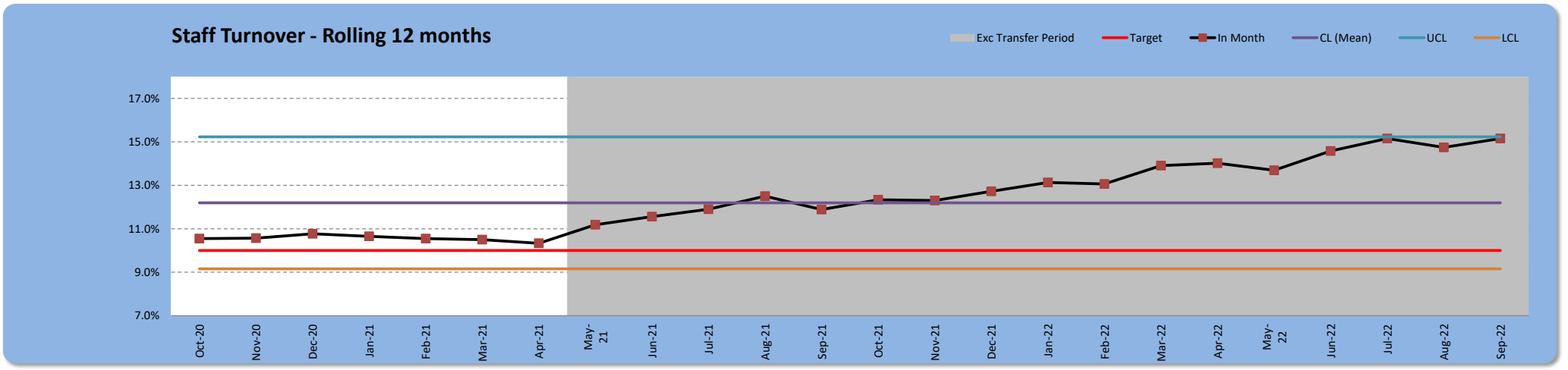
Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:	Target:	Amber:	Rolling figure stands at:
0.8%	0.7%	1.8%	10%	9%	15%

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





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

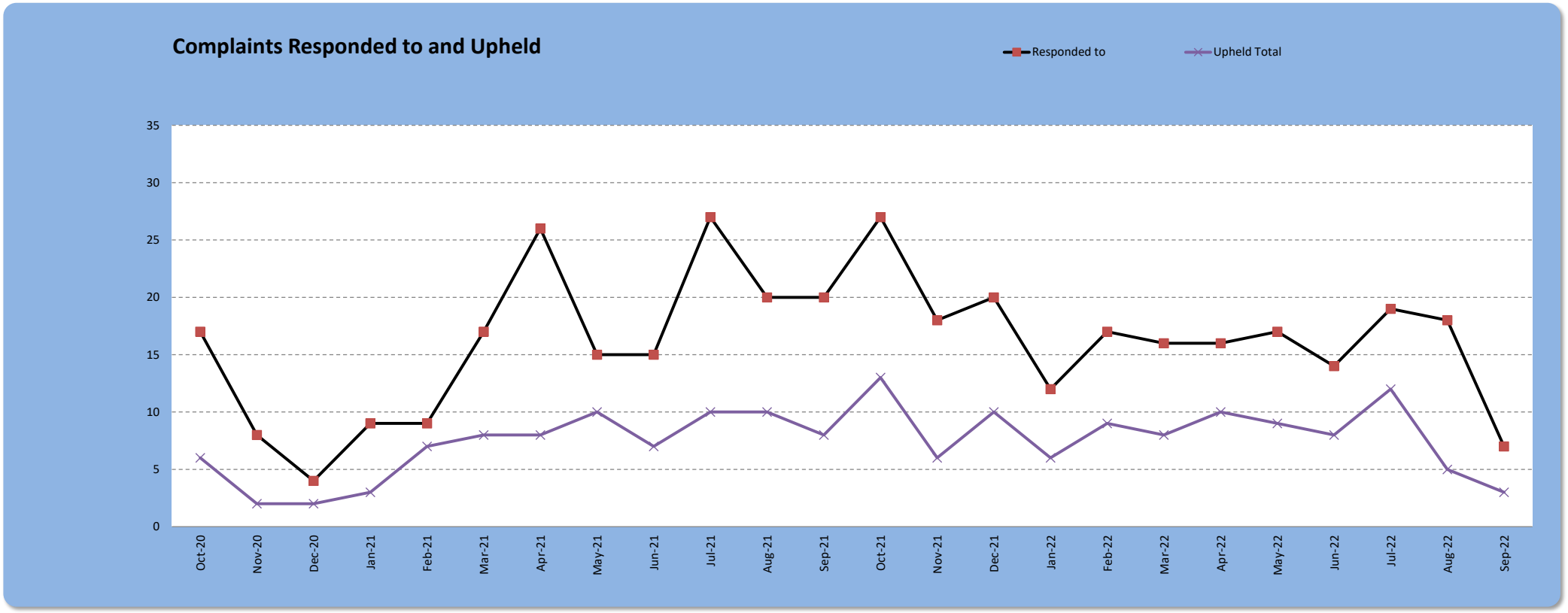
PI RETURN FORM 2022-23

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Sep 2022**

YTD Upheld	No. of Complaints upheld in month	Current month upheld stands at:
50.0%	n/a	0

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



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

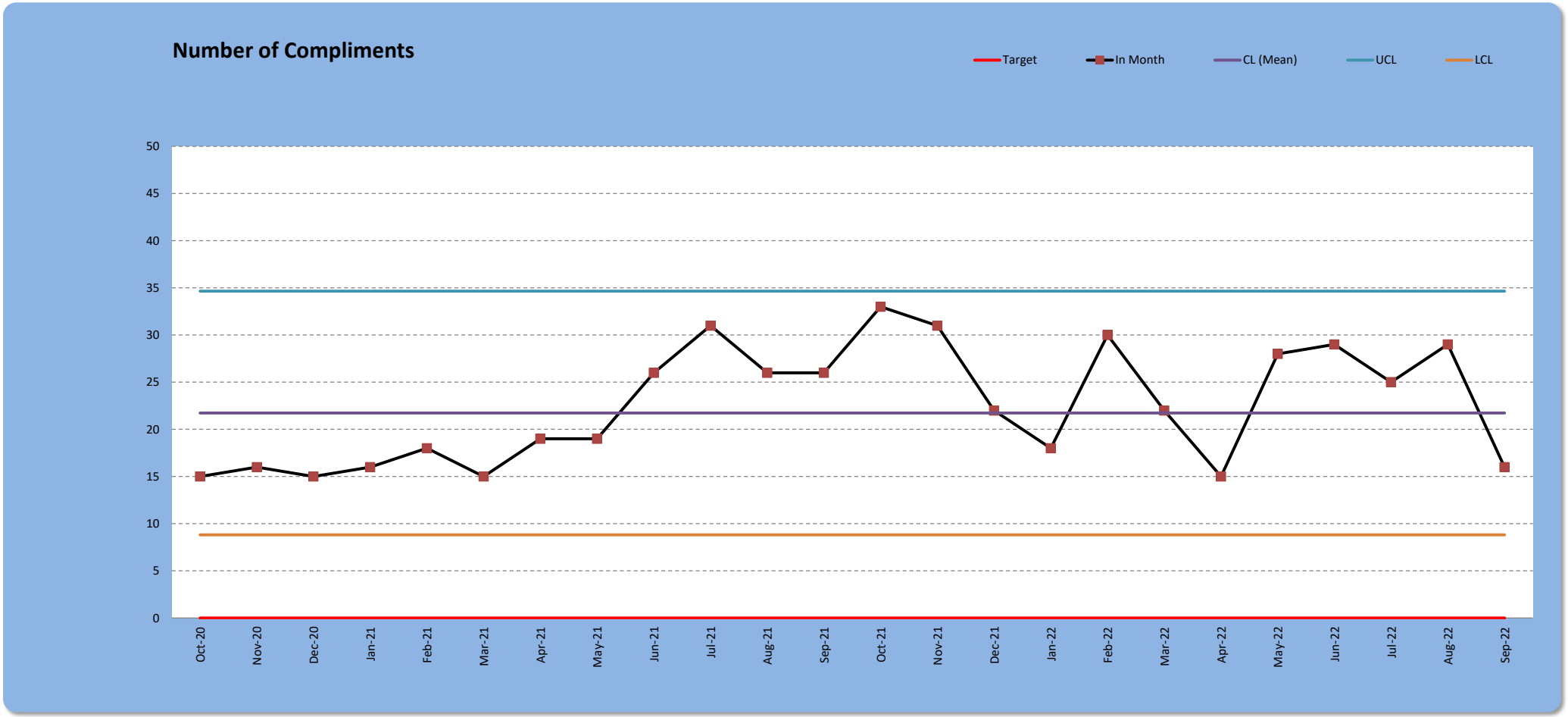
PI RETURN FORM 2022-23

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Sep 2022**

Target:	Amber:	Current month stands at:
n/a	n/a	16

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



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

NHS
Humber Teaching
NHS Foundation Trust

Executive Team:

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

Caring, Learning
& Growing Together

Issue Date: 12/10/2022

Humber Teaching
NHS Foundation Trust

Waiting Time Recovery Quarter 2 Update

Introduction

The purpose of this report is to provide an update of the Trust performance against waiting times, identifying areas of pressure and an update on progress of the recovery plans in place.

The areas of focus are:

1. 52 week waits
2. 18 week incomplete
3. IAPT (Improving Access to Psychological Therapies)
4. EIP (Early Intervention Psychosis)
5. Children's and adult's ASD (Autism Spectrum Disorder)
6. Children's ADHD (Attention Deficit Hyperactivity Disorder)
7. Core CAMHS
8. Neurodiversity Front Door
9. Adult ADHD (Attention Deficit Hyperactivity Disorder)
10. MAS (Memory Assessment Services)
11. OAP (Out of Area Placements)
12. Crisis Care Line

Performance and Recovery Plans are monitored and reviewed regularly via the Operational Delivery Group (ODG), Performance and Accountability Reviews and the Executive Management Team (EMT). The Divisions and Services continue to work closely with the Patient Access and Performance Manager to review the plans and ensure they will either deliver the projected recovery or can effectively be maintained through considering the impact of referrals and activity from the wider system..

Referral trends continue to be monitored and analysed post COVID to confidently determine levels of demand for planning purposes.

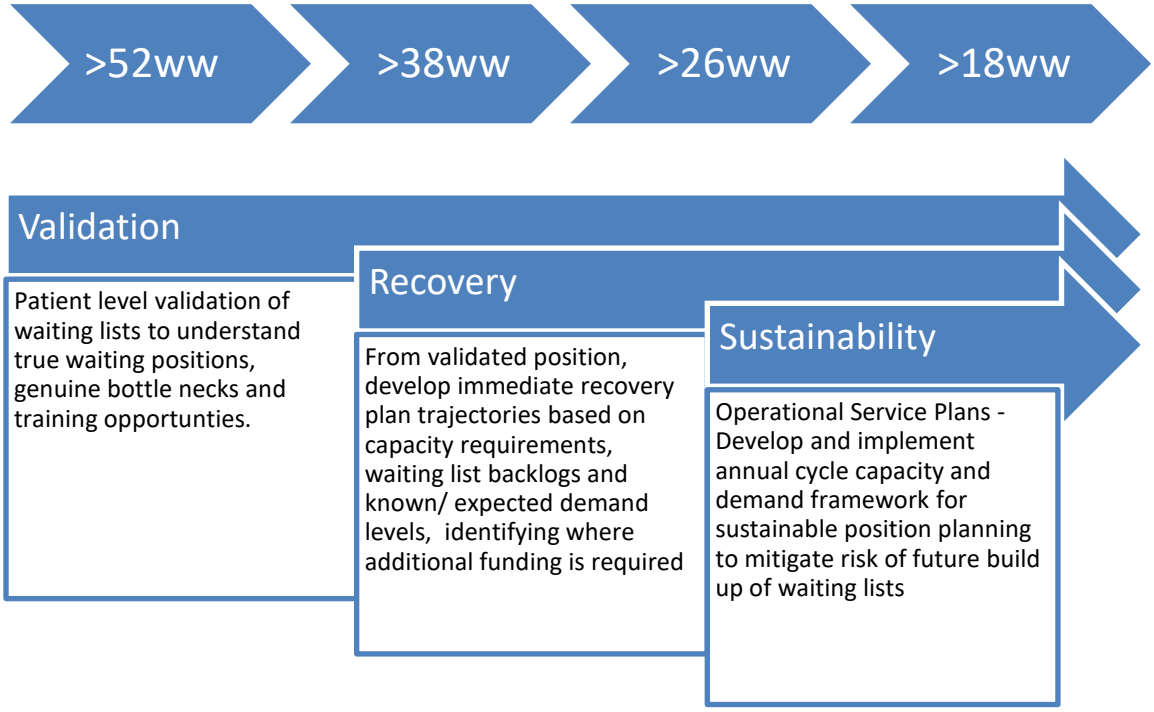
Approach

As part of the Trust's operational performance management framework, weekly performance meetings occur with service leads to review the waiting list position and gain assurance that the position is accurate. These meetings are designed to:

- Agree management plans and their intended impact
- Determine areas of escalation
- Agree a method for Capacity & Demand planning
- Support early intervention of emerging issues and concerns

The overall performance focus remains on bringing all services in line with the 18wk standard where applicable (or minimum standard applicable to that service) as well as to continue to work with services and the ICB to establish suitable waiting time targets where these are not nationally mandated.

Due to the number of patients currently waiting longer than 18wks, the monitoring approach remains the same and will be an ongoing commitment:



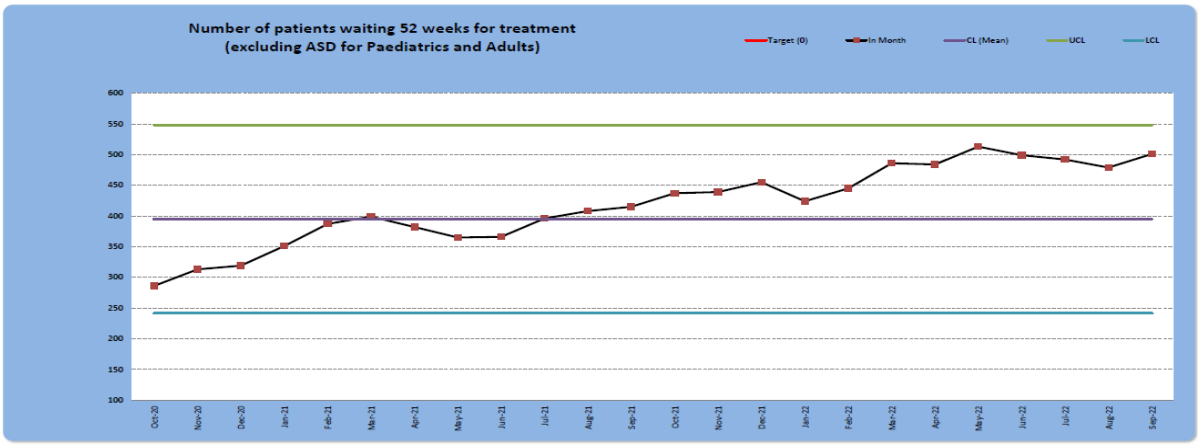
Service Areas/Performance Indicator

1. 52 Week Waits

Current Position

There has been a steady growth in the number of patients waiting over 52wks for their treatment over the last 2 years as demonstrated by the chart below:

Indicator Title	Description/Rationale		
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



The following table demonstrates:

- the main service areas contributing to the over 52ww position (ADHD for both children and adults).
- Service areas current progress/position compared to the end of Q4 of 21/22

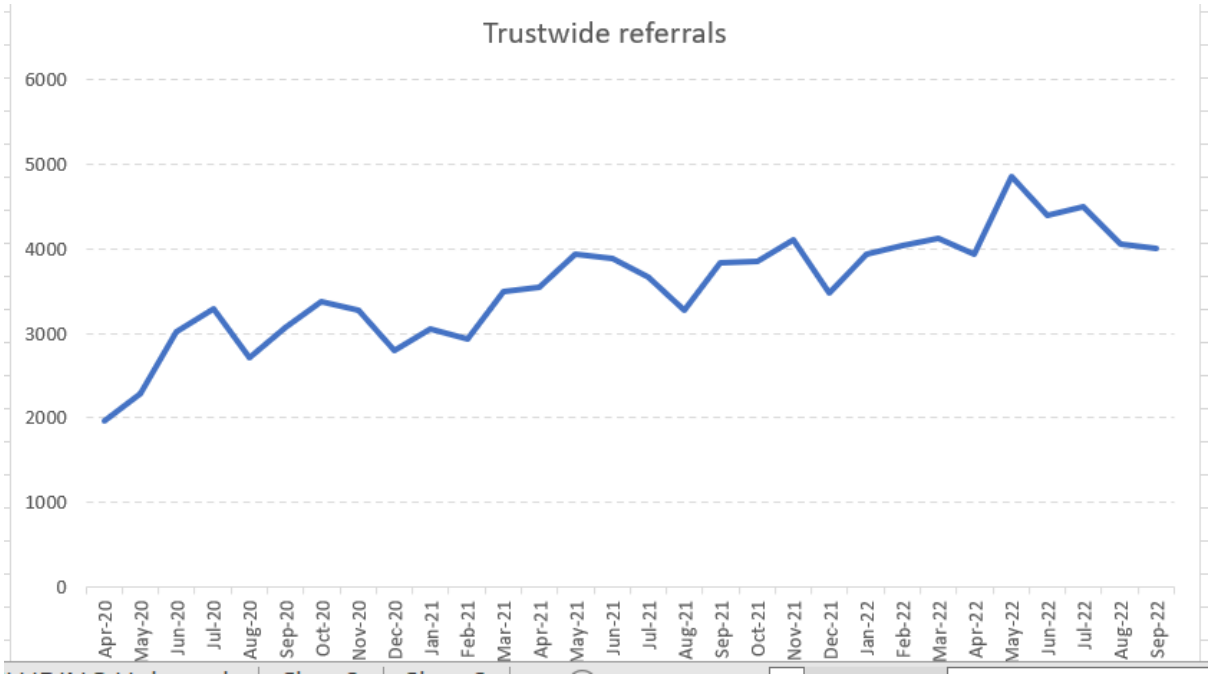
	No. of patients waiting over 52weeks		
Service Area	**Q1**	**Q2**	
Children's ASD	555	333	↓
Adult ASD	96	66	↓
Children's ADHD	181	193	↑
Adult ADHD	93	127	↑
Memory Service	61	49	↓
Core CAMHS	79	49	↓
Children's LD	21	23	↑
Paediatric Therapy	6	4	↓
MH Specialist Services	4	1	↓
Department of Psychological Medicine	0	4	↑
S&R	20	8	↓
*Vale of York Community	20	26	↑

Vale of York Community Data Cleansing Update

Vale of York – 16 of the 26 over 52wws remain a focus with ongoing work with Eating Disorder Leads and CMHT Leads to determine the correct course of action. Patients are currently being clinically reviewed to determine clinical safety prior to closing the episode. It is expected that a significant proportion of these waits will be closed as not requiring further intervention in the next quarter.

Challenges

Whilst the profile for patients waiting over 52weeks for assessment/intervention shows increase over the past 2 years, the chart below demonstrates a similar position in terms of referral growth. This continues to be monitored to understand true demand levels post COVID and to take into consideration natural seasonal variance. Staff absences/vacancies continue to be contributing factors in delaying progress in some areas with recovery trajectories.

- 

NB: the above chart includes Lorenzo based activity only.

Plan

The recovery of the 52ww position is a key area of focus and is being monitored at service level on a weekly basis. This oversight and monitoring is in place to support progress and to ensure recovery plans are current and responsive.

The approach being taken is as follows:

Validation of Waiting Lists

- Service Managers and/or Clinical Leads review their waiting list to update at patient level at the weekly performance meetings. The expectation at the meeting is that the service will be able to advise the following:
- Validity of waiting list position
- That there is a management plan for individual patients being reviewed
- Identify where recovery initiatives are required to enable progress
- To confirm that agreed actions have been completed

Capacity and Demand Work

Capacity and demand planning has taken place with those areas with 52 week wait pressures and this has determined that the following services require short-term waiting list initiatives to enable performance to return to within 52ww, these are:

- *Children's ASD*
- *Adult's ASD*
- *Children's ADHD*

- *Adult's ADHD*
- *Core CAMHS (Hull)*
- *Memory Service*

All services are required to undertake detailed capacity & demand analysis to determine the level of capacity required to meet their individual waiting time targets (18wws maximum) as part of the annual business planning cycle.

2. ***RTT Complete and Incomplete (18ww standards)***

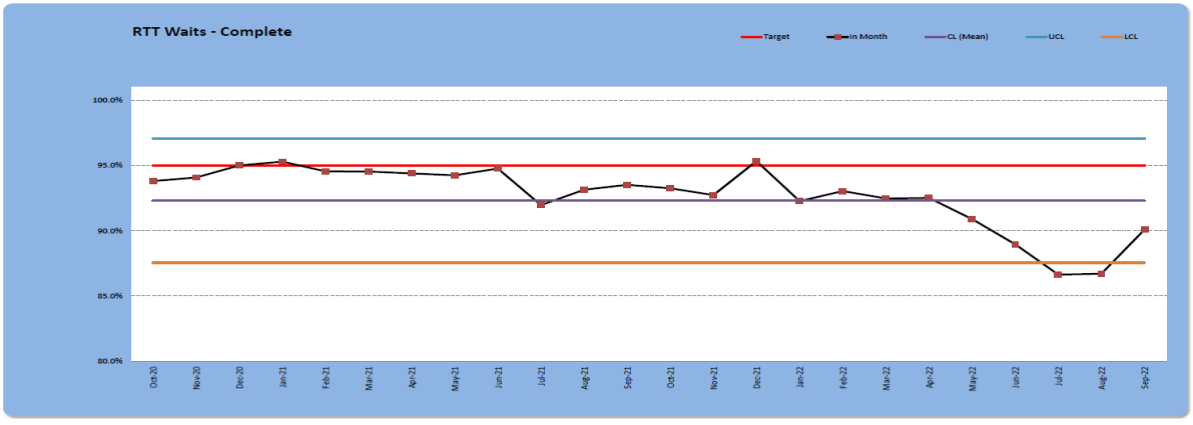
The Complete standard relates to the number of patients who have commenced treatment within the reporting period within 18wks

The Incomplete standard relates to waiting times for patients waiting to start treatment at the end of each month, who are within 18wks

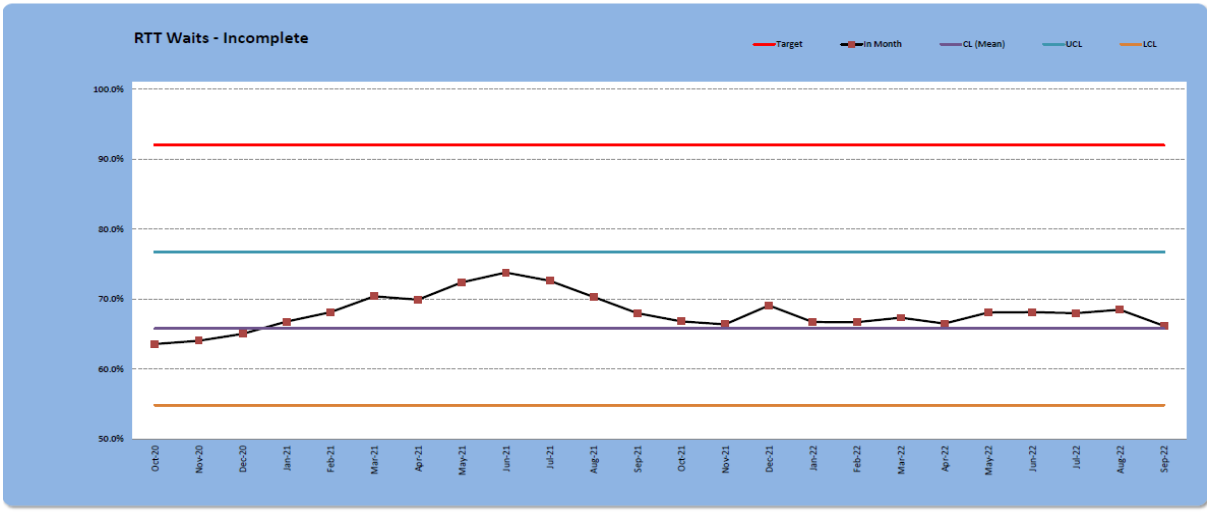
Current Position

There is a correlation between the complete and incomplete standard. As our focus remains on incomplete pathways and is primarily on those patients waiting the longest (over 52ww), there will ultimately be a positive impact to the 18ww incomplete standard and a worsening of the complete standard. This is due to having a higher number of clock stops for patients who have already waited for longer than 18weeks. This is an expected as part of recovery and will improve.

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



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



Whilst the validation of the waiting lists results in a number of patients being removed from the waiting lists and as the services focus on their longest waiting patients i.e. over 18ww, there will be a deterioration in the RTT Complete performance, and an improvement experienced in our Incomplete position.

Challenges

The challenge remains that whilst addressing the longest waiting patients, the 18ww position will continue to be difficult. The main challenges are:

- Growing referral rates
- Focus on recovery of longest waiting patients

Plan

To recover the incomplete position, performance monitoring meetings will continue to focus the service areas on:

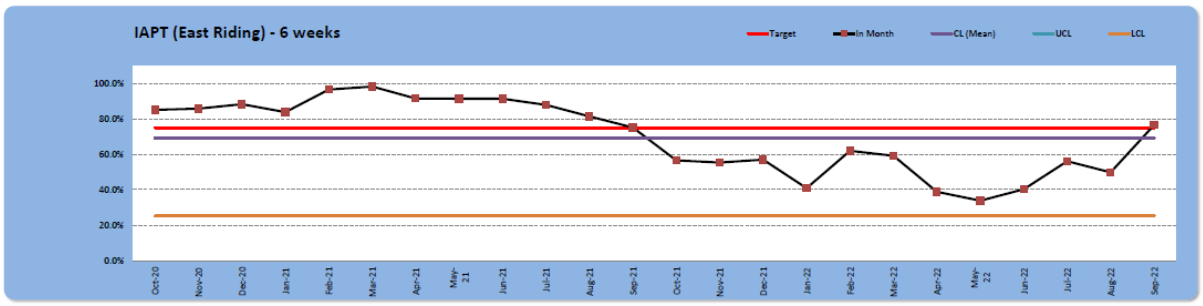
- Managing the longest waiting patients
- Implement and monitoring of recovery plans
- Continue with validation work to maintain a true waiting list position
- Undertaking capacity and demand modelling to anticipate future service/investment requirements.

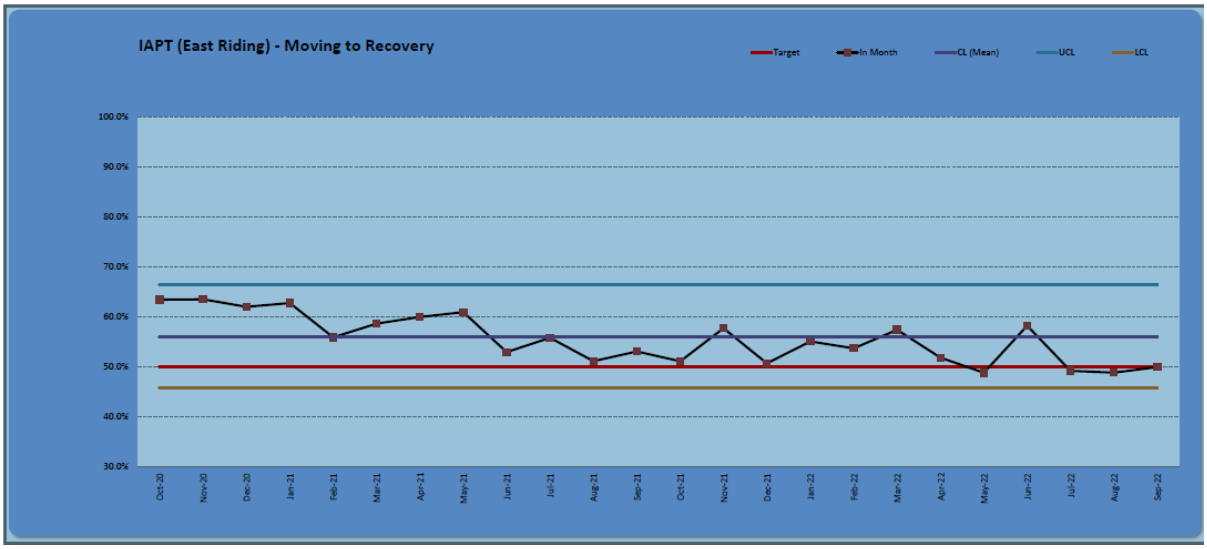
3. Improving Access to Psychological Therapies (IAPT)

Current Position

Since December, the service has continued to maintain performance against the 18week standard, performing at 99% in September against a 95% target.

Achieving the 6week standard has continued to be a challenge due to an increase in patients requiring more specialist interventions, namely counselling and high intensity therapy, however 76% against a 75% target was achieved in September.





Several initiatives have been mobilised to improve the position and results are now being realised:

- Remote working
- Negotiated increase capacity with contracted providers

The service has continued to work closely with providers to ensure that they are delivering capacity in line with contracted activity levels. This proactive approach with providers is improving relationships and allowing for early discussions to plan and exploit flexibility to support with modality peaks and troughs in referrals.

Challenges

Recruitment and retention have continued to be challenging both from a Humber and private provider perspective. A substantial increase in subspecialty demand has resulted in the need to refresh plans and revisit options for independent provider support for these specialist areas whilst recruitment and retention incentives are explored.

A positive impact of the development of the Primary Care Mental Health Networks across Trusts is a reduction in referrals into the service but this has led to an increase in the complexity of presenting need. This will impact on quality indicators for recovery and as more complex cases are likely to require onward referral or signposting following the IAPT intervention. September position stands at 49.8% against a 50% standard for recovery.

Plan

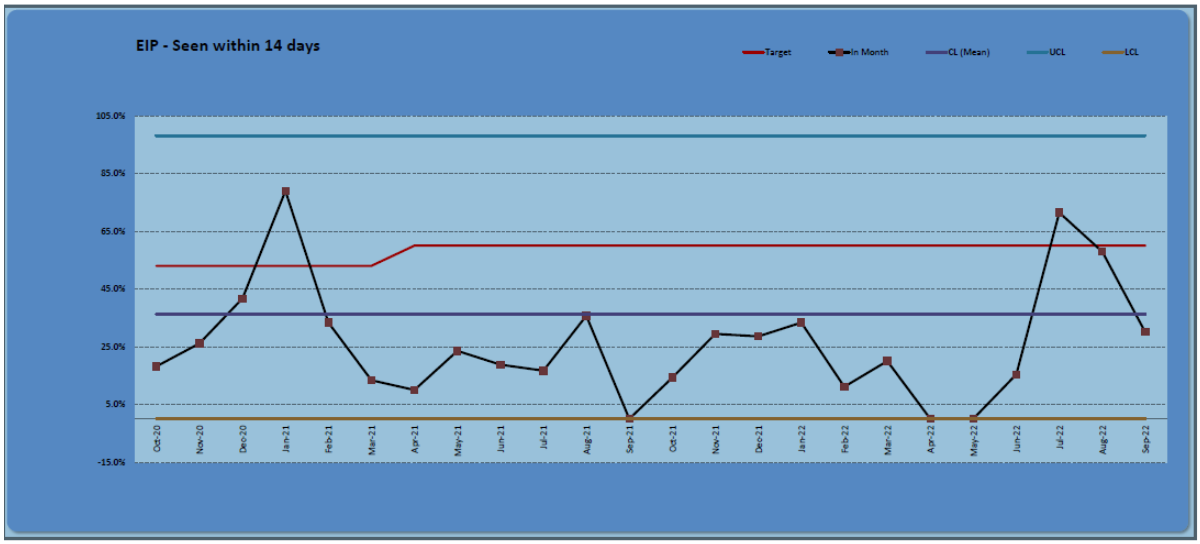
The service continues to focus on recruitment and retention. There has been an improvement in staff absence levels, 4.38% September compared to 5.72 in June, this will continue to be monitored closely.

4. Early Intervention Psychosis (EIP) - 14day standard

Current Position

The chart below details the proportion of referrals whose first contact takes place within the 14-day standard. It indicates that performance against this standard has been volatile since January 2022 and fell during September to 30% against a 60% standard.

Early Intervention in Psychosis	Percentage of patients who were seen within two weeks of referral	Executive Lead Lynn Parkinson	OP 9



Challenges

Over the past 12months referrals have gradually increased at a time when staff absences and vacancies have been high. The service is now fully recruited, some newly recruited staff have come into post from September and will be undergoing preceptorship before being able to take on full caseloads.

Plan

The service will continue with robust monitoring of staff absence and sickness in line with Trust policy with regular reviews to support improvement in productivity and access times whilst new staff are inducted and trained.

It was expected that an immediate improvement in waiting times would be achieved by August 2022 when staff recruitment was complete but an increase in referral volume has caused a reduction against targets despite the service being able to achieve them for June/July. The appointment of a new clinical lead, working with the Team Leader has allowed review of current processes and pathways and an agreement that all assessments will be allocated by the leadership team based on productivity and capacity of staff able to undertake assessments.

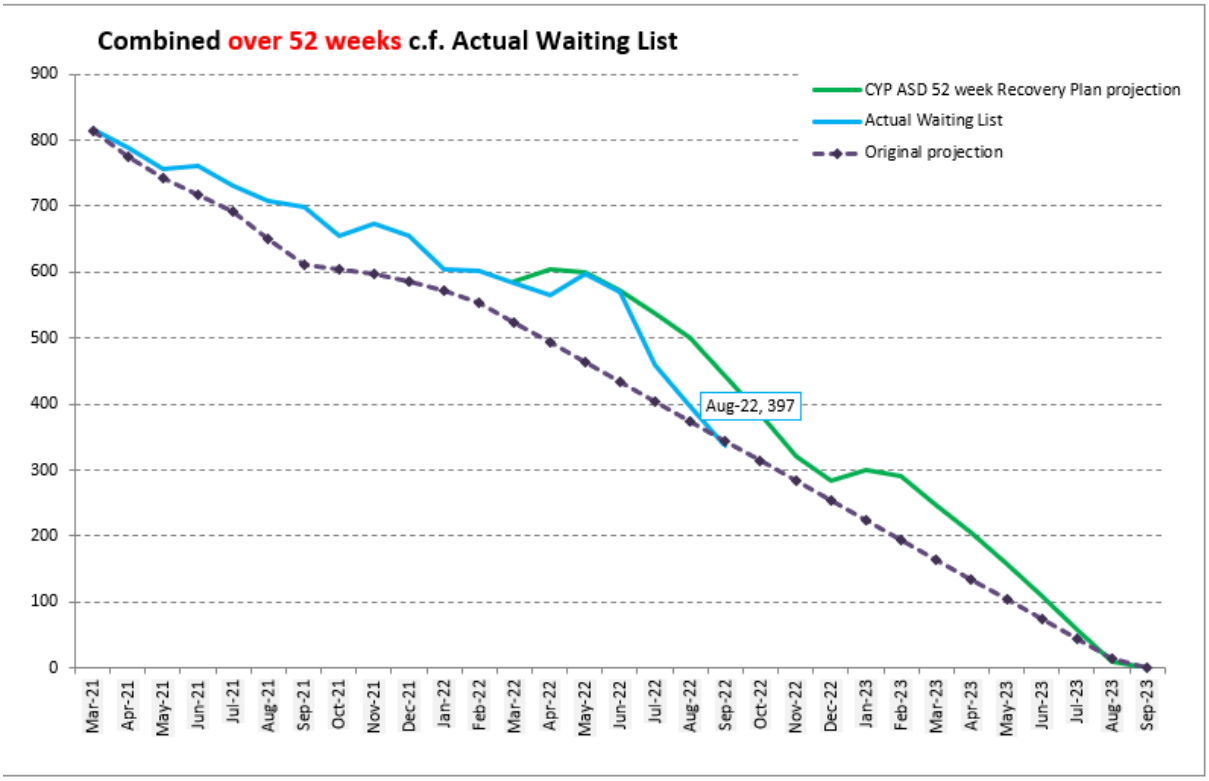
All caseload allocations to staff who can fulfil a Care Coordinator role will be done by the leadership team based on capacity and productivity information and monitored through

clinical, management and professional supervision rather than wait for discussion within a weekly MDT when some staff are not able to attend

5. Children's Autism Spectrum Disorder (ASD)

Current Position

The recovery of the over 52ww position for children's ASD has continued to make good progress. The recovery plan has been refreshed to incorporate an increase in demand. Independent provider provision and activity remains in line with previous plan and continues to be closely monitored.



Challenges

Use of independent sector providers has been essential during the recovery phase for children's ASD waiting times. The recovery work is taking place concurrently with a transformation programme aimed to operationalise the new neurodiversity service with a newly developed staffing model. Independent sector provider specialisms, costs and capacity can vary considerably and hence the service is now working with 3 providers to ensure flexibility and delivery against plan.

Plan

A refreshed plan has been developed which takes into consideration the number of patients waiting over 52wks as of 1st October 2022 and the number of patients expecting to tip over into the 52ww position between October 2022 and September 2023. This has enabled an understanding of capacity required to recover the 52ww position by the agreed date.

6. Children's Attention Deficit Hyperactivity Disorder (ADHD)

Current Position

The 52ww position for children's ADHD has deteriorated since the last update. There is a very close link with the ASD recovery work and the ADHD position. Clinical triage of the ASD list is resulting in some children and young people being identified as better meeting the criteria for ADHD and hence they are included then in the ADHD waiting time data.

Challenges

The following challenges exist for this service:

- An increase in demand due to ASD recovery progress
- Recruitment and retention of internal staff
- Funding arrangements in place as part of the block contract
- Consideration of wider staffing plans for neurodiversity service delivery

Plan

Recovery funding and capacity has been identified for 335 ADHD cases. This will be focused on those additional cases expected as a result of the ASD recovery progress. A contract with an independent provider is now in place. The plan is to commence with transfers and assessment starting by the end of October.

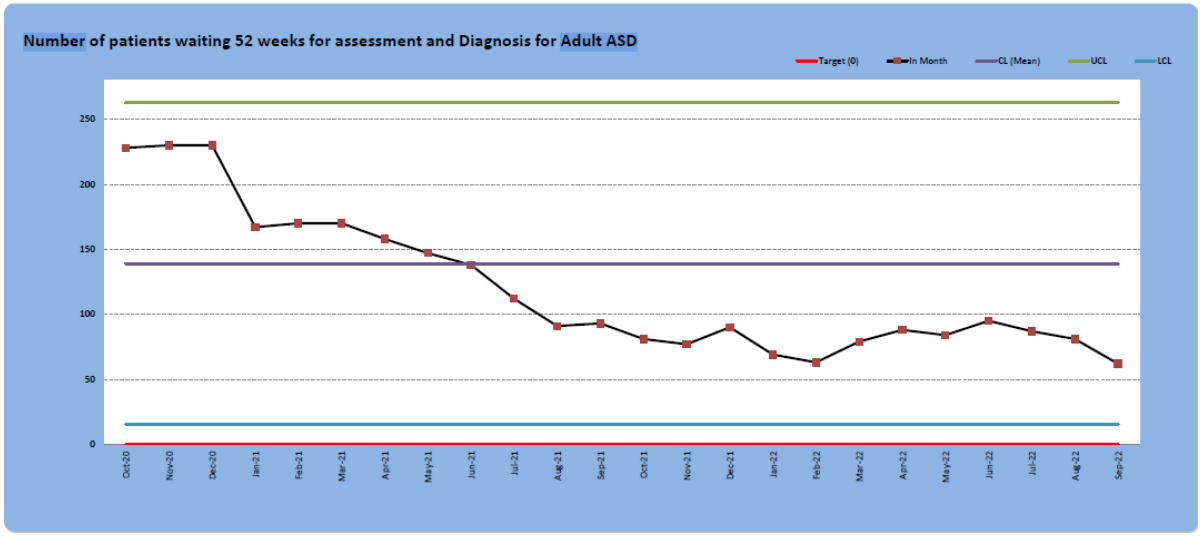
Demand levels and backlog size has been determined to enable a projected understanding of activity levels required for assessments. Once delivery of the additional capacity commences and is on plan a recovery trajectory will be finalised an included in the next update.

7. Adult ASD

Current Position

The service has committed to a recovery plan that is being actively monitored. The September position in the chart below demonstrates continued improvement towards recovery of the over 52wws as a result of funding sourced and mobilisation of an independent sector provider contract to increase capacity.

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



Challenges

Referral rates are continuing to rise and the service closely monitoring this position and will revise the recovery plan if the rate remains higher than anticipated levels.

Plan

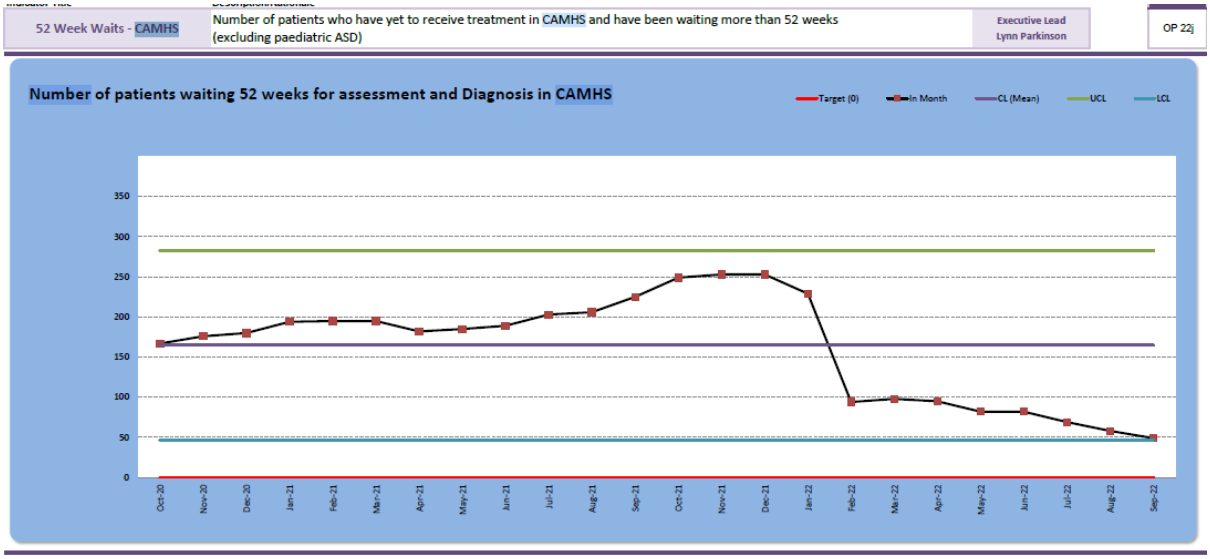
Focus will remain on monitoring and delivery of the recovery plan. Capacity and demand modelling will be revised as required if the referral rate continues to rise.

8. Core CAMHS

Current Position

Core CAMHS and Neurodiversity services were separated from a reporting perspective in February 2022. This has enabled clearer oversight of the core CAMHS position in terms of waiting times.

The chart below indicates an improving position.



Challenges

The service has continued to see higher numbers of urgent referrals with greater levels of acuity/complexity and whilst the team prioritise these high priority referrals, the routine waiting times are challenged.

Plan

Capacity and demand modelling work has been undertaken and this is now being aligned with service and operational pathway and process changes to further improve the rate of recovery.

9. Adult Attention Deficit Hyperactivity Disorder (ADHD)

Current Position

There are currently 127 patients waiting over 52weeks which is a deterioration

Challenges

The service is working with finance and commissioning colleagues to confirm funding streams to identify capacity for recovery. These complexities relate to previous cost per case arrangements recommencing after the introduction of the COVID block arrangements.

Discussions are underway with our place partners to agree an approach to ensure capacity is in place for the safe management of the ADHD pathway. This is based on:

1. Sufficient psychiatry capacity
2. Alternative arrangements for non medication interventions

Plan

Work has been completed to understand the trajectory for recovery and can be implemented once the above has been resolved to confirm funding levels and safe management of patients requiring intervention.

10. Memory Assessment Services (MAS)

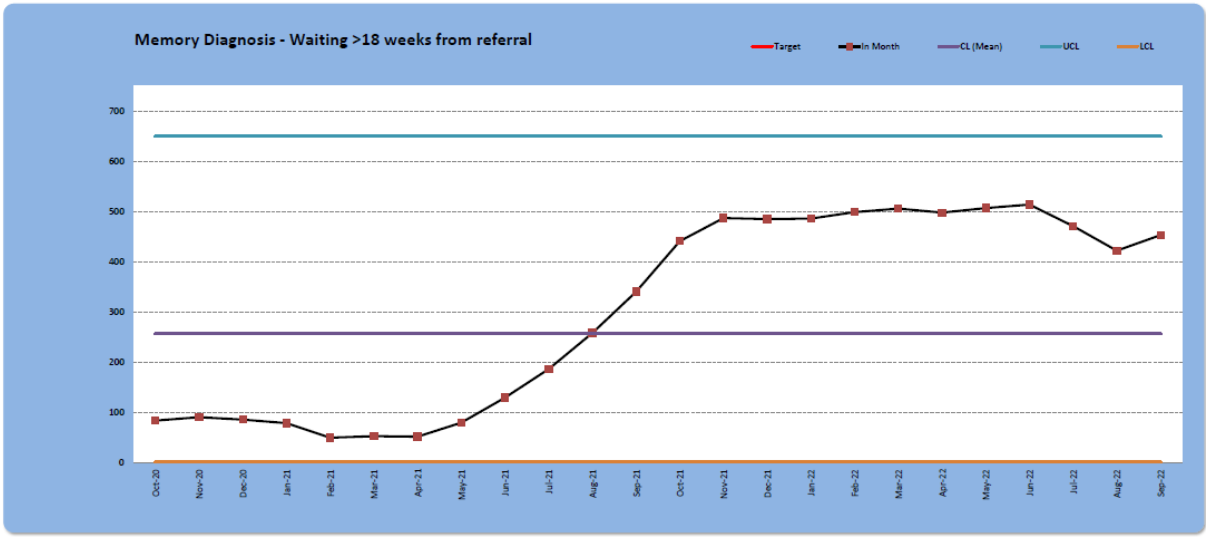
Current Position

The service has completed the capacity and demand modelling work and have a full understanding of their capacity requirements for non recurrent recovery and ongoing service delivery.

The Memory Assessment Service pathway has 4 stages, all of which have waiting list challenges. Each stage has been assessed to understand the full recovery requirements:

1. Assessment (f2f)
2. Formulation
3. Diagnosis
4. Feedback

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

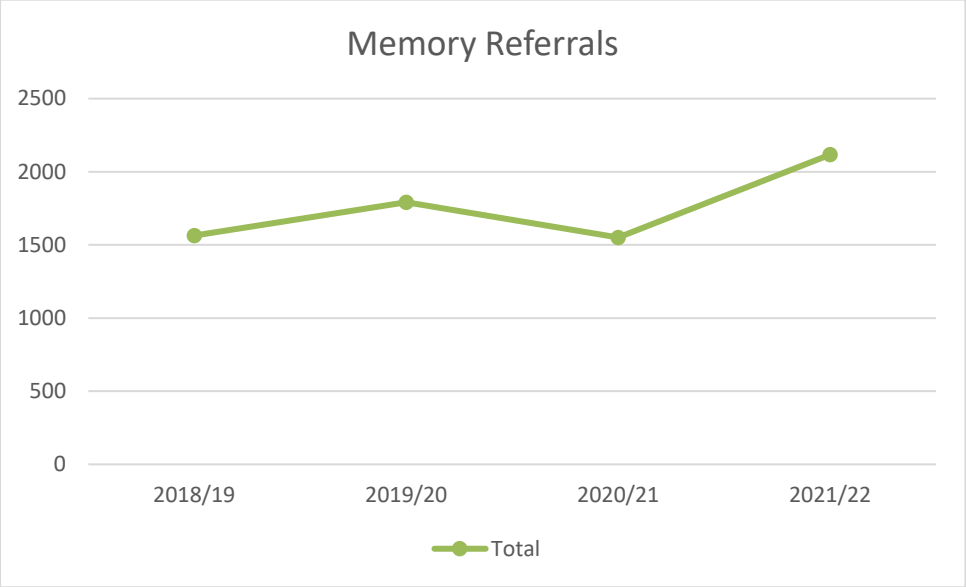


Challenges

Consistency of psychiatry capacity continues to be a challenge and the service are relying on locum personnel.

In addition, there is an interdependency with referral levels and focus on improving dementia diagnosis rates which will ultimately contribute to increased demands on the service.

The below demonstrates a 36% increase in referrals from 2018 to current.



Plan

The service has plans to introduce a new delivery model from Q1 2023/24 which is predicated on a new staffing model. The capacity and demand modelling work has highlighted a clear need for a temporary increase in staff, this proposal is currently under review and discussion with commissioners.

11. Conclusion

The Board is asked to note the progress being made as outlined in the areas of operational performance which have been highlighted as part of the recovery planning.

Agenda Item 10

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting – 26 October 2022</td></tr>
<tr><td>Title of Report:</td><td>Finance Report Month 6 (September 2022)</td></tr>
<tr><td>Author/s:</td><td>Name: Peter Beckwith
Title: Director of Finance</td></tr>
<tr><td>Recommendation:</td><td>
<table>
<tr><td>To approve</td><td></td><td>To receive & discuss</td><td></td></tr>
<tr><td>For information/To note</td><td>✓</td><td>To ratify</td><td></td></tr>
</table>

The Trust Board are asked to note the Finance report for September and comment accordingly.
</td></tr>
<tr><td>Purpose of Paper:</td><td>This report is being brought to Board Members to provide the financial position for the Trust as at the 30 September 2022 (Month 6).

The report provides assurance regarding financial performance, key financial targets and objectives</td></tr>
<tr><td colspan="2">Key Issues within the report:</td></tr>
<tr><td>Matters of Concern or Key Risks to Escalate:
• The Year to Date Agency expenditure was £4.472m, this is £0.812m more than the previous year’s equivalent Month 6 position.
• Primary Care is showing an overspend of £0.918m which is primarily caused by the increased use of Locum Doctors</td><td>Key Actions Commissioned/Work Underway:
• An Agency Recover Plan has been developed aimed at reducing the level of agency costs and of recruiting to permanent medical consultancy posts
• A Primary Care Recovery Plan has been developed with oversight at Executive Management Team</td></tr>
<tr><td>Positive Assurances to Provide:
• The Trust recorded an overall financial position of a deficit of £0.239m consistent with the Trust’s planning target
• Cash balance at the end of Month 6 was £31.440m
• The Better Payment Practice</td><td>Decisions Made:
• The Trust Board are asked to note the Finance report for September 2022, and comment accordingly.</td></tr>
</table>

Code figures show achievement of 91.2%	

Governance:

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

Monitoring and assurance framework summary:

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

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

FINANCE REPORT – September 2022

1. Introduction

This report is being circulated to The Board to present the financial position for the Trust as at the 30 September 2022 (Month 6). 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 30 September 2022

Under the ICB planning process which concluded on 20 June, the Trust is required to achieve a break even position for the year and this updated the previous plan which was a £1.011m deficit.

The Month 6 target accounts for this change with the profiled position being a deficit of £0.239m which has been achieved. Going forward the monthly targets will reflect the requirement to break even at the yearend which will mean a minor monthly surplus.

Table 1 shows for the period ended to 30 September 2022 the Trust recorded an operating deficit of £0.239m, details of which are summarised in table 1 on the following page.

There is one item which doesn't count against the Trust's financial control targets, which is the Donated asset Depreciation of £0.038m year to date, this takes the ledger position to a deficit of £0.277m.

Humber Teaching NHS Foundation Trust

Table 1: 2022/23
Income and Expenditure

	22/23 Net Annual Budget £000s	In Month			Year to Date		
		Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
Income							
Trust Income	**160,519**	**14,790**	**14,932**	**142**	**80,059**	**79,324**	**(735)**
Clinical Income	**16,406**	**1,393**	**1,356**	**(37)**	**8,116**	**8,670**	**554**
Total Income	**176,926**	**16,183**	**16,288**	**105**	**88,175**	**87,994**	**(181)**
Expenditure							
Clinical Services							
Children's & Learning Disability	36,887	3,633	3,710	(77)	18,294	18,228	67
Community & Primary Care	31,207	2,967	3,024	(57)	15,762	16,182	(420)
Mental Health	55,191	5,374	5,300	74	28,050	27,758	292
Forensic Services	12,624	1,252	1,305	(53)	6,301	6,297	4
	135,908	**13,226**	**13,338**	**(112)**	**68,407**	**68,465**	**(58)**
Corporate Services							
	35,432	**2,183**	**2,428**	**(244)**	**16,359**	**15,790**	**570**
Total Expenditure	**171,340**	**15,410**	**15,766**	**(356)**	**84,766**	**84,255**	**512**
EBITDA	**5,586**	**773**	**522**	**(251)**	**3,409**	**3,739**	**330**
Depreciation	4,596	579	446	133	2,298	2,676	(378)
Interest	148	12	(31)	44	74	(77)	151
IFRS 16	-	-	(21)	21	-	67	(67)
PDC Dividends Payable	2,341	195	195	-	1,171	1,171	-
PSF Funding	-	-	-	-	-	-	-
ICS Contribution	-	-	77	(77)	-	141	(141)
Operating Total	**(1,499)**	**(13)**	**(143)**	**(130)**	**(133)**	**(239)**	**(106)**
BRS	(1,500)	(49)	(179)	130	106	-	106
Operating Total	**1**	**36**	**36**	**(0)**	**(239)**	**(239)**	**(0)**
Excluded from Control Total							
Donated Depreciation	70	6	14	(8)	35	38	(3)
	(69)	**30**	**22**	**(8)**	**(274)**	**(277)**	**(3)**
Excluded							
Commissioning	1	0	11	(11)	1	12	(11)
Ledger Position	**(71)**	**30**	**11**	**(19)**	**(275)**	**(289)**	**(14)**
EBITDA %	**3.2%**	**4.8%**	**3.2%**		**3.9%**	**4.2%**	
Surplus %	**-0.8%**	**-0.1%**	**-0.9%**		**-0.2%**	**-0.3%**	

2.2 Income

Trust Income is showing a position of under achieving against budget by £0.735m. Of this £0.346m relates to Covid income which has been received and deferred to offset future potential pressures relating to Covid expenditure including the seasonal risk of Out of Area funding demands.

Clinical income which is specific to other income sources is overachieving by £0.554m.

2.3 Divisional Expenditure

The overall Operational Divisional Gross Expenditure is showing an overspend of £0.058m.

2.3.1 Children's and Learning Disability

Children's and LD is reporting a £0.067m underspend. There are some pressures relating to the CAMHS Inpatient Unit and the use of Agency Medics in Community CAHMS, this is offset by underspends elsewhere in the service.

2.3.2 Community and Primary Care

Community and Primary Care is reporting an overspend of £0.420m.

Primary Care is showing an overspend of £0.918m which is primarily due to pressures caused by the required increase of Locum Doctors which are significantly more expensive than substantive staff, offset by underspends in Community and Management of £0.444m.

Primary Care have produced a recovery plan which has oversight at Executive Management Team. The main aim of this plan is to reduce the reliance on Locum Doctors. Three new GPs were due to start with the Trust in August however visa delays have stalled this and Locum expenditure has continued to be used to fill these roles.

2.3.3 Mental Health

The Division is showing an underspend of £0.292m. There are pressures within the Unplanned service division which relates to the acuity of patients within Adult and the Older Adult Units which requires increased safer staffing numbers. This is currently offset by underspends within the Planned division.

2.3.4 Corporate Services

Corporate Services are showing an underspend of £0.570m.

2.3.5 Depreciation

The actual Depreciation position at Month 5 is currently showing an overspend of £0.378m. A review of Depreciation in line with the Revaluation of Assets is currently being undertaken and will be reported through the Finance and Investment Committee.

3. Cash

As at the end of Month 6 the Trust held the following cash balances:

Table 2: Cash Balance

Cash Balances	£000s
Cash with GBS	31,049
Nat West Commercial Account	339
Petty cash	52
Total	**31,440**
Of this £5.116m relates to the Provider collaborative	

Included within this amount is the Provider Collaborative cash amount of £5.116m, this has increased as the payment mechanism between lead provider collaboratives has moved to recharges rather than the former block payment mechanism.

4. Agency

Actual agency expenditure for August was £0.700m. The year to date spend is £4.472m, which is £0.812m above the same period in the previous year.

Table 3: Agency Spend v previous years

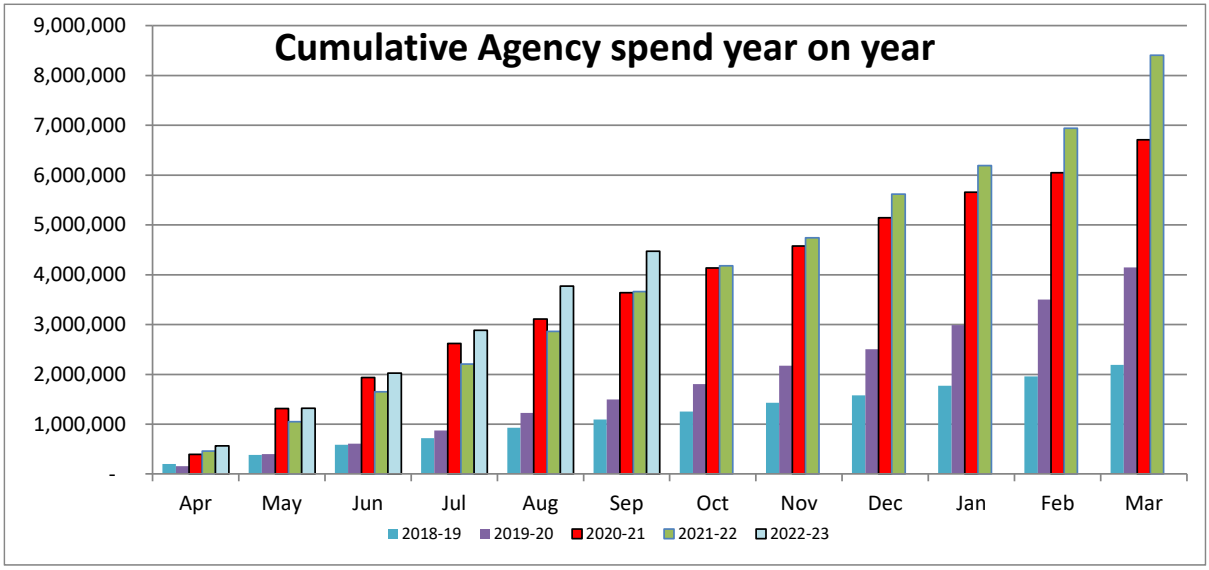


Table 4: Agency Spend by Staff Group

Staff Type	Apr-22	May-22	Jun-21	Jul-22	Aug-22	Sep-22	Total
	£000	£000	£000	£000	£000	£000	£000
Consultant	319	313	279	553	384	353	2,200
Nursing	125	201	230	135	289	144	1,123
AHPs	13	(27)	27	14	10	13	50
Clinical Support Staff	50	214	132	95	154	193	838
Administration & Clerical	56	57	39	59	53	(2)	261
Grand Total	**563**	**759**	**706**	**855**	**890**	**700**	**4,472**

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

A plan to recover agency spend has been approved by EMT and is being overseen by the Director of Finance as SRO.

5. Better Payment Practice Code BPPC

The BPPC figures are shown at Table 5. The current position is 91.0% for Non NHS and 92.9% for NHS. This represents an improvement on the previous month for Non NHS which was 90.6%. The NHS position has had a reduction from 93.2%. The overall payment is 91.2% and is a minor improvement from the previous month. Work is ongoing to improve the position internally through Communications and then by monitoring.

Table 5: Better Payment Practice Code

Better Payment Practice Code	YTD Number	YTD £
NON NHS		
Total bills paid	19,611	52,154
Total bills paid within target	17,230	47,437
Percentage of bills paid within target	**87.9%**	**91.0%**
NHS		
Total bills paid	557	8,185
Total bills paid within target	475	7,602
Percentage of bills paid within target	**85.3%**	**92.9%**
TOTAL		
Total bills paid	20,168	60,339
Total bills paid within target	17,705	55,039
Percentage of bills paid within target	**87.8%**	**91.2%**

6. Recommendations

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

Humber Teaching NHS Foundation Trust

Agenda Item 11

<table>
<tr><td>Title & Date of Meeting:</td><td colspan="4">Trust Board Public Meeting – 26th October 2022</td></tr>
<tr><td>Title of Report:</td><td colspan="4">NHS England Operating Framework</td></tr>
<tr><td>Author/s:</td><td colspan="4">Name: Peter Beckwith
Title: Director of Finance</td></tr>
<tr><td>Recommendation:</td><td colspan="4"><table><tr><td>To approve</td><td></td><td>To receive & discuss</td><td></td></tr><tr><td>For information/To note</td><td>✓</td><td>To ratify</td><td></td></tr></table>
The Trust Board are asked to note the new NHS England Operating Framework and comment accordingly.</td></tr>
<tr><td>Purpose of Paper:</td><td colspan="4">This report is being brought to Board to summarise the new NHS England Operating Framework.</td></tr>
<tr><td colspan="5">Key Issues within the report:</td></tr>
<tr><td colspan="2">Matters of Concern or Key Risks to Escalate:

○ No items to escalate, however it should be noted the new framework will take time to be embedded</td><td colspan="3">Key Actions Commissioned/Work Underway:

○ None</td></tr>
<tr><td colspan="2">Positive Assurances to Provide:

○ The core responsibilities of the Trust for the provision of safe, effective and high quality care remains</td><td colspan="3">Decisions Made:

○ None</td></tr>
<tr><td>Governance:</td><td></td><td>Date</td><td></td><td>Date</td></tr>
</table>

Caring, Learning & Growing Together

Please indicate which committee or group this paper has previously been presented to:	Audit Committee		Remuneration & Nominations Committee		
	Quality Committee		Workforce & Organisational Development Committee		
	Finance & Investment Committee		Executive Management Team		
	Mental Health Legislation Committee		Operational Delivery Group		
	Charitable Funds Committee		Collaborative Committee		
			Other (please detail) Report to Board	✓	

Monitoring and assurance framework summary:

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

NHS England
Operating Framework 2022

1. Introduction

This report is being brought to Board to summarise the new NHS England Operating Framework.

2. Background

NHS England wrote to Trust and ICB Chief Executives and Chairs on the 12th October 2022 to advise of the publication of the new NHSE England Operating Framework.

The operating framework sets out the roles that NHS England, ICS and providers will now play in the new structure following the establishment of ICS's on a statutory basis under the Health and Care Act 2022.

The Operating Framework also reflects how NHS England will operate and bring itself together with Health Education England and NHS Digital.

3. Operating Framework Structure

The Framework (previously referred to as Operating Model) has four core foundations, referred to as

- Purpose (*Why NHSE are here*)
- Areas of Value (*How NHSE deliver value*)
- Leadership behaviours and accountabilities (*How NHSE Work*)
- Medium-Term priorities and long term aims (*what NHSE are working to achieve*)

3.1 NHSE Purpose

NHSE defines it purposes as '*To Lead the NHS in England to deliver high quality services for all'*.

NHSE will achieve this purpose by:

- enabling local systems and providers to improve the health of their people and patients and reduce health inequalities;
- making the NHS a great place to work, where our people can make a difference and achieve their potential;

- working collaboratively to ensure our healthcare workforce has the right knowledge, skills, values and behaviours to deliver accessible, compassionate care;
- optimising the use of digital technology, research and innovation; and
- delivering value for money.

3.2 NHSE Purpose

NHSE identifies 8 ways in which it is uniquely placed to add value, these are identified as:

- Setting Direction
- Allocating Resources
- Ensuring Accountability
- Supporting and Developing People
- Mobilising Expert Networks
- Enabling Improvement
- Delivering Services
- Driving Transformation

3.3 How NHSE work

NHSE has set out 12 leadership behaviours aligned to 6 key values which are linked to the NHS constitution, these are set out below:

NHSE (as part of its change programme) will be working to develop a set of shared behaviours for the new organisation.

4. Accountabilities and Responsibilities

The new operating framework sets out the accountabilities and responsibilities of providers, ICBs and NHSE England to reflect the changes in legislation an the move towards system working.

These are summarised in the table below

NHS providers	Integrated Care Boards	NHS England
Accountability (What they need to deliver)		
○ Statutory responsibilities for safe, effective, efficient, high-quality services ○ Effective system working and delivery	○ Effective system leadership which balances immediate and longer term priorities ○ Overseeing NHS delivery of these	○ Use input from ICBs, providers and their partners to agree the mandate for the NHS with government and secure required resources

NHS providers	Integrated Care Boards	NHS England
of their contribution to ICS strategies and plans ○ Financial performance and requirements set out in NHS planning guidance, including quality and access ○ Compliance with provider licence, Care Quality Commission standards ○ • Reducing unwarranted variation, especially through collaboratives (collaboratives can support and enable the delivery of some of these accountabilities and responsibilities).	strategies and plans, ensuring progress toward and achievement of objectives for annual planning and Long Term Plan priorities. ○ Overseeing the budget for NHS services in their system. ○ Ensuring delivery of the ICB core statutory function of arranging health services for its population and compliance with other statutory duties ○ • Work with local authorities to act as the stewards of	○ National NHS performance and transformation as set out in NHS mandate and constitution ○ National and regional NHS contribution to effective system working and delivery ○ Foster relationship and alignment with government ○ Stewards of the NHS ○ Set strategy for the future ○ • Foster productive relationships with partners and major stakeholders.
Accountability (who do they account/provide assurance to)		
○ Operationally within the NHS: ○ ICBs for 'business as usual' delivery of services and performance and their agreed contribution to the system strategy & plan ○ NHS England national	○ Operationally within the NHS: ○ NHS England, via Regional Directors – including for delivery of the outcomes and priorities expressed in the Joint Forward Plans ○ NHS England, as regulator (with associated statutory powers)	○ Parliament, via the Secretary of State ○ People, communities and service users.

NHS providers	Integrated Care Boards	NHS England
commissioners of specialised services ○ NHS England as regulator (with associated statutory powers) - by escalation/ exception or agreement with ICB ○ Care Quality Commission for leadership, quality and safety of services. ○ Locally: ○ People, communities and service users; all ICS partners; Foundation Trusts to Board of Governors (and members).	○ Care Quality Commision as part of ICS (not as individual organisations) for leadership, quality, safety and integration of services. ○ Locally: ○ • People, communities and service users.	
Roles (What is done Day-to-day)		
○ Delivering services ○ Setting organisational strategy and plans ○ Education and training ○ Monitoring and improving service performance and finance ○ Working with system partners to deliver wider ICS strategies, plans and shared functions	○ Working with partners to set system-level strategy and plans ○ Working with partners to ensure effective arrangements in place across system for joint working to deliver plans, performance, outcomes and transformation ○ Commissioning, agreeing and managing contracts,	○ Shaping and setting national policy, strategy, plans and priorities for the NHS in England, including in collaboration with ICBs ○ Providing support for systems and providers to achieve those priorities, including statutory intervention if required ○ Delivering ‘shared services’ to the NHS

NHS providers	Integrated Care Boards	NHS England
○ Research and innovation.	delegation and partnership agreements with providers and primary care ○ Contribute to long term workforce planning ○ Help inform national goals and mandate ○ Delivery of Integrated Care Partnership strategies and joint 5 year forward plan.	○ Providing national oversight and assurance of NHS delivery and performance ○ Ensuring NHS organisations work effectively with partners at system and place base level.
Role in oversight, support and intervention (Who and what do they oversee?)		
○ Self-assessment ○ Input to regulator assessment ○ Liaison with / escalation of issues to ICB(s) ○ Peer review and support.	○ First line oversight of health providers across the ICS to oversee performance and contribution to overarching plans ○ Coordinate/help tailor any support for providers ○ Assurance/input to regulator assessment ○ Liaison/escalation of issues to NHS England.	○ Oversight of ICBs' delivery of plans and performance ○ By exception and generally in agreement with ICB - direct oversight of providers' delivery of NHS performance and contribution to effective system working* ○ Lead on support for organisations in segmentation three and four of our Oversight Framework ○ • Joint working with other regulators e.g. CQC.

NHS providers	Integrated Care Boards	NHS England
Specific legal powers in relation to other bodies (Formal or statutory functions)		
○ In relation to other providers and partners, as per contracts, delegation and joint working agreements ○ Agree joint 5 year forward plan and joint capital plan with partner ICB.	○ In relation to providers and partners, as per contracts, delegation and joint working agreements ○ • Agree joint 5 year forward plan and joint capital plan with partner trusts.	○ Appoint ICB and trust (not Foundation Trust) chairs and Chief Executive Officers ○ Establish and annually assess each ICB, agree its constitution and any changes to this and determine its allocations ○ Set financial objectives for systems ○ Conduct annual assessment of each ICB ○ Determine the need for enforcement action with respect to ICBs and providers aligned with Oversight Framework and Enforcement Guidance. Interventions with providers will happen with the awareness of the relevant ICB.

5. Impact for the Trust

As per the table above, the main impacts for the Trust can be summarised as:

- The Trust will retain its statutory responsibilities for the delivery of safe, effective, efficient, high-quality services
- The Trust will continue to comply with the provider licence, Care Quality Commission (CQC) standards and NHS planning guidance requirements
- The Trust should contribute to effective system working via ICS strategies and plans
- The Trust will remain accountable to people, communities, services users, board of governors and ICS partners
- The Trust will be accountable to ICBs for 'business as usual' delivery of services and performance, and for their agreed contribution to the system strategy and plan
- The Trust are accountable to NHSE as regulator by escalation/ exception or agreement with ICB
- The Trust should expect to deliver some of these accountabilities and responsibilities with the support of provider collaboratives

6. Next steps

NHSE will formally merge with HEE and NHS Digital on 1st April 2023 with work on organisational design continuing into 2023/24.

NHSE will develop a organisational change and transformation programme, recognising changes to ways of working will take time.

Agenda item 13

<table>
<tr><td>Title & Date of Meeting:</td><td>Trust Board Public Meeting Wednesday 26 October 2022</td></tr>
<tr><td>Title of Report:</td><td>Infection Prevention and Control Annual Report 2021/22</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></td><td>To receive & discuss</td><td></td></tr>
<tr><td>For information/To note</td><td></td><td>To ratify</td><td>x</td></tr>
</table></td></tr>
<tr><td>Purpose of Paper:</td><td>To provide an overview of the key work undertaken with regards to infection prevention and control for the reporting period 1 April 2021-31 March 2022, highlighting the progress and achievements made against the Trust Infection Prevention and Control Strategy 2018-22. It also provides a summary of the key work completed and IPC challenges that have occurred as a consequence of the COVID-19 pandemic.

The report was approved by the Quality Committee at its meeting in September. The Board are requested to ratify the report.</td></tr>
<tr><td colspan="2">Key Issues within the report:</td></tr>
<tr><td>Matters of Concern or Key Risks to Escalate:
Ongoing challenges associated with the aging estate. This includes;
The limited availability of suitable en-suite provision to support the effective isolation of COVID positive patients
Ventilation noted to be of a variable standard across the Trust estate.
Ongoing water safety challenges noted in Mill view and Maister Lodge.</td><td>Key Actions Commissioned/Work Underway:
Commissioned survey of the ventilation within each Trust inpatient and primary care area undertaken
Ventilation remedial and improvement project commenced.
An increase in en-suite provision factored in to all new building schemes</td></tr>
<tr><td>Positive Assurances to Provide:
Achievement of all contractually and locally agree performance thresholds. This includes no trust apportioned cases of MRSA. MSSA, E.coli bacteraemia 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%.</td><td>Decisions Made:
Appointment of a Trust Authorised Ventilation Engineer.
A Trust Ventilation group has now been established.</td></tr>
</table>

• The Trust mandatory infection control training compliance rate has exceeded 90% for both clinical and non-clinical staff.	

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee	29/09/22	Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	12.9.22
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	QPaS 18.8.22

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	

Humber Teaching
NHS Foundation Trust

Infection Prevention and Control

Annual Report 2021-2022

1. Introduction

The Trust recognises that the effective prevention and control of healthcare associated infection (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 for Health and Adult Social Care on the Prevention and Control of Infections and related guidance (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 2021 to March 2022 and provides information and assurance to the Trust Board of Directors of the achievements and progress made against the Trust Infection Prevention and Control Strategy 2018-2022, and the key criteria identified within both the Health and Social Care Act 2008 and the IPC Board Assurance Framework document (v1.8 December 2021).

2.0 Goals agreed as outlined within the IPC strategy 2018-2022

2.1 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'

2.1.1 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 and 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. 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 and Control Strategy 2018-2022 is seen as an essential element in continuing the Trusts focus on reducing HCAI's and in ensuring compliance to Care Quality Commission (CQC), Regulation 12 - 2.8 (assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated). 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.

2.1.2 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 and 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 and 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)

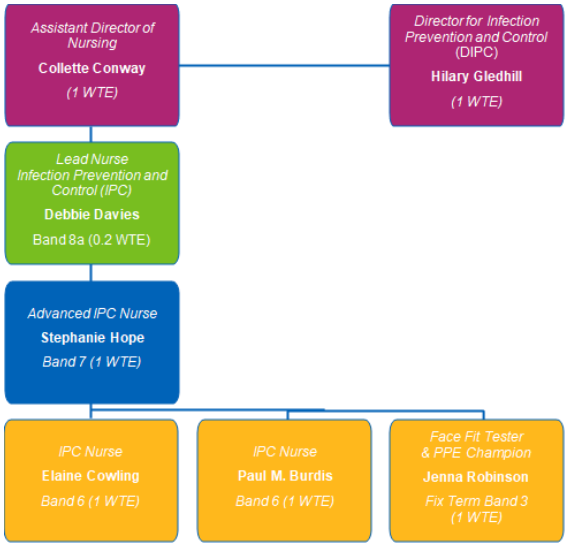
The HAIG is a multi-disciplinary forum for providing expert advice and organisational perspective and oversight for all matters relating to infection prevention and control.

The group provides a forum to receive, review and plan the implementation of national and local policy relating to infection control practice. This forum enables debate and the sharing of knowledge. The number of meetings was increased during 2021-2022 to allow the opportunity to share the continuously evolving national IPC guidance but also to share learning. The IPC meeting schedule has now returned to the pre-pandemic schedule but will be stepped back up at any point if required. 4 Formal meetings were held during April 2021-March 2022. An informal group meeting has also continued on a quarterly basis to ensure all actions and works streams agreed within the formal meeting are progressed.

2.1.3 The Structure and Responsibilities of the Infection Prevention and Control Team (IPCT)

The structure of the nursing team during April 2021 to March 2022 can be seen in Table 1 below. To improve the resilience in the team due to the massive increase in workload funding was approved for a Face Fit Test Tester and PPE Champion on a temporary 12 month contract which will be reviewed in September 2022.

Table 1. The Structure of the Nursing Team as of March 2022



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 standards already achieved but to enhance or improve on areas where progress has been a little slower. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust

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. The Lead Nurse has met regularly 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- 2022 and continues to provide an effective and responsive service.

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 is readily accessed by all staff across the Trust.

2.1.4 The IPC Link Practitioner Network

The IPC Link Practitioner programme remains an important support to staff in all clinical areas and a large amount of the infection prevention teams time has been spent on ensuring that each area has access to a link practitioner who has received guidance and training and ongoing support 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 110 active IPC Link Practitioners across the Trust concentrated across all Care Divisions. They have utilised their enhanced level of

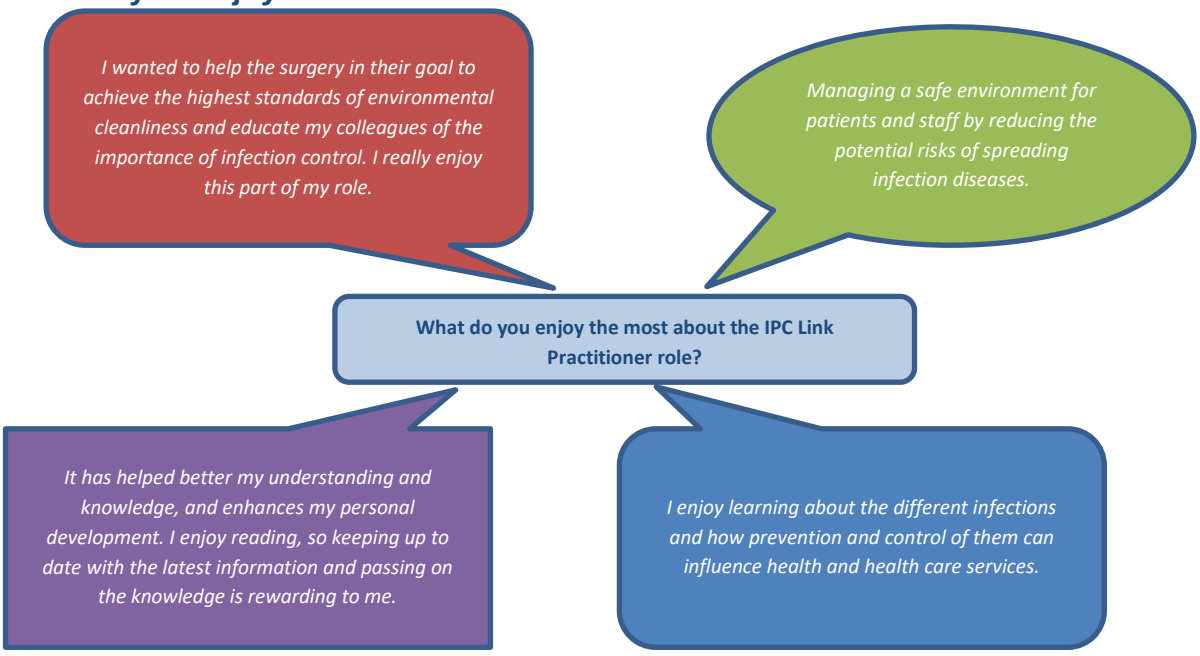
knowledge and skills to support compliance with national standards and help embed IPC practice into their clinical areas of work.

2021-2022 has seen a significant increase in engagement across the community teams resulting in an ever-growing number of areas participating in a new suite of IPC audit tools designed specifically for the community setting. 23 additional community teams have been recruited (including teams within ISPHN areas and Scarborough, Whitby and Malton).

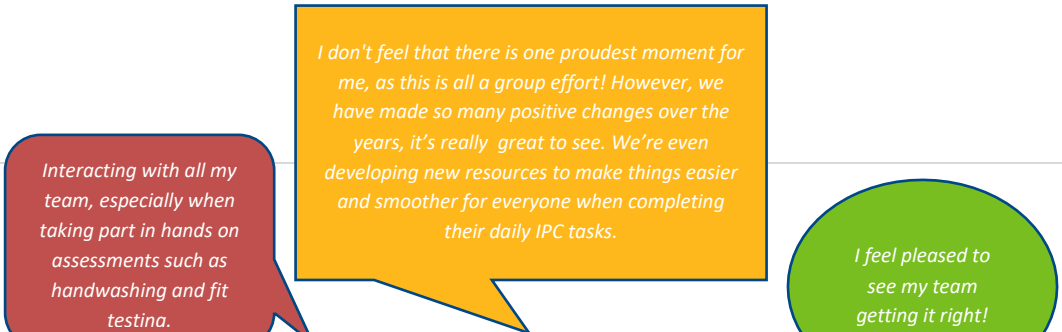
We continue to actively recruit and assist in the promotion of the role of the infection prevention and control link practitioner. As part of the International Infection Prevention Week (November 2021) we asked the established link practitioners to provide an insight into their role. A selection of the responses received were placed on the intranet.

An example of some of the responses can be seen below;

What do you enjoy the most about the IPC Link Practitioner role?



What is your proudest moment as an IPC Link Practitioner for your team?



The IPC link practitioner meetings programme has now recommenced quarterly, ensuring that there continues to be an effective forum to share good practice, challenges, share and discuss ideas for the celebration of national IPC awareness events.

2.1.5 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.

The Trust performance against key objectives can be seen below;

2.1.6 Meticillin-resistant *Staphylococcus aureus* (MRSA) Bacteraemia 

(Achieved Trust agreed threshold). 0 apportioned MRSA bacteraemia cases have been identified within the reporting period.

2.1.7 Meticillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia ✓

(Achieved Trust agreed threshold). 0 Trust apportioned cases of MSSA bacteraemia identified during 2021-2022.

2.1.8 Escherichia *coli (E.coli)* Bacteraemia ✓

(Achieved contractually agreed threshold) 0 trust apportioned cases reported within the Trust in 2021/2022.

2.1.9 Clostridiodes difficile infection ✓

(Achieved contractually agreed threshold)

1 trust apportioned case reported within the Trust in 2021-2022. A review of the patients journey concluded that the acquisition may have been linked to the potential contamination of a piece of specialist equipment that was being shared between patients. The equipment was noted to have potentially been used when also caring for another patient noted to be previously C difficile positive (non-trust apportioned).

The serotyping of the faecal samples of both the cases may have assisted in the determination of whether these cases were linked but unfortunately this was not possible as the reference laboratory was under immense pressure and the service had been temporarily suspended. The patient was noted to recover without incident.

Staff were reminded of the importance of ensuring that thorough cleaning between patients of all equipment is essential at all daily safety briefings. The subsequent monitoring of the cleaning of equipment has raised no issues and no other positive patients have been identified.

2.2.5 Hand Hygiene Compliance ✓

(Achieved Trust agreed threshold of 95%)

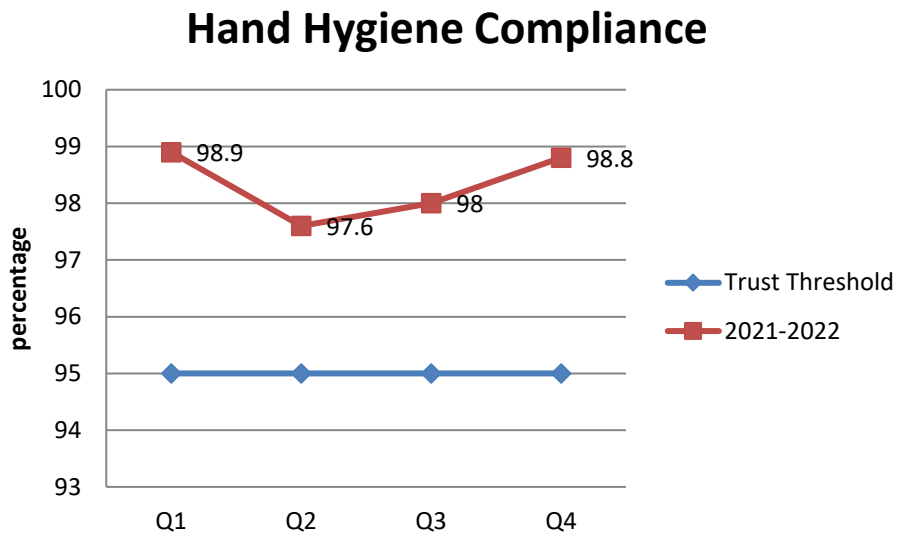
Hand hygiene remains a fundamental component in the prevention of nosocomial infections. The IPC team continued to promote hand hygiene compliance in accordance with the 'WHO five moments for hand hygiene'. Hand hygiene compliance, including bare below the elbows is a mandatory requirement for all individuals 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 2 the annual compliance threshold of 95% has been achieved in all 4 quarters during 2021-2022.

Areas which did not consistently achieve 95% compliance in all 4 quarters include,
Q2 -Swale (77%), Ullswater (93 %), STaRS (83%)
Q3- Swale (90 %), Pine View (93%), STaRS (93 %)
Q4 -Mill View Court (93%)

The dips in scores recorded above was noted in the main to be due to non-compliance with the 'bare below the elbows' principles potentially hampering the hand hygiene process. Compliance in all areas continues to be actively addressed and managed via the matrons and monitored via the HAIG.

Table 2. Trust Hand Hygiene Compliance percentage according to Quarter 2021-2022



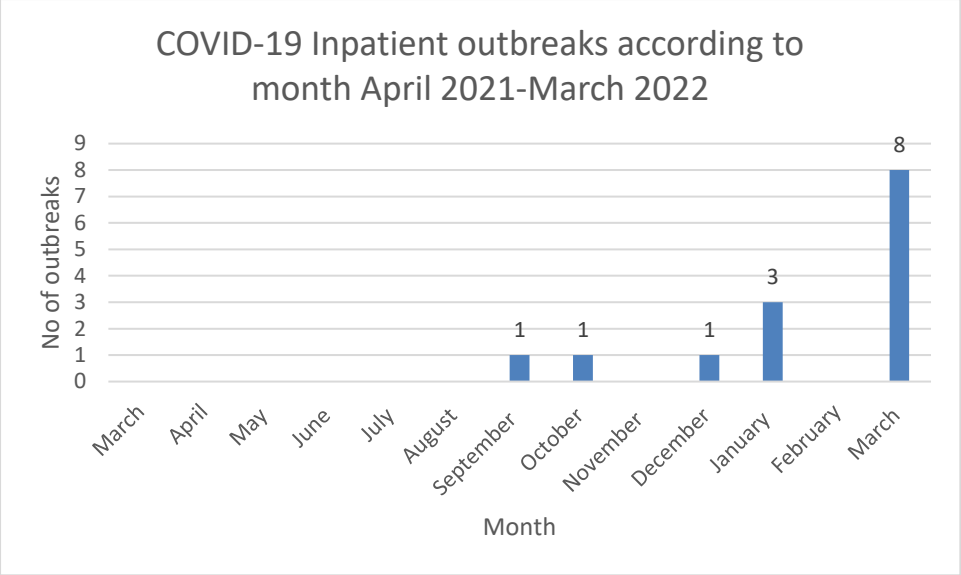
2.3 Outbreaks of Communicable Infection

Outbreaks of infection continue to be the major cause of infection related incidents in any hospital in the United Kingdom. Outbreaks occur when there are two or more linked infections which may or may not be preventable. Usually, these events are, by definition, unpredictable. Historically this has mainly been associated with viruses such as Norovirus or Influenza. However, with the emergence of COVID-19 we have mainly been dealing with outbreaks associated with this virus and fortunately no outbreaks related to other traditional winter viruses.

In line with the mandatory national reporting requirements the Trust have reported 14 outbreaks of COVID-19 during 2021-2022. Table 3 highlights the number of outbreaks according to month.

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 3. COVID-19 Inpatient Outbreaks according to month 2021-2022



An outline of the outbreaks identified throughout can be seen below in Table 4.

Table 4. COVID-19 Details of Outbreaks identified 2021-2022

Unit	Date Outbreak declared	Date ward reopened	No of patients affected	No of staff affected	Learning
Swale	30.3.22	11.4.22	6/14	11/26	Probable staff to patient transmission.
PICU	28.3.22	8.4.22	2/6	7/33	Patient non-compliance / refusal to undertake a screen noted in a small number of patients.
Granville Court	27.3.22	14.4.22	9/16	18/50	Staff noted to be working with respiratory symptoms although LFD negative. No breaches in staff IPC practice identified. Conflicting guidance -expected to be managed as per residential home guidance.
Westlands	22.3.22	1.4.22	6/18	1/30	Patient compliance with IPC measures noted to be poor. The sharing of E-.cigarettes noted between patients
Millview Lodge	21.3.22	1.4.22	7/9	7/27	No issues identified. All COVID screening completed in

Unit	Date Outbreak declared	Date ward reopened	No of patients affected	No of staff affected	Learning
					accordance with the Trust guidance
Ouse	4.3.22	16.3.22	8/14	1/27	Patients managed successfully in 2 cohorts. Reminder needed re the risk assessing of all group activities.
Newbridges	4.3.22	7.3.22	5/18	5/46	Identification of positive cases on routine screening. All patients displaying no symptoms at the time of the screen. Patient compliance low in an individual case. Patient mask wearing compliance low
Memorial Ward Whitby	1.3.22	9.3.22	2/14	1/40	Potential patient to patient transmission. All IPC measures in place
Pine View	26.1.22	7.2.22	12/13	8/35	Staff anxieties acknowledged resulting in an increased number of staff undertaking additional tests
Derwent	19.1.22	28.1.22	6/9	6/28	Probable staff to patient transmission. No breaches in staff practice identified. Patient sharing of e-cigarettes.
Millview Court	10.1.22		4/13	0	No IPC issues identified
Maister Lodge	30.12.21	7.1.22	1/6	6/40	1 patient managed without incident. Evidence of 50 % of the staff acquiring out of the work place
PICU	8.10.21	22.10.22	2/8	2/32	Isolation not commenced in a timely manner for the index case. Covid screening compliance

Unit	Date Outbreak declared	Date ward reopened	No of patients affected	No of staff affected	Learning
					inconsistent. Poor evidence that day 2-3 and day 5 compliance was being completed.
Westlands	1.9.21	17.9.22	9/17	4/35.	Delay in the notification of a patient's positive Covid status

As shown in Table 3 March 2022 saw the greatest number of outbreaks reported in any one month since the commencement of the pandemic. General factors which impacted on the number and management of each incident included;

- The increased level of infection circulating within the community exacerbating the level of risks to both staff and patients. Patients were noted to be leaving the units more regularly to visit cafes/shops as part of their agreed level of Section 17 leave.
- The revoking of the Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 (February 2022) affected the ability to isolate patients. This was noted to have become difficult to manage, particularly in instances when the positive individual was not detained, had Mental Capacity and chose not to comply. It was extremely pleasing however that we were able to receive the ongoing support and expertise from the mental health legislation team who committed to attending each outbreak meeting. We are pleased to report that we have avoided the use of 'blanket restrictions' and the units have been supported to operate in the least restrictive way possible and in accordance with the MHA and MCA codes of practice in each of the outbreak episodes.
- The anomalies between the national guidance for the public and the guidance for the management of staff and patients in a health care setting which causes some tension and needed a great deal of communication to both staff and patients on why the guidance differed between the two populations. This was particularly problematic when the patients found they were expected to spend longer periods of isolation in comparison to the general public.

Leaning provided from the individual incidents also included;

- A variable vaccination uptake rate was apparent in the adult mental health unit population.
- Mask wearing compliance was low in the learning and disability patient group.
- The sharing of e-cigarettes noted between patients (female inpatient unit).
- The refusal of patients to comply with COVID screening programmes as they became quickly aware of the effects that this would on their ability to socialise with other peers during an infective period.
- Day 1 COVID-19 screening completed but day 3-5 screening not always undertaken or recorded appropriately.
- The limited / lack of en- suite facilities in a number of the affected units.

- Despite significant challenges excellent feedback has been provided from all the inpatient areas on the responsiveness and quality of the Hotel Services performance and the level of support that they have provided particularly during the periods of outbreak. The positive feedback has also been extended to the preferred external contactor that is used when resources within the Trust are stretched.
- The Trust Track and Trace service was not always informed of a staff members status in a prompt manner. This is deemed to be an essential requirement to ensure that the staff member is provided with support and up to date advice but also was essential for IPCT surveillance purposes.

No adverse outcomes were reported during 2021-2022 for any of the patients who yielded a positive test result during the above mentioned outbreaks. All recovered satisfactorily and have either returned to their place of residence or remain within our care due to their ongoing mental health needs.

3.7 Antimicrobial Stewardship

Slowing the development of microorganisms' resistant to antimicrobials, increasing the longevity of our available agents and minimising the occurrence of healthcare acquired infections is a national and international priority. All healthcare professionals are therefore encouraged to facilitate good prescribing practices

The Drugs and Therapeutic Group within the Trust is responsible for the monitoring and provision of advice on the optimal and cost-effective prescribing of antimicrobial agents. Its aim is to facilitate the development, implementation and audit of policies, guidelines and protocols related to antimicrobial prescribing, with reference to local variations in antimicrobial susceptibility. All antimicrobial data collected is presented and reviewed at both this meeting, HAIG and the respective Clinical Network meeting.

Electronic prescribing is now in place in all clinical inpatient areas which assists in ability to improvement the level of stewardship. Each antibiotic prescribed on the system is subject to a prompt review and validation process by the pharmacist allocated to the specific unit.

3.7.1 Summary of the antimicrobial audit completed in the MH Inpatient Units Q3 2021-2022

Data extrapolated from the Lorenzo system highlighted that 275 antibiotics were prescribed within Quarter 3 2021-22 across all mental health and learning disability units (excluding CAMHS). Of those 103 (37.45%) required some level of intervention by the Pharmacist allocated to the unit. The main issues identified are reported to be centred around the;

- Incorrect choice of drug
- The correct length of duration
- The lack of documentation around the reason for the prescribing of the antibiotic.

It has been recognised that to make any improvements to the quality of prescribing an enhanced level of detail is required to ensure that the specific areas of low compliance can be targeted. It has been agreed that a manually conducted prevalence audit schedule will be introduced by the Pharmacy Team during 2022-2023

3.7.2 Summary of the antibiotic audit completed in the Community Inpatient Units Q3 2021-2022

A two-week prevalence audit was carried out at Fitzwilliam ward, Malton and Memorial ward Whitby during the Q3 reporting period of 2021-2022.

Whitby
It is pleasing to note that the prescribing of the antibiotics during this period was noted to be extremely low (3 antibiotic prescriptions only during this period). The choice of antibiotics prescribed was deemed to be appropriate in all 3 cases however the duration of the trimethoprim was noted to be longer than the 3 days recommended for females. No clear rationale was provided for the extended duration.

Malton
8 patients were prescribed antibiotics over the 2 weeks period.
Four of these patients had been transferred to the ward from secondary care on antibiotics to complete the course.

Out of the four initiated on antibiotics by the hospital, 50% (2 patients) were prescribed for 7 days with no clear rationale provided on the patient records as to why seven days were required as opposed to the 5 days recommended in the national guidelines.

3.7.3 Summary of primary care performance during 2021-2022

Monthly locally enhanced surveillance data (which includes the inclusion of two antibiotic indicators) has continued to be collated in 2021-2022 for each of the Trust primary care settings. This allows comparison against others practices in the Hull and East Riding regions but also nationally.

Audits completed during 2021-2022 demonstrated that the

i) The volume of antibiotics prescribed in a small number of our practices was higher than the average.
ii) The amount of Trimethoprim prescribed in 3 of our primary care practices was higher than expected.

All data collated has been reported to the Clinical Network Groups and the individual prescribing clinicians, when possible, for discussion regarding their prescribing habits and the actions that are required.

Possible factors for the increase in prescribing included the difficulties to recruit. A number of practices have relied on the regular use of a temporary workforce which makes any improvement difficult to sustain with such a fluid workforce.

Plans are in place to continue to monitor the performance in all primary care but also to complete a deep dive in the areas where performance is continually lower than required. Further detailed audits have either been completed or planned in the areas where we are seen to be an outlier.

3. Goal 02 – Enhancing prevention, wellbeing and recovery

'We are committed to keeping patients informed about all aspects of their care and ensure they are involved in key decisions'

It is important that patients are engaged in their health care decision making process as those who are engaged as decision makers tend to be healthier and have better outcomes. To support this access to a good quality health information is deemed to be essential.

A member of the IPCT is an active participant within the Patient and Carer Experience (PACE) Forum and work has commenced to ensure IPC initiatives, policies, information resources are shared with PACE members via the engagement leads to raise awareness and gain valuable input and feedback. An IPC Patient and Carer and Experience action plan has been developed in Q3 of this year with the intention to complete all actions during the ensuing year.

A review of all the patient related infection control information available has taken place during 2021-2022 to ensure the information that is already in place remains accurate, current and in line with both the national guidance and trust branding requirements. It is acknowledged that further work is required to improve and enhance the resources available for the public to access on the Trust external website and this work will continue to be progressed throughout 2022-2023.

4. 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 has been acknowledged as an essential component in the reduction of HCAI and as such the Infection Prevention and Control Team have availed themselves of every opportunity to meet virtually with colleagues both locally and nationally to share learning, and best practice.

Meetings have included attendance at;

- The Yorkshire Region Infection Prevention and Control Society Meeting
- NEY IPC Lead Nurses Forum
- The National Infection Prevention and Control Mental Health Special Interest Group

Meetings with the Yorkshire Infection Prevention Society and Mental Health Special Interest Group have been virtually attended and have been invaluable by providing mutual support and share information during such a challenging period. WhatsApp continues to be used on a regular basis by both of the above mentioned groups during such a challenging period.

It is also pleasing to note that the Lead Nurse was able to personally attend the Annual Infection Prevention Society Conference in September 2021 which provided a selection of presentations from national and international speakers which were both stimulating and thought provoking.

5. 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 major goal 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 to support all staff in the delivery of their responsibilities during 2021-2022 has included:

5.1 A Review of Infection Prevention and Control Policies and guidelines

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 all been reviewed and updated by the IPC team ensuring that practice and guidance is current and evidence based.
Policies and guidelines updated during 2021-2022 have included:

Name	Document type and identifier	Date approved	Changes made
Isolation Precautions Policy	Policy (N-020)	May 2021 QPaS	Full scheduled review. Minor changes required only
MRSA (Meticillin – Resistant Staphylococcus Aureus Policy	Policy (N-021)	May 2021 QPaS	Full scheduled review. Minor changes required only
Infection Prevention and control admission, transfer and discharge Policy	Policy (N-033)	January 2022 QPaS	Full scheduled review. Minor changes required only
Infection Prevention control arrangements Policy	Policy (N-014)	January 2022 QPaS	Reviewed and refreshed to ensure it reflects the Trust current

			organisational structure and governance arrangements for infection control-Minor amendments required only
Infection and Control Aseptic Technique (ANTT)	Protocol (524)	HAIG September 2021	Scheduled protocol review. Infection Prevention Society Audit tool added (appendix 2) Reference section updated
Guideline for the Management of a Patient with a Transmissible Spongiform Encephalopathy (TSE)	Guideline (G39)	HAIG May 2021	Minor amendments

The IPCT have developed and or provided input in to the development of a variety of other Trust policies and Standard Operating Procedures (SOPs) that have, and continue to support staff. These remain constantly under review to ensure they reflect the changes that are required as a consequence of the next phase of the pandemic.

5.2 The Delivery of the 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 Corporate Induction programme for all staff newly appointed by the organisation. The session 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 2021 to April 2022 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.

As shown in Table 5 below the Trust Infection prevention and control compliance target of 85% has been exceeded in every month during 2021-2022.

Table 5 Infection Prevention and Control Training Compliance 2021-2022

Compliance percentage	April 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Level 1	97.1	98.3	97.0	98.1	97.2	97.4	97.2	97.27	98.4	97.4	96.8	97.4

Level 2	94.6	94.8	95.0	95.4	94.9	94.9	94.9	95.3	95.8	95.3	95.1	96.0

5.3 PPE Training

Training to ensure that PPE is correctly used has been one of the key measures to assist in the prevention of 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 confident and competent in the use of PPE.

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. It is acknowledged that work is still required to evidence the work that is completed and to achieve this work a joint programme is underway to develop a competency package. It is anticipated that the work will be completed in quarter 2 of the next reporting period.

5.4 Face 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 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.

A SOP for The Selection of Respiratory Protective Equipment (RPE) and Face 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 fit test trainers in their new role.

To support the amount of work that has been generated a fulltime Band 3 Trust Face Fit Tester and PPE Champion has been recruited on an initial 12-month fixed term contract. This position will be reviewed in September 2022.

The IPCT have also enlisted the support of the National Face Fit Testing Team (NFFTT), to provide the necessary training for further 30 staff members across the Trust.

At the time of writing this report the Trust has 63 Face Fit Test Trainers, however this figure remains under constant review to ensure the figures do not reduce dues to staff leaving or being promoted. We have arranged further assistance in September 2022 to boost the number of accredited trainers once again.

As requested via the national procurement teams we have expanded the type of FFP3 masks we with us now fitting 9 different masks. This has reduced our reliance with one company which was noted to be a major problem in the early stages of the pandemic as the majority of the stocks were produced in China. The diversification approach will continue throughout the ensuing year.

6. 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'

6.1 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 inpatient areas during 2021-2022 can be seen in Tables 6 and 7.

Table 6. Inpatient Environmental Audit results 2021-2022

Inpatient Unit	Q1	Q2	Q3	Q4	Main issues identified in areas when compliance score under 90%
Avondale	**94%**	**99%**	**100%**	**100%**	
MVC	**91%**	**100%**	**93%**	**96%**	
Newbridges	**96%**	**97%**	**88%**	**99%**	Q3 Some building work noted on the day of inspection. Domestic cupboard required a clean and storage to be improved. Daily cleaning check list not always competed. Lime scale present on water outlets.
PICU	**88%**	**99%**	**97%**	**99%**	Q1 Incorrect assembly of 1 sharps bin on day of inspection and debris/stain noted on one wall.

					Incorrect storage of items noted in kitchen. Daily cleaning check list not always competed
Westlands	**88%**	**88%**	**99%**	**91%**	Q1. Dining furniture needs replacement. Lime scale identified in a selection of outlets. Water flushing sheets for little used outlets not consistently completed. Soap dispenser nozzles needed cleaning. Q2 Water flushing sheets for little used outlets not consistently recorded. Laundry area cluttered due to the incorrect storage of an individual`s laundry within the area.
Maister	**100%**	**99%**	**100%**	**99%**	
MVL	**86%**	**94%**	**96%**	**99%**	Q1. Building work noted on the day of inspection. Dirty utility noted to be cluttered due to as being utilised as a storage facility during the ongoing works.
Darley House (COVID WARD)	**88%**	**Not open**	**91%**	**97%**	Q1 The unit was not occupied on the day of inspection however work was required to ensure that it remained clean and available for immediate use if required. Some cleaning issues and remedial work required. Flushing of the outlets in place but occasionally a gap noted in the required documentation
Ouse	**96%**	**100%**	**96%**	**99%**	
Swale	**97%**	**97%**	**100%**	**91%**	
Ullswater	**90%**	**97%**	**93%**	**97%**	
Pine View	**94%**	**99%**	**99%**	**94%**	
Lilac	**87%**	**97%**	**94%**	**97%**	Q1. Daily cleaning check list not always competed. Lime scale present on water outlets. Incorrect assembly of 1 sharps bin on day of inspection
Willow	**94%**	**97%**	**99%**	**97%**	
Granville	**99%**	**97%**	**97%**	**99%**	
Whitby Frankland	**97%**	**94%**	**99%**	**94%**	
Malton Fitzwilliam	**93%**	**100%**	**99%**	**100%**	
Orion (CAMHS)	**94%**	**94%**	**99%**	**97%**	
Nova	**99%**	**93%**	**96%**	**99%**	
STaRS	**97%**	**96%**	**91%**	**97%**	

Key to scores Good Improvement required Unsatisfactory

Table 7. Primary Care Environmental Audit results 2021-2022

Surgery	Q1	Q2	Q3	Q4	Main issues identified in areas when compliance score under 90%
Northpoint Medical Practice	**17/5 88** **14/7 95**	**88%**	**98%**	**96%**	Q1 Lime scale evident on a number of outlets. Wall damagE Q2 Cleaning of the floor not evidenced in all areas. Lime scale still evident. Wall damage
Peeler House Surgery	**17/5 95** **16/7 96**	**98%**	**95%**	**96%**	
King Street Medical Centre	**93%**	**91%**	**96%**	**96%**	
Manor House Surgery	**08/7 86%** **20/7 86%**	**84%** **64%**	**28/10 66%** **25/11 88%** **06/1 95%**	**91%**	Q1 The standard of daily cleaning Daily cleaning check lists not always completed Hand hygiene basins not all in line with required specification Q2 Not all hand hygiene basins in line with required specification Resealing of clinical flooring required
Field House Surgery	**95%**	**95%**	**93%**	**89%**	
Market Weighton Practice	**20/04 86%** **20/07 96%**	**86%**	**96%**	**96%**	Q1 and 2 Cleaning issues identified Hand hygiene basins not all in line with required national specification. Daily cleaning check lists not always completed
Princes Medical Centre	**96%**	**93%**	**96%**	**93%**	
Practice Two		**79%**		**86%**	Q1 and 3 HTFT specifications for cleaning standards not achieved by external contractors.. Issues noted with sharps bin collections.

Historically the IPC audit has only been undertaken annually in the primary care setting areas in the areas where good compliance has been noted however this has now been increased to quarterly in all areas 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.

Table 7 demonstrates that a significant amount of effort has been put into improving each primary care setting to ensure it reaches an acceptable standard and level of cleanliness. This is made more difficult however in those buildings that are not owned by the Trust and the need for effective communication and negotiation skills with our landlords cannot be over emphasised. Where it has been possible the cleaning contracts have been brought in house to ensure that the cleaning consistency is maintained at an acceptable standard.

6.2 Sharps Management

Needlestick injuries (NSIs) are one of the most common injuries for healthcare workers according to the RCN (2011). NSIs through venepuncture and injection are the most common causes of inoculation exposure. Inoculation exposure injuries not only have potential health consequences for those affected, but also a psychological impact.

The regular monitoring of sharps practice is completed in all areas as part of the infection prevention and control audit programme.

An additional external sharps audit however has been completed by Daniels Healthcare (November 2021) to determine whether staff are managing and disposing of staff in accordance with national guidance.

Fifty (50) Wards/Departments were visited during the audit and one hundred and eighty one (181) sharps containers were sighted.

The audit results were encouraging on the day of the inspection; The audit found no (0) sharps containers with protruding sharps, none (0) that were incorrectly assembled and none (0) that were more than three quarters full.

Four (4) containers however were not signed or dated whilst in use in accordance with national and Trust guidance.

All sharps' containers were reported to be sited in an appropriate location and Small sharps containers and Daniels trays were available to take to the patient were applicable

Immediate feedback was provided on the day of the inspection. The finalised audit report has been cascaded to all charge nurses, team managers and matrons.

6.3 The Introduction of the National COVID-19 IPC Board Assurance Framework (BAF) Document

On the 5th May 2020 NHSE/I issued a BAF document to support IPC and the management of COVID-19. The completion of the BAF was included within the 2021/22 IPC work plan and progress against any outstanding action is now monitored at all formal HAIG meetings The BAF has been reviewed regularly and

updated and the results of which are discussed as a standing agenda item on each Healthcare Associated Group Meeting. The most recent version (1.8) was presented to the Trust Board of Directors on 30th March 2022, providing assurance that we are meeting our responsibilities in the management of the pandemic. A renewed version of this document is awaited at the time of report.

6.5 Environmental Cleaning

During 2021-2022 The coronavirus (COVID–19) outbreak has continued to challenge our cleaning services beyond any expected or planned levels of support service delivery. The staff group have demonstrated a magnificent response to the increased demands for effective cleaning in all areas. Staff have worked additional hours to ensure the units have received enhanced frequencies of cleaning, ensuring they support their clinical colleagues to prevent cross contamination and maintain a high standards of infection prevention and control.
The National Standards have been reviewed in conjunction with Hotel Services, the IPCT and the Matrons. A draft implementation plan has been developed to adopt the standards outlined within the national guidance within the nationally agreed time frame. An update of progress is provided at each HAIG meeting and all targeted dates have been met up to the time of the report. There are currently no concerns that the implementation date of October 2022 will not be met.

Despite significant challenges excellent feedback has been provided from all the inpatient areas on the responsiveness and quality of the Hotel Services performance and the level of support that they have provided particularly during the periods of outbreak. The positive feedback has also been extended to the preferred external contactor that is used when resources within the Trust ae stretched.

As part of the International Infection Prevention Week 2021 we asked for feedback from the Hotel Services Teams.
Two examples of the pride and care taken in the work that they have done can be seen below in the feedback they provided;

Quote 1 “You know how much I love my Job I’d like to think I maintain a high standard! When the pandemic came it was scary and along with that came a sense of having to keep everyone as safe as possible to protect them from it i.e patients, staff and of course ourselves. Working in full PPE isn’t easy especially is warmer weather (it’s like your own private sauna) however the hope that what your doing is keeping others safe is what keeps you going and makes it bearable! We are given the equipment and the chemicals to make this possible and believe in them. It’s difficult when patients have got COVID as you feel (well I do) you’ve let them down or not done something properly or possibly missed somewhere and feel you’ve failed them 😔😔. On a plus side the ones who’ve not had it you feel you’ve contributed to their safety in carrying in what you do! I feel responsible for the females/areas and the cleanliness of their surroundings and take pride it what I do 😊😊

Quote 2 “ From the start of the day or shift every minute is ever changing, you never know what is going to greet you at the door both domestics or cooks have same start to any given day, the domestics are crucial to any given site weather inpatient or office same rules apply, infection control, is everywhere we they look, this also means in the kitchens, no difference, same standards across the board, if we don't follow strict rules and guidance, then the organization would fail and not function properly. Our staff from the start of shift take on board many different instructions regarding anything from D&V to covid... Often identify things before most as there the eyes and ears in some circumstances, nursing staff often are distracted with patient care and appreciate the domestic house keepers, input on the day to day cleaning /cooking ensuring standards are met, often domestics in particular end up doing tasks to help out the nursing teams ensuring that all standards are kept, so in short the whole hotel services team are part of the bigger picture often without being seen, they just

6.6 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 2021-2022 the Infection Prevention and Control team and the Estates Department have continued to work closely to ensure that the new and existing patient facilities are constructed in a way that enhances good infection control practice. 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 regular joint estates and IPC group meetings have been held 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.

During 2021- 2022 IPC advice and input has been provided in the;

- The planning and installation of the staff well-being package within all clinical inpatient units
- The planning stages of the proposed major redesign programme at Granville Court.
- Major redevelopment scheme proposed within the Humber Centre
- Improvement of seclusion facilities across the full mental health and learning disability site.

The importance of maintaining the multi-disciplinary approach cannot be over emphasised and will remain a key priority.

6.7 Ventilation Requirements

The requirement for good ventilation has been acknowledged as essential in any work place 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.

In accordance with the updated Health Technical Memorandum (HTM 03-01) the Trust has appointed an Authorised Ventilation Engineer and a ventilation group has been established. Two meetings have been held within 2021-2022.

A survey of the ventilation within each Trust inpatient and primary care area has been completed during 2021-2022. Work is currently underway to review the results and to make recommendations based upon the findings. It is anticipated that the review will have been completed by the end of July 2022. At the time of writing this report this has now been completed and an action plan to implement any development work is being formulated. In the interim a programme of urgent remedial work is taking place i.e. repair of extraction fans not working in a variety of areas.

Additional improvement work has included the installation of hepa- filtered air scrubbers which are designed to assist in improving the air quality in an area of potential muti -occupancy.

6.8 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 Management Group (WSMG) 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 Management Group (WSMG) 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. Quarterly WSG meetings are in place supplemented with the addition of a subgroup of the Water Safety Group who meet fortnightly to monitor progress of any outstanding actions until a positive outcome has been achieved.

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, and this continues where required.

The Trusts Water Safety Policy and Plan has been updated and approved in December 2021 to satisfy the requirements of HTM 04-01 addendum for water safety and governance.

An externally validated audit of the Trusts performance has been conducted by the Trust appointed Authorised Water Engineer in December 2021.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 and Control. The audit completed in December 2021 demonstrated

‘reasonable assurance’ which was an improvement from the previous audit completed.

Ongoing water related issues as of 31st March 2022

Maister Lodge
Legionella detection was found at site initially following the creation of the Maister Court ward and has persisted at various locations around the site. A full review of the site is currently being undertaken to identify the underlying source.

Mill View site
Legionella found at site following pre samples prior to development works on vanity unit replacements, staff welfare and creation of the COVID pod. Whilst a number of improvements to the system have been completed legionella is still present in the hot water system and an extensive programme is in place to resolve.

Humber Centre
Legionella found following improvement works to the ADL kitchen on the Oaks corridor and improvement works across the site.
Whilst the issue in the ADL kitchen sink only affects one outlet, all previous actions have failed to rid this area of Legionella. It has been agreed that a local dosage is required to this area only. Development is to fit filters to the sink to allow the area to be used whilst developing plans for the treatment.

All mitigations remain in place to maintain both staff and patient safety. This includes the use of legionella filters / isolation of any unprotected outlets, the enhancement of water flushing regimes and the completion of staff and patient vulnerability assessments to ensure ongoing safety.

7. 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 the usual high level of IPC engagement and attendance at both national and local events has been limited once again this year due to the ongoing impact of the pandemic and the cancellation of mass gatherings. We have however continued to promote and support all the relevant key dates by virtual means and the provision of resources and information.

The link nurse practitioners and colleagues however arranged several promotional activities within their respective areas throughout the year and an example of their work can be seen below;

Hand Hygiene Day 5th May 2021

International Hand Hygiene Day Westlands

For International Hand Hygiene Day, Laura Smyth, Occupational Therapy Student at Westlands Inpatient Unit facilitated a group.

Patients and staff were invited to a group

Granville Courts Celebration Board Produced for International Infection Prevention Week

It is hoped that the opportunities will continue to increase during the oncoming year and the team are already planning a timetable of activities. The first of which includes IPCT representation at the Hull Pride event in July 2022 where we will be providing information and advice on key infection control topics.

8. Summary

The COVID-19 pandemic has continued to prove a huge challenge during 2021-2022 but the organisation has risen to the challenge, with all staff working together flexibly to provide a safe environment for both patients and staff. Despite all these 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. We continue to support the restoration of all our service activities, but we are aware that this comes with new hurdles and challenges. We are also aware that we may not be at the end of any further surges or other respiratory viruses emerging over the ensuing months.

Whilst COVID-19 management has taken up a massive proportion of our time and resources we now need to resume some of our improvement work to ensure that we are able to sustain our historic high level of performance in the prevention of all other infections and that our IPC training programme for staff remains reflective of their ongoing needs

The environmental constraints within areas of our aging estate poses one of the key 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 ventilation capabilities and the size of the unit's footprint adversely affects the ability to provide adequate space when social distancing is required. The lack of en-suite provision in some inpatient areas continues to make the effective isolation of infective patient more difficult and increase the risk to others. Work needs to continue to ensure that ongoing improvement continues to address the issues were feasible within the constraints of the buildings.

The Infection Prevention and Control Strategy 2018-2022 will be review and will be updated to reflect all our key objectives and aspirations.

Our key priorities for 2022-2023 are to;

- Ensure staff are adequately prepared for any other surges of COVID-19 but also any other communicable disease that may emerge and require an emergency response.
- Fully implement and embed the National IPC manual for England within the organisation.
- Develop a robust antimicrobial stewardship programme across all divisions within the Trust.
- Deliver the agreed PACE action plan.
- Review the IPC educational programme to ensure that it remains responsive to the needs of all staff working within or on behalf of the organisation.
- Ensure continued collaboration with the estates and capital team to ensure that the design of all of our buildings and new builds to take into account the latest evidence around containment of respiratory viruses such a SARS CoV-2 (COVID-19).
- To maintain our newly formed relationships with colleagues both locally, regionally, and nationally.

Humber Teaching NHS Foundation Trust

Agenda Item 14

<table>
<tr><td>Title & Date of Meeting:</td><td colspan="4">Trust Board Public Meeting – 26th October 2022</td></tr>
<tr><td>Title of Report:</td><td colspan="4">Trust Behavioural Standards Refresh</td></tr>
<tr><td>Author/s:</td><td colspan="4">Steve McGowan Director of Workforce and OD</td></tr>
<tr><td>Recommendation:</td><td colspan="4"><table><tr><td>To approve</td><td></td><td>To receive & discuss</td><td></td></tr><tr><td>For information/To note</td><td>X</td><td>To ratify</td><td></td></tr></table></td></tr>
<tr><td>Purpose of Paper:

Please make any decisions required of Board clear in this section:</td><td colspan="4">EMT agreed revised Behavioural Standards in August.

A presentation was given to the Workforce and OD Committee in October on the new standards.

The refreshed version of the Trust Behavioural Standards is provided for information.</td></tr>
<tr><td colspan="5">Key Issues within the report:</td></tr>
<tr><td colspan="2">Matters of Concern or Key Risks to Escalate
• N/A.</td><td colspan="3">Key Actions Commissioned/Work Underway:

• Refreshed standards presented to Workforce and OD Committee in October 2022;

• Communications plan in place for roll out across the Trust.

• Appraisal documentation to be amended to include for 2023 onward.</td></tr>
<tr><td colspan="2">Positive Assurances to Provide:

• Builds on the success of the existing behavioural standards document with an increased focus on equality and diversity;
• Positively received at Workforce and OD Committee;</td><td colspan="3">Decisions Made:

• N/A</td></tr>
</table>

• Corporate branding and focus on 'Being Humber'.	

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	12/10/22 (presentation)
	Finance & Investment Committee		Executive Management Team	15/08/22
	Mental Health Legislation Committee		Operational Delivery Group	
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail) EDI Working Group members	

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	√			

Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			Yes	

Background

The Trust agreed Behavioural Standards in 2019. These were published in the form of a booklet.

These were reviewed in 2022.following consultation with staff networks, managers and staff the following changes were made :-

- New Branding and accessible formats– devised by the communications team now has a title of ‘Being Humber’
- Added Equality and Diversity Section
- Updated Trust objectives

A number of options around branding and communications were presented to the CEO for decision in July. These were put into the final proposal and presented and signed off by EMT in August 2022.

A presentation was given to Workforce and OD Committee on 12th October.

Future communications include:

- Posters, badges, cups, mugs all with ‘Being Humber’ branding;
- Assessment of new standards as part of the 2023 Appraisal
- Presentations to Senior Leadership Forum, professional forums etc
- Video message
- Presentation pack for all managers to cascade key messages
- Challenges and workshops to embed ‘Being Humber’ campaigns

NHS
Humber Teaching
NHS Foundation Trust

BEING HUMBER

Caring, Learning
& Growing Together

Our Behavioural Standards

WHY HAVE BEHAVIOURAL STANDARDS?

We want Humber Teaching NHS Foundation Trust to be ‘a provider of high quality services’ and ‘a great place to work’.

As an organisation we are committed to Caring, Learning and Growing and passionate about supporting our colleagues to be healthy, engaged and empowered to make a difference. Everyone who works for the Trust plays a part in achieving this.

This framework sets out the behaviours expected of all colleagues which are not explicitly described in our job description. The personal skills and attributes around ‘how’ we are expected to approach our work should be combined with professional and technical skills to inform every action we take.

OUR MISSION, VISION AND VALUES

OUR MISSION

Humber Teaching NHS Foundation Trust - a multispeciality health and social care teaching provider committed to Caring, Learning and Growing.

OUR VISION

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

OUR VALUES

Caring for people whilst ensuring they are always at the heart of everything we do.

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

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

OUR GOALS

- Innovating quality and patient safety
- Enhancing prevention, wellbeing and recovery
- Fostering integration, partnership and alliances
- Promoting people, communities and social values
- Developing an effective and empowered workforce
- Optimising an efficient and sustainable organisation

EXPECTATIONS AT A GLANCE

- BE OPEN AND HONEST
- BE PROUD OF THE ROLE YOU DO AND HOW THIS CONTRIBUTES TO PATIENT CARE
- VALUE THE CONTRIBUTION OF EVERYONE
- BE FRIENDLY AND WELCOMING
- SHARE LEARNING WITH OTHERS
- RECOGNISE DIVERSITY AND CELEBRATE THIS
- TEAM WORKING ACROSS ALL AREAS
- SEEK OUT AND ACT ON FEEDBACK
- ENSURE ALL OUR ACTIONS CONTRIBUTE TO SAFE CARE AND A SAFE WORKING ENVIRONMENT
- COMMUNICATE EFFECTIVELY: LISTEN TO OTHERS AND SEEK CLARITY WHEN NEEDED
- PUT PATIENTS AT THE CENTRE OF ALL WE DO
- SHOW SUPPORT TO BOTH COLLEAGUES AND PATIENTS
- RESPECT SHOWN TO EVERYONE

WHAT WE EXPECT TO SEE AND HEAR	WHAT WE DON'T EXPECT TO SEE AND HEAR
Being friendly and welcoming Simply introduce yourself. • Explaining who you are and telling them your role helps to put people at ease • Smiling, making eye contact, using open body language and appropriate tone of voice helps in building rapport with people	**Unfriendly behaviour and ignoring people** No introductions, including avoiding eye contact with individuals. • Closed body language where you appear unapproachable and rude • This can make people feel vulnerable and invisible. It is inappropriate to ignore people even if you are not the person they need to speak to. It creates a bad impression
Respect shown to and for everyone Show empathy, put yourself in their shoes (patients and colleagues) to try to see things from their perspective i.e., understand how they are feeling, their roles and pressures. • Talk directly with people about their care and any issues you are dealing with • Use appropriate language • Treat others as they wish to be treated • Have an awareness of the different cultural needs and beliefs and provide appropriate resources and support	**Disrespectful behaviour including that which constitutes bullying, harassment or discrimination** Ignoring what the other person is saying and showing no regard for how they are feeling or their perspective. • Gossiping and talking about people 'behind their back' or talking over people • Aggressive behaviour • Any behaviour which is humiliating or offensive to others and constitutes bullying or harassment • Any use of bad language

WHAT WE EXPECT TO SEE AND HEAR	WHAT WE DON'T EXPECT TO SEE AND HEAR
Act professionally always Present yourself in a professional way, in how you speak to people and your dress code. • Follow our Trust policies • Make sure confidentiality is always maintained, be aware of where you're having conversations and the information you have access to • Speak up and escalate concerns appropriately, either about unsafe practice or inappropriate behaviour • Be open to challenge and welcome feedback from others • Regularly review your performance against feedback to ensure you are doing the best in your role and working within current practices	**Unprofessionalism** Being disrespectful to people. Not following the appropriate dress code. • Inappropriate conduct or failure to follow policies and processes causes undue worry for patients and colleagues • Breaching confidentiality by discussing patient or colleagues information including leaving documentation visible on desks or in an open environment • Criticising others for speaking up on behalf of patient safety and any inappropriate behaviour • Ignoring feedback provided and refusing to take issues on board or make changes to behaviour • Continue to work as you have done rather than reviewing performance and ensuring you are working within current practices • Bringing personal issues into the workplace and letting them interfere with your work

WHAT WE EXPECT TO SEE AND HEAR	WHAT WE DON'T EXPECT TO SEE AND HEAR
Put patients at the centre of all we do Care is provided at the right time, by the right people in the right way. • Patients are involved in decisions about their care • Time taken to really care • Time taken to really listen to patients and respond to their needs • Engage with the patient's family or carer • Care provided with compassion and empathy • Information provided to patients in a timely way, keeping them updated about what is happening with their care • Engage with all members of the multi-disciplinary team to provide care • Focus on quality of care being given and seek assistance when required	**Patients are not seen as important** Patients and families are ignored and treated unfairly. • Decisions are made for patients without their involvement • Apathy, lack of compassion giving the impression you don't care and saying you are too busy to help • A lack of communication with the patient and their family or carer/s • Putting individual agendas before patient care • Lack of or no information provided to patients, so they are left wondering what is happening • Your mood affecting how you treat patients • Ignoring other team members involved in the patients care, not working together or passing on essential information regarding the care
Value the contribution of everyone in the team Value and recognise, through praise, the contribution everyone makes to the team • Share compliments - tell people when they have done a good job and make sure you pass on compliments you have heard and received • Recognise good practice and behaviour • Acknowledge ideas and encourage individuals to try new ways of working and practising • Celebrate success of everyone • Provide feedback to colleagues when things are going well and when they aren't	**Colleagues are not valued** Ignore and fail to recognise the contribution everyone makes to the team • Compliments are not shared, and feedback not given to team members • Ideas are either dismissed or not encouraged • Feedback only given when things aren't going well and given in public, causing humiliation • Patronising and judgemental behaviour, including belittling team members • Ignoring the achievements and successes made by the team and team members

WHAT WE EXPECT TO SEE AND HEAR	WHAT WE DON'T EXPECT TO SEE AND HEAR
Effective communication Communicate effectively in face-to-face, telephone and written interactions. • Show empathy and understanding of your message and consider how it will be taken on board • Keep people informed ensuring communication is timely, is delivered using the most appropriate method and language people understand • Active listening, take time to really listen so the person talking to you really knows you are hearing what they have to say • Show patience and understanding, take time to really understand what someone is trying to tell you so we can take intelligent action as a result • Encourage everyone to have a voice • Give everyone a chance to ask all their questions, remembering there is no such thing as a 'daft question' • To make the most of virtual meetings I have my camera on and participate to the best of my ability	**Ineffective communication** Communication is unclear or blunt and lacks empathy. • People are not kept informed, and communication is done in a way which is easiest for you • Jargon, abbreviations, terminology, and language is used which people may not understand • No time taken to listen • No opportunity given for questions which may leave people feeling anxious or unclear • Interrupting people inappropriately in interactions
Open and honest in your actions • Take responsibility for your own work and tasks • Take responsibility for your own actions • Honesty when things go wrong, take ownership and accountability • Keep promises you make following them through	**Being dishonest** • Blaming others when things go wrong, taking no ownership for your actions • Failing to keep promises or make empty promises

Contact us

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Agenda Item 15

Title & Date of Meeting:	Trust Board Meeting Public – 26th October 2022
Title of Report:	Emergency Preparedness Resilience and Response (EPRR) Assurance Process 2022-23
Author/s:	Name: Lynn Parkinson Title: Accountable Emergency Officer
Recommendation:	To approve ✓ / To receive & discuss / For information/To note / To ratify
Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The NHS core standards for EPRR are the minimum requirements commissioners and providers of NHS-funded services must meet. These core standards are the basis of the EPRR annual assurance process. Commissioners and providers of NHS-funded services must assure themselves against the core standards. The Trust has self-assessed against the 10 domains which has increased to 55 applicable core standards and 1 deep dive with 13 applicable standards. There are additional and new standards which has impacted on the compliance level of Humber Teaching NHS Foundation Trust. Following approval by the Trust Board, the compliance statement, and assessment will be submitted to the Integrated Care Board by 28th October 2022. Appendix A – Core standards and action plans Appendix B – Statement of Compliance

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:	**Key Actions Commissioned/Work Underway:**
• Failure to meet the deadline for the assurance process would risk being categorised as non-compliant against the core standards for EPRR. • Failure to meet the NHSE compliance requirements could lead to Humber Teaching NHS FT not	• The Health Command Training programme is underway. Delivery has already taken place with the Strategic Commanders, Tactical Training dates for our on-call managers are now available and Operational training will follow. • The Identification of operational commanders is in the process of being determined.

being 'properly prepared for dealing with a relevant emergency'. This is a responsibility placed on NHS funded providers under the Civil Contingencies Act (2004), the Health Care Act 2022 and NHS Act 2006. • This year's core standards have been revised to 55 with additional and new standards included which has impacted on Humber Teaching NHS Foundation Trust compliance level.	
Positive Assurances to Provide: • Peer review of compliance rating to be completed with ICB EPRR lead on 17/10/2022 • Health Command Training will be completed by March 2023 which will include Strategic, Tactical and Operational commands.	**Decisions Made:** • All non-compliant and partial compliant standards will be transferred to an EPRR action plan for completion over the next 12 months, this will be monitored via the Operational Delivery Group with escalation as required to the Executive Management Team.

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	10.10.22
Mental Health Legislation Committee		Operational Delivery Group	27.9.2022
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

Monitoring and assurance framework summary:

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

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

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

Emergency Preparedness Resilience and Response (EPRR)
Assurance Process 2022-23

1. Introduction

The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health or patient safety. Under the Civil Contingencies Act (2004), Health and Care Act 2022, NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

2. NHSE EPRR Core Standards assurance process

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

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

These standards will be and are reviewed and updated as lessons are identified from testing, national legislation, and guidance changes and/ or as part of the rolling NHSE EPRR governance programme. It must be noted that the deep dive standards are not required to be considered as part of the Trust compliance rating.

3. Trust NHS EPRR Core standards

The Trust received the 2022/23 assurance email from the EPRR regional team in July 2022 outlining the process and expectations for this year's submission.

The letter, from Steven Groves, National Director of EPRR for NHSE, thanked Trusts for their continued support and highlighted that this year's assurance process will reflect the establishment of Integrated Care Boards as Category 1 responders and their local leadership role. We were asked to undertake a self-assessment against the relevant individual core standards and rate our compliance with each. The compliance level for each standard is defined as:

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

	will not be reached within the next 12 months

We will comply with this request by:

- Self-assessing our compliance with the 55 applicable standards and submitting our statement of compliance and action plan by 28th October 2022 to the Humber and North Yorkshire Integrated Care Board.

4. Previous Years Position 2021-22

We self-assessed against the 36 applicable core standards and 7 deep dive standards of Oxygen Supply.

Our overall position for that year was determined as 'substantially compliant' with us meeting the criteria of between 89-99% compliance with the core standards. Our total compliance figure was, out of 36 core standards we complied with 33, therefore standing at 91.7%. An action plan was implemented to achieve full compliance with the outstanding core standards and this has been completed and the standards achieved.

5. Current Position

We have self-assessed against this year's 55 applicable core standards and 13 deep dive standards for Evacuation and Shelter, our overall position has been determined as 'partially compliant'. Our total compliance figure is, out of 55 core standards we have complied with 46, therefore an overall rating of 84%. Any standard that has been rated partially or non-compliant has been transferred into an action plan and this will form the EPRR improvement plan for the 12 months to follow.

Assurance Rating Thresholds **• Fully Compliant = 100%** **• Substantially Compliant =99-89%** **• Partially Compliant = 88-77%** **• Non-Compliant = 76% or less**	**Percentage Compliance**	**84%**
	Overall Assessment	**Partially Compliant**

Although this is a reduced position from the 'substantial' compliance reported in 2021/22 it is a direct result of the increase up to 55 core standards (36 in 2021/22), the introduction of new standards and the introduction of Health Command Training requirements of which is dependent on NHSE providing the schedule of training. In undertaking the self-assessment process, we have ensured that robust evidence to support our rating is available and that it will withstand scrutiny through audit.

Appendix A - Core Standards and Deep Dive with Actions

16	Duty to maintain plans	Evacuation and shelter	Partially Compliant	Trust evacuation and shelter plan in development.	Timescale for completion is April 2023	
21	Command and control	Trained on-call staff	Partially Compliant	Training has been completed with our 2nd on call (Directors). Tactical level training has commenced with our 1st on call (Managers) and will be completed by end of November 2022.	Timescale for completion is March 2023	NHSE have mandated that all key staff have completed training by end of March 2023. This is contingent on training packages being available.
22	Training and exercising	EPRR Training	Partially Compliant	Training portfolios are under development - awaiting template from NHSE.	Timescale for completion is March 2023	
24	Training and exercising	Responder training	Partially Compliant	Training portfolios are under development - awaiting template from NHSE.	Timescale for completion is March 2023	
55	CBRN	Telephony advice for CBRN exposure	Partially Compliant	CBRN plan requires updating. Internal targeted training to be developed once the plan has been revised.	Timescale for completion is March 2023	

56	CBRN	HAZMAT / CBRN planning arrangement	Partially Compliant	CBRN plan requires updating	Timescale for completion is March 2023	
57	CBRN	HAZMAT / CBRN risk assessments	Partially Compliant	CBRN plan requires updating	Timescale for completion is March 2023	
65	CBRN	Training programme	Partially Compliant	CBRN plan requires updating. Internal targeted training to be developed	Timescale for completion is March 2023	
67	CBRN	Staff training - decontamination	Partially Compliant	CBRN plan requires updating. Internal targeted training to be developed	Timescale for completion is March 2023	

Deep Dive – Evacuation and Shelter

This year's EPRR assurance deep dive is Evacuation and Shelter following the publication of the Evacuation and Shelter guidance for the NHS in England and is being used to identify areas of good practice and should guide organisations in the further development of their shelter and evacuation arrangements.

Note: These standards do not contribute to the overall Trust compliance rating.

DD1	**Evacuation and Shelter**	**Up to date plans**	**Not Compliant**		**Trust evacuation and shelter plan in development.**	**Timescale for completion is April 2023**
DD3	**Evacuation and Shelter**	**Incremental planning**	**Not Compliant**		**Trust evacuation and shelter plan in development.**	**Timescale for completion is April 2023**
DD4	**Evacuation and Shelter**	**Evacuation patient triage**	**Not Compliant**		**Trust evacuation and shelter plan in development.**	**Timescale for completion is April 2023**
DD5	**Evacuation and Shelter**	**Patient movement**	**Not Compliant**		**Trust evacuation and shelter plan in development.**	**Timescale for completion is April 2023**
DD6	**Evacuation and Shelter**	**Patient transportation**	**Not Compliant**		**Trust evacuation and shelter plan in development.**	**Timescale for completion is April 2023**
DD7	**Evacuation and Shelter**	**Patient dispersal and tracking**	**Not Compliant**		**Trust evacuation and shelter plan in development.**	**Timescale for completion is April 2023**

DD8	Evacuation and Shelter	Patient receiving	Partially Compliant	The Trust is signed up to the Yorkshire and Humber medium and low secure evacuation plan	Trust evacuation and shelter plan in development.	Timescale for completion is April 2023
DD9	Evacuation and Shelter	Community Evacuation	Partially Compliant	The Trust supports community evacuation via its participation in Local Resilience Forum arrangements such as Tidal Surge planning.	Trust evacuation and shelter plan in development.	Timescale for completion is April 2023
DD10	Evacuation and Shelter	Partnership working	Partially Compliant	The Trust is signed up to the Yorkshire and Humber medium and low secure evacuation plan	Trust evacuation and shelter plan in development.	Timescale for completion is April 2023
DD11	Evacuation and Shelter	Communications-Warning and informing	Not Compliant		Trust evacuation and shelter plan in development.	Timescale for completion is April 2023
DD12	Evacuation and Shelter	Equality and Health Inequalities	Not Compliant		Trust evacuation and shelter plan in development.	Timescale for completion is April 2023
DD13	Evacuation and Shelter	Exercising	Partially Compliant	The Trust has taken part in the regional Medium and Low Secure evacuation plan	Trust evacuation and shelter plan in development.	Timescale for completion is April 2023

				exercise on 5th September 2022.		

6. Conclusion

This Action Plan will become the part of the Trusts EPRR work programme for the remainder of 2022-23 and this will be monitored regularly as part of the EPRR quarterly reports to the Operational Delivery Group with escalation to the Executive Management Team as required.

7. Recommendations

The Executive Management Team and Trust Board are asked to:

- Consider the compliance self-assessment, rating, associated actions and approve accordingly.

- Authorise the Accountable Emergency Officer to approve and sign the compliance statement following the Trust Board meeting and for the EPRR team to submit their final submission to the Integrated Care Board by the 28th October 2022.

Appendix B

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

Humber Teaching NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Humber Teaching NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Partial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed

26/10/2022	**26/10/2022**	
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Ref	Domain	Standard name	Standard Detail	Mental Health Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Lynn Parkinson, Deputy Chief Executive, Chief Operating Officer and Accountable Emergency Officer	Fully Compliant	No further action		
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Emergency Preparedness Resilience and Response arrangements Policy. Updated and approval at Operational Delivery Group on 26th July 2022	Fully Compliant	No further action		
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	EPRR Annual Report was presented at Public Board Meeting on 27th April 2022. EPRR Assurance process is presented to the Trust Board annually. Chief Operating Officer reports to the Trust Board monthly on EPRR.	Fully Compliant	No further action		
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual work programme and this is reported quarterly to the Operational Delivery Group and defined in the EPRR Arrangements policy.	Fully Compliant	No further action		
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Arrangements policy is signed off at the Operational Delivery Group and includes the following: Role and resources, structure chart, internal governance process and is described within the document.	Fully Compliant	No further action		
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	This is described in the EPRR arrangements policy under section 5.1. Learning from incidents is captured via debrief forms and participation in regional processes.	Fully Compliant	N/A		
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	This is explicitly described in the EPRR arrangements policy in S7.2 and also S10 of the Trust Risk Management Policy. EPRR risks are included as part of the Operational Risk Register and are reported to the Trust Board. The EPRR risk register includes consideration of the LRF community risk registers and national risk registers and was last revived in September 2022.	Fully Compliant	No further action		
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The Trust is in the process of moving to recording risks on Datix. The EPRR team have scheduled training with the Trust Risk Manager in order to facilitate this new way or working.	Fully Compliant	No further action		

9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The recent re-write of the Major Incident Plan was shared with the relevant CCGs at the time and our partner Acute Trust as part of the consultation.	Fully Compliant	No further action		
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a Major Incident Plan and associated plans in place to manage critical, major and business continuity incidents. The plan was updated and approved at EMT in April 2022 to reflect lessons learned from Covid-19.	Fully Compliant	No further action		
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire	The Trust has a severe weather and winter plan and covers the Trusts geographical areas. This plan is updated 3 yearly or when national legislation dictates. It was last updated in 2021. The Trust also has a heatwave plan which was updated in 2021	Fully Compliant	No further action		
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to EFP3 Resilience in Acute setting incorporating the EFP3 resilience principles	The Trust has a policy that covers the management of an outbreak of communicable infections which is in date and due for review in October 2023 or if national guidance changes.	Fully Compliant	No further action		
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The influenza plan has been reworked into a pandemic plan which takes into account any new and emerging infections. This will be approved at the September ODG and go out for consultation to the HAIG group members.	Fully Compliant	No further action		
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure	During the covid pandemic the Trust committed to training peer vaccinators within the Trust to deliver covid vaccinations to its staff, patients and Social Care staff as well as supporting the PCN to deliver their vaccination programme to their patients. The mass countermeasures as described are included in the Major/Critical Incident plan and the pandemic plan	Fully Compliant	No further action		
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary	This is referred to in the Major/Critical Incident Plan in Section 7 and outlines our commitment to provide psychological support to our partners in the event of a mass casualty event.	Fully Compliant	No further action		
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation and Shelter is referred to in the Major/Critical Incident Plan in Section 7.	Partially Compliant	Trust evacuation and shelter plan in development.	EPRR Team	Apr-23
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a physical security of premises policy which outlines the lockdown process in detail in Appendix 1. This is in date and was approved at the H & S Group in August 2022.	Fully Compliant	No further action		

18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	This is included in the Major/Critical Incident Plan in S10 and also in the Visiting celebrities, VIPs and other official visitors policy, due for review in 2025	Fully Compliant	No further action		
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust understands it would have a support role in multiagency arrangements for excess deaths and mass fatalities if requested. The Trust has no mortuary facilities however participate in the Humber LRF arrangements for excess deaths.	Fully Compliant	No further action		
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	This is explicity described in the EPRR arrangements policy section 4.6 and 7.4. The Trust has also developed an on call standard operating procedure which outlines the definitions of Major, Critical and Business Continuity incidents. The escalation process is outlined at Appendix 4. All on call staff have access to on call documents via an electronic pack. We also induct new on call managers, offer buddy arrangements and offer workshop sessions using real scenarios taken from previous on call to prepare them for on call duties.	Fully Compliant	No further action		
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	As above. Although with the introduction of the new mandatory training requirements by NHSE means that this is now only partially met until the training can be delivered.	Partially Compliant	Training has been completed with our 2nd on call (Directors). Tactical level training has commenced with our 1st on call (Managers) and will be completed by end of November 2022.	EPRR Team	Mar-23
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Training needs analysis is available and the training and exercising schedule and process is outlined in S12 of the Operational Managers on call standard operating procedure. Training and exercising is recorded on the training and exercising schedule. This will be complemented by individual portfolios once NHS England;s National Minimum Occupational Standards based training for key roles is fully established and embedded.	Partially Compliant	Training portfolios are under development - awaiting template from NHSE.	EPRR Team	Mar-23
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Communication tests were carried out on 12th April 2022 and next test is scheduled for 3rd October 2022 to test Incident response. Table-top YH Low/Medium secure evacuation Plan exercise went ahead on 05/09/2022. Continue to operate in a live incident (Covid pandemic). Heatwave live incident 18/19th July 2022 tested Trust Heatwave Plan and Service/Team BCP's. Debrief forms distributed for any learning.	Fully Compliant	No further action		
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Evidence of EPRR related training and exercising is held by the EPRR team, this will continue until a decision is made by the Trust to include the Principles of Health Command Training onto ESR as mandatory training requirements for key individuals.	Partially Compliant	Training portfolios are under development - awaiting template from NHSE.	EPRR Team	Mar-23

25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	All services within the Trust have individual BCPs and are held on the Trust Intranet and in the on call packs. The Major/Critical Incident Plan has action cards for roles associated with incident response All staff should be aware of the Plan as consultation is done with the individual operational divisional groups and is on the staff intranet. EPRR is no longer part of the Trust induction however attendance at the monthly Trust and Divisional operational groups ensures that all staff are aware of EPRR matters as there is a standing agenda item.	Fully Compliant	No further action
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The Trust has an identified ICC at the Trust HQ site and also a backup located at Whitby Community Hospital. The EPRR BCP covers off the contingency arrangements for the Trust ICCs. Grab box is available for both locations and hard copies of Major/Critical Incident plan, action cards and equipment are included.	Fully Compliant	No further action
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	All EPRR related documents are version controlled and available on the Trust Intranet as well as in the on call packs. Services are expected to have a hard copy version of their BCP retained by the Plan owner. The Trust is driving to become paperless to reduce its carbon footprint where possible and does not advocate paper copies unless absolutely necessary, this also removes the risk of outdated versions being used.	Fully Compliant	No further action
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	The Trust has arrangements in place to manage a business continuity incident and this is referenced in the Major/Critical Incident Plan S5 & 9. The Trust has Business Continuity Plans across all services of the Trust which are updated annually.	Fully Compliant	No further action
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	There are some trained loggists available 24 hours and although a number have left the organisation this is being addressed by some additional training. Access to the current loggists are tested every 6 months as they are included on our Comms test which is conducted out of hours.	Fully Compliant	No further action
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	This is documented in the EPRR policy and authorisation of sitreps is by the Deputy COO. The EPRR team coordinate all sitreps during an incident response.	Fully Compliant	No further action
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	N/A	Guidance is available to appropriate staff either electronically or hard copies	N/A		
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	N/A	Guidance is available to appropriate staff either electronically or hard copies	N/A		

33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The EPRR team work closely with the communications team. The Trust media policy outlines that during major/critical incidents all media liason is via the communications team. Our On Call standard operating procedure has a defined process in Appendix 2 for media enquireies out of hours, this is also held in the on call pack. Trust has a media policy as above.	Fully Compliant	No further action
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).		Fully Compliant	No further action
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	As 33. The Trust communications department works closely with the EPRR team and also works collaboratively with stakeholders and partners to enable messages via its social platforms to be communicated out.	Fully Compliant	No further action
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Communications are key members of our Strategic and Tactical command structures. The Trust media policy outlines the communications teams role in a major/critical incident	Fully Compliant	No further action
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	This role is delegated to the Deputy Chief Operating Officer who attends the LHRP meetings.	Fully Compliant	No further action
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The Trust regularly participates in Humber Local Reslience forum at both Tactical and Strategic Level. Previously NHSE represented organisations at the North Yorkshire Local Resilience Forum however this will now be the ICB.	Fully Compliant	No further action
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual aid is explicitly described in the Major/Critical incident plan in S7. Mutual aid protocol is at Appendix O	Fully Compliant	No further action
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	N/A	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	N/A		
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	N/A	• Detailed documentation on the process for managing the national health aspects of an emergency	N/A		
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	N/A	• LHRP terms of reference • Meeting minutes • Meeting agendas	N/A		

43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	The Trust along with other organisations across the Humber region are signed up to the Humber Information Sharing Charter which demonstrates the Trusts commitment to share appropriate information in a fair and transparent way. There are however, no specific written Tier 2 agreements in place for sharing information specifically for EPRR purposes, these sharing arrangements are informal with our partners and is an accepted way of working within an incident environment with consideration for relevant guidance.	Fully Compliant	No further action
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The EPRR policy outlines the process of BCM in S7. The Trust also has an overarching Business Continutity Plan in place which covers the organisation's approach, ownership, and impacts.	Fully Compliant	No further action
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The EPRR policy outlines the process of BCM in S7. The Trust also has an overarching Business Continutity Plan in place which covers the organisation's approach, ownership, and impacts.	Fully Compliant	No further action
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Business Continuity Plans are in place for all services within the Trust and all contain a Business Impact Analysis.	Fully Compliant	No further action
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	All services within the Trust have individual BCPs	Fully Compliant	No further action

48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	All Trust Business Continuity Plans are tested annually. This is documented on the final page of the plan with type of test undertaken, lessons/actions identified and amendments made to the plan. We also carry out table top business continuity exercises each year across multiple teams. The last table top business continuity exercise was held with Community Services on 12th May 2022 with the debrief held on 13th June 2022.	Fully Compliant	No further action		
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	The Trust maintains a strict management and accountability framework for information governance and data security. The Trust demonstrates its continued compliance with data protection legislation which is assured by maintaining a 'Standards Met' Data Security and Protection Toolkit.	Fully Compliant	No further action		
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	Status of BCPs and their compliance with the rolling programme for updating is fed back monthly to the divisional operational delivery groups and quarterly to the Organisational Delivery Group.	Fully Compliant	No further action		
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Annual audits are undertaken by External Audit on Business Continuity. Audit to commence in September 2022.	Fully Compliant	No further action		
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews	Recommendations from annual audits inform improvements to the BCPs as well as lessons learned through incidents and exercising.	Fully Compliant	No further action		
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	It is a Trust requirement that BCPs are considered as part of the contract process and there is an expectation that external provider/suppliers have these in place.	Fully Compliant	No further action		
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning	N/A				
55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	The Trust has a CBRN plan that explicitly details all of the required actions to be taken in terms of HAZMAT/CBRN response including training and this is based on information in the national guidance documents. The IOR DVD is also available on the Trust intranet.	Partially Compliant	CBRN plan requires updating. Internal targetted training to be developed once the plan has been revised.	EPRR Team	Mar-23

56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	The Trust has a CBRN plan that explicitly details all of the required actions to be taken in terms of HAZMAT/CBRN response including training and this is based on information in the national guidance documents. The IOR DVD is also available on the Trust intranet.	Partially Compliant	CBRN plan requires updating	EPRR Team	Mar-23
57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	It is beyond the scope of the Trust to manage suspected CBRN incidents internally and specialist assistance would be sought from external agencies. The Trust would implement its CBRN plan and dynamically risk assess the risk to others and staff as identified in the Action cards. The LRF has a community risk register and risk assesses industrial premises etc, the EPRR risk register is informed by this. The Trust has a waste management policy and waste management standard operating procedure that includes the removal of hazardous waste.	Partially Compliant	CBRN plan requires updating	EPRR Team	Mar-23
58	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.		Rotas of appropriately trained staff availability 24 /7	N/A				
59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	The Trust has access to necessary equipment required to deal with immediate dry decontamination of self presenters in a healthcare settings. These supplies are detailed in the CBRN plan although inventories of supplies are not kept by EPRR but supplies maintained in local areas as part of their operational procedures.	Fully Compliant	No further action		
60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.		Completed equipment inventories; including completion date	N/A				
61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks		Record of equipment checks, including date completed and by whom.	N/A				
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment		Completed PPM, including date completed, and by whom	N/A				
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.		Organisational policy	N/A				
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Maintenance of CPD records	N/A				
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	The Trust has a CBRN plan that explicitly details all of the required actions to be taken in terms of HAZMAT/CBRN response including training and this is based on information in the national guidance documents. The IOR DVD is also available on the Trust intranet along with the CBRN plan.	Partially Compliant	CBRN plan requires updating. Internal targetted training to be developed	EPRR Team	Mar-23

66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Maintenance of CPD records	N/A				
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	The Trust has a CBRN plan that explicitly details all of the required actions to be taken in terms of HAZMAT/CBRN response including training and this is based on information in the national guidance documents. The IOR DVD is also available on the Trust intranet along with the CBRN plan.	Partially Compliant	CBRN plan requires updating. Internal targetted training to be developed	EPRR Team	Mar-23
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		The Trust has a rolling programme of FFP3 training by the IPC team to ensure that staff are trained in their use. We currently have 60 staff across the Trust and all inpatient units who are trained as fit testers. We also have 3 member of the IPC Team who are fit testers who can support in the place of any gaps.	Fully Compliant	No further action		

Humber Teaching NHS Foundation Trust

Agenda Item 16

Title & Date of Meeting:	Trust Board Public Meeting – 26th October 2022
Title of Report:	Workforce Disability Equality Scheme (WDES) Annual Report 2022
Author/s:	Steve McGowan, Director of Workforce and OD
Recommendation:	To approve: ; To receive & discuss: ; For information/To note: X ; To ratify:
Purpose of Paper: Please make any decisions required of Board clear in this section:	To present the WDES annual report for consideration prior to publication on the Trust website.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate • The Trust has no disabled staff represented across pay bands 8c – VSM in non-clinical roles.	**Key Actions Commissioned/Work Underway:** • Action plan to improve representation;
Positive Assurances to Provide: • The relative likelihood of disabled staff entering the formal capability process continues to be extremely low and demonstrates that disabled staff are not disadvantaged by the Trusts formal capability processes; • 82.4% of disabled staff believe the Trust has made adequate adjustments to enable them to carry out their work, compared to 71.9% nationally;	**Decisions Made:** • N/A

• The engagement score of our disabled staff (6.7) is better than the national average (6.45); • The percentage of our staff with a disability who are satisfied with the extent to which they believe we value their work is better than the national average; The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from managers in last 12 months is better than the national average; The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from other colleagues in last 12 months is better than the national average; The percentage of our disabled staff believing that the trust provides equal opportunities for career progression is better than the national average.	

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	12/10/22
Finance & Investment Committee		Executive Management Team	10/10/22
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) EDI Working Group members	

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	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			Yes	

NHS
Humber Teaching
NHS Foundation Trust

Humber Teaching NHS Foundation Trust

NHS Workforce Disability Equality Standard (WRES)

Annual Report 2022

Caring, Learning
& Growing Together

contents

1.0

Executive Summary

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that enables NHS organisations to compare the experiences of Disabled and non-disabled staff. The submission was new for 2019 and like the Workforce Race Equality Standard (WRES) it provides an opportunity for NHS Trusts to hold up the mirror to organisational performance on the equality agenda and develop action plans to address areas of challenge.

The Trust undertook several initiatives in the last 12 months and as a result demonstrates better than the national average scores in most metrics.

Other Key findings include:

- The relative likelihood of disabled staff entering the formal capability process continues to be extremely low and demonstrates that disabled staff are not disadvantaged by the Trusts formal capability processes;
- 82.4% of disabled staff believe the Trust has made adequate adjustments to enable them to carry out their work, compared to 71.9% nationally;
- The engagement score of our disabled staff (6.7) is better than the national average (6.45);
- The percentage of our staff with a disability who are satisfied with the extent to which they believe we value their work is better than the national average;
- The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from managers in last 12 months is 13.8%, this is double the comparative figure for staff without a disability which is 6.8%. However, the Trust figure is 2.3% lower than 2020 and is better than the national average;
- The percentage of staff with a disability who believe they have experienced harassment, bullying or abuse from other colleagues in last 12 months is 20.4%, this compares to 11.7% of staff without a disability, but again this is better than the national average;
- The Trust has no disabled staff represented across pay bands 8c – VSM in non-clinical roles.
- The percentage of our disabled staff believing that the trust provides equal opportunities for career progression is better than the national average.

The immediate focus of our WDES work is to ensure that no disabled staff experience a worse than average experience compared to disabled staff across the NHS. This is not the limit of our ambitions, and given we benchmark above the average for those measures where comparison is available, our workforce equality action plan is focused on these areas and where our scores have significantly deteriorated based on the 2021 score.

2.0

Introduction

The Workforce Disability Equality Standard (WDES) is mandated by the NHS Standard Contract and applies to all NHS Trusts and Foundation Trusts.

The WDES is a data-based standard that uses a series of ten measures (metrics) to improve the experiences of Disabled staff in the NHS. All of the metrics draw from existing data sources (recruitment dataset, ESR, NHS Staff Survey, local HR data).

The metrics have been developed to capture information relating to the workplace and career experiences of Disabled staff in the NHS.

The national WDES 2021 Annual Report has shown that Disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling unwell, when compared to non-disabled staff.

Humber Teaching NHS Foundation Trust is an award winning organisation, providing a broad range of care and services across a wide geographical area.

We employ approximately 3,000 staff across more than 79 sites at locations throughout five geographical areas; Hull, the East Riding of Yorkshire, Whitby, Scarborough and Ryedale.

We provide care to a population of 765 thousand people of all ages who live within an area of more than 4,700 square kilometres, which contains some areas of isolated rurality, dispersed major settlements and pockets of significant deprivation.

Our workforce is paramount to delivering high quality care for our patients and the organisation strives to be an employer of choice locally and one which offers long term employment opportunities combined with structured personal and professional development. Those with a disability represent 19.1% of the East Riding population, 19.7% of the Humber population and 17.5% of the North Yorkshire population. Disabled employees represent 7.13% of Humber Teaching NHS Foundation Trust's workforce. This report seeks to understand the experiences across the ten WDES metrics (see appendix 1) relation to our Disabled Staff.

Employing approximately **3,000** staff

Operating across more than **79** sites

Serving 5 geographical areas; Hull, the East Riding of Yorkshire, Whitby, Scarborough and Ryedale.

Those with a disability represent

19.1% of the East Riding population

19.7% of the Humber population

17.5% of the North Yorkshire population

Disabled employees represent **7.13%** of Humber Teaching NHS Foundation Trust's workforce

82.4% of disabled staff believe the Trust has made adequate adjustments to enable them to carry out their work.

3.0

WDES Related Activity

As a Trust we are committed to using the WDES data and interpreting it in order to improve representation within the workforce. Here is a summary of some of the WDES related activity that we as a Trust have undertaken since the 2020/2021 report:

Improving the quality of our data

Data quality is fundamental in enabling us to accurately understand the experience of our workforce and supports the creation of effective workplans. In the past 12 months we have successfully reduced the number of 'unspecified' entries in ESR (HR system) for protected characteristics by 85.4%. This improvement has been achieved through better communication and ensuring that our staff understand the importance of this data and providing reassurance about what it is used for. We have also ensured that we engage our new starters in the importance of sharing this information in our corporate induction session.

Implementation of new Bullying and Harassment Training for Managers

In the past 12 months we have revised and implemented a new bullying and harassment training module in order to address the WDES metric pertaining discrimination at work from a manager/team leader or other colleague.

Recruitment

There has been a focus on improving and strengthening our recruitment practices over the last 12 months in order to positively impact the diversity of our workforce across all bandings in our organisation. To reinforce this there has been the implementation of training to promote value-based recruitment across the trust. We have also worked in collaboration with NHS Improvement to address the low representation of people with disabilities in bands 8c - VSM. Also, the development of Managers Fundamentals training has widened participation in Recruitment & Selection training, which has a focus on enhancing workforce diversity through recruitment practices.

Empowering our staff networks

There has been a focus on ensuring that all of our colleagues have a voice and a role to play in impacting positive change across the organisation. We have revised our Equality, Diversity and Inclusion Working Group and structured it to ensure that it supports collaboration with the organisation's Humber Ability Network, utilising it as a forum to review key policies and procedures that impact staff from ethnic minority backgrounds. There is Exec support for protected time to attend networks (subject to operational feasibility), and an Executive sponsor aligned to each network.

Annual Appraisal

100% target for all staff to benefit from an appraisal which includes opportunity for career development conversations.

Leadership Development Programmes

A number of leadership development programmes have been developed at the Trust which seek to encourage participation of those with disabilities and long-term condition at all levels. This includes;

- Two ring fenced places on the Humber High Potential Development scheme for sponsorship by the staff networks.
- Access to the Trust Leadership (band 4-7) and Strategic Leadership (8a+) programmes with a Trust KPI for all those in leadership positions to access this.

There has been a focus on ensuring that all of our colleagues have a voice and a role to play in impacting positive change.

4.0

Data Summary

Detailed below is the organisation's WDES data which was submitted in July 2021 covering the period 1st April 2021 – 31st March 2022.

Metric 1 Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce. (Data source: ESR).

1a.	Non-clinical workforce					
	Disabled staff in 2021	Disabled staff in 2022	Non-disabled staff in 2021	Non-disabled staff in 2022	Unknown/null staff in 2021	Unknown/null staff in 2022
Cluster 1 (Bands 1–4)	6.85% (40)	6.86% (40)	71.06% (415)	74.27% (433)	22.09% (129)	18.87% (110)
Cluster 2 (Band 5–7)	5.22% (6)	4.48% (6)	89.57% (103)	88.06% (118)	5.22% (6)	7.46% (10)
Cluster 3 (Bands 8a–8b)	13.89% (5)	12.20% (5)	77.78% (28)	80.49% (33)	8.33% (3)	7.32% (3)
Cluster 4 (Bands 8c–9 & VSM)	0.00% (0)	0.00% (0)	91.67% (11)	92.31% (12)	8.33% (1)	7.69% (1)

1b.	Clinical workforce					
	Disabled staff in 2021	Disabled staff in 2022	Non-disabled staff in 2021	Non-disabled staff in 2022	Unknown/null staff in 2021	Unknown/null staff in 2022
Cluster 1 (Bands 1–4)	6.48% (48)	6.46% (50)	68.96% (511)	74.16% (574)	24.56% (182)	19.38% (150)
Cluster 2 (Band 5–7)	6.98% (82)	7.88% (98)	74.98% (881)	73.53% (914)	18.04% (212)	18.58% (231)
Cluster 3 (Bands 8a–8b)	6.76% (10)	5.84% (9)	83.78% (124)	81.82% (126)	9.46% (14)	12.34% (19)
Cluster 4 (Bands 8c–9 & VSM)	3.70% (1)	3.57% (1)	85.19% (23)	92.86% (26)	11.11% (3)	3.57% (1)
Cluster 5 (Medical and Dental staff, Consultants)	3.23% (1)	2.63% (1)	87.10% (27)	76.32% (29)	9.68% (3)	21.05% (8)

	Disabled staff in 2021	Disabled staff in 2022	Non-disabled staff in 2021	Non-disabled staff in 2022	Unknown/null staff in 2021	Unknown/null staff in 2022
Cluster 6 (Medical and Dental staff, Non-consultant career grade)	7.14% (1)	9.09% (1)	71.43% (10)	72.73% (8)	21.43% (3)	18.18% (2)
Cluster 7 (Medical and Dental staff, Medical and Dental trainee grades)	17.65% (3)	15.00% (3)	64.71% (11)	50.00% (10))	17.65% (3)	35.00% (7)

Metric	2021/2022	2020/2021	National Figures (2021)
2. Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts	1.1	0.18	1.11*
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0.0	0.0	1.94*
4a. Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	Disabled 30% Non-Disabled 24.5%	Disabled 29% Non-Disabled 20.1%	Disabled/LTC 33%** Non-disabled 25.8%**
4b. Staff experiencing harassment, bullying or abuse from managers in the last 12 months	Disabled 13.8% Non-Disabled 6.8%	Disabled 16.1% Non-Disabled 6.8%	Disabled/LTC 17.2%** Non-disabled 9.8%**
4c. Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Disabled 20.4% Non-Disabled 11.7%	Disabled 15.7% Non-Disabled 11.2%	Disabled/LTC 25.3%** Non-disabled 16.6%**
4d. Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	Disabled 58.7% Non-Disabled 59.5%	Disabled 56.3% Non-Disabled 54.9%	Disabled/LTC 49.7%** Non-disabled 48.3%**
5. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	Disabled 53.6% Non-Disabled 60.9%	Disabled 52.5% Non-Disabled 58.8%	Disabled/LTC 51%** Non-disabled 57%**
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled 24.4% Non-Disabled 13.3%	Disabled 24.6% Non-Disabled 15.2%	Disabled/LTC 30.2%** Non-disabled 22.2%**

Metric	2021/2022	2020/2021	National Figures (2021)
7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Disabled 45.3% Non-Disabled 51.7%	Disabled 49.3% Non-Disabled 54%	Disabled/LTC 34.7%** Non-disabled 44.6%**
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Disabled 82.4%	Disabled 80.5%	Disabled/LTC 71.9%**
9. The staff engagement score for Disabled staff, compared to non-disabled staff.	Disabled 6.7 Org average 7.0	Disabled 6.8 Org average 7.1	Disabled/LTC 6.45** Non-disabled 6.97**
10. Percentage difference between the organisation's board voting membership and its organisation's overall workforce.	6.77%	6.7%	

*2021 NHS WDES Report **2021 NHS Staff Survey Results

5.0

Summary of Progress

Below is a brief summary of the Trust's progress against each metric.

WDES Metric	Description
1	**Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.**

Disabled representation in the workforce remains similar to the previous year. 6.77% of the workforce identifies as being disabled which is a small increase on the previous year's figure of 6.7%, however there continues to be no disabled staff represented across pay bands 8c – VSM in non-clinical roles and there has been a decline in cluster 7 clinical roles for staff with a disability or long-term condition.

2	**Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.**

The relative likelihood of disabled staff being appointed from shortlisting is 1.1 which is a decline on the previous year of 0.18. The Trust aligns to the nationally reported figure of 1.11.

3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.**

The relative likelihood of disabled staff entering the formal capability process continues to be extremely low and demonstrates that disabled staff are not disadvantaged by the Trusts formal disciplinary processes.

4a	**Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months.**

30% of disabled staff reported experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. Despite a 1% deterioration from the previous year, this is still better than the national average of 33%.

4b	**Staff experiencing harassment, bullying or abuse from managers in the last 12 months.**

13.8% of disabled staff reported experiencing harassment, bullying or abuse from a manager in the last 12 months. This is a decrease of 2.3% on 2020 figure and is better than the national average of 17.2%.

WRES Indicator	Description
4c	**Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.**

20.4% of disabled staff reported experiencing harassment, bullying or abuse from other colleagues in the last 12 months. This is an increase of 4.7% on 2020 figure but is still below the national average of 25.3% given the increase, this needs to be closely monitored in 2022/23.

4d	**Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.**

58.7% of disabled staff reported the last time they experienced harassment, bullying or abuse at work they or a colleague reported it. this is better than the national average of 49.7%.

5	**Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.**

53.8% of disabled staff believe the Trust provides equal opportunity for career progression or promotion. This is better than the national average of 51%.

6	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**

24.4% of disabled staff believe they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This is better than the national average of 30.2%.

7	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**

45.3% of disabled staff were satisfied with the extent to which the Trust values their work. This is better than the national average of 34.7%.

8	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**

82.4% of disabled staff believe the Trust has made adequate adjustments to enable them to carry out their work, an increase on 80.5% in 2020. This is better than the national average.

9	**The staff engagement score for Disabled staff, compared to non-disabled staff.**

The engagement score of disabled staff (6.7) is better than the national average of 6.45.

10	**Percentage difference between the organisation's board voting membership and its organisation's overall workforce.**

The Trust board has gone through some changes over the past 12 months where new additions have undeclared ESR disability declarations and this is being resolved through data cleansing.

6.0

Conclusion

Trust performance in most indicators is better than the NHS average. Whilst we would like to be leading in all indicators, the focus and attention will be on those areas that are below the national average, or in relation to indicator 1, where representation is at its lowest. As such, the focus of the action plan will be around the following areas:-

- Improving representation, particularly at Band 8c to VSM in the Trust

The Trust's workforce equality action plan is attached at Appendix 1.

Appendix 1

Trust equality action plan 2022/23

Action
Reduce the number of 'unspecified' in staff records.
Deliver bullying and harassment awareness training for managers.
Quarterly workforce E&D deep dive report.
Investigations Toolkit to be produced to ensure consistency and fairness of approach.
Review and revise the Disciplinary Policy and Procedure. To include template letters and forms.
ED&I Recruitment Deep Dive (from data in TRAC).
Move requesting flexible working process to ESR.
Review and revise the Bullying and Harassment Policy and Procedure.
IT solution for Job Evaluation in the trust.
Explore the NHS Rainbow Badge scheme.
Review and revise the Trust Behavioural Standards.
Produce a Trust 22/23 Equality, Diversity, and Inclusion Annual Report.
Quarterly workforce E&D deep dive report.
Produce a Gender Pay Gap Report 2022/3.
Review and revise the Job Evaluation policy and procedure and toolkit.
Provide career coaching and mentoring for staff and self-confidence sessions to increase the confidence for women to apply for promotion.
Produce a costed proposal for reverse mentoring.
To continue to promote the Humber High Potential Development Scheme to BAME and disabled staff.
To continue to promote the Leader and Senior Leadership programmes to BAME and disabled staff.
To continue to promote NHSI targeted development to our BAME and disabled staff.
ED&I Workforce Lead to review the advertising strategy for band 8c - VSM roles to ensure roles are promoted as widely as possible and targeting those who are BAME and/or disabled.
To develop a 'respect' campaign across the Trust (this will be aimed at patients and service users as well as staff).To adopt a zero tolerance approach to staff not completing their ED&I training.

Appendix 2

Data Sources

Metric	Data Source
Metric 1 - Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.	ESR
Metric 2 – Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	Trust's recruitment data
Metric 3 – Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	Trust's HR data
Metric 4 – Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.	Question 13, NHS Staff Survey
Metrics 5 – 8.	Questions 14, 11, 5, 28b, NHS Staff Survey
Metric 9 – Disabled staff engagement.	NHS Staff Survey
Metric 10 – Percentage difference between the organisation's board voting membership and its organisation's overall workforce.	ESR and/or trust's local data

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Humber Teaching NHS Foundation Trust

Agenda Item 17

Title & Date of Meeting:	Trust Board Public Meeting – 26th October 2022
Title of Report:	Workforce Race Equality Scheme (WRES) Annual Report 2022
Author/s:	Steve McGowan, Director of Workforce and OD
Recommendation:	To approve: ; To receive & discuss: ; For information/To note: X; To ratify:
Purpose of Paper: Please make any decisions required of Board clear in this section:	To present the WRES annual report for consideration prior to publication on the Trust website.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate

- Representation across the non-clinical workforce remains low, with focus required on roles improving representation in band 7 and above;
- Black, Asian and Ethnic Minority staff experiencing harassment, bullying or abuse from patients, relatives or the public is up 6.4% rise on last year's figure.
- Black, Asian and Ethnic Minority staff reporting that they personally experience discrimination at work by a manager/team whilst showing a marginal improvement in 2021, is still above the national average;
- In 2021, Black, Asian and Ethnic Minority staff representation on the Trust board (voting membership) was still at 0%.

Key Actions Commissioned/Work Underway:

- Action plan to improve representation;
- A recent appointment to Board will change representation in 2022;
- Action plan to address the perceptions of staff regarding experiences from patients, services users, their family and managers.

Positive Assurances to Provide:	Decisions Made:
• Black, Asian and Ethnic Minority staff are more likely to access non-mandatory training and CPD in the Trust than compared to the national average; • The Trust remains better than the nationally reported figure for BAME staff entering a disciplinary; • Black, Asian and Ethnic Minority staff experiencing harassment, bullying or abuse from staff has increased, however the Trust compares favourably to regional and national metrics; • A higher percentage of the trust's Black, Asian and Ethnic Minority staff than the national average believe that the Trust provides equal opportunities for career progression or promotion.	• N/A

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	12/10/22
Finance & Investment Committee		Executive Management Team	10/10/22
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail) EDI Working Group members	

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	√			
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			Yes	

NHS
Humber Teaching
NHS Foundation Trust

Humber Teaching NHS Foundation Trust

NHS Workforce Race Equality Standard (WRES)

Annual Report 2022

Caring, Learning
& Growing Together

contents

1.0

Executive Summary

The Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract in 2015, with the first report being published in June 2016. Since then, the Trust has published its progress annually against a number of indicators, with a focus on tackling inequality in the workplace and showing progress against the nine WRES indicators. This activity provides an opportunity for the Trust to fully understand local challenges and make necessary changes, whilst also having an appreciation for regional and national comparisons, to further chart our progress on a broader scale.

The Trust undertook a number of initiatives in the last 12 months and as a result demonstrates better than the national average scores in 5 out of the 9 indicators in 2021/22. In two of the indicators (where scores remain below national average), the Trust has shown improvement on 2020/21 scores, showing a positive trajectory, whilst acknowledging there is still work to do. Notably, the Trust scores in the top ten performing Trusts for WRES indicator 2, 'Relative likelihood of staff being appointed from shortlisting.'

Key findings include:

- There has been a 21% increase in Clinical Trainee Grade Black, Asian and Ethnic Minority staff. However, representation across the non-clinical workforce remains low, with focus required on roles improving representation in band 7 and above;
- Black, Asian and Ethnic Minority staff are more likely to access non-mandatory training and CPD in the Trust than compared to the national average;
- The Trust remains better than the nationally reported figure for BAME staff entering a disciplinary;
- Black, Asian and Ethnic Minority staff experiencing harassment, bullying or abuse from patients, relatives or the public is up 6.4% rise on last year's figure. This is now worse than the national average.;
- Black, Asian and Ethnic Minority staff experiencing harassment, bullying or abuse from staff has increased, however the Trust compares favourably to regional and national metrics;
- Black, Asian and Ethnic Minority staff reporting that they personally experience discrimination at work by a manager/team showed a marginal improvement in 2021, however, this is still above the national average;
- A higher percentage of the trust's Black, Asian and Ethnic Minority staff than the national average believe that the Trust provides equal opportunities for career progression or promotion.
- In 2021, Black, Asian and Ethnic Minority staff representation on the Trust board (voting membership) was still at 0%.

The immediate focus of our WRES work is to ensure that no staff from Black, Asian and Minority background experience a worse than average experience compared to Black, Asian and Minority background staff across the NHS. This isn't the limit of our ambitions but will be the focus of our work in the short term. Our workforce equality action plan is focused on these areas and where our scores have significantly deteriorated based on the 2021 score.

2.0

Introduction

The Workforce Race Equality Standard (WRES) is an annual report implemented by NHS organisations to measure and provide key insight into the experience of Black, Asian and Ethnic Minority staff in the workplace. The WRES was initially commissioned by the NHS Equality and Diversity Council and NHS England in 2015, as they identified a strong need to create a robust reporting mechanism to understand the experiences of Black, Asian and Ethnic Minority staff within NHS organisations.

There are 9 indicators used in the WRES report (see appendix 1); indicators 1 – 4 are taken from the Trust's HR data systems; indicators 5 – 8 are taken from the national NHS Staff Survey and indicator 9 pertains to the Trust's Board. The WRES report is now implemented annually by all NHS organisations and has become an integral means by which we measure our performance and progress in relation to the experience of our Black, Asian and Ethnic Minority staff.

Humber Teaching NHS Foundation Trust is an award winning organisation, providing a broad range of care and services across a wide geographical area.

We employ approximately 3,000 staff across more than 79 sites at locations throughout five geographical areas; Hull, the East Riding of Yorkshire, Whitby, Scarborough and Ryedale. We provide care to a population of 765 thousand people of all ages who live within an area of more than 4,700 square kilometres,

which contains some areas of isolated rurality, dispersed major settlements and pockets of significant deprivation.

Our workforce is paramount to delivering high quality care for our patients and the organisation strives to be an employer of choice locally and one which offers long term employment opportunities combined with structured personal and professional development.

Black, Asian and Ethnic Minority people represents 3.8% of the East Riding population, 5.1% of the Humber population and 2.6% of the North Yorkshire population. Black and Ethnic Minority people represent 5.3% of the Humber Teaching Trust's workforce. This report seeks to understand the experiences across the nine WRES metrics (see appendix 1) for our Black, Asian and Ethnic Minority staff.

Employing approximately **3,000** staff

Operating across more than **79** sites

Serving 5 geographical areas; Hull, the East Riding of Yorkshire, Whitby, Scarborough and Ryedale.

Black, Asian and Ethnic Minority people represents

3.8% of the East Riding population

5.1% of the Humber population

2.6% of the North Yorkshire population

Black and Ethnic Minority people represent **5.3%** of the Humber Teaching Trust's workforce

We provide care to a population of 765 thousand people of all ages who live within an area of more than 4,700 square kilometres.

3.0

WRES Related Activity

As a Trust we are committed to using the WRES data and interpreting it in order to improve representation within the workforce. Here is a summary of some of the WRES related activity that we as a Trust have undertaken since the 2020/2021 report:

Improving the quality of our data

Data quality is fundamental in enabling us to accurately understand the experience of our workforce and supports the creation of effective workplans. In the past 12 months we have successfully reduced the number of 'unspecified' entries in ESR (HR system) for protected characteristics by 85.4%. This improvement has been achieved through better communication and ensuring that our staff understand the importance of this data and providing reassurance about what it is used for. We have also ensured that we engage our new starters in the importance of sharing this information in our corporate induction session.

Implementation of new Bullying and Harassment Training for Managers

In the past 12 months we have revised and implemented a new bullying and harassment training module in order to address the WRES indicator pertaining discrimination at work from a manager/team leader or other colleague.

Recruitment

There has been a focus on improving and strengthening our recruitment practices over the last 12 months in order to positively impact the diversity of our staff from Black, Asian and Minority Ethnic backgrounds across all bandings in our organisation. To reinforce this there has been the implementation of training to promote value-based recruitment across the trust. We have also worked in collaboration with NHS Improvement to address the low representation of people from ethnic minority backgrounds at board level.

Also, the development of Managers Fundamentals training has widened participation in Recruitment & Selection training, which has a focus on enhancing workforce diversity through recruitment practices.

Empowering our staff networks

There has been a focus on ensuring that all of our colleagues have a voice and a role to play in impacting positive change across the organisation. We have revised our Equality, Diversity and Inclusion Working Group and structured it to ensure that it supports collaboration with the organisation's BAME Network, utilising it as a forum to review key policies and procedures that impact staff from ethnic minority backgrounds. There is Exec support for protected time to attend networks (subject to operational feasibility), and an Executive sponsor aligned to each network.

Annual Appraisal

100% target for all staff to benefit from an appraisal which includes opportunity for career development conversations.

Leadership Development Programmes

A number of leadership development programmes have been developed at the Trust which seek to encourage participation of BAME colleagues at all levels. This includes;

- Two ring fenced places on the Humber High Potential Development scheme for sponsorship by the staff networks.
- Access to the Trust Leadership (band 4-7) and Strategic Leadership (8a+) programmes with a Trust KPI for all those in leadership positions to access this.
- 3 out of 4 places on the NYE Bevan Programme for aspiring board members offered to BAME employees and a similar commitment for diverse access for future cohorts.

4.0

Data Summary

Indicator	2021/22				2020/21			
1. Percentage of staff in Bands	Non-Clinical							
	Band	White	BAME	Unknown	Band	White	BAME	Unknown
	Under Band 1	0% (0)	0% (0)	0% (0)	Under Band 1	0% (0)	0% (0)	0% (0)
	Band 1	84% (16)	16% (3)	0% (0)	Band 1	80% (16)	15% (3)	5% (1)
	Band 2	92% (297)	2% (7)	6% (19)	Band 2	93% (318)	3% (9)	4% (15)
	Band 3	96% (145)	1% (1)	3% (5)	Band 3	97% (132)	1% (1)	2% (3)
	Band 4	92% (83)	4% (4)	4% (3)	Band 4	94% (80)	5% (4)	1% (1)
	Band 5	88% (51)	9% (5)	3% (2)	Band 5	89% (50)	9% (5)	2% (1)
	Band 6	95% (37)	3% (1)	2% (1)	Band 6	97% (31)	0% (0)	3% (1)
	Band 7	95% (35)	0% (0)	5% (2)	Band 7	93% (25)	0% (0)	7% (2)
	Band 8a	93% (28)	0% (0)	7% (2)	Band 8a	92% (24)	0% (0)	8% (2)
	Band 8b	100% (11)	0% (0)	0% (0)	Band 8b	100% (10)	0% (0)	0% (0)
	Band 8c	100% (1)	0% (0)	0% (0)	Band 8c	100% (2)	0% (0)	0% (0)
	Band 8d	100% (8)	0% (0)	0% (0)	Band 8d	100% (6)	0% (0)	0% (0)
	Band 9	0% (0)	0% (0)	0% (0)	Band 9	0% (0)	0% (0)	0% (0)
	VSM	100% (4)	0% (0)	0% (0)	VSM	75% (3)	0% (0)	25% (1)
	Clinical							
	Band	White	BAME	Unknown	Band	White	BAME	Unknown
	Under Band 1	0% (0)	0% (0)	0% (0)	Under Band 1	0% (0)	0% (0)	0% (0)
	Band 1	0% (0)	0% (0)	0% (0)	Band 1	0% (0)	0% (0)	0% (0)

	Band 2	77% (70)	10% (9)	13% (12)	Band 2	71% (61)	7% (6)	22% (19)
	Band 3	89% (443)	6% (32)	5% (25)	Band 3	87% (434)	7% (35)	6% (31)
	Band 4	91% (166)	6% (11)	3% (6)	Band 4	91% (141)	3% (5)	6% (9)
	Band 5	80% (285)	5% (19)	15% (54)	Band 5	84% (294)	4% (13)	12% (43)
	Band 6	91% (549)	4% (24)	5% (31)	Band 6	89% (502)	3% (18)	7% (41)
	Band 7	94% (264)	2% (5)	4% (12)	Band 7	93% (245)	1% (3)	6% (16)
	Band 8a	87% (114)	6% (8)	7% (9)	Band 8a	86% (109)	6% (8)	8% (10)
	Band 8b	91% (21)	4% (1)	5% (1)	Band 8b	90% (19)	5% (1)	5% (1)
	Band 8c	92% (21)	4% (1)	4% (1)	Band 8c	100% (22)	0% (0)	0% (0)
	Band 8d	100% (1)	0% (0)	0% (0)	Band 8d	50% (1)	50% (1)	0% (0)
	Band 9	50% (1)	50% (1)	0% (0)	Band 9	50% (1)	50% (1)	0% (0)
	VSM	100% (2)	0% (0)	0% (0)	VSM	100% (2)	0% (0)	0% (0)
	Consultants	39% (15)	47% (18)	14% (5)	Consultants	42% (13)	48% (15)	10% (3)
	Non-Consultants	55% (6)	36% (4)	9% (1)	Non-Consultants	36% (5)	43% (6)	21% (3)
	Trainee Grade	30% (6)	50% (10)	20% (4)	Trainee Grade	35% (6)	29% (5)	35% (6)
	Other	71% (77)	4% (4)	25% (27)	Other	70% (91)	4% (5)	26% (34)

Indicator	2021/22	2020/21	2021 NHS National Average
2. Relative likelihood of staff being appointed from shortlisting	1.26	0.64	1.61*
3. Relative likelihood of staff entering a formal disciplinary investigation	1.09	1.09	1.14*
4. Relative likelihood of staff accessing non-mandatory training and CPD	0.91	0.84	1.14*
5. % of staff experiencing harassment, bullying or abuse from patients, relatives or the public	30.4% BAME staff 25.6% White staff	24% BAME staff 22.4% White staff	29.2% BAME staff** 27% White staff**
6. % of staff experiencing harassment, bullying or abuse from staff	25.5% BAME staff 18.1% White staff	24% BAME staff 17.7% White staff	27.6% BAME staff** 22.5% White staff**
7. % of staff believing that trust provides equal opportunities for career progression or promotion	46.4% BAME staff 59.8% White staff	41.7% BAME staff 57.7% White staff	44.4% BAME staff** 58.7% White staff**
8. % of staff personally experiencing discrimination at work by Manager/team	18.2% BAME staff 4.6% White staff	18.4% BAME staff 3.8% White staff	17% BAME staff** 6.8% White staff**
9. % difference between the organisations' Board voting membership and its overall workforce	Staff 87.6% White Staff 5.3% BAME Board 100% White Difference 12.4%	Staff 87.3% White Staff 4.7% BAME Board 100% White Difference 12.7%	12.6% Difference*

Data source * 2021 NHS WRES Report **2021 NHS Staff Survey Results

5.0

Summary of Progress

Below is a brief summary of the Trust's progress against each indicator. Whilst there has been positive improvement the Trust recognises that there remains more to do.

WRES Indicator	Description
1	Percentage of staff in each AfC Bands 1-9 and VSM compared to overall workforce

168 out of the staff in the Trust come from Black, Asian and Ethnic Minority backgrounds which is 5.3% of the overall workforce.

In terms of improvements there has been a 21% increase in Clinical Trainee Grade Black, Asian and Ethnic Minority staff.

Whilst there is no significant change from last year in representation across the bandings, the data presents a requirement to focus on improving the representation of staff from Black, Asian and Ethnic Minority backgrounds specifically across the non-clinical workforce, specifically band 7 and above, where there is no Black, Asian and Ethnic Minority representation

The data is showing some minor improvement in the representation of BAME staff in bands 4-7 in clinical roles however there is recognition that this remains and area of focus for all bands in the clinical workforce.

2	Relative likelihood of BAME staff being appointed from shortlisting

The 1.26 ratio this year shows that there has been a decline in the numbers of people from Black, Asian and Ethnic Minority backgrounds being appointed from shortlisting from 0.64 in 2020/21. However, the Trust figure remains significantly better than the national figure of 1.61, with North East and Yorkshire region reporting 1.7. In the national WRES standard report for 2021 the Trust presents as one of the top ten best performing for this indicator. The national guidance is that anything between 0.80 and 1.25 is in the non-adverse range.

3	Relative likelihood of BAME staff entering a formal disciplinary investigation

This metric is consistent with the 2021 report and shows that there is no significant difference in the likelihood of entering into a formal disciplinary between White staff and Black and Ethnic Minority Staff . The Trust remains better than the nationally reported figure 1.14 for this indicator.

WRES Indicator	Description
4	**Relative likelihood of staff accessing non-mandatory training and CPD**

BAME staff are 0.91 times more likely to access non-mandatory training and CPD in the Trust which is within the non-adverse range as set out in the national WRES report. This demonstrates equality of access and shows a more positive position than the national figure of 1.14 and the North East and Yorkshire figure of 1.07.

5	**Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public**

The figure of 30.4% of Black, Asian and Ethnic Minority staff experiencing harassment, bullying or abuse from patients, relatives or the public is a 6.4% rise on last year's figure. The BAME average reported nationally in the NHS staff survey is 29.2%, showing the Trust is marginally worse than average for this indicator. This needs to be a focus in 2022/23.

6	**Percentage of staff experiencing harassment, bullying or abuse from staff**

The figure of 25.5% of Black, Asian and Ethnic Minority staff experiencing harassment, bullying or abuse from staff represents a 1.5% increase from last year's figure and is 7.4% higher than White staff. However, there has however been a steady decline since 2017 when the figure was 38.1% and the Trust compares favourably to the national average figure reported in the 2021 WRES report of 27.6%.

7	**Percentage of staff believing that trust provides equal opportunities for career progression or promotion**

46.4% of Black, Asian and Ethnic Minority staff believe that the Trust provides equal opportunities for career progression or promotion. Whilst acknowledging there is still work to do, this represents a 4.7% improvement in 2020, and is above the national average of 44.4%.

8	**Percentage of staff personally experiencing discrimination at work by manager/team leader or other colleagues**

This year's figure of 18.2% of the Trust's Black, Asian and Ethnic Minority staff reporting that they personally experience discrimination at work by a manager/team represents a marginal improvement from 18.4% in 2020. However, this figure is below the national average of 17%, so will be an area of focus in 2022/3.

9	**% difference between the organisations' Board voting membership and its overall workforce**

In 2021, Black, Asian and Ethnic Minority staff representation on the Trust board (voting membership) was 0%. This will be a focus on 2022.23.

6.0

Conclusion

Trust performance in a number of the indicators is better than the NHS average. Whilst we would like to be leading in all indicators, the focus and attention will be on those areas that are below the national average, or in relation to indicator 1, where representation is at its lowest. As such, the focus of the action plan will be around the following areas:-

- Representation at Band 7 and above in the Trust;
- Those who believe they have experienced harassment, bullying or abuse from the public an, patients and service users in last 12 months;
- Those who believe they have experienced discrimination at work from their manager / team leader or other colleagues in last 12 months.

The aim will be to improve performance in these three areas over the next 12 months. The action plan is attached at Appendix 1.

Appendix 1

Trust equality action plan 2022/23

Action
Reduce the number of 'unspecified' in staff records.
Deliver bullying and harassment awareness training for managers.
Quarterly workforce E&D deep dive report.
Investigations Toolkit to be produced to ensure consistency and fairness of approach.
Review and revise the Disciplinary Policy and Procedure. To include template letters and forms.
ED&I Recruitment Deep Dive (from data in TRAC).
Move requesting flexible working process to ESR.
Review and revise the Bullying and Harassment Policy and Procedure.
IT solution for Job Evaluation in the trust.
Explore the NHS Rainbow Badge scheme.
Review and revise the Trust Behavioural Standards.
Produce a Trust 22/23 Equality, Diversity, and Inclusion Annual Report.
Quarterly workforce E&D deep dive report.
Produce a Gender Pay Gap Report 2022/3.
Review and revise the Job Evaluation policy and procedure and toolkit.
Provide career coaching and mentoring for staff and self-confidence sessions to increase the confidence for women to apply for promotion.
Produce a costed proposal for reverse mentoring.
To continue to promote the Humber High Potential Development Scheme to BAME and disabled staff.
To continue to promote the Leader and Senior Leadership programmes to BAME and disabled staff.
To continue to promote NHSI targeted development to our BAME and disabled staff.
ED&I Workforce Lead to review the advertising strategy for band 8c - VSM roles to ensure roles are promoted as widely as possible and targeting those who are BAME and/or disabled.
To develop a 'respect' campaign across the Trust (this will be aimed at patients and service users as well as staff).To adopt a zero tolerance approach to staff not completing their ED&I training.

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Humber Teaching NHS Foundation Trust

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Council of Governors Public Meeting Minutes 14 July 2022
Author/s:	Caroline Flint Chair
Recommendation:	

To approve		To receive & discuss	
For information/To note	✓	To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The minutes of the Council of Governors meeting held on 14 July are presented for information.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • No issues raised	**Key Actions Commissioned/Work Underway:** • N/A
Positive Assurances to Provide: • Meeting was quorate • Positive Patient Story – Abbie's Story	**Decisions Made:** • N/A

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

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

Monitoring and assurance framework summary:

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

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

Humber Teaching NHS Foundation Trust

Minutes of the Council of Governors Public Meeting held on Thursday 14 July 2022 via Microsoft Teams

Present:
Rt Hon Caroline Flint, Chair
Michele Moran, Chief Executive
Jenny Bristow, Appointed Governor, Humberside Police
Sue Cooper, East Riding Public Governor
Tony Douglas, East Riding Public Governor
Marilyn Foster, Service User & Carer Governor
Patrick Hargreaves, Hull Public Governor
Tom Nicklin, Staff Governor
Doff Pollard, Whitby Public Governor/ Lead Governor
Helena Spencer, Hull Public Governor
Brian Swallow Hull Public Governor
William Taylor, Staff Governor

In Attendance:
Francis Patton, Non-Executive Director/SID
Dean Royles, Non-Executive Director
Mike Smith, Non-Executive Director
Hanif Malik, Associate Non-Executive Director
Stuart McKinnon-Evans, Non-Executive Director
Peter Beckwith, Director of Finance
Jenny Jones, Trust Secretary
Katie Colrein, Membership Officer
James Collier, Communications Officer

Apologies:
Cllr Julie Abraham Appointed Governor East Riding of Yorkshire Council
Andy Barber, Appointed Governor, Smile Foundation
Cllr Linda Chambers Appointed Governor, Hull City Council
John Cunnington, East Riding Public Governor
Tim Durkin, Wider Yorkshire & Humber Public Governor
Craig Enderby, Staff Governor
Joanne Gardner, Staff Governor
Anthony Houfe, Service User and Carer Public Governor
Soraya Hutchinson, East Riding Public Governor
Ruth Marsden, East Riding Public Governor
Sharon Nobbs, Staff Governor
Jacquie White, Appointed Governor, University of Hull
Lynn Parkinson, Chief Operating Officer

The meeting was held virtually via Microsoft Teams and was also live streamed.

The Chair welcomed new Governors to the meeting and introductions were made

32/22	**Declarations of Interest** Any changes to declarations should be notified to the Trust Secretary. The Chair requested that if any items on the agenda presented anyone with a potential conflict of

	interest, they should declare the interest and remove themselves from the meeting for that item.
33/22	**Minutes of the Meeting held on 14 April 2022** The minutes of the meeting held on 14 April were agreed as a correct record.
34/22	**Matters Arising and Actions Log** The action log was noted and no matters arising were raised.
35/22	**Patient Story – Abbie's Story** The Council of Governors heard from Abbie-Leigh about her journey though services and how she became involved in volunteering. Abbie-Leigh was supported by Emily, Clinical Psychologist who she volunteers with. Abbie-Leigh's experience of using services helps her to understand all aspects of the service and what patients are experiencing. Confidence was something that Abbie-Leigh struggled with, but this has significantly improved, and she now leads groups. She was involved in the Covid vaccination programme and became a telephone befriender, and keeps in contact with this person. Volunteer work included the Recovery College and developing a podcast to help others. Abbie-Leigh volunteers at Westlands and joins in with the assessments, MDTs and other areas of work. Gaining in confidence has enabled her to progress a Masters' course in Cognition and Neuroscience. Hanif Malik is assisting the Engagement Management with the Hull Youth Action group and asked Abbie-Leigh what would be helpful to encourage young people to become involved and how they could be retained. Abbie-Leigh said it is not always clear on what volunteers do or how they can get involved. They need to find something they enjoy doing and be supported by members of staff. Doff Pollard thanked Abbie-Leigh for sharing her story. She asked her what the most important thing the trust has done to help her on her journey. Abbie-Leigh responded that is was the support received that makes the most impact. In response to Dean Royles question around skills and learning and what was key to this, Abbie-Leigh explained that it was about knowing where the boundaries are and getting to know this as a person and how it could lead to a career going forward. Experience of being included in handover meetings and making a contribution is also helpful. Jenny Bristow explained her role to Abbie-Leigh in that she is a Police Officer as well as an appointed Governor. She thanked her for sharing all aspects of her story and how she had turned her life around which is fantastic to hear about and showing that anything is possible. She wished her well for the future. Abbie-Leigh felt that her experience as a patient had helped her understand others and understand what they are going through. Emily added that being an expert by experience helped her relate to patients more and that she is an inspiration to both patients and staff. Stuart McKinnon-Evans asked if there was a point in the journey where Abbie-Leigh felt that she was a different person with the new confidence she had found. Abbie-Leigh said that it was an ongoing thing and that it was bit by bit progression. The Chief Executive congratulated Abbie-Leigh for her achievements and for sharing her story. She felt it needed to be shared so that staff also know about the work that volunteers do and to spread the work that has been done on the podcast.

36/22	**Chair's Report** The Chair provided a verbal update on her recent activities. • Non-Executive Director appraisals took place with Sue Cooper. The Chief Executive appraisal was also carried out with Francis Patton, Senior Independent Director. • A small working group was established to look at support to Governors with a report later on the agenda. • Two Governor Development days have been held. The latest one was in a new format and included NEDs who chair Committees having an informal question and answer session about their work. A presentation on risk and how this is assessed and managed in the Trust was given. There was also a presentation on Primary Care for services across the Trust with a particular focus on GP practices and health inequalities. • An induction session for new Governors was held this week • The knowledge visit programme for NEDs and Governors is being progressed • The Council of Governors has ratified the appointment of Dr Phillip Earnshaw as the new NED at its private meeting held today. Phillip will be joining us from 25 July • Interviews have taken place for the Medical Director and Head of Corporate Affairs post and the recruitment process is being progressed. • The Chair visited Westlands and Townend Court since the last meeting. There was also a staff awards event in Scarborough this week and an opportunity to meet District Nurses and Specialist nurses from the community teams • A meeting with residents from Market Weighton was held and a further meeting planned **Resolved:** The verbal updates were noted
37/22	**Chief Executive's Report** The Chief Executive presented her report which gave an update on the local issues. The Council's attention was drawn to: **Recruitment Process** As mentioned by the Chair the process to appoint the Medical Director and Head of Corporate Affairs is progressing. **Chief Executive's Challenge** Thanks were extended to everyone who took part in the cycle ride with the Chief Executive. Over £6,000 has been raised so far for Health Stars to benefit patients and the staff health and wellbeing fund. **Menopause Friendly Employer** The Chief Executive is delighted with this recognition and thanked everyone involved for their contribution. **Awards** Various awards were detailed in the report, and these are a positive achievement for staff and a tribute to the work they are doing. **Mental Health Act Proposals** Detail was included in the report re this, and changes are being progressed. The Chief Executive thanked Mike Smith for his help and support to the Executive team and also the Mental Health Legislation Committee (MHLC).

0-19 Service
The Trust is pleased to welcome the 0-19 service for Hull into the organisation. Close working with the East Riding 0-19 service is being established to integrate these services and reduce variation across the patch.

Prison Service Tender
The Trust does not provide Prison services however when the Hull Prison tender came up, a decision was made to put in a joint bid with Tees, Esk & Wear Valley (TEWV) NHS Foundation Trust to provide the community element which links into community Forensics which has been successful.

Zero Events & Communications Update
Detail was provided in the report for these areas.

Integrated Care Service (ICS)
The Integrated Care Service (ICS) went live on 1 July 2022 and a first Board meeting was held that day with the second meeting held this week. The Chief Executive is a member of the Integrated Care Board (ICB) and also the lead for the Provider Collaborative element and innovation work.

Most of the place leads have now been identified for the six places in the ICS. The Chief Executive is hosting a staff webinar on 21 July which Governors can join if they wish. Confirmation of the place leads is below:

Area	Place Lead (NHS Rep)	Chair (Local Authority)
North Lincs	Helen Kenyon	Rob Walsh
York	TBC	Ian Floyd
North Yorkshire & York	Wendy Balmain	Richard Flinton
North Lincs	Alex Seale	Peter Thorpe
East Riding	Simon Cox	Caroline Lacey
Hull	Erica Daley (Interim)	Matt Jukes

Covid Update
Extreme pressures continue to be seen as demand for services has not subsided. Acuity of patients continues to be high in services.

Out of area placements has dramatically decreased which is positive news. Covid rates are increasing with 10 patients testing positive, there is also high staff sickness increase due to Covid. Infection prevention guidance is being reviewed regularly and a number of wards have reverted back to mask wearing and social distancing. Winter planning work has started in the organisation and with partners for the system in preparation for winter and also the flu vaccination season.

Doff Pollard thanked the Chief Executive for the updates. She was particularly interest in place and the role that Governors may have in supporting the ICB and the need to ensure there is the understanding how things are being worked through and the opportunities as Governors, to to know of the integrated work that is taking place. The Chief Executive said that time has been spent on discussing membership and how Governors' link with members. This is one of the reasons that it was included in the job description for the Head of Corporate Affairs to have the connection between Governors and place.

Resolved: The report and verbal updates were noted.
Details of the webinar to be shared with Governors and Place leaders to be shared

	with Governors and NEDs **Action KC/JJ**
38/22	**Chairs of Trust Board Sub Committees' Report** The Chair explained that following discussion at a Governor Development Day, a suggestion was made for NEDs to provide updates to the Council of Governors on the work they undertake. Verbal updates were provided at today's meeting, with will be written reports for future meetings. Stuart McKinnon-Evans, Chair of Audit Committee, Collaborative Committee & Charitable Funds Committee provided updates on these areas **Audit Committee** The Trust is in a good shape from an audit and control perspective based on the work of the internal and external auditors, specialised Counter Fraud team, information that comes to the Committee from the Executives, performance and risk management. At the meeting on 21 June, the focus was on year end reporting. Significant assurance was given for the Trust's control framework. **Collaborative Committee** It has been establishing provider oversight arrangements through the collaborative approach of a number of organisations from NHS independent and third sector, to provide Child and Adolescent Mental Health Services (CAMHS) and in patient providers of adult low secure and specialist services. The Trust is the lead provider and committed to provide arms-length approach. Arrangements have been in place for nearly two years. Working arrangements are still bedding in and were endorsed by the recent Well Led review. There has been a particular focus on the Schoen Clinic and urgent action taken on receipt of a CQC report. It is an early case study around how we can respond to an issue on our patch. Teams generally are reporting that this is adding value to services which is working well and still developing. **Charitable Funds Committee** The charity has had a difficult time raising funds over the last couple of year and work is taking place with them to reinvigorate this and the channels that funds can be raised and identify a clearer statement around funds for future campaigns. More examples of the work of the charity are included in the Chief Executive's report. Mike Smith, Chair of Mental Health Legislation and Interim Chair of Quality Committee gave updates on the recent meetings **Quality Committee** The last meeting was in May and considered patient safety strategy refresh and approved the Quality Accounts. The Committee looked through medicines management work with pharmacy technicians and the innovations with as a result of the Community mental health survey. Patient safety training and White Ribbon ambassadors and there is a White Ribbon action plan. Research and development work was reviewed. There was an action from the Well Led review for the Committee Chair to attend a patient safety group and Mike was pleased to report that he had attended this group yesterday. This group develops and updates policies and procedures to come to the Quality Committee for approval. The Trust is in good shape from a quality point of view as demonstrated with the quality dashboard, friends and family compliance, incident data, the safeguarding

annual report, domestic abuse and child neglect being particular areas of focus in the report.

In addition, the audit and effectiveness group investigates activity via deep dives, alongside the Clinical Risk Management Group and a Clinical Governance group for each Division.

At the Governor Development session Doff Pollard raised a question around reporting of incidents. It was confirmed that all incidents are logged onto Datix and are reviewed daily via a Corporate Safety Huddle. Staff members can review the incidents on the system to show any action that has been undertaken or feedback.

A presentation was also received on community services showing the work that has been done over the last two years around service integration, maximising the use of skills and setting up virtual wards.

The training report was also received which showed over 100 students across the three year nursing programme. The issue is placements, but a strong performance.

Mr Smith received positive assurance from the meeting, the reports and updates provided.

Mental Health Legislation Committee
Discussion was held on the MHA/Use of Force Act which came into force this year. Are new responsibilities like a responsible person and new reports however this is what the Trust does. We are a positive outlier in terms of restrictive intervention, and we do this much less than other organisations. And considered Human Rights against safety. The Committee looked at the Multi-Agency Public Protection Arrangements (MAPPA)

Updated were also provided at the meeting for the Mental Health Bill, Mental health Act and Mental Capacity Act.

Finance & Investment Committee
Francis Patton Chairs the Finance & Investment Committee and provided an update on the work of the Committee. The last meeting was held in April and looked at the Insight report, finance and business development. The NHS England financial position and ICS finances were both on budget in April. The pay award for staff was discussed and is still progressing. Other areas including the Budget Reduction Strategy (BRS), cash position and the Risk Management Annual report were reviewed. The cash position is strong and includes some provider collaborative funding. A cashflow forecast will be coming to a future meeting.

Workforce & Organisational Development Committee
This meeting is chaired by Dean Royles and met yesterday. Areas discussed included reports from the groups that report into the Committee for staff Health & Wellbeing, Equality and Diversity and training. Reports covered areas including workforce, sickness, training and recruitment. A deep dive into leavers details has been undertaken and the outcome discussed. Work on the gender pay gap was discussed and comparison on the number of vacancies between last year and this year which this year equates to 12.5%. The gap for between male and female staff is 11.5% which is below the national average of 15.5%.

Questions
Tony Douglas asked why are staff are leaving and what progress is being made to recruit hard to fill posts?

	The main reasons for leaving were promotion, work life balance and retirement. The number of registered nurses in post has increased by 40 and there has been improvement in the consultant numbers too. The Chief Executive explained the work that has been done to support recruitment including establishing he Task and Finish group, Golden Hellos and the Humberlievable campaign. Discussions continue to focus on this area and there is partnership working across the patch as it is a national issue. Will Taylor asked what the de-escalation thresholds and the definitions within Datix reporting are? The policy sets out levels from no harm to level 5. The daily huddle meeting assesses all incidents. There is also the Greatex system for reporting good practice. The policy will be circulated for information. **Resolved:** The updates from the Committee chairs were noted Incident reporting policy to be shared with Governors **Action MM**
39/22	**Governor Development Proposals** The Chair outlined the development of the report and outlined the proposals. In discussion, Doff Pollard raised a point from Tim Durkin who could not be present. He was disappointed that one of the proposals was to discontinue the Finance and Audit meeting. The Chair explained that the new proposals provided for more regular up to date assurance engagement with NED Chairs on Finance and Audit, Quality, Workforce and Mental Health Legislation. In addition, Governor Development Days and specific briefings can be utilised as well as reintroducing an introduction to NHS finance seminar for Governors. If the proposals are supported an action log will be produced and brought to the Council of Governor meetings until all actions are completed **Resolved:** The Council of Governors approved the Governor Development Support Report and recommendations.
40/22	**Appointments Terms & Conditions Committee Effectiveness Review and Terms of Reference** The effectiveness review for the Committee was presented by Sue Cooper, Chair. The report included a review of the Committee's work over the year including NED appointments, NED re-appointments and details of attendance. The terms of reference have been reviewed and were attached for approval. Membership of the Committee was discussed. If any other Governors are interested in joining the Committee please contact the Membership Officer, Katie Colrein. **Resolved:** The effectiveness review and terms of reference were approved
41/22	**Governor Groups Feedback** Verbal updates were provided from the chairs of the Governor groups for meetings that have taken place recently. **Appointments, Terms and Conditions Committee** Sue Cooper provided an update on the work of the Committee as part of the item

	above. **Engaging with Members Group** The focus of the last meeting was on the Annual Members Meeting (AMM). Doff Pollard, Chair reported that other areas discussed were around communication with members and the links with the Patient and Carer Experience team and volunteers. A suggestion was made to have short films to explain what a Governor does and what being a member means. Governors want to have an active role at the AMM and to attend in person to be able to talk to any public members who may attend. **Resolved:** The report and verbal updates were noted.
42/22	**Responses to Governor Questions** No formal questions for the CoG meeting had been received. The Chair reported that Governors did ask questions directly to her and other members of the Board regularly. These were followed up in real time. This is welcome but Governors can formally send in questions to be answered at the Council of Governors meetings. **Resolved:** Governors to be sent a note on submitting questions for CoG meetings
43/22	**Performance Update** Mr Beckwith presented the performance as at the end of May 2022. Areas of interest were detailed on the front sheet of the report. Positive assurance was given in terms of mandatory training, clinical supervision and an improvement in out of area bed usage. Will Taylor asked about the requirements of clinical supervision. Mr Beckwith will provide an update outside of the meeting to Governors on this query. A further question was asked in relation to waiting times for patients and how these figures compared nationally. Mr Beckwith reported that an update is due to be provided to the July Board meeting and this will be shared with Governors. It was noted that contact is made with people on the waiting lists to see how they are doing and whether they need support from other services including the use of digital platforms. Waiting times is a national issue not just around the workforce, but also funding. The Trust has received some additional money but this due to the numbers being seen, there is a short fall. It is a major challenge and a key risk for the organisation and perhaps a topic for a future development session. The work with schools around mental health was mentioned and work is taking place with Local Authority partners to support people and reduce waiting lists. It has also been discussed at the Integrated Care Board (ICB) **Resolved:** The report and verbal updates were noted. An update to be provided on the clinical supervision query **Action PBec** Update on waiting times to be provided to Governors **Action PBec**
44/22	**Finance Update** The report covering the period March 2022 to May 2022 was presented. The Trust recorded a break-even position for 2021/22 financial year and an overall deficit of £0.275m for Month 2 which is consistent with the Trust's planning target. Cash balance at the end of Month 2 was £32.529m of which £4.682m relates to the Provider Collaborative. A 2% pay award allocation has been built into the plan in preparation for any agreements. Cash remains strong and there are no outstanding loans. **Resolved:** The report was noted.

45/22	**Fit & Proper Persons Compliance** The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires all trusts to ensure that all executive and non-executive director posts (or anyone performing similar or equivalent functions) are filled by people that meet the requirements of the FPPR. The definition of directors includes those in permanent, interim or associate roles, irrespective of their voting rights at Board meetings. The report was presented at the June Board meeting and at the Appointments Terms and Conditions Committee and was presented to Governors for information. **Resolved:** The report was noted
46/22	**Public Trust Board Minutes March, April & May 2022** The minutes of the public Board meetings for March, April and May were provided for information. **Resolved:** The minutes were noted.
47/22	**Any Other Business** No other business was raised.
48/22	**Date and Time of Next Meeting** Thursday 13 October 2022, 2.00pm by Microsoft Teams

Signed……. Date
Chair

Humber Teaching NHS Foundation Trust

Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Humber, North Yorkshire, York Integrated Care Board (ICB) Update
Author/s:	Michele Moran Chief Executive
Recommendation:	

To approve		To receive & discuss	
For information/To note	✓	To ratify	

Purpose of Paper:	To provide an update to the Board

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • Nothing to escalate	**Key Actions Commissioned/Work Underway:** • Digital strategy • Workforce 180 days plan
Positive Assurances to Provide: • N/A	**Decisions Made:** • N/A

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

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

Caring, Learning & Growing Together

			Other (please detail) Board Update	✓

Monitoring and assurance framework summary:

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

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

Humber and North Yorkshire Health and Care Partnership

NHS
Humber and North Yorkshire
Integrated Care Board (ICB)

Item 11

Report to:	Integrated Care Board
Date of Meeting:	12 October 2022
Subject:	**ICB Operating Arrangements with Place Health and Care Partnerships and Sector Collaboratives**
Director Sponsor:	Amanda Bloor, Deputy Chief Executive / Chief Operating Officer
Author:	Julie Warren, Interim Director of Primary Care and Assurance

STATUS OF THE REPORT: *(Please click on the appropriate box)*

Approve ☒ Discuss ☒ Assurance ☒ Information ☐ A Regulatory Requirement ☐

SUMMARY OF REPORT:

The purpose of this report is to describe how Humber and North Yorkshire Integrated Care Board (HNY ICB) will work together with the 6 Places and 5 Sector Collaboratives to develop and mature operating arrangements over the course of 2022/23. This is in readiness for them to operate with increased autonomy and delegation of local decision-making from April 2023 onwards.

The paper presents a timeline for Places and Sector Collaboratives to indicate their ambition for delegation, including where appropriate, alignment with partner organisation delegation, in readiness for the 2023/24 operating year. This approach builds on engagement that has already taken place with Local Authority Place Chief Executives and Place and Collaborative Directors.

For 2022/23 eleven transitional operational agreements have been developed, one for each of the six Place Health and Care Partnerships and five Sector Collaboratives. These are based on the NHSE MOU developed with ICBs (draft at Sept 2022). They describe how each will work with the ICB on system priorities, performance improvement, governance, and ICS development, to deliver outcomes for patients, the local population, and the wider NHS.

The transitional operational agreements form a key part of the ICB operating model in 2022/23 and align with the ICB's system oversight arrangements from NHS England.

RECOMMENDATIONS:

Members are asked to:

i) Note the transitional operational agreements developed and being agreed with Place Health and Care Partnerships and Sector Collaboratives.

ii) Note that the final transitional operational agreements will be brought back to the ICB in November 2022.

iii) Note that the statutory guidance on *Arrangements for Delegation and Joint Exercise of Statutory Functions: Guidance for Integrated Care Boards, NHS Trusts, and Foundation Trusts* was published 28 September 2022.

iv) Note that transitional operational agreements will evolve in accordance with the timeline set out in this paper and further national guidance.

v) Comment on and support the approach being taken to develop operating arrangements and corresponding governance in readiness to deliver delegated duties in support of the collective ambitions of the ICS from April 2023.

ICB STRATEGIC OBJECTIVE (*please click on the boxes of the relevant strategic objective(s)*)	
Realising our vision	☒
Improving outcomes in population health and healthcare	☒
Supporting broader social and economic development	☒
Tackling inequalities in outcomes experience and access	☒
Delivering our operational plan 2022/23	☒
Developing our ICS	☒

IMPLICATIONS	
Finance	Agreed budgets will be delegated, as appropriate, as detailed within the ICB Operational Scheme of Delegation for the 2022/23 agreements.
Quality	Places are establishing a Quality Place Group that enables the proactive identification, monitoring and escalation of quality issues and concerns to HNY ICB. Arrangements will be made for appropriate attendance at the System Quality Group and/or ICB Quality Committee.
HR	Principles of matrix working underpin the Operating Arrangements, for example: ICB members of staff embedded in place are a shared and enabling resource to implement Place and Collaborative programmes. Members of staff at all levels will require organisational development support to develop culture, behaviours and skills for system working.
Legal / Regulatory	Capsticks have been providing support and advise to place discussions. Although the agreements are not legally binding. Collaborative of Acute Providers have sought legal advice and the outcome is awaited.
Data Protection / IG	There are no immediate implications, however as progress is made data protection/IG principles and legislation will need to be considered and reported on.
Health inequality / equality	Each Place is developing priorities to improve health inequalities and work across the system collectively.
Conflict of Interest	No conflicts of interest have been identified prior to this meeting.
Sustainability	No immediate sustainability implications have been identified.

ASSESSED RISK:
There are no significant risks associated with this paper. The ICB Board will be kept up to date on local developments and further national guidance which may impact upon operating arrangements, delegated responsibilities, and/or proposed governance.

MONITORING AND ASSURANCE:
The recommendations will be implemented and continually reviewed though the HNY ICB Chief Operating Officer's Tactical Delivery Group. Members of this group include the COO, Executive Director of Finance & Investment, NHSE Locality Director and Directors of all the Collaboratives and Places. Assurance on delivery and performance is received through the System Oversight and Assurance Group.

The transitional operational agreements relate to the ongoing relationship between HNY ICB and each Place and each Provider Collaborative. It is expected these agreements will run until April 2023. In late September 2022 the awaited national guidance was published on delegation. Alongside this and the MOU framework for the ICB with NHSE, a timeline has been produced to the new arrangements coming into place from April 2023.

ENGAGEMENT:

The content of the transitional operational agreements are unique to each Place and Collaborative have been developed through engagement with Place Directors and Collaborative Directors and discussed with members of the respective boards or equivalent.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☒ Yes ☐

If yes, please detail the specific grounds for exemption

Humber and North Yorkshire ICB
Arrangements with Place Health and Care Partnerships and Sector Collaboratives

1.0 Introduction

The purpose of this report is to describe how the ICB will work with the Place Health and Care Partnerships and Provider Collaboratives to develop and mature operating arrangements over the course of 2022/23 and in readiness to operate with increased autonomy and delegation of local decision-making in 2023/24.

2.0 Current Arrangements 2022/23

2.1 Current Operating Model

The current operating model is based on mutual accountability (See Figure 1). The model consists of 6 Places and 5 Sector Collaboratives and has been operation since 1 July 2022.

NHS England is developing, in partnership with ICBs, a Memorandum of Understanding (MOU) for 2022/23. This is not legally binding but sets out the agreed operating model based on a good governance approach of statutory delegated duties.

HNY ICB has developed a non-legally binding transitional operational agreement in partnership with the 6 Place and 5 Collaboratives. These set out the principles that underpin how the HNY ICB and Places/Collaboratives will work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services.

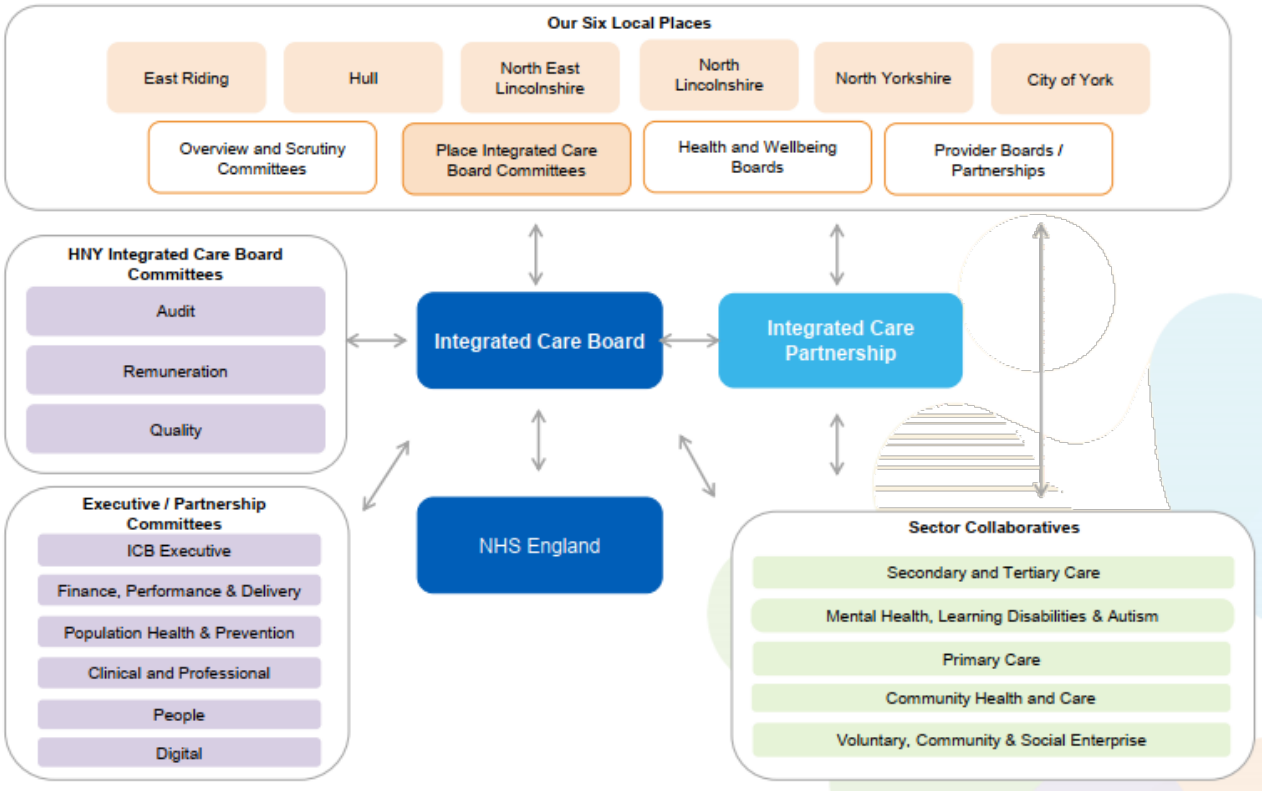


Figure 1. HNY ICB Current Operating Model

2.2 Transitional Operational Agreements

We have been working closely with the 6 Places and 5 Collaboratives to develop transitional operational agreements since summer 2022. For the Places, this builds on the work undertaken with Place Directors and Place LA Chief Executives. For the Collaboratives, this builds on the work undertaken with the Collaborative Directors / Chief Executive Leads/SROs through the priority agreement meetings with the ICB Chief Executive and Chief Operating Officer.

The agreements are transitional and reflect that integrated care systems and relationships between partners are at a formative stage. Agreements will be updated to reflect NHSE statutory guidance, published 28 September 2022, outlining options for delegation or joint working arrangements under the Health and Care Act 2022 from 1 April 2023 .

The transitional operational agreements have been developed based on an NHS England template to ensure some level of consistency. The Places and Collaboratives have provided their latest aims/priorities, plans on a page and governance arrangements that reflect the unique arrangements across the system.

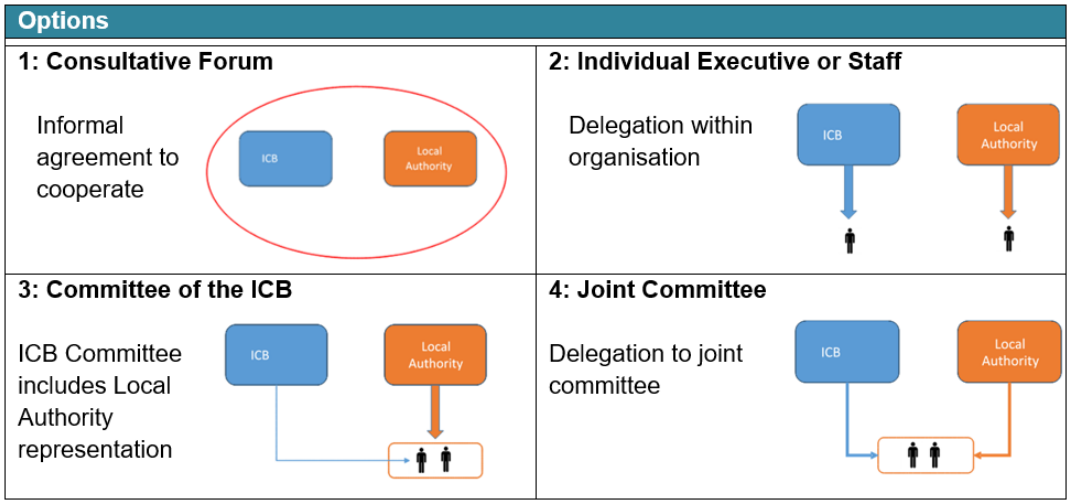
The operational agreements describe:

- The principles that underpin how the ICB and each constituent Place Health and Care Partnership or Sector Collaborative will **work together to discharge their duties**, to ensure that people across the system have access to high quality, equitable health, and care services.
- The **system priorities and deliverables** for each Place Health and Care Partnership or System Collaborative.
- The partnership and place arrangements including how local delivery and governance is managed, monitored, and escalated through HNY ICB System Oversight arrangements, including how the ICB gets assurance on plans and priorities.

It should be noted that the agreements are in draft and currently with the Place and Collaborative Directors for local agreement through individual meetings. It is proposed that the final agreements come to the ICB Board for review in November 2022.

2.3 Places: Current Arrangements

- As outlined at 2.1, Places are developing transitional operational agreements. This includes detail of the assessment framework that was to support a consistent understanding of Place maturity across each ICB. An initial assessment was completed in September 2021 and repeated in September 2022. This assessment supports Places in their development towards a 'thriving' Place and is a helpful aid to identify areas of good practice to support system wide development as well as where clear support is required. We aim to instil a strong culture of shared learning.
- Places have established local meetings with executives / senior officers across partner organisations and have worked together to a set of identified priorities, aligned to local Joint Strategic Needs Assessments, Health and Well Being Board strategies and the NHS forward view requirements.
- Place Directors have authority to make decisions in respect of those functions within their Places.
- Within the approved HNY ICB Operational Scheme of Delegation, Place Directors are able to approve new contracts and commitments up to the value of £1.5m providing this is within
- existing budgets. Early review demonstrates this is inflexible and will therefore be subject to change as part of the wider governance review.
- There are regular meetings held with Local Authority Chief Executives and the ICB COO.
- The Deputy Chief Executive/Chief Operating Officer has established a weekly Tactical Delivery Group, joined by Place Directors.
- Several development sessions have been held with Place Directors and Place Local Authority Chief Executives on the different governance arrangements for Place dependent upon delegation, particularly on membership/voting and conflicts of interest. These models are detailed below:



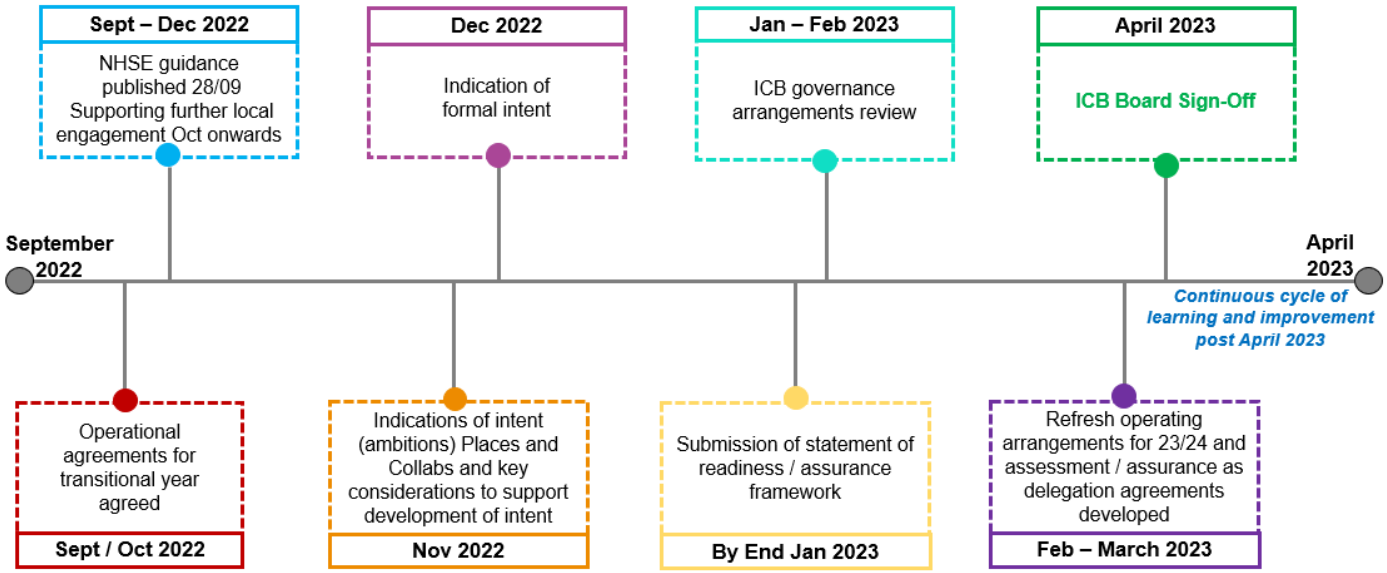
- The ICB has been awaiting statutory guidance on arrangements for delegation and joint exercise of statutory functions, which has now been published on 28 September 2022. Over the coming weeks we will be working through the guidance to understand the new parameters of delegation, but it is still expected to broadly cover the options described.

2.4 Collaboratives: Current Arrangements

- There are regular meetings held with the ICB Chief Executive and COO with each collaborative Chief Executive Leads and the Collaborative directors.
- Following a priority agreement meeting, clear priorities have been agreed for 2022/23 in line with national requirements.
- A development session has been scheduled to further map the evolution of the collaborative arrangements
- The Deputy Chief Executive/Chief Operating Officer has established a weekly Tactical Delivery Group that includes all Collaborative Directors.

3.0 Working Towards Increased Autonomy

The below timeline sets out our ambition working towards increased autonomy and delegation of local decision-making.



Timeline subject to review as the ICB assimilates the guidance and agrees the next steps.

4.0 Assessment of Delegated Budgetary Options

4.1 Places

During 2022/23, budgets have been aligned to the 6 places in line with the previous CCG budgets. Financial and budgetary management continues to work broadly in the same manner as before with financial risk managed at place and across the ICB. An operational scheme of delegation has been approved by the ICB and provides the framework for decision making.

The financial and budgetary framework for 2023/24 will be developed over the coming months that will respond to both the requirements set out in national planning guidance but the desire to delegate the majority of resource to place. A robust financial risk management strategy will underpin any revised budgetary framework that will facilitate the delivery of financial plans at place, ICB and system.

4.2 Collaboratives

Collaboratives are responsible for the deployment and use of specific resources to deliver several strategic priorities. One of the most significant of these is the funding that is being prioritised and deployed through the MH collaborative.

The formal delegation of resource will need to match and align with the functions delegated to the collaboratives which will be developed as the ICB operating model continues to mature. This will be a focus of the plan for 2023/24.

5.0 NHS England Statutory Guidance

On 28 September 2022, NHS England published statutory guidance outlining options for how NHS organisations can exercise some of their statutory functions via delegation or via joint working arrangements under the Health and Care Act 2022.

The 2022 Act introduces new sections 65Z5 to 65Z7 to the 2006 Act. These changes will give relevant organisations (NHS England, ICBs, NHS Trusts and Foundation Trusts) greater flexibility to collaborate in exercising their statutory functions, either through delegation or joint exercise of

those functions – enabling better integration of their services to improve outcomes for patients and facilitate the best use of resources across care pathways at system and place level.

As detailed in the timeline in this paper, we intend to go through the guidance and engage with our Places and Collaboratives as to their intentions, recognising the options now available within the new scope, any restrictions and conditions outlined in the guidance. **It should be noted that NHS England still clearly recommends that systems do not seek opportunities to make use of these new powers within 2022/23.**

6.0 Recommendations

HNY ICB Board Members are asked to:

- Note the transitional operational agreements are being developed and agreed with Place Health and Care Partnerships and Provider Collaboratives.
- Note that the final transitional operational agreements will be brought back to the ICB in November.
- Note that the statutory guidance on *Arrangements for Delegation and Joint Exercise of Statutory Functions: Guidance for Integrated Care Boards, NHS Trusts, and Foundation Trusts* was published 28 September 2022.
- Note that transitional operational agreements will evolve in accordance with the timeline set out in this paper and the guidance from NHSE.

- Comment on and agree the approach being taken to develop operating arrangements and corresponding governance in readiness to deliver delegated duties in support of the collective ambitions of the ICS.

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Agenda Item 20

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Finance and Investment Committee – Chair's Log
Author/s:	Francis Patton Chair of Committee/Non-Executive Director
Recommendation:	

To approve		To receive & discuss	X
For information/To note		To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The aim of this paper is to provide assurance to the Trust board on the financial performance of the Trust and any business development opportunities identified. It is recommending that the Primary care strategy and a strategic review of future potential cost reduction asks are part of the December Board development session.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- The ICS deficit position at month 5 and possible implications arising from it.
- The high level of agency spend versus plan.
- The deficit position of Primary Care.
- The need to reprofile the 22/23 capital plan.
- That the ask for the 23/24 BRS plan and future years might be increased over the planned 1.5%.

Key Actions Commissioned/Work Underway:

- Agency recovery plan being overseen by the Executive.
- The Primary Care recovery plan being overseen by the Executive.

Positive Assurances to Provide:

- The Trusts continued delivery against plan and positive cash position.
- Continued delivery of the 22/23 BRS.
- The strong governance around the YHCR programme.
- That the liability against IR35 is being reviewed and quantified.
- That the new approach to the Estates strategy synchronises with the Trust Strategic plan and splits out the overarching strategy from the more detailed delivery

Decisions Made:

- That Primary Care should be a discussion topic at the December Board development session.
- That a strategic review of the implications of an increased cost reduction be explored at the December Board development session alongside the wider 23/24 planning framework.

plan. • That the 23/24 BRS plan is already in development. • That there is a clear agreed strategy for the development of a joint EPR system.	

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

Monitoring and assurance framework summary:

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

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

Key Issues:

The committee is providing assurance that the Trust financial performance remains on plan and that the Trust has a healthy cash position. Good assurance was also provided around the ongoing delivery of the budget reduction strategy, delivery of capital spend to date, the Yorkshire Health Care Records programme, risk 5 on the BAF, the development of the new Estates strategy, the development of the new BRS for 23/24 and the HNY HCP Convergence Charter. There was also positive assurance around ongoing business development opportunities.

Concerns were flagged around the ICS position at month 5 and possible implications on the Trust and the delivery of both the Agency spend recovery plan and the Primary care recovery plan. The committee felt that the present economic conditions, uncertainty over the Government and the ICS financial position could result in further cost pressures going forward which needed Board discussion.

The key areas of note arising from the Committee meeting held on 19th of October were:

- In terms of the Insight report the key issues raised were: -
    - There was no in year finance update at the most recent NHSE Board Meeting however there was a focus in the 2023/24 financial planning process. At the board meeting the NHS Chief Financial Officer (Julian Kelly) warned that inflationary pressures and planned efficiency savings could force the NHS to rethink the level of patient services, including cancer, mental health, and steps to reduce waiting times. Key pressure highlighted in the NHS Board Report included:
        - Covid expenditure above spending review assumptions
        - Inflationary Pressures (SR planned 2% - current CPI 9.9%)
        - Pay Settlement A total of £14bn pressures have been highlighted with further potential pressures of up to £6-7bn.
    - As discussed at the Board development session at Month 5 the Humber and North Yorkshire ICB recorded a deficit position of £7m, this represents a £8.5m adverse variance to plan. Adverse positions are being reported in all Acute Trusts, with bed pressures and efficiency target shortfalls the main reason for the variance.
    - The NHS is hoping for a decision in December on the total budget for the new hospital programme and for investment in five major hospitals at critical risk from issues with reinforced autoclaved aerated concrete (RAAC) NHS England board reported that seven hospitals were severely impacted by RAAC and would need new builds to mitigate their risk of closure over the next 10 years. A decision on the next eight NHP projects has been scheduled for early December.
    - The NHS Employers body has written to the chancellor to request urgent changes to the way pension tax is calculated. NHS employers are concerned that pension growth could be skewed upwards by rapidly rising inflation, in the context that growth could rise above the annual allowance

- The Trust recorded an overall deficit of £0.239m for Month 6 consistent with the Trust's planning target. Cash balance at the end of Month 3 was £31.440m of

which £5.116m relates to the Provider Collaborative. Aged debtors stood at £4.144m and creditors at £8.303m. The committee encouraged the team to review both areas before the next meeting in January. Areas of concern discussed were that agency expenditure was £4.472m, which is £0.812m more than the previous year's equivalent Month 6 position; Primary Care recorded a deficit of £0.918m, primarily due to the increased costs of locums; the Year-to-Date Trust Income position is showing an underachievement of £0.735m of which £0.381m is risk. In response to those concerns work is continuing with Commissioners in relation to the income risk; work continues to reduce the level of agency costs with the aim of recruiting to permanent medical consultancy posts and a full plan was reviewed; a Recovery Plan is in place regarding Primary Care and regular finance accountability meetings are being held with the service. That said FIC are recommending that, following a review by the Executive, Primary Care comes to the next Board time out in December for discussions on how it should be managed within the strategy going forward.

- At month 6 Children's and LD reported a £0.308m gross expenditure underspend; Community and Primary Care reported an overspend of £0.474m; Mental Health reported an underspend of £0.661m; Forensic services reported an underspend of £0.001m Corporate Services reported an underspend of £0.512m

- In terms of BRS for 2022/23 the Year to Date (YTD) actual savings are £1.446m. The Mental Health Division is currently forecasting an underachievement of £0.324m which does relate to savings from Unidentified Post Reductions. The Service is reviewing all vacant part posts with the aim of any savings that are identified being used to offset the potential underachievement. The Service is estimating that an in-year underspend of £0.300m will be achieved which would cover the bulk of the underachievement non recurrently and that the underachievement would be carried into 2023/24.

- Again, as discussed at the Board development session and highlighted above in terms of financial concerns the committee received an update on Agency spend and the plans to address it. The Trust is targeted with a 10% reduction in agency spend and at month six is over the target. The action plan developed by the Executive is targeting a 2% reduction between 21-22 and 22-23 leading to a 29% reduction between 22-23 and 23-34 but this is connected to recruitment initiatives for nurses and consultants in a difficult market. FIC will continue to monitor delivery of the recovery plan.

- The Committee received a Capital Programme update. The Trusts original capital programme was approved in April 2022 and totalled £14.151m which was inclusive of £7.661m of resource to be drawn down from the Hull City Council S75 agreement (£1.8m Granville court, and £5.861m YHCR). Since the capital programme was agreed the proposed treatment of the S755 agreement has altered following the annual accounts process, and whilst the cash remains the S75 funding can no longer be drawn down to support the capital programme as a revenue grant, the consequence of which is that CDEL cover is required to support this expenditure.

  As a result, the original 2022/23 programme needed reprofiling by circa £1.8m to manage within CDEL levels although the reprioritised 22/23 plan is over-committed by £0.300m (4.5%) to ensure CDEL is maximised. Draft programmes

for 2023/24 and 2024/25 also exceed current CDEL levels and programmes will be revised and brought back to EMT. Confirmation of CDEL for £1.276m of South Yorkshire YHCR is still awaited.

At the end of August 2020 £1.696m had been spent, comprising, £0.782m of estates schemes, £0.149m of digital scheme and £0.765m on the Yorkshire and Humber care record. Within that

- The Humber Centre scheme phase 1 is almost complete (Gym and Shop) and phase two has been tendered with contracts awarded (Reception). Total expenditure is expected to be £1.325m for the year, which is £1.175m less than planned.
- The purchase of Granville court is being pursued; however, the refurbishment/alternative plans have not yet been finalised which means the work will not take place during this financial year.
- The corporate accommodation scheme was expanded to include the following: - Relocation of the Trust HQ post room(£0.030m), - DME training facilities at the East Riding Community Hospital (£0.105m) - Audio-visual equipment for use around all sites (£0.100m).

The committee noted the update and expressed some concern that the Trust was building up issues for future years but noted the restrictions of the CDEL limitations.

- The Committee received an update report on the YHCR programme showing that CDEL approval from Humber and North York's ICB has been provided and capital expenditure can proceed but that the CDEL approval from South Yorks has not formally been provided and that continued dialogue with the South Yorks ICB will be held and the expenditure will be held back until formal approval has been made. The committee were assured that there was close Governance on the running and finances of this programme.
- The Committee received and noted both the draft BAF and risk register. The Committee recommended that issues around agency costs and Primary care were added to negative assurance on the BAF and agreed with the overall assurance level of yellow.
- The Committee received a report on employment tax issues and issues arising from IR35 which requires engaging organisations to assess whether a role being undertaken by an agency worker working through an intermediary, is one of employment. The Trust has a provision of £2.6m on the balance sheet but this needs bringing to a head particularly from an audit perspective as the Trust may have a financial liability in respect of underpaid tax. The extent of the any liability is unknown and the external auditors have recommended determining whether a liability exists. A plan to mitigate risk has been developed and approved by the Executive management team and the output from this this will come to January FIC.

- The Committee received the Estates Strategy update which was a summary position of the development of the Trust's updated Estate Strategy and to outline the structure by with the updated strategy is recommended to take. The new approach would mean that the document is restructured into two parts; Estate Strategy that is directly aligned with the Trust Strategy and an Estate Plan that will include locality plans, property disposal, acquisition and consolidation plans, and document scheduled changes in operational requirements. The proposed document structure provides assurance that the Estate Strategy is aligned with the Trusts Strategy. The Estate Strategy will provide a framework from which estate development and capital investment proposals can be aligned with the Trust's strategic goals. The provision of a distinct Estates Plan can be used to establish the workstreams that will be monitored via the Estates Strategy and Capital Delivery Group and the Finance and Investment Committee. The Estate strategy was in draft form and will come in fill form to the January committee with the Estates plan coming to the April meeting. The Committee were very supportive of the new approach but suggested that it should go further than the bricks and mortar estate linking in with the digital approach being taken and should be linked to the IT/Digital strategy and Green strategy and to the ICS Estates strategy.

- The Committee received the draft Budget Reduction Strategy (BRS) 2023-24 to 2025-2026. Savings of £1.282m have been proposed to date leaving a gap a in savings developed of £0.840m compared to the target (1.5% saving). The Committee congratulated the team and keeping a culture of cost saving in place throughout Covid and for the work so far on the plans but highlighted the present economic issues, ICS issues versus plan and the potential need for more cost savings in future years. As a result, the committee felt that this was an area that needed further discussion at the December Board development session to start scenario planning and what we might need to look at in terms of services offered and savings to be made.

- The Committee received the Digital Update and - HNY HCP Convergence Charter which has been created to provide a clear approach for ICS partners to join information together using shared care record, EPR and back-office services. The charter has been developed independently by channel 3 consulting and the ICS digital executive and ICS EPR steering group, ICS partners and our digital team have all been fully engaged with the process and support the decisions made in the charter which is that the four Acutes will procure a new single EPR and Humber Teaching NHS Foundation Trust will procure a single EPR for community and mental health.

Humber Teaching NHS Foundation Trust

Agenda Item 21

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Collaborative Committee Assurance Report
Author/s:	Stuart McKinnon-Evans Non-Exec Director - Audit Chair (Chair)
Recommendation:	

To approve		To receive & discuss	
For information/To note	x	To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Collaborative Committee is one of the sub committees of the Trust Board This paper provides an executive summary of discussions held at the meeting on Friday 14 October 2022 and a summary of key points for the Humber Teaching NHS Foundation Trust Board to note.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- Due to staffing pressures the Mill Lodge CAMHS day care model has been paused
- Staffing pressures at both Mill Lodge and Inspire CAMHS units which has resulted in increased out of area placements and increased financial spend on CAMHS
- Low level of referrals and admissions into Schoen Clinic

Key Actions Commissioned/Work Underway:

- Clear and robust support and oversight for CPaQT in place for management of patient safety incidents at Stockton Hall Hospital
- Work is underway across all 3-work stream to implement our agreed strategic plans and priorities
- CPaQT is working with Schoen Clinic York to establish appropriate assurance for the provision of day care
- New reporting schedules have been developed for CPaQT monitoring, Provider Collaborative Oversight Group and Collaborative Committee reporting and assurance
- Collaborative Committee asked for a report at the next meeting on the actions to address the CAMHS overspend and address that both units in HNY are not operating at contracted capacity
- Continue to triangulate oversight and assurance mechanisms (metrics; case management; lines of sight; soft intelligence; creating open cultures)

Positive Assurances to Provide:	**Decisions Made:**
• No HNY service users are in the Edenfield service, following the BBC Panorama programme exposing alleged abuse of patients by staff there – all providers have been asked to review and provide their plans to prevent such harm in line with NHSE directive • Considerable assurance received from NHS England at the recent Specialised Provider Collaborative Quarter 1 contract monitoring meeting • Significant reduction in CAMHS Delayed Transfers of Care and waiting list following intensive work with all health and social care partners • Quality assurance visit to Inspire on Monday 10 October 2022 was extremely positive • Schoen Clinic Lessons Learned report shared and each 'lesson learnt' has active actions underway. Acknowledged the significant assurance and work undertaken by the CPaQT • Generally, good evidence that the CPaQT are responding with agility to the dynamic interplay between in-patient and community provision, including assessing the potential impact of introducing more day care into the mix	• Risk and Gain Share ToR were ratified • Day Care Provision at Inspire was ratified • IFR Policy for Out of Natural Clinical Flow was ratified • Work plan reviewed and will be amended to reflect discussion at the meeting

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

	Date		Date
Audit Committee		Remuneration & Nominations Committee	
Quality Committee		Workforce & Organisational Development Committee	
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	14.10.22
		Other (please detail)	

Monitoring and assurance framework summary:

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

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the	N/A	Comment

		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	

Committee Assurance Report – Key Issues

The aim of this report is to provide assurance to the Board about the Collaborative Committee which has been established by Humber Teaching NHS FT (HTFT) as the Lead Provider within the Humber and North Yorkshire (HNY) 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 the Collaboration Planning and Quality Team (CP&QT) which is accountable to the Collaborative 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 planning, 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:

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

The meeting on 14 October 2022 was quorate

Quarterly Insight Report

Report shared with the Collaborative Committee to give a high-level oversight of regional and national work on Specialised Provider Collaborative. From next meeting onward the Insight Report will include high level summary from each of the 3 work stream areas.

Quality Assurance and Improvement

- Collaborative Planning and Quality Team (CPaQT) will undertake an annual quality review with Stockton Hall Hospital and enhanced oversight of incident management
- All providers have been asked to submit plans in place for assurance following the Edenfield/BBC Panorama expose
- CPaQT is supporting Schoen Clinic York with communications to wider Provider Collaborative regarding them being reopen to referrals and potential admissions
- CPaQT is working with Schoen Clinic York to establish appropriate assurance for the provision of day care
- New reporting schedules have been developed for CPaQT, PCOG and Collaborative Committee

Schoen Clinic Lesson Learned

Report shared at the Collaborative Committee – high level summary:

- The case management function needs to be sufficient and integrated into the quality oversight arrangements
- Meaningful and embedded involvement strengthens the quality agenda considerably, provided this will well-resourced, well-led and explicitly featured in reporting structures and

processes
- There needs to be clearly agreed 'lines of sight' from the front line all the way through to Board via POCG and CC – qualitative and qualitative data needs to be triangulated from a range of sources with a focus on assurance, not relying on reassurance
- Each 'lesson learnt' has active actions underway
- Support between providers has been evident throughout
- Providers have been active in reviewing practice/policy in Schoen Clinic throughout

Risk Register

- Agreed to add CAMHS financial risk to the CAMHS and Overall Risk Register
- Agreed to add descriptor of movement in the risks
- Agreed to have a cover sheet for the risk register

Work Stream Updates

1 CAMHS

- Total Patients receiving care Inside Natural Clinical Flow - 13
- Total Patients receiving care Outside Natural Clinical Flow - 14
- Delayed Transfers of Care and Waiting List both have reduced since last month
- Inspire PICU ward is temporarily closed to admission due to staffing pressures and this will be escalated to NHS England for regional oversight
- CAMHS in-patient service review is underway

2 Adult Eating Disorder

The committee reviewed the AED work stream strategic plan and priorities as part of the AED assurance report.

- Total Patients receiving care Inside Natural Clinical Flow: 10
- Total Patients receiving care Outside Natural Clinical Flow: 1
- Continued variance in specialised community ED service impacts on how people are managed and admissions from those areas. Work was to be undertaken as part of CMHT transformation funding – however challenges with the funding has resulted in services being paused.
- Tees, Esk and Wear Valleys (TEWV) NHS Trust who are contracted to provide specialised community eating disorder provision across Vale of York and North Yorkshire place have struggled to recruit to specialised community ED provision – consequently have reached out to the Specialised Provider Collaborative to seek assistance. In the interim the outpatient support will be commissioned by TEWV from Schoen Clinic York, with specialised commissioning support from the Specialised Provider Collaborative.

3 Adult Secure

- 69 low secure patients of which 44 are within natural clinical flow
- 83 medium secure patients of which 74 are within natural clinical flow
- Single Point of Access has been identified as leading the way nationally with monitoring and assurance of referrals into secure services. High compliance for accuracy of data compared to other Specialised Provider Collaboratives across the region
- Alignment of Learning Disability forensic outreach and liaison and mental health forensic outreach liaison is progressing well across Humberside and work is to commence in

November across North Yorkshire and York.

Finance

- Budget updated to reflect financial inflation uplift as agreed with NHS England
- CAMHS is demonstrating an end of year pressure which is being closely monitored and will be added to the overall risk register.
- Collaborative Committee asked for a report at the next meeting on the actions to address the CAMHS overspend and address that both units in HNY are not operating at contracted capacity.

Contract and Performance Assurance Report

- Shared with the Collaborative Committee as an update to progress of agreeing both Sub-Contract and Lead Provider to Lead Provide contracts
- Assurance given that even if individual contracts remain unsigned, NHS-standard contractual provisions would apply in the event of a dispute.

Planning Update

- To date no planning guidance received from NHS England
- Understood to be national pressures – however await further information from NHS England

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Agenda Item 22

Title & Date of Meeting:	Trust Board Public Meeting – 12th October 2022
Title of Report:	Workforce and OD Committee Assurance Report
Author/s:	Name: Dean Royles Title: Non-Executive Director and Chair of Workforce and OD Committee
Recommendation:	

To approve		To receive & discuss	
For information/To note	√	To ratify	

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 12th October 2022 and a summary of key points for the Board to note. The minutes of the meeting held on 13 July 2022 are attached for information

Key Issues within the report:

Matters of Concern or Key Risks to Escalate:

- **August 2022 Workforce Insight Report**

The number of vacancies is higher than it has been for the past two years. This is as a result of increasing our establishment faster than we have been able to recruit staff. Although our vacancies are at the highest level, we have 200 more staff in post in comparison to two years ago. From a recruitment point of view, we recruited 95 nurses into the organisation in a five-month period. Benchmark figures for turnover indicate that there is an increase across all regions.

We are working through the operationalisation of apprenticeships but are still committed to making this work and we will have a further review and discussion on this in January.

We will have a trajectory update on the STAT man training for the non-compliant areas, HG and SMc will pull this together.

Key Actions Commissioned/Work Underway:

- **Risk Register's and BAF**

We have received the risk register and BAF, we have discussed rising vacancy rates, rising turnover and rising absence. We have asked EMT to review the risks to see whether they are appropriately rated and to consider any other mitigations.

We have asked EMT to review the rating on the BAF to see whether this should be amber.

- **WRES and WDES Action Plans**

Both the WRES and WDES reports have been received and these will go to board. We have noted the benchmarking around those in terms of comparing to the NHS average in those areas and the need to focus on a few key priorities. Progress has been noted in these areas in comparison to when these reports were first undertaken years ago.

Positive Assurances to Provide:

- **Staff Health and Wellbeing Engagement Group**

Update received from SMc who chaired the staff health and wellbeing group. The group has been operating for 18 months and this was part of a refresh in terms of membership and terms of reference to ensure we are receiving more feedback.

The estates refurbishment continues to be well received. There is still active engagement with this to ensure staff take advantage of what is on offer in terms of improving the environment for staff.

- **Equality, Diversity and Inclusion Group**

Update from KP. The networks continue to be variant following a refresh. The networks are being used to consultant on EDI issues but also policy and procedures which has been well received.

There is some ringfenced leadership available to members of the group. Well received inclusion week.

A chair is still be sought for the Humber ability group but in the meantime, this is operating very effectively as a peer network which welcomes support from HG as exec sponsor.

- **Medical Education Committee**

KF gave an update. This continues to be a very active group led by Soroya. We welcome the emphasis that continues to be played on and we noted the number 1 ranking in the region of the medical education training and welcomed this achievement.

- **Guardian of Safe Working Hours Quarterly Report**

We received the paper for the guardian of safe working report, we receive the assurance and the work which is ongoing to continue work in this area and we express our thanks to Dr Qadri.

- **Workforce Wellbeing Team**

Decisions Made:

- **Review of Strategy Metrics for Developing an Effective and Empowered Workforce**

We received the update on the metrics for the strategy. We agreed the approach to sign of high-level board metrics on the people part and that there will be a further discussion on more detailed metrics as we develop the people plan and how we measure and report on this.

- **Presentation on Work Experience and Apprenticeships**

We received an update on the work experience and apprenticeships.

LP and HG both support this. SMc is going to have a discussion at MT to review the apprenticeship pay rate for first year.

Great presentation, very well received. The team are doing an effective job to portray the wellbeing message to staff. Feedback is very positive and encouraging from the group. • **Updated Behavioural Standards** We received an update on the being Humber campaign and the Trust values have been well received, we are looking forward to those being embedded within the organisation as we launch in October and beyond.	

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	13.07.22
Finance & Investment Committee		Executive Management Team	
Mental Health Legislation Committee		Operational Delivery Group	
Charitable Funds Committee		Collaborative Committee	
		Other (please detail)	

Monitoring and assurance framework summary:

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

Have all implications below been considered prior to presenting this paper to Trust Board?	Yes	If any action required is this detailed in the report?	N/A	Comment
Patient Safety	√			
Quality Impact	√			
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			

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

Humber Teaching NHS Foundation Trust

Minutes of the
Workforce and Organisational Development Committee
Held on
Wednesday 13th July 2022
9:30 – 12:30pm
Microsoft Teams

Present:
Members:

Mr Dean Royles (DR)	Non-Executive Director (Chair)
Steve McGowan (SMc)	Director of Workforce and OD
Mr Francis Patton (FP)	Non-Executive Director
Hilary Gledhill (HG)	Executive Director of Nursing (11:20 -

Other attendees:

Mrs Emma Collins (EC)	Senior HR Business Partner (10:05 – 10:40)
Mrs Lynn Parkinson (LP)	Chief Operating Officer
Lucy McRae (LM)	Personal Assistant (Note taker)
Karen Phillips (KP)	Deputy Director of Workforce and OD
Tracy Flanagan	Deputy Director of Nursing

34/22	**Apologies for Absence** Pete Cook (PC) Samantha Jaques-Newton (SJN)
35/22	**Declarations of Interest** None to discuss.
36/22	**Minutes of the meeting held in April 2022** Minutes were taken as an accurate record and accepted.
37/22	**Action Log** The action log was discussed, and no updates were noted.
38/22	**Chairs logs from any groups reporting to this committee** LP fedback on staff health and wellbeing. Overall making good progress against the action plan. Have been reviewing this within the last two meetings in light of staff survey results. It was agreed there was one area we need to add to our plan and we will work on this in terms of actions. This was relating to staff coming to work when they are too unwell. Making good progress with staff breakrooms, 7 areas need updating. Continuing to look at the Metrix relating to staff health and wellbeing overall view is good progress is being made. Overall the plan still stands in good stead for the coming year. Good engagement. Looking at the element on the workplan about developing staff network, progress is being made in this area. Nothing to escalate as concerning. DR agreed about the enthusiasm and commitment of staff within this group. SM stated there was a strength of feeling within the meeting yesterday around the cost of living. No answers were provided regarding this, but the team listened intently, it is useful as a committee to understand the impact that the cost of living is having on staff. There are no easy fixes, we have done a

	number of things within the Trust . Nationally it is a bigger issue. LP fedback that this conversation is still ongoing within EMT and within this the strength of feeling will be fedback. There are concerns about October and the anticipated next rise of fuel costs, winter and energy costs rising. Staff were also raising dilemmas some staff are beginning to feel around home working and being in the office. These are variable on position, whether driving into base is beneficial and using fuel or working at home and using energy. LP and SM need to discuss this concern and what this means in particular for the upcoming winter. SM stated more people will come into the office from October and November and in the winter months, especially those people who live within a close proximity to Headquarters as they will come in to keep warm. Need to ensure we have enough office space which is sufficient for all our staff in the event there is a rush in return to work. This is a frightening thing to be discussing in 2022 but it is reality for us. SM stated this will be discussed with PB in terms of remote working and office working. TF fedback on the national discussions around the professional nurse advocate role which is very focused on staff health and wellbeing. Part of the agenda for this is around access to hardship funds. It is difficult to acknowledge the difficulty some of the staff may be experiencing and it is important we respond to this appropriately. LP stated we have HC as a professional advocate on the staff health and wellbeing group and she brought this concern forward within the meeting ensuring this is taken into consideration within the group. DR stated we need to demonstrate empathy around this area, we can provide support to staff and ensure we direct staff to areas of financial support and signposting. In a national pay system, there is a limited amount we can do in terms of pay and conditions without finding ourselves in difficulty. The pay award is now three months overdue, there needs to be an opportunity within the board of the importance of highlighting and settling it. ***Assurance report – Cost of living crisis impact**** KP fedback on equality, diversity, and inclusion. This update is following the meeting on the 8th June which DR attended. Attendance was significantly improved, we have previously struggled with operational attendance, each division was represented. AM provided a policy development update. We are now ensuring all our workforce policies go through TCNC, various other channels and networks. The EDI working group is used as an opportunity to share some of those policies for comment. A number of policies are upcoming. Individuals within the group are stating they do not have time to look into them and contribute to them. We are reviewing timescales to ensure that we are distributing the policies on time and ensuring they are circulated. MD gives an update on EDI and inequalities as a standard item. MD actively chairs the digital poverty group. MD's update is really welcome and it is a testament of the joint working which happens between workforce, EDI agenda and patient carer agenda which is very positive to see. Whilst MD worked very closely with JB she is going to start building a good working relationship with our new EDI lead commencing with the Trust. We had representation from the BAME network within this meeting. BAME network had a lot of issues to raise, most of which are within the 0 tolerance agenda which include incidents which are occurring between staff and patients and how they are managed and addressed. Concerns have been collated for this and they sit within the EDI assurance report documentation. AM provided a verbal update on the quarterly EDI insight report. We have circulated all the national reports and these are all discussed within the network for comments. There was a discussion on how we will be updating and refreshing on the EDI actions within the next few months on the back of all of those reports. FP stated in the front sheet of this there were no matters of concern necessarily just assurance. KP stated she did not disagree with this. DR stated there were issues around capacity from the BAME network in terms of individuals not having time to review the policies. DR fedback on how he was impressed with the attendance within the meeting and how operational managers were there to provide an update in terms of a service perspective. Inevitably within the BAME network, people tend to review workforce issues but access to services and health inequalities could feature well here. ***Assurance report – DR stated we need to escalate the issue around capacity which was raised from the BAME network which the exec team are looking into. SM has also been engaging on this issue. It is important not to look at this in isolation of the vacancies we have across the Trust and other ongoing pressures. This issue has never been more stretched than it currently is given coming out the pandemic and in reference to vacancy levels.***

	DR fedback briefly on medical education, it was a really vibrant meeting and well chaired, a lot of enthusiasm was shared, there was a good feel around the meeting. No one at the meeting to feedback thoroughly. ***Assurance report – Well led review discussed the chairs attending the subcommittees. DR has attended all three, staff health and wellbeing, equality and diversity and medical education.****
39/22	**Workforce Insight Report** SM fedback on this section. In terms of vacancies there is 232 more staff within the organisation than there was 12 months ago. But there is also growth within the establishment level the vacancy rate remains high. We have more nurses and consultants within the Trust in comparison to two years ago. GP employment is still an issue and this is highlighted within primary care and the issues with covering costs for this. Apprenticeships are still an issue in terms of getting these up and running. With exemptions, there is still work to do there and this was discussed within the accountability reviews. We have still got 40 apprenticeships within the organisation. Work experience is starting, we had the few within the directorate. In terms of STAT man 90% is good overall. Data is telling us there is a collection of individuals whose courses are out of date so there needs to be a push to get these individuals compliant. This was picked up at the accountability review. Overall individuals who are accessing our training this is broadly positive about most of the training we have on offer. There is one particular course which needs more work. 80% of our workforce is female. One in three part time, 35% of our organisation is over 50. When we are discussing apprenticeships and work experience this is to bring down the average age within our organisation which we did in the last 12 months and this is detailed in the workforce plan. As this data creates a pressure for us due to higher retirement levels and potentially higher sickness. BAME and LGBT were representative of the communities that we serve, disability not so much. In terms of sickness, this has been increasing. It has been recognised in board that it has increased seven of the eleven directorates and they are in a worse position in comparison to 12 months ago. 30% of our sickness is stress related which was predicted when we discussed this 12/18 month – 2 years ago when COVID began. This has been recognised and it is important to ensure we have support mechanisms in place for our staff and that we have the increased push to bring more staff in as we know this is around burnout and capacity and how the last two years has affected all staff. We do need to pick up the 4.4% to 5 to 5.7% as this is a big increase within the past 12 months. In reference to casework, there is interesting data produced here. The overview over the last 12 months in our case is particularly from a protected characteristics view to see if there are any disproportionate actions which have been taken or anything which would flag concern. There is a higher percentage of male staff which are suspended or put into restricted practice or subject to disciplinary or bullying investigations. When 80% of our workforce is female but there is a higher percentage of male staff being suspended and or restricted this is something to be considered. We know we have the mechanisms in place to review suspensions and see how decisions are made. However, this does need monitoring. Overall investigations are average, there is work needed around the outside of the process of an investigation, the initial commissioning and decision making. 39 days out of 97 are taken up as admin, we need to do something to ensure this process is done quicker as there is a big impact on the individual and their team during an investigation. We need to try and bring them to a conclusion more quickly. Good stuff about SLAS and recruitment, we are currently beating the track NHS SLAs. This gives confidence we are on track and recruiting new staff and processing them quickly on the system. There is also an increased demand around this. SM praised recruitment for their hard work and support in processing and getting through difficult circumstances. FP enquired as we are doing well in recruitment, but due to our establishment rising the demand for recruiting is increasing therefore vacancies are increasing. The percentage has gone from 9, 10 , 12.7 to 12.88%. We need to think about how to handle this increase as we grow and develop and take on more services, the areas we need we are still struggling to recruit. DR fedback that in June 2021 the percentage was at 12.44% so in terms of the year we have been similar. We are growing the workforce in terms of recruitment at the same pace as the establishment. SM stated if

	we look at the 0-19 service this is a good example of what CHCP gave us and what the establishment is which came with a huge vacancy factor as CHCP did not transfer across every post they gave us a certain number of people and then monies for vacancies. There is confidence we will fill some of these vacancies, but this does come to our Trust with vacancies attached as we get the job from CHCP to fill the vacancies and these figures are in the data as the staff and monies came across to us in May. Primary care is an example where we have taken on practices and inherited vacancies or very quickly had people leave because they have other plans and they we have had to step in and cover. FP stated medical and dental staff are not large quantities of staff however they are big vacancies to fill. SM agreed and stated that in terms of the finances this has a big impact on the Trust due to agency spends. When reflected in the risk assessment, the risk for the Trust not having continuity of care for medical and dental the risk is lower as we have long term agency cover within these roles in comparison to nursing. However the cost is hugely prohibitive due to the hourly rates they charge on the nursing side. LP fedback that on the 0-19 staff on the original TUPE transfer we had 105 staff however we actually transferred 80 which is to a degree disappointing. This is not inhibiting our service delivery and it is giving us an opportunity to re skill mix faster than we would have been able to without the vacancy position. We have pressures around GP recruitment and vacancies. We are making progress slowly but surely in relation to psychiatry vacancies. GP recruitment has worsened. FP asked for clarity on turnover. On the regional benchmarking, the employee transfer dismissals, and the fixed term contracts, when these are removed from a benchmark perspective this looks reasonably on target. FP asked SM whether the region takes out the employee transfer dismissals. SM informed he did not know neither did KP. This will be looked into further. DR enquired about turnover to query something within the paper on page 28. Two points in May did not appear correct. In terms of turnover for a rolling 12 months, in estates in ancillary, over the last year turnover has been 18 - 19% then it has dropped to 4.59% this year. SM stated this seems to be an error. Scientific and professional was 10 - 11% last year then has risen to 14.6% within the last 12 months. SM confirmed this will be investigated to determine whether it is accurate or an error in the data. TF discussed the PALS and customer satisfaction score, and this has been investigated and it relates to a fairly low number. JB had been doing work with PB to ensure we can get the number of people completing the valuation up. Part of the issue is staff that have been asked to do PILLS are also doing the adult and immediate life support training and staff are feeling aggrieved about the fact they are having to do both courses. Overall, we have really good positive outcomes, only one course scoring at red. SM is confident the process in terms of courses is working correctly and we are getting positive feedback. There may be a way of changing the requirement for staff to do both courses and this can be investigated. FP asked when we recruit people if we ask them what attracted them to the Trust. We can then start to understand which things are helping recruit. This information would be useful to obtain then we can start to tailor the recruitment package for different groups of people. DR stated this could be included in a general discussion within an induction asking what brought the individual to Humber. FP asked whether section 3 of the BAME data is benchmarked. SM asked FP what he meant by benchmarking. SM stated we compare ourselves to the figures from East Riding, North Yorkshire and Humber population. We look at this through leadership roles and different gradings and this will come when we bring the RES data which will be done for ethnicity and disability. We do not necessarily compare ourselves to other organisations. FP stated he meant in terms of other organisations and ensuring the benchmarking is compared in similar areas with similar types of workforces so we can understand how we benchmark against a proper comparator. FP stated North Yorkshire is not a proper comparator to us. SM stated Humber is, if we look into ethnicity so non white are at a highest 5.1% and we know in our organisation this is 5.4% we can state percentage wise there are more employees from a non-white background in comparison to the population we serve. There was a conversation last Wednesday regarding ensuring leadership is reflected within more senior roles rather than roles which are lower down within the organisation. This is to ensure we are representative and ensuring there is appropriate leadership across all the organisation, to ensure we capture the views from staff and the experiences they will bring. We ensure that we are not blocking career progression. FP queried the length of time in regard to staff suspensions. Fully understanding of the pressures of COVID and other factors. However, if staff are suspended for 146 days that is a long time to be

	sat with pressure on them and understand what is occurring. We need a way to speed things up as it is not good to leave someone sat waiting 3 – 4 months for a decision to be made. SM agreed with this, stating it is important to have the data and understand the impact this has on the individual, their families, their colleagues. Bring this to a conclusion, investigations can take a while, particularly within the public sector. The data is stating that all the stages including the admin, decision making, setting up of the hearing if needed and availability are causing delays. Therefore, we need to cover this as prioritization. KP agreed with the fact that diaries would be an issue, it is hard to find gaps in diaries. SM stated we need to reprioritise our diaries sometimes especially in terms of investigations as they are priority and will be having a huge impact on a member of staff. There is a cultural shift but there is support from colleagues and the exec team to move this forward within the upcoming months. LP stated to SM within the PDF pack on page 37 it is the old appraisal data. LP's appraisal data is at 18% which is not correct. LP has achieved 100% on her appraisals. SM stated the latest appraisal figure overall is 90% which is quite positive. There is still 240 outstanding but over 2000 have had their appraisal in the appropriate window. All the directorates are pretty far on with this. LP fedback on the latest quarterly accountability performance review, there is clearly challenges within the data. However, the divisions are clearly working on this data and understanding it in a way which they haven't previously. LP thanked the HR team, a lot of this is around the improvement within the data in recent years. However, it is very rare that if we as a question they have not understood their data and do not know where they are with it. Despite the challenges, LP feels comfortable that their understanding of it has improved significantly. SM agreed with this. In the last round of accountability reviews SM did 2 and KP did 2. There are real improvements within the data, some very positive shifts which were good to see. SM thanked LP for her support and leadership on this. It does feel like there is a real understanding about the importance of the workforce data, it adds to patient safety and patient and staff care. We are starting to deal with some of the difficult issues. SM thanked EC, as her support in these areas has been excellent. ***Assurance report – Really good insight report, lots of data and intelligence in there that is giving us a good understanding of the challenges in the organisation. There is a increased confidence within the data and we are looking at metrics that are measuring priority areas around workforce. We recognise that divisions and directorates within their accountability reviews are paying close attention to this data which is improving decision making around the workforce. We are growing the workforce as we are growing the establishment, some of that progress may be better were it not for inheriting services, where the vacancy rates remain high and then we must work to fill those. We investigated the impact of suspensions and restrictive practice on staff from protected characteristics to ensure that there was no disproportionate effect.******
40/22	**Risk Registers and BAF** KP fedback on this section. There are currently 15 risks rated 9 or above. There are 3 risks rated 15 with regards to recruitment and retention of nurses and the recruitment of GPs. There are key actions in place and this is under these particular areas which are under scrutiny of the recruitment task and finish group. Whilst we are not seeing these risks start to reduce, we are seeing enhanced scrutiny and it is worth noting that we are stating to do deep dives into this as part of an ODG initiative to start to take and then look at wider actions enabling us to move forward. The job planning risk is currently sitting at 12. Regarding this there is now a system in place we are already starting to see compliance with job planning really starting to improve. There is confidence we will see this risk lessen particularly by the next we have this next committee meeting. ***Assurance Report – We have looked into the assurance report. There are 3 risks which are over 15 which remain.***
41/22	**Guardian of Safe Working Hours Quarterly Report** Nothing to discuss at present. No one fedback on this section.

42/22	**Leavers Deep Dive Report 2021/22** SO fedback on this section. The purpose of this paper is to analyse the turnover data and the leaving reasons at the Trust over the 12-month period from the 1st April 2021 to the 31st March 2022. The board has set a 10% for the Trust turnover and the data in the paper is currently sitting 4.96% above the 10% target. Since the last deep dive in April 2021 the rate has been steadily increasing with a total of 4.43% from the previous year. The figure last year sat only marginally above that 10% so it has increased a fair bit since then. We have got the figure for the turnover with the TUPE dismissal and fixed term contracts removed, which does reduce the turnover rate to over 12.49% meaning 82 of the 489 leavers left for one of those reasons listed either TUPE dismissal or end of fixed term contract. Looking at the national benchmarking data and the data we obtained from NHS improvement covers the period January 2021 to December 2021. This is a slightly different time period in comparison to our data. However, it is still relevant, and the more recent data was not published at the time the report was written. The national turnover rate is 10.7% for that period. The Humber rate is above that. We looked at the national nursing turnover rate and the national mental health clinical staff turnover rate, both which have been reducing over the last few years. The nursing turnover rate currently sits at 10.1% and the national mental health turnover rate is 13.1%. Again, Humber is above this figure. More locally we looked at the local peers within the ICS and their turnover rate was 12.4%. Investigating further into how much service leavers had, so most staff who left within this 12-month period had between 3 and 5 years' service and then that was closely followed by staff who had less than one years' service. In reference to the nursing staff group, most nurses left within 3 – 5 years of service which was closely followed by those with 10 – 20 years' service. Looking at reasons for leaving, the highest reason within the 12 month period was due to retirement, there has been some changes to the pension this year which may have impacted that. The second reason for leaving was work life balance followed by promotion. Staff leaving due to work life balance was more prevalent in this report than the previous year and particularly when looking at that nursing group. Looking at the reasons for leaving years service, staff that left on under 1 years service, retirement wasn't in the top three reasons for leaving. Despite the highest number of leavers being due to retirement it was not in the top three reason for this staff group. Staff with 1 – 2 years service, retirement was the second top reason for leavers and staff with 3 – 5 years of service it was also the second top reason for leavers. Slightly less than ¼ of the total leavers are nurses so 110 of the 489 leavers were nurses and that is a 3% reduction from March 2021. Less nurses left us this year in comparison to last year. The highest number of nurses leaving remains within community and primary care and this has increased from last year. That is closely followed by children's and LD. 12 of the 489 leavers were from the GPs and consultants' group, so 2.5% of leavers were from this group. 8 of the 12 leavers were within community and primary care. We have had disruption to the responses on the exit questionnaires due to changing systems, we have changed from SurveyMonkey, to MST Forms and now to ESR. Therefore, have seen a gap in responses. There are now measures within ESR to catch the appropriate data. FP stated there is really good data, analysis and understanding what the causes are for leavers. However we need to know what we are going to do about this, are we going to benchmark or discuss with other organisations who are really good at this and ask what they do differently to help us improve and keep staff. The issue regarding aging is going to be a continuing issue that we are going to have to try and manage. It needs adding to the end of both deep dive reports about what are our next steps. In the report there is a section on our benefits and progression however appreciate we need more information on this. SM stated we need to be aware that in both deep dives there is no silver bullet, there is nothing we can do which will automatically change all of this. In terms of the sickness deep dive, if we recruit more staff this takes pressure off staff covering current vacancies which would hopefully result in improving sickness absence. Likewise, if staff know they are coming into shifts which are fully staffed with contracted staff, this will impact positively on turnover rate. FP asked how we can increase the percentage around exit interviews as 8% is fairly low. SM stated he has requested that we should try and get an improved uptake. There have been some system reasons as to why this has not worked as well. It is important we give the person the opportunity to complete the questionnaire whilst they are

	working their notice to ensure they are still part of the organisation and also feel like they are. KP fedback that now we have moved to ESR, the reminders within the system are automated. Therefore, if people are reminded, they are more likely to complete the questionnaire. The business partners are pushing to ensure that line managers are proactively having those conversations with their employees within those last few days of work and feeding the information back to us. We need to determine how to capture that information in terms of trends effectively but there is an expectation to see the figure on ESR improve. DR suggested we could have a six-question questionnaire and send this to staff members when they are working their notice, as they may prefer this to an in-person conversation. This may also gain some regional funding as it would be an innovation to be doing something different. SM stated it will always be limited for the way we do it at present as we are reliant on managers informing us of their employee leaving and giving their notice as without this, we cannot provide them a questionnaire to fill in. FP stated when the reasons for leaving are investigated there are some areas we potentially could impact on and others we couldn't. We could potentially encourage someone to delay their retirement age. But in comparison with work life balance or promotion opportunities this is potentially something to do with lack of action which in turn we could do more on. TF asked SO to clarify on the data around the highest reason for people leaving was due to retirement, however the largest number of staff leaving was with a length of service between 3 – 5 years. This does significantly make us think about a different set of actions which is needed for those coming up to retirement and incentivising them to stay. SO stated this is an anomaly and is somewhat captured within the report. However more information is needed on this to determine whether people are joining then leaving after a few years and retiring. SM stated when we inherited the community contract, we inherited a lot of older members of staff which will result in their service with us only being for a few years but actually their overall NHS service would be significant, meaning they have not joined us purposely just before retiring they have been nearing the end of their NHS contract. We did a deeper dive around this, and the numbers were quite high.
43/22	**Sickness Deep Dive Report 2021/22** EC fedback on this section, this is the 2nd year we have produced this report. Sickness rate for the Trust was 5.51% last year, 1% higher than the previous year. In excess of the Trust target of maintaining absence below 5%. Like in the previous year, anxiety, stress and depression accounted for 35.7% of all days lost and that was seen across every division in directorate and almost every professional group. In addition, occupational health data showed that half of the referrals were related to mental health concerns and over half of those were reported as work related mental health concerns. In reference to COVID related absence, this increased in 2021/2022 in comparison to 2020. 90% of our Trust COVID absence was in our operational divisions. Our sickness absence was broadly in line with our peers. It was slightly higher in terms of absence compared to Humber Coast and Vale providers and was slightly lower in comparison to mental health trusts nationally. We have a range of resources available to staff in relation to staff health and wellbeing. We have recently introduced our new absence management policy tool kit which is embedded into the health and wellbeing group also. FP stated this is great data and detailed breakdown of everything which is excellent. FP enquired about the 35% of anxiety stress and depression and asked whether we can break this down further to determine whether or not this is work pressures or home pressures to allow us to get another grasp on it. EC stated 57% of those mental health concerns were classed as being work related, it does not breakdown specifically on the type of the mental health concern, but it does break down when it relates to alcohol and/or substance missus. This is determined by the level the referral code is taken down to. FP stated it is important to gain this data so we can target the areas where we need to support and help and this would be a discussion to be had with occupational health about whether they can break this down. FP asked EC if section 10 of the report could be built on so we can determine what we are doing in terms of helping the staff. DR stated the percentage in terms of COVID absence will relate to people who have just tested positive and therefore have to isolate, they may not necessarily be ill with symptoms. EC confirmed this as correct, this likely accounts for why it is disproportionate across corporate and operational as there is an opportunity to work from home if you have a positive test.

	Assurance report – There is good data coming in from the deep dive report in relation to sickness absence that is helping us understand in increasing detail about the issues around the organisation. We have had a look at the COVID related absence on that. Generally speaking, acute organisations have less sickness absence than mental health trusts. When we investigate the benchmarking, it is noted we are benchmarking equally in comparison to other similar trusts and organisations.
44/22	**Trust Workforce Plan 2022/23** EC fedback on this section. This is the third year we have had workforce planning in this format. Produced in collaboration with leaders across the trust, as well as professional leads and finance and strategy partners. We have made refinements year on year, but we have definitely seen improvements in the engagement and collaboration with the plan, which has been positive in the last couple of years. The projection for 2022/2023 is growth of establishment by 206.26 FTE the full detail of this is within the report but this relates to plan changes which have been identified as a funding source and in addition to this leaders are also identified as 53.9 FTE of growth, currently without any identified funding. In the report children's, LD division and finance is particularly impacted by this. The children's is related to the 0-19 TUPE and finance and some investment in digital roles. In terms of professions, the growth is mainly impacted on nursing, admin and estates and support to nursing professional groups. Our position overall is planned growth for this year and we are also starting with an overall increased vacancy rate for the Trust. This does mean significant recruitment is needed this year to meet that demand. There is a forecasting section in the report which relies on a lot of different assumptions such as 10% turnover rate and TUPE transfers being in line with their plans. Taking all this into account what we have forecasted is to achieve an 8% vacancy rate by the end of March 2023 we would need to hire an additional 565 members of staff. So far, this information has been triangulated with the finance returns and the service plans and it has been brought into our hard to recruit plans and targets as well particularly for the nursing, consultants and the GPs. The next steps for this plan will be the continued monitoring at a divisional level as part of the workforce planning cycle. SM fedback that EC has done a fantastic job on this, and it is working really well now we have a co-ordinated plan together with OPs and finance. All of our data sources are the same, PB signed this off, it matches the finance plan. This is what we have submitted to the center and into the ICS for our requirements. We do not include the unfunded within the numbers of the data however it would be useful to have it as part of the plan because if we look at the numbers from last year, they invariably go up because the unfunded becomes funded part way through the year. If we do not included the unfunded it looks like we did not know it was coming and this not does do credit to the OPs team because they do know what is coming even thought it might not be funded which is why we need to include this information, to show thoroughness and show they have a handle on the work. FP stated in the 'matters of concern' section on the front page, we should probably put in there if we wanted to reach an 8% target that it is over 500 at the moment but it looks like we have 206 but we need to try fill some of those vacancies which raises it to 500 which is a fairly key issue for the Trust to face. The retirement profile is a big risk, 649 employees either at retirement age or will reach it in the not too distance future. 18% of the workforce could be finished within the next 12 months or not far off. Some of this data would not impact until March 2027 which is a long way off. FP asked EC what percentage of employees are over 60 currently. SM stated at present the figure is 277 for employees over 60. FP asked LP if we have looked into different ways of recruitment instead of being consultant based. LP agreed and stated over the last two – three years the pressure has been on to look at alternative roles particularly those in the hard to recruit categories. Pharmacy technicians are frequently discussed and this has had great success and has been reported through the quality committee. We now have a cohort of 11 approved clinicians coming through there training which is quite arduous training for them to gain an approved clinician status. Due to timing this has not been included within this plan but it will be for next year. There are workshops coming up within the next few weeks to look at what this means for re-skill mixing the psychiatry medical workforce because those roles should really prompt us with that position. There has to be some recognition that as it stands at the minute our inpatient areas are constrained in their skill mixing. There is work on this area and LP has had various conversations with TF and HG. The safer staffing

	prescribed approach at the minute is unfortunately sticking to the traditional models of skill mix around registered nursing and healthcare assistance. There is a want to look further into inclusion of AHP's of psychology and psychology assistance within our inpatient areas. But now we cannot count those as there is work in place and more work for us to do around this. LP stated she is pleased and the division review around this process is better than it ever has been but the grim reality is there is still further work to be done in order to face those challenges of the hard to recruit, to work for us going forward. But incorporated discussions and challenges have been made around these assumptions in this report. It is satisfactory where it is at the minute. FP asked SM is PB giving a vacancy factor to reduce this. SM stated overall in the budgets the vacancy factors are included within this. There is nothing within the operational team, but 5% within the corporate areas. In the inpatient areas this is not apparent but in the community services there is a budget when we do not replace staff immediately with bank or agency. SM stated we did bring the average age of the organisation down, this is where working to apprenticeships is really important. Apprenticeships are all at different levels, but they do tend to be filled by younger staff. It is important for us to bring those people in as it changes the age profile of us as an organisation and gets people to stay with us. This is such an important thing in terms of the long-term health of the organisation. ***Assurance report – This workforce plan has improved year on year. There is a real sophistication about the detail within this report which will be helpful to business partners working with OPS team about what it is we are trying to achieve in the year. To bring the vacancy factor down we will need considerable additional recruitment. The average age of the workforce is coming down, but there are risks around this with people reaching retirement age and recognition on the back of COVID that we have latent demand for leavers as people feel they have come to the end of shift, been loyal and supported during times of crisis in COVID and now is an appropriate time to end their employment.***
45/22	**Gender Pay Gap Report 2021/22** KP fedback on this section, this is the 5th report. The Trust has a gender pay gap of 11.4% which is an improvement of 1.51% on the previous year. Our percentage is significantly lower than the national average gender pay gap of 15.4%. The workforce demographic is in line with the national NHS figures, 78.7% is female and 21.3% is male. Women occupy 74.84% of the highest paid jobs and 81.08% of the lowest paid jobs. Our median bonus gender pay gap is 50%. As we have evolved and there is a testament within the EDR reports, we have successfully reported a lot on these areas. The quality of our report and our actions which now follow have really improved and I think we are demonstrating that we have got a real good grip on our data and actions which we need to take to move things forward. There is work underway for development of a talent management succession planning process to provide a balance with promotion and succession planning and development opportunities. We have career coaching and mentoring for staff and we are putting rigor negotiations of starting salaries for medical staffing posts. Within the report there is a mention about the implementation of the new clinical excellence award policy, currently we are going through a period of transition with this now. The PROUD programme we have is encouraging our leaders to use their appraisals to look at career development. There is a lot going on within the organisation to address certain gaps. FP asked for clarify on one of the tables within the report 'gender average pay, median pay'. FP asked whether the figure £7290 was bonus pay. KP confirmed this was correct. DR confirmed in section 5.3 of the report the pay gap is generally driven by low paid women within the organisation. In quartile one, 1 in 4 men are in the lowest quartile meaning there is 4 women for every 1 man within this quartile. In comparison, in the upper quartile, we have 3 women for every 1 man. We need to look at how we can make changes in terms of bonuses and accelerating women into senior leadership positions which is right to do. SM fedback that staff side would like us to do is offer staff which TUPE transfer in non-agenda for change on non-agenda for change contracts, so this is in relation to receptionist staff within primary care which are minimum wage type roles. Staff side have asked previously if we would consider offering the equivalent agenda for change or if people could remain on their existing terms and conditions, but this is not something we have supported as a Trust currently. There is a discussion to be had to decide

	whether this is impacting disproportionately upon female staff as a result of what we have done is include this on our workplan on EMT to consider this again in February with a view to maybe an offer going forward within the next financial year. There is an opportunity here, but we need to look as this as it is expected to disproportionately affect female staff given several them work in receptionist type roles. DR stated even though this report appears negative, there is no other organisation where 3 out of 4 of the highest earners are women. ***Assurance Report – Additional action will be to take this report to board in February to see whether or not anything can be done financially within the next financial year. DR stated even though this report appears negative, there is no other organisation where 3 out of 4 of the highest earners are women.***
46/22	**AHP National Strategy** Deferred to the next meeting. No one to feedback.
47/22	**Medical Job Planning Audit Report** KP fedback on this section. This concludes a significant assurance that appropriate safeguarding's are in place and are in control for the management of console and job planning. Scheduled findings made 5 recommendations, 2 were moderate and 3 were minor. There is only 1 outstanding action which we need to move forward with and this is completing all the job plans by 30th November. We are well on track with all the actions in there. ***Assurance Report - There is only 1 outstanding action which we need to move forward with and this is completing all the job plans by 30th November. We are well on track with all the actions in there.****
48/22	**Trust Equality & Diversity Report 2021/22** KP fedback on this section. This is the first time we have sent this out for design so aesthetically it looks great. It is a look back on 2021/2022. This includes a look back on all reports such as the gender pay gap, the RES and the DES. The report demonstrates a real collaboration between the workforce and the patient care agenda. This report goes to the EDI working group, as do the others but this provides a good opportunity to summarise and round up everything we are doing. DR asked if it had been to quality committee yet, it was confirmed not at present but in due course the report will go to that meeting. FP asked KP a question on the report on page 151 'milestones impacted by the COVID19 pandemic'' and whether or not if the milestones were hit. KP stated we have done these, and this is reflected within the deep dives but this is not stated as well as it should be within this report. SM agreed stating this could be worded better as it appears there are actions not complete due to COVID19 which is not the case. DR asked KP if this report had been through the LGBT and BAME network and whether they have contributed to it. KP stated they have not seen the complete design yet, but they have seen previous iterations and contributed and commented. SM stated there may be one or two amendments added to the report prior to it going to board and they will be additional things which have been done over the past 12 months but not yet added to the board. SM asked DR and FP if when the report goes to board, they can state it has been to this committee and was reviewed. DR asked if the report is going to the next board meeting. SM confirmed the plan is for it to go to the July meeting. All attendees discussed the potential of the report going to quality committee first to see if further amendments are needed. LP agreed with this discussion as it would be more robust if it went to quality committee prior to board. DR stated it may be beneficial to take this report to discussion within a public board, state it has been looked at within this committee to see whether this would lend itself a good discussion. SM stated this would be beneficial, but the September meeting would be better as the networks have not yet seen the final version of this. This would also allow quality committee to discuss it, LP to pick up operational items on the report and provide networks and others a view of it prior to board. HG

	stated there is an additional quality committee in September so if the report goes to this meeting it will allow LP the opportunity to review and add any additional items to the report. ***Assurance Report – We reviewed the equality and diversity report. We looked at this from a workforce perspective and a layout in terms of assurance. We note that it has been discussed and contributed to by our networks BAME and LGBT because of the interplay with quality. This report will go to quality committee in August prior to board. It is suggested this becomes one of those escalated board level discussions.***
49/22	**Hard to Fill Recruitment Task and Finish Group** SM fedback on this section. Most of this item has been covered, there is a lot of repetition. SM asked whether we can drop this from the agenda for this meeting as this is forming part of the insight report. The main table of this item has been removed and added within the insight report. DR and FP confirmed there were no questions for this item and they were happy for this to be removed from the agenda and moved to insight. ***Assurance Report – The hard to fill recruitment task and finish group appropriate detail of this will now be included within the insight report and will now be added as part of regular updates which we will now receive on the workforce plan. This item is to be removed from the agenda****
50/22	**Safer Staffing Report** TF fedback on this section. This is the 6th month report, it has been to EMT and is hopefully going to board in July. The headlines of the report are that the majority of the units are maintaining good and safe fill requirements. HG and the medical director must make a statement around assurance around safer staffing. This paper provides the assurance in more detail at a unit level. The performance has improved since the last period. We now have 2 more boards reporting good assurance, only 2 reporting adequate, 0 reporting low. This is despite a very tricky period at the end of last year and the beginning of this year in terms of COVID. Sickness is an issue, and the most recent safer staffing dashboard continues to demonstrate some concerns around sickness. HG has asked the clinical leads if they can have a look in more detail at the sickness within inpatient units in light of the most recent safer staffing dashboard. There is a bit of a paradox that potentially the Humber Centre is suggesting that a year ago the same reporting period for May 2021, there were more controls mandated nationally and that has meant that the transmission among staff and the general wider population had been controlled better. Nationally mandated restrictions around COVID have been lifted we have seen an increase in transmission as people have returned to behaving pre-pandemically. In most areas the vacancy position has improved which is largely down to international recruitment. 20 international recruits were allocated, almost all of them to within an inpatient environment so this has significantly improved especially in places like Malton as there were significant issues previously around vacancies. In terms of our care outpatient day data, we remain above the national and regionally average which is really positive and this is one of our strongest sources of assurance. In the reporting period from 2019 when we first started looking at the national care outpatient day data there has been an incremental rise nationally and regionally. This leaves us in a position where we set our originally targets around care outpatient day, they are based on the 2019 model hospital national average, and we had a discussion in EMT a couple of weeks ago to think about whether or not we now need to think about increasing our target to reflect that rise nationally and regionally. The organisational level averages are a very crude measure really given the diversity of services within any of our organisations and we are no different we have a wide variety of different services, some of which have significantly higher levels of care outpatient day. The model hospital has been rebooted as a new system. They have started publishing fresh data from the back of last year and we can look at some of our units at unit level to see how we compare. For forensic services, they do not provide the detail we need for it to be meaningful for some of our individual units. The different between Ouse and Swale, they would both be classed as forensic units but they are very different in the way they operate and the patient cohorts they work with. We have been thinking about how we manage that and benchmarking around our care, our preparation day and how we reflect this in the safer staffing

	dashboard and recognise that we may need to refresh our target, and this might have an impact on some compliance and the months following. This does encourage us to continue to stretch and look at how we improve further where we are with our staffing levels. HG stated as we bring the new data into this we may receive more ambers and reds so just to be mindful of this. HG stated that she had information back from the inpatient units about sickness as this was flagged at board previously. It has been confirmed it is COVID which is driving the sickness, there have been massive amounts of staff off with COVID. There were 16 staff members of sick previously, 14 of which were COVID related. HG and LP are keeping a close eye on sickness rates and if they raise to a certain point mask wearing will be reintroduced. Most of our inpatient units have COVID on the units so all these staff are wearing masks anyway, there is only a few units which have managed to keep COVID free. HG stated there is an error within the report, there is 3 units with adequate assurance, Mill View Lodge is adequate, and this has been rectified ready to go to board. ***Assurance Report – We regularly receive this report, we have got some rising concerns around COVID absence. The majority of our areas have seen a fall in vacancies. In terms of positive assurance, the number of ambers are reducing.***
51/22	**To Review the Meeting and Assurance Report** Completed as appropriate.
52/22	**Any Other Business** LP stated Surge in COVID. This has triggered a rise in absence at a level. This will also be affected in terms of summer annual leave in July and August. This will have an impact on our overall service delivery. The director of operations and chief nursing officer are keeping this under close review and working with IPC to determine the appropriate cause of action. **** Assurance Report - LP stated Surge in COVID. This has triggered a rise in absence at a level. This will also be affected in terms of summer annual leave in July and August. This will have an impact on our overall service delivery. The director of operations and chief nursing officer are keeping this under close review and working with IPC to determine the appropriate cause of action****
53/22	**Date and Time of Meetings in 2022: 12th October 2022**

Humber Teaching NHS Foundation Trust

Agenda Item 23

Title & Date of Meeting:	Trust Board Public Meeting – 26 October 2022
Title of Report:	Quality Committee Assurance Report – August 2022
Author/s:	Dr Phillip Earnshaw, Non-Executive Director, and Chair of Quality Committee
Recommendation:	

To approve		To receive & discuss	
For information/To note	X	To ratify	

Purpose of Paper: *Please make any decisions required of Board clear in this section:*	The Quality Committee is one of the sub committees of the Trust Board This paper provides a summary of discussions held at the Annual Report meeting on 29th September 2022 with a summary of key issues for the Board to note. The approved minutes of the meeting held on 3 August 2022 are presented for information.

Key Issues within the report:

Matters of Concern or Key Risks to Escalate: • The NICE guidance report noted the Risk Register entry around gaps in compliance in NICE guidance with the concern around low levels of baseline assessments completed.	**Key Actions Commissioned/Work Underway:** • The risk register entry for NICE guidance was circulated as requested from the Annual NICE guidance report discussion for members information and updates will be reported back • LP and KF will look at the variances in NICE guidance work and report back
Positive Assurances to Provide: • Assurance was received in all of the annual reports discussed	**Decisions Made:** The Quality Committee approved the following: - • The Annual Infection Prevention Control Report (for presentation to Board) as part of the required reporting • The Annual Clinical Audit Report • The Annual Patient Safety Report • The Annual NICE Guidance Report

Governance: *Please indicate which committee or group this paper has previously been presented to:*		Date		Date
	Audit Committee		Remuneration & Nominations Committee	
	Quality Committee		Workforce & Organisational Development Committee	
	Finance & Investment Committee		Executive Management Team	
	Mental Health Legislation Committee		Operational Delivery Group	
	Charitable Funds Committee		Collaborative Committee	
			Other (please detail) Report produced for the Trust Board	

Monitoring and assurance framework summary:

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

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

Executive Summary - Assurance Report:
Key Issues The key areas of note arising from the Annual Report Quality Committee meeting held 29th September are as follows: PE chaired his first meeting and thanked MS for his work as interim chair.

There were no declarations of interest at the meeting.

The minutes of the meeting held on 3rd August 2022 were agreed as a true record and the action log approved with updates for all actions. The Quality Committee Assurance report was noted, and the updated work plan noted and agreed with a minor amendment.

Annual Clinical Audit Report 2021/22
The report was noted as read with key highlights presented showing the achievements of clinical audit over the past year. It was agreed it was an interesting report showing the improvement journey of clinical audit over the past few years noting the enthusiasm of the team supporting clinical networks in regard to clinical audit, with the breadth and depth of audit embedding into the way clinical teams are working found to be impressive. The team and author were thanked for the report.

The report was approved by the Quality Committee

Annual Infection Prevention Control Report 2021/22
It was noted the report was presented in line with reporting requirements for infection Prevention Control (IPC) and the new Board Assurance Framework along with the ongoing requirements from the Health and Social Care Act and outlined the progress on the key performance indicators (KPIs) and the existing IPC strategy, cataloguing the breadth of work the relatively small IPC team have been involved with over the past year and acknowledging the incredible contribution the team has made to complete this work despite the ongoing challenges of the pandemic. Thanks were passed on to the team to let them know the appreciation of all the work they have completed for the Trust, and recognition of their central role in the midst of a global pandemic.

The report was approved by the Quality Committee for submission to Trust Board.

Annual NICE Guidance Report 2021/22
The report was presented with TF explaining the importance of reflection on the current journey of NICE Guidance, with the potential disruption of Covid-19 confirming traction was retained and reporting improved to give network oversight of their position of NICE guidance. The next steps were outlined to address those gaps in guidance along with the initiatives in place to move networks towards fully implementing guidance. It was noted NICE guidance has been placed on the risk register to ensure oversight and maintain a level of scrutiny of the improvement work around the risks of having gaps in NICE guidance, noting the concern was around the low levels of baseline assessments. A discussion was held regarding the risk register entry and the path of escalation up to Quality Committee where required.

The report was approved by the Quality Committee.

Annual Patient Safety Report 2021/22
The report was noted as read with the key areas highlighted to the committee including the safety huddles, the progress on all the six patient safety priorities, the top five patient safety incidents and the improved reporting of near misses. NHS England have now published the new Patient Safety Incident Review Framework (PSIRF) which will fundamentally change how Patient Safety incidents are responded to in the NHS and Trusts have 12 -18 months to implement. A discussion was held, and it was agreed that some minor amendments should be made, to make culture more explicit than implicit within the report.

The report was approved by the Quality Committee with the minor amendments suggested at the meeting.

Annual Psychology Report 2022

The report shows the increase in psychology staff within the Trust along with the new roles embraced by the Trust over the last year of Clinical Associate Psychologist (CAP) and MDT Approved Clinician (AC), with four in each role currently training within the Trust. It was noted there has also been an increase in places on the doctorate course for clinical psychologists with 26 commissioned places this year, starting in October. A few suggestions were given on the layout of the report for next year including reviewing elements in other annual reports from professional groups acknowledging the difficulty in capturing the work completed. It was great to receive the report. Next year we will look for it to follow more of a standard annual report format and for there to be more emphasis on impact and looking outside of the team.

Fascinating to see how embedded they are in multiple facets of the trust's work. We would like to understand how this input makes a difference. It was agreed there was some fantastic work highlighting the breadth of work the team is involved in.

Thanks, and appreciate were passed to the team for their great work and the initial report was received and noted by the committee.

Any other business
FP noted this would be his last Quality Committee as his responsibility had been moved to another committee and the chair thanked him for his commitment in attending the past meetings, and DM was thanked for his contribution as interim Medical Director now he is returning to his previous role.

It was noted the date of the next committee meeting was to be rearranged due to previous commitments for the chair and a new date would be sent out to members once organised.

The approved minutes of the last meeting as attached as appendix A

- for primary care functions it seems to work best if someone distils the key point of guidance as bureaucratic process doesn't work well in small practices.

Appendix A

Humber Teaching NHS Foundation Trust

Quality Committee
Minutes

For a meeting held on Wednesday 3rd August 2022
9.30 – 12.30 (Virtual meeting via MS Teams)

Present		
Core Members		
Mike Smith	Non-Executive Director (interim Chair)	MS
Dean Royles	Non-Executive Director	DR
Francis Patton	Non-Executive Director	FP
Hilary Gledhill	Director of Nursing, Allied Health & Social Care Professionals	HG
Dr Michael	Medical Director (Interim)	DrM
Lynn Parkinson	Chief Operating Officer	LP
Kwame Fofie	Clinical Director and Deputy Medical Director	KF
Tracy Flanagan	Deputy Director of Nursing, Allied Health & Social Care Professionals	TF
Colette Conway	Assistant Director of Nursing, Patient Safety and Compliance	CC
Sam Jaques-Newton	Head of Allied Professionals and Practice Development	SJN
Su Hutchcroft	Compliance Officer (minute taker)	SH
In attendance		
Mandy Dawley	Assistant Director of Patient and Carer Experience and Engagement	MD
Sadie Milner	Quality Standards Practice Development Nurse	SM
Cathryn Hunter	Quality Improvement Manager	CH
Michele Moran	Chief Executive	MM
Observing		
Frances Healey	Leeds and York Partnership	FH
Dr Phillip Earnshaw	Non-Executive Director (Shadowing Chair)	PE

45/22	**Apologies for Absence** It was noted there were no apologies received for today's meeting. MS welcomed Philip Earnshaw, who was attending his first meeting, having joined the Trust in July 2022 as a Non-Executive Director (NED) and will be taking over as chair of the Quality Committee from the next meeting. Frances Healey was welcomed to the meeting, being invited to observe in her role as Non-Executive Director of the Leeds and York Partnership. Dr Michael was welcomed, attending as interim Medical Director, covering the role until the newly appointed Medical Director takes up the post. Full introductions were completed during the meeting.
46/22	**Minutes of the Last Meeting (November 2021)** The minutes of the meeting held on 4th May 2022 were accepted as a true and accurate record.

47/22	**Action List and Matters Arising** The action log was noted with all items closed. MS congratulated everyone on closing all actions and noted with the committee meeting quarterly this allows time to complete meeting actions.
48/22	**Quality Committee Board Assurance Report (November 2021)** The Assurance Report, which was presented to the February 2022 Trust Board, was noted as read. MS explained this report was completed for the Board meeting following each committee and gets included in the following quality committee papers for members who have not seen the information, to clarify what has been sent to the Board.
49/22	**Work Plan (May-22)** The work plan was noted and agreed. Amendments were noted regarding the CMHT transformation evaluation report being deferred to the November Quality Committee.
50/22	**Presentation –Suicide Strategy** Dr M introduced the presentation, noting credit to TF, KF and Paul Johnson for their contributions to the strategy and explained as per the previous Board paper, this is an organisational strategy developed in line with the National Confidential Enquiry into Suicide and Safety in Mental Health (NCISH) toolkit report which created the 10-way approach to safer care. The strategy has been aligned to this approach looking at how this is reflected in our organisation's work. It was noted work on actions has already begun, prior to the strategy being approved. Dr M handed over to TF for the presentation. TF went through the presentation slides, noting the strategic plan has been refreshed and in action for a few months. The drivers of the refreshed plan were noted, including the national strategy is due to be refreshed later this year. Involvement in a review of risk management led by NHS England has given insight into what will likely be included in this refresh, and this will be linked in when published. The NCISH toolkit was explained with the 10 ways to improve safety, and details on our five priorities which include 1. Family involvement 2. Develop guidelines for both depression and self-harm 3. Personalised Risk Management 4. Focus on reducing drug and alcohol use 5. Lower staff turnover TF explained consultation on the draft strategy has been undertaken and includes clinical leads, matrons and general managers, networks and professional forums. It has been presented to the Adult Mental Health Service User Group and Trust Patient and Carer Group to ensure services users and carers have had the opportunity to comment and shape the strategy. Consultation then took place with the wider medical workforce and following approval, implementation plans will be co-produced and delivered for each priority. In reference to the forward in the strategy document, noting MD has done some excellent work with relatives, carers, and loved ones who have been bereaved by

	suicide, linking in with the work by Jo Kent at ICB level, to think about how we support individuals and wanted to reflect, both how we work with service users and carers, in terms of suicide prevention but also what we have learnt from incidents and the opportunity, which we are very grateful for, in hearing the experiences of those who have been bereaved, to ensure we meaningfully engage with what they are telling us. TF explained that MD, our Head of Patient and Carer Experience, following a very difficult suicide of someone in our services, gave us a lot of learning after the death. Her family throughout engaged with us in a very humbling manner, being truthful and forthright about their loss, grief and sadness but wanted to ensure, more than anything that we could learn as an organisation and would be open and honest about what we could have done differently and learn about and carry forward the thinking about the changes required in practice and how we engage with carers and service users in difficult times, especially around listening and giving the right level of emphasis around the concerns they bring to us. It was noted the family have attended the Board to speak about their experiences. It was noted the draft suicide and self-harm strategic plan was attached with papers. Comments were taken from the meeting: - • It was agreed a very comprehensive presentation, clear and articulate and easy to read • LP noted the strong connection between the plan and work undertaken in Hull and East Riding of Yorkshire Crisis Care Concordat, showing the overlap between plans. • Dr M noted the tremendous work that has been undertaken by TF and Paul Johnson and thanked them for their work • Regarding engagement with stakeholders, it was explained within the ICBs there is a suicide prevention work steam and will be working very closely with Jo Kent (ICB lead) and this will be shared to cascade to her stakeholders along with the Police, Fire Department and other agencies working with the ICB. It was noted the ICB will have to create a similar strategy in response to this and our strategic plan should sit nicely into the overarching document • Frances Healey thanked Humber (from her NHS England work) explaining before leaving her current role, there was a lot of work undertaken to shift national policy in relation to the ligature traffic light assessment, which was a story started through Humber in 2015. Humber were involved as fore runners for the national work though learning shared. • DR commented since the success will be in the general health agenda, and should we seek to explore this more? He noted the short terms strategy the development of depression secondary care pathways in years 2-3, which could be year 4-5 before implementation and wondered is this something that could be brought forward, not as a proposal but being ambitious about making a difference. TF confirmed this was a valid point and explained as part of the understanding of the baseline assessment, there are more structural service pathway elements missing, either as an organisation or system, and some of the transformation work has started this but will needs more conversation around gaps with the ICB discussing what will be commissioned. • MM thanked everyone noting it was good to really see the evolution of it. Commenting that this is an organisational strategy but the majority of people who lose lives to suicide are not necessarily known to the organisation. This is being written as an organisation which spans a wide variety of services including primary care and community and enquired how we are bringing in the preventative work in

	GPs and health trainers etc and felt this could be brought out more in the document. It was noted it felt a bit nurse led and we need to remember that we have a wide staff base rather than just nursing. MM requested that the close culture work across the organisation is linked in and thanked DrM, TF and the rest of the team for the great work. It was great to see the engagement allowing staff to own the document. • FP echoed the comments of MM, being easy to read and grounded, with great consultation. In terms of key concerns on the report front sheet, he felt they were more assurance and didn't feel there were any key concerns at all within the document. It was also noted Goal five should read optimising rather than maximising as this has been updated. • KF thanked everyone for their contributions noting the strategy is a dynamic living document and feedback to improve is well received. Regarding the observations of acute hospital, we have a good relationship, and have an on call 24/2 liaison team in A&E to ensure everyone with mental health problems or suicide is seen, along with the frequent attender's work. Our system working includes work with public health and the Humber Bridge Board working at the Humber Bridge to see what we could do to reduce suicide there and felt this may have not been reflected in the document. **Approval – the Quality Committee approved the strategy and presentation to go to Trust Board with the minor amendments discussed above.**
51/22	**Quality Insight Report** The report was noted with HG highlighting the following key areas: - • Gap analysis of the Ockenden Maternity Services, shows the six recommendations the Trust wants to take forward to strengthen our position (HG noted the full report is available on request) • Safeguarding investigation, gave an update on the recommendations confirming the majority of actions are closed with one item where audit outcomes are awaited. • CQC PMC, action plan update showing the progress made. LP/HG are overseeing the work around the staff within the practice, with divisional senior leads and corporate services supporting the actions • Incident reporting in Q1 has risen, but this shows an indication of good reporting with level of harm free care is still high at 93% over the quarter. It was noted two units which in the main created this increase have had some very high acuity • Quality Dashboard - Safeguarding adults' referrals have been noted as falling, this has also been a national picture. The safeguarding team are working with the risk team to ensure all referrals through datix are being reviewed and referred where appropriate. An update on this work will be brought to the next Quality Committee • Clinical supervision has been noted at its highest compliance showing staff are seeing the benefits of regular supervision. MS thanked HG for a comprehensive report. Comments from the meeting included: - • FP agreed a really comprehensive report and enquired regarding supervision, noting the good compliance, and asked if we were picking up on the points of emotional wellbeing and 'focusing on my development as a clinician'. TF confirmed we are still in the process of collating the feedback for the survey launched in clinical supervision week, and being cautious on sample size, may need a more

	detailed survey or work within teams. Once the analysis is competed this will highlight any areas that may need to be explored in further detail. This can then feed through into the work of the Professional Nurse Advocates. This will also inform what needs to be emphasized and what strategies are required in terms of improving quality and help shape the next steps. It was felt a good response to first survey, and this will be repeated to test seeing if making difference. FP felt it was really positive • Serious incidents – FP noted mental health seemed to be behind the pace slightly in terms of overdue actions and asked what was being done regarding this. HG explained MH are on top of their actions in the main, but these have just tipped over into the next quarter causing some to be overdue. CC confirmed a lot of these actions were closed down yesterday with evidence received • Safeguarding referrals – KF explained he was aware that the figures from local authority during pandemic and in and out of lockdown etc and wondering whether referral levels are a drop off back to pre-pandemic levels. HG noted we had higher levels pre-covid, but this was a very good point and will get team to look at this MS noted a really good report and requested the information to be communicated in the assurance report to the Board. **ACTION** • **Safeguarding referral levels update report to be presented at next Quality Committee (HG) including safeguarding team to look at levels of adult referrals back to pre-pandemic levels**
52/22	**Allied Health Professionals (AHP) Annual Report presentation** The report was noted as read and SJN gave a presentation highlighting the key points in the annual report, which included: - • There are 230 Allied Health Professionals (AHPs) working in the Trust, in seven of the 14 professional groups, and include paramedics, drama, car (creative therapies), speech and language therapy, physiotherapy, occupational therapy and dieticians and cover a variety of specialist roles such as CAMHS, mental health, community and Learning Disability. • The pandemic has given more opportunities to connect and develop the service, making benchmarking the service easier and allowing benefit of advice and skills of those in other geographical areas. SJN links in with regional and national work, raising the profile of AHPs at Humber and the great work they do • Key achievements of 2021-22 which include three bids awarded, set up of an AHP twitter page which gained 154 followers, Leading on three outcome measures across the Trust, participated in national research studies and established three new AHP posts • National AHP day 14th October, holding an event to share good practice through case studies and discussion and planning a face-to-face event these year with themes or research, co-production, health inequalities, retention and future workforce as well as a green challenge about sustainability Comments taken from the group included: - • PE thanked SJN for the presentation, and enquired, being a GP by background, noted it talked about starting work in primary care staffing models and wondered if the Trust has taken advantage of this and could the Trust offer these services to primary care? SJN noted she had been looking at this with the Primary Care

	Clinical Lead and thinks there is an opportunity that could be grown and development for staff where we have stagnation of the Band 6's to give them opportunities. SJN is also looking at integration and discussing with divisions about using staff as a hub on a sessional basis. SJN noted she externally supervises some occupation therapists through the collage of Occupational Therapy and have been able to use links through this. • LP noted a great report and presentation and asked SJN if she felt she gets sufficient support from the senior leaders in division to achieve ambitions as discussed today. SJN confirmed she did, noting sometimes it has been a bit difficult but is getting easier after two years in post and has been included in work force plans for divisions, starting to work closely with them. LP confirmed she will discuss when they next meet on how to strengthen further in the future to optimise this work • MM thanked SJN for a great presentation showing the fantastic work and asked if there is anything extra, we could be doing as organisation and if so, what would it be? SJN noted the starting point was having some professional leadership under her as last year it was a struggle juggling the role and having responsibility and direction in these roles now will make a great difference • A number of positive messages were also received via the chat facility. MS thanked SJN for the presentation and would like to see this message spread further to both staff and the Board.
53/22	**Divisional Quality Improvement Plan (QIP) update** The paper was noted with LP giving an update on the changes in clinical leads for divisions: - • Children and LD Services – Trish Bailey has now left, and the role has been increased to 1.6 WTE, with a clinical lead for Children's Services who starts in post in September and Debbie Cahill has moved into the clinical lead for LD services • Richard Weldrick has been appointed clinical lead for Forensic Services replacing Patti Boden • Community and Primary Care Services – Kerry Brown and Iqbal Hussain job share the clinical lead post with KR covering community and IH covering primary care KF explained the paper gives a summary of quality improvement activities across the divisions with updates from the last paper presented in February 2022. The quality improvement activities are monitored in the clinical networks and ideas are generated there, and this paper is a summary of each of the QIPs which are presented to QPaS regularly and discussed for further assurance The main themes in the QIPs include: - • Developmental work 5-6 and 6-7 staff development, SI training • Service transformation, including transformation from programme activities to personal care, Single Point of Access, forensic team community transformation in forensic services and community transformation in Community and Primary Care, along with out of area Clinical out flow in Forensic services and language identification measures • New models of care, including electronic transfer of prescriptions, general health screening on our health inclusion vehicle and development of community palliative end of life projects and the trauma informed care (ARC) model • Clinical skills development in areas of autism and personality disorder, paediatric

	training for the urgent care centre • Service evaluation in terms of progress with using research, audit and dashboards as a way of making sure service development programmes are monitored and progress updated to QPaS • Using methodical review process for serious incidents, complaints, freedom to speak up and whistleblowing. • Waiting list management, which has been a challenge through covid, has themes now coming through on how the divisions are managing these areas. Comments were noted: - • HG noted the QIPs come to QPaS in the entirety and looking back from when they started there is now a breath to the QIPs which needs to be applauded. MS noted as part of well led review recommendation, he ,attended QPaS as the main reporting group for Quality Committee, and noted the well-attended meeting with a long agenda but stated everyone in meeting was on top of the brief which made the meeting flow and covered a lot of work in two hours, being very well chaired and as chair of QC is assured that QPaS is really driving work across the whole of the trust and confirmed there is a lot of detail behind the QIP summary • LP also noted the QIPs shows a sign of the on-going strengthening of clinical leadership within the division, with a few years ago divisions being very operationally led but demonstrates the development of professional leadership which can link to SJN work with AHPs which contributes to the quality improvement work undertaken by these plans. No questions raised and the Quality Committee were assured with the report MS thanked KF/LP for work in area
54/22	**Risk Register** **a) Quality Committee Risk Register Summary** **b) Board Assurance Framework** HG highlighted the following: - • There are 15 risks with a current rating of nine or above • Five risks have reduced in rating and no new risks with a rating of nine or over have been reported since the last presentation at Quality Committee • It was noted the BAF will undertake a full refresh across the whole organisation once the new strategy has been approved by Board. The Risk register and BAF were noted as read with assurance given to the committee. Comments from the meeting were taken: - • FP enquired the FP – BAF SG1 – and enquired if the statement 'currently the quality of staff supervision is unknown by the Trust' was still correct. HG noted moving into Q2 this should be able to be reduced following the work undertaken by TF as mentioned earlier. HG noted the wording unknown is related to the quality of supervision rather than the quantity of supervision.
55/22	**Patient and Carers Experience (PACE) Annual Report and Film** The annual report was taken as read and MD showed the key highlights from the annual report through an animated film, which included: -

	• Capturing the views of young people through the introduction of the Youth Board (Humber Youth Action Group) • Launched the Panel Volunteers initiative and strengthening our approach to values-based recruitment so that we employ the right staff (source; Quality Accounts Priority 21/22) • Launched an eight module Patient and Career Experience training package on the Recovery Collage platform to provide patients, service users, carers and staff with knowledge, information, tools and techniques when getting involved with Trust activities • Launched 'Making Every Member Count' initiative to maximises involvement opportunities within the Trust • Continue to reach out to communities through the Patient and Carer Experience forums, virtual services and awareness weeks • Continue to initiate implementation of the Patient Safety Partners role in line with National and Trust Patient Safety Strategies • Over the past year, responded to 535 complaints, with 235 being formal, almost double the previous year's figures. Of those formal complaints, just over half were not upheld. The report was noted, and the following comments taken: - • The committee agreed the animated film was excellent. • MS noted a QR code at the end of the film and enquired on more detail. MD explained it is currently 'feedback fortnight' and have been working with the Communications Team to create bespoke social media posts across the full Trust graphical area bespoke to the services provided in those areas. The QR code and email have a link to a survey. FP noted the fantastic work with every one of the initiatives looking great. He enquired who signs off the co-produced work and MD confirmed the internal and online co-production forms are submitted to PACE team and MD reviews each of them and signs off, then at the Staff Champion and Patient Experience forum meetings there is a draw and successful team receive a £25 voucher. FP also enquired regarding appendix one and the figures for the national GP patient survey. MD explained this was historical data relating to 2021 and noted she has just finished analysing the 2022 scores. Primary Care are very good at looking at their data identifying areas for improvement. They host regular practice manager meetings to discuss the results and preparing action plans on back of current survey results, as well as the 'You Said We Did' work, identifying actions to address the feedback which is publicised on the surgery notice boards and their websites. MD stated we are also part of a national family and friends project, having been invited as we are very unique with regards to the amount of data, we receive from FFT in primary care, due to us using the SMS text service. There will be a thematic algorithm for FFT data and Cath Hunter is on board with the project and will support practices to take on QI charters from the information received. The themes on the GP survey once analysed are very similar to the themes from the FFT. Once people have made contact with the surgery, the majority responses are positive, but the main issue is getting through to surgeries and primary care is working on access and looking at new telephone systems.

	PE asked for clarity if these were the 2021 results collected January to March 2021 as the most recently result have now been published. MD confirmed yes that was correct and PE stated he thought the results were amazing noting all the pressures that were around at the time, and it would be great to look at this year results and confirmed primary care usually does really well as long as patients can get through to the surgeries and get appointments MS confirmed it was an excellent presentation but noted in the film the two pie charts with increasing complaints but could not see the explanatory narrative from full the report and wondered if this needs to be explicit in a publicly available film. MS also suggested that this would be a wonderful item to go to the annual members meeting. MM agreed and with this and felt it needs to be shared, along with presentation at the Board in September. MM confirmed she knowns know how hard team works as she sees every single complaint response that goes out. **Approval – The Quality Committee approved the Patient and Carer Experience (PACE) Annual Report and film**
56/22	**Equality and Diversity Annual Report** Dr M explained this item was around the PACE aspect and the report had already been to the Workforce and Development Committee. The report was taken as read. MD explained there is a lot of work going on in both the team and the Trust to strengthen our systems and processes around understanding our demographical data, about understanding the protected characteristics and equalities population accessing our services. In order to do this, MD has developed a clinical template in CDC form for Lorenzo and clinical template for SystmOne which asks a host of questions about people's demographical information. It reaches out not only to the nine protected characteristics but also veterans, members of the armed forces, homeless, or those struggling to access services and will give us a lot more information. Some staff are feeling uncomfortable about why we are asking these questions, so we have co-produced a booklet called 'Why do we ask' which covers the nine protected characteristics and health information to explain why this information is being asked for both public and staff. It was agreed a copy of the booklet should be shared. **To support communities around interpretation and translation, development of the FFT forms in to the seven most** popular languages, with hard copies available in surgeries to people to complete. There has also been a digital survey form developed and online survey form with the 'reach deck' translation tool, allowing us to reach out to more people digitally. MS thanked MD for a great report, noting in terms of the health and equalities agenda the information that will be picked up will really help and will tie in with information discussed at Mental Health Legislation Committee regarding detention statistics where some cannot be recorded as are not on the form. DR confirmed the report was discussed at Workforce and OD committee which welcomed a report that incorporates both workforce issues as well as service delivery issues, health inequality and access to services issues being covered in the report. DR explained the Workforce and OD Committee felt it would be good for the report to come to the Quality Committee before it went to the Trust Board meeting.

	FP noted section three, regarding the wording 'impacted by the covid pandemic' and felt it read as though the work has not happened as they have been impacted. It was suggested that this should be re-worded. MD will feedback to the team. **Approval – The Quality Committee approved the Annual Equality and Diversity Report subject to minor amend in wording** **ACTION – to circulate copy of booklet 'Why do we ask' to members**
57/22	**Zero Events Annual Report** SM presented the report and explained each year a suite of zero events is agreed, from areas of potential risk and patient safety events, areas we would want to improve our care or reduce avoidable harm. During 2021/22 there were five Zero Events reported and improvement work was undertaken in relation to these. Key highlights were as follows: - • Pressure ulcers have been reduced by a third and have had no category four pressure ulcers in the last year. This work is driven by the pressure ulcer review and learning group (PURL) who review all pressure ulcer incidents across the trust, undertaking specialist reviews, ensuring appropriate risk assessments, care planning and wound care management has been completed. The group has regular attendance from community services as well as the safeguarding team to allow escalation of any safeguarding concerns • Significant reduction in failure to recognise and escalate the deteriorating patient with reduction from 11 last year to just two events this year. Work has been led through the Physical Health and Medical Devices group (PHMD) a sub group of QPaS, and the role out of the new skills competency work • There has been a slight increase in the number of falls, but the trend has moved from the community wards to mental health units due to increased reporting and training. There has been a face-to-face local training package developed and Royal College of Physicians have re-introduced their e-learning package with good uptake on training. The falls zero event is continuing for the coming year with a focus on mental health inpatient units • The zero-event starting in Q4 2021, relating to level of harm in relation to sexual safety BAME and LGBYQ+ incidents, having recognised that patient on patient incidents were appropriately recorded but the issue a appears to be around staff considering the level of harm to themselves or colleagues when reporting. This has been stepped down with the work is being taken through the sexual safety forum • Section four shows the approved zero events for 2022/23 and reporting on a number of these will start in Q1. MS enquired where did the zero events once approved at EMT go, and HG confirmed they went to the Trust Board in the CEO report and a six-monthly report and position statement will be received through Quality Committee. Frances Healey commented she was delighted to hear we were using Fallsafe, as she had been involved in the development of the original package and wondered if we were also using the equivalent model of Carefall for medics. SM confirmed that we have now got medical representation on the falls working group so hopefully will move forward on this, and noted training has in the past probably been more geared towards nursing staff but are aware we need to look at this further.

	MM discussed section 3.5 of 'no under reporting of harm' and the trend doesn't demonstrate the embedded nature of this, noting this has been stepped down, felt it may be good to have the conversation around the reasoning for this. SM confirmed this was discussed at QPaS and the sexual safety forum around how to drive forward and it was felt as a zero event wasn't the right mechanise for this but had given oversight and learning around issues and concerns. It was felt moving this work through other groups could drive the improvement forward. HG noted these incidents are looked at every day by the safety huddle and taken forward if harm level is not recorded correctly or more information required fed back to team. SM noted an update on how the staff member is requested on all violence on aggressing incidents before closing the datix down. MM suggested it may be worth looking at the figures at Quality Committee in the future for assurance that we are changing the message. TF confirmed that it had agreed that zero event would be stepped down, and this work would still continue with us being part of the national safety collaborative, although the work has finished at a national level, it is now been picked up at regional level and linked into work with Hayley Jackson and Sexual Safety Forum which will report into QPaS to ensure we are still keeping an emphasis on providing the right level of escalation and what action may need to be taken. KF agreed it was very important work and understand the need to continue monitoring. In terms of the patient safety and patient, staff usually get reporting right but the area that is an issue is harm to themselves or colleagues and work is about changing the culture as violence and abuse should not be seen as business as usual. The figures are important but changing the mindset and culture is also important. **ACTION – Quality Committee request a deep dive on the figures for no under reporting of the level of harm in relation to sexual safety, BAME or LGBQT+ incidents relating to staff or patients to ensure assurance gained (TF)**
58/22	**Safeguarding Annual Report** HG presented the annual report on behalf of the Safeguarding Team to give assurance that the Trust is appropriately discharging its safeguarding duties. Covering three local authority areas, north Yorkshire, East riding and Hull meaning triplicate committee and area meetings, which the team support along with all the in-house meetings. The report shows the increased in demand reflecting the national picture with an increase in supporting staff, attending agency meetings, attending and leading long term segregation and seclusion reviews and the 0-19 Hull contract which came live in May has again increased demand. Additional resources have been added to the team following a discussion at EMT due to the increased workload. HG gave assurance that the team are working with partners and covering all the work required, confirming the work in being completed properly and feedback received from partner agencies is positive. Comments and questions included: - • FP noted the table 5.1 is excellent and worthy of being a one-page plan at the beginning at report • DR commented a good report showing the work load and how the team were keeping on top of it. He enquired around the rising level of safeguarding, being the

	perfect storm with increase cost of living and covid etc, and realise that executive colleagues will be raising this informally in meetings but wondered if there was a role for Quality Committee to raise and escalate this formally? HG confirmed this is being picked up constantly with partnership meetings and is being worked on. • MM wanted to note thanks to the team for the great work which has drastically increased, and we are seeing the effects. Regarding the point made by DR, she will take this into the ICB as felt it was a really going point and need to do more from the system point of view. Sitting on the Quality Committee for the ICB, this would be a good start to have that conversation and will ensure feedback to the Trust Quality Committee. MS thanked HG and the team for the report. **Approval – The Quality Committee approved the Annual Safeguarding Report for submission to the Trust Board.**
59/22	**Quality Improvement Annual Report** DrM introduced the Quality Improvement Annual Report which comes to the Quality Committee each year and handed over to Cath Hunter, Quality Improvement Lead for the Trust. CH explained the report is an end of year summary of Quality Improvement (QI) work with the infographic on the front page of the report showing the key information which includes: - • 200 charters logged to date with 44% co-production and 87% will benefit our patients and carers • 17 QI stories have been watched via MS Teams by 428 NHS staff, patients and carers • 19% of charters have been led by medics • September 2021 the QI strategy, was co-produced by patients and carers was approved by the Trust Board • Appendix E shows the targets set within the strategy and the target set which have been achieved so far include, increasing the number of charters and increasing training places. One area not showing progress is 33% reduction in staff expressing insufficient capacity as a reason for not undertaking a new QI activity by 2026, and although hasn't degreased, it may require additional data to review direction of measure. • As part of the priorities for 2022/23, there is a joint patient strategy group with patient and carers to mean there are patient, staff and carers providing assurance for the QI strategy, and are continuing with the doctors approach and looking at how this can be lifted aspects of this approach to apply to other areas of the Trust, which has limit progress so far, but this could be due to current pressures and will try again in the autumn • Looking at the carers occupational budget, to add quality information and links to the apps so carers can access directly • Main threats to quality improvement continues to be capacity of staff on front line and the QI central team. LP noted that CH brings useful quarterly QI reports to the Operational Delivery Group (ODG) and at the last meeting had a discussion around staff capacity for both projects

	and training. LP has asked CH to go to each of the divisional operational delivery groups to receive commitment from them around where they want to focus the training. This will then be reviewed by ODG. LP noted it being difficult at the moment, as there are priorities on some areas of statutory and mandatory training, but if we want to improve and increase the bedrock of QI supporting all our improvement work the training is intrinsic. MM thanked CH for a great report good, which shows everything central to patient care. It was felt the work LP discussed would be good to go to EMT before feedback comes back to Quality Committee as MM would also like to include discussion on what work is involved in corporate side in relation to QI. **ACTION – the Quality Committee request EMT to review the QI information from ODG prior to reporting back to Quality Committee (DrM/LP)**
60/22	**Quality and Patient Safety Group (QPaS) minutes (25 May 2021)** The minutes of the April and June 2022 meetings along with a summary of the July 2022 meeting were noted with no queries raised.
61/22	**Items Arising from the meeting requiring Communication, Escalation or Risk Register consideration and any lessons learnt** The following items were agreed for escalated to the Trust board via the Assurance report: • Suicide presentation and strategic plan • Quality Insight Report • Quality Risk Register – noting no substantive changes to quality risk • Allied Health Professionals Annual Report • Divisional QIP summary with assurance received • The approval of the Patient and Carers Experience report and film, recommending to the Board • The approval of the Equality and Diversity annual Report from the PACE perspective • The Zero Events Report with a request for a deep dive on under reporting of the level of harm event • The approval of the Safeguarding annual report • The QI report. EMT are requested to review the QI information from ODG prior to reporting back to Quality Committee It was agreed there had been no negative information received today.
62/22	**Any Other Business** MS asked Frances Healey how she felt the committee had gone today as an observer and she stated it was fantastic to have opportunity to listen and found particularly delightful and insightful, that with a very full agenda all items had sufficient air time with meaningful discussion. She noted she has learnt there is only so much time for a quality committee and how you dedicate to the right areas to make the most difference. Today had been wonderful peer learning and thanked the committee for the allowing her to attend.

	PE stated he felt there was great learning and was greatly impressed by the colleagues presenting at today's meeting and realised there is the balancing act about what we are statutory required to bring and what we would like to focus on and allocating time to items that really matter. MS closed the meeting thanking all those who had presented and to the executive leading and nurturing great team work
63/22	**Date and time of next meeting** The next meeting has been arranged for Thursday 29th September 2022 for the Annual Reports. via MS Teams. The meeting invite details will be updated nearer the meeting date.