

Trust Board Meeting 22 May 2019
Agenda - Public Meeting

For a meeting to be held at 9.30am Wednesday 22 May 2019, in the Conference Rooms, Trust Headquarters

		Lead	Action	Report Format
	Standing Items			
1.	Apologies for Absence	SM	To note	verbal
2.	Declarations of Interest	SM	To receive & note	√
3.	Minutes of the Meeting held on 24 April 2019	SM	To receive & approve	√
4.	Action Log and Matters Arising	SM	To receive & discuss	√
5.	Kirsty's Poem (Patient Story)	JB	To receive & note	√
6.	Chairman's Report	SM	To note	verbal
7.	Chief Executives Report	MM	To receive & ratify	√
8.	Publications and Highlights Report	MM	To receive & note	√
	Quality and Clinical Governance			
9.	Care Quality Commission Inspection Report	MM	To receive & note	√
	Performance & Finance			
10.	Performance Report	PBec	To receive & note	√
11.	Finance Report	PBec	To receive & note	√
	Assurance Committee Reports			
12.	Mental Health Legislation Committee Assurance Report	MS	To receive & note	√
13.	Finance & Investment Committee Assurance Report	FP	To receive & note	√
14.	Audit Committee Assurance Report	PB	To receive & note	√
15.	Charitable Funds Committee Assurance Report & 25 March 2019 Minutes	PBee	To receive & note	√
	Corporate			
16.	Board Assurance Framework (Oliver Sims, Corporate Risk Manager attending)	MM	To receive & note	√
17.	Risk Register (Oliver Sims, Corporate Risk Manager attending)	HG	To receive & note	√
18.	Annual Safety Report	PBec	To receive & note	√
19.	Annual Declarations Report	PBec	To receive & approve	√
20.	Items for Escalation	All	To note	verbal
21.	Any Other Business			
22.	Exclusion of Members of the Public from the Part II Meeting			
23.	Date, Time and Venue of Next Meeting Wednesday 26 June 2019, 9.30am in Meeting Room 1, Level C, Whitby Hospital, Spring Hill, Whitby YO21 1DP			





Agenda Item: 2

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Declarations of Interest			
Author:	Name: Sharon Mays Title: Chairman			
Recommendation:	To approve		To note	✓
	To discuss		To ratify	
	For information		To endorse	
Purpose of Paper:	<p>The report provides the Board with a list of current Executive Directors and Non Executive Directors interests. Changes have been made to the declarations for Professor Mike Cooke and Peter Beckwith which are:-</p> <ul style="list-style-type: none"> • Peter Beckwith - Sister is a Social Worker for East Riding of Yorkshire Council and son is a Student at the St Mary's Health and Social Care Academy • Professor Mike Cooke has been appointed as Chair for the Cochrane Common Mental Disorders Expert Advisory Board. 			
Key Issues within the report:	Contained within the report			

Monitoring and assurance framework summary:

Links to Strategic Goals				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
√	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			
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)	<ul style="list-style-type: none"> • Non Executive Director, The National Skills Academy for Health • Appointed as a Trustee for the RSPCA Leeds and Wakefield branch
Mr Peter Beckwith, Director of Finance (Voting Member)	<ul style="list-style-type: none"> • Sister is a Social Worker for East Riding of Yorkshire Council • Son is a Student at the St Mary's Health and Social Care Academy
Mrs Hilary Gledhill, Director of Nursing (Voting Member)	No interests declared
Dr John Byrne, Medical Director (Voting Member)	<ul style="list-style-type: none"> • Executive lead for Research and Development in the Trust. Funding comes into the Trust and is governed through the Trust's Standing Instructions
Mrs Lynn Parkinson, Chief Operating Officer (Voting Member)	<ul style="list-style-type: none"> • None
Mr Steve McGowan, Director of Human Resources & Diversity (Non Voting member)	No interests declared
Non Executive Directors	
Mrs Sharon Mays – Chairman (Voting Member)	<ul style="list-style-type: none"> • Trustee of Ready Steady Read • Sister is Head of Compliance Standards and Information at Tees Esk and Wear Valley NHS Foundation Trust
Mr Peter Baren, Non Executive Director (Voting Member)	<ul style="list-style-type: none"> • Senior Independent Director Beyond Housing Limited • Government appointed independent Director – British Wool Marketing Board • Son is a doctor in Leeds hospitals
Ms Paula Bee, Non Executive Director (Voting Member)	<ul style="list-style-type: none"> • Chief Executive Age UK Wakefield District • Vice Chair Age England Association • Board Member – Wakefield New Models of Care Board • Chair, Age UK, Yorkshire and Humber Support Services
Mr Mike Cooke, Non Executive Director (Voting Member)	<ul style="list-style-type: none"> • Trustee, Yorkshire Wildlife Trust • Chair of Yorkshire Wildlife Trust • Consultant Advisor, University of York • Advisor , National Institute for Health Research • Independent Executive Mentoring Coach • Chair of NIHR International Collaboration Panel Steering Group to embed Applied Research in Health Care Settings • Chair of Knowledge and Dissemination Panel, University of York Mental Health Network Plus NIHR grant

	<ul style="list-style-type: none"> • Chair, Cochrane Common Mental Disorders Expert Advisory Board
Mr Mike Smith, Non Executive Director (Voting Member)	<ul style="list-style-type: none"> • Director MJS Business Consultancy Ltd • Director Magna Trust • Director, Magna Enterprises Ltd • Owner MJS Business Consultancy Ltd • Associate Hospital Manager RDaSH • Associate Hospital Manager John Munroe Group, Leek • Non Executive Director for The Rotherham NHS Foundation Trust
Mr Francis Patton, Non Executive Director (Voting Member)	<ul style="list-style-type: none"> • Chairman, 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 and Chairman, SIBA, The Society of Independent Brewers • Director, Fleet Street Communications • Chairman, Barnsley Facilities Services Limited • Director, Over Promise and Under Deliver • Non Executive Director Barnsley NHS Foundation Trust

Item 3

Trust Board Meeting – Public Meeting

Minutes of the Trust Board Meeting held on Wednesday 24 April 2019 in the Conservatory/Fitness Suite, Alfred Bean Hospital, Bridlington Road, Driffield, YO25 5JR

Present: Mrs Sharon Mays, Chair
Mrs Michele Moran, Chief Executive
Mr Peter Baren, Non-Executive Director
Ms Paula Bee, Non-Executive Director
Prof Mike Cooke, Non Executive Director
Mr Francis Patton, Non Executive Director
Mr Mike Smith, Non Executive Director
Mr Peter Beckwith, Director of Finance
Mrs Hilary Gledhill, Director of Nursing
Mr Steve McGowan, Director of Workforce and Organisational Development
Mrs Lynn Parkinson, Chief Operating Officer

In Attendance: Mrs Michelle Hughes, Interim Head of Corporate Affairs
Dr Kwame Fofie, Consultant Psychiatrist
Mrs Jenny Jones, Trust Secretary
Ms Amy Smith, Communications Officer
Tom Nicklin, Patient and Carer Experience Champion, (for item 71/19)
Charlotte Watson, Support Time and Recovery Worker (for item 71/19)
Mrs Alison Flack, Transformation Programme Director Mental Health Humber Coast & Vale (for items 78/19 & 79/19)
Huw Jones, Public Governor
2 Members of the Public

Apologies: Dr John Byrne, Medical Director

65/19 **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 other items on the agenda presented anyone with a potential conflict of interest, they excuse themselves from the meeting for that item.

66/19 **Minutes of the Meeting held on 27 March 2019**
The minutes of the meeting held on 27 March 2019 were agreed as a correct record with the following amendments:-

51/19 Chief Executive's Report

It was noted that the fifth paragraph, fifth sentence on page 3 should read "A number of students have also applied who will be encouraged to look at other vacancies in the Trust if they are unsuccessful".

54/19 Workforce and Organisational Development Committee Assurance Report

The first sentence of the third paragraph was amended to read "Mr Smith queried the number of vacancies and the number of **over established posts** in the report".

70/19 **Matters Arising and Actions Log**
The actions list was discussed and Board



Patient Story – Tom’s Story

Tom attended the meeting to tell his story of a journey through admission to our inpatient facilities, PSYPHER and the benefit of being involved in co-production work with the Trust.

Tom is involved in volunteering with the organisation and coaches the PSYPHER football team. He explained that during his journey he realised that many young men, in particular, were unable to talk about their illness and for many, it was a sense of failure and a distinct lack of purpose. He is helping others to try to overcome this.

Mr Smith asked if by helping in this way it was of therapeutic value to Tom’s own well being and recovery. Tom said that in some ways it did, but it was more the ways that he is able to help other young men who may be struggling with their illness. Through sport some normality is provided which he acknowledged may not be for everyone, but it helps some. The Chief Executive explained that pro-active work is taking place with a local sports club and Tom’s coaching work would be an ideal link into this.

Professor Cook thanked Tom for his inspiration and for telling his story. He asked what Tom’s plans for the future were. Tom would like to work in the NHS helping others. He felt that had it not been for the human contact and engagement with the PSYPHER team he would not be in the position he was today. He felt that mental health teams often struggle with red tape and the paper work which prevents them from engaging with clients.

Dr Fofie pointed out that evidence suggests that there is a lack of engagement with young men and the co-production and writing of care plans is key. Tom agreed that co-production is key although not all individuals may want or be able to do this.

Mr Patton asked about the snowflake generation and asked Tom his thoughts on early engagement with schools. Tom explained that through members of his family he is aware that mental health is discussed in schools, but delivery is by a teacher rather than a qualified professional. He felt that if this was delivered by someone who has lived experience of issues, the reality and what it feels like to have an illness would be better understood.

Peer support workers employed by the Trust, are roles that could be used to help in inpatient units and the community and this is being taken forward by the Workforce Director and Chief Operating Officer. Tom supported this as he felt they would be a great asset to the NHS.

The Chair thanked Tom for sharing his story with the Board.

Chair’s Report

The Chair provided an update in relation to the work she has undertaken since the last meeting that included:-

- Visit to the Psychiatric Intensive Care Unit (PICU) as part of the Governor and Board, Knowledge and Engagement visit programme.
- Supporting the Speech and Language Therapists with their first Continuous Professional Development (CPD) event.
- A meeting with Cllr Lunn who is a partner Governor. Some actions were agreed and a meeting with the Director of Public Health and the Chief Executive is being arranged to discuss these matters.
- Attendance at the visit with Sean Duggan, NHS Confederation Chief Executive
- A meeting took place with the chair of Help for Health to discuss the Impact Appeal.
- The process for the recruitment of a new Non Executive Director has started with the Human Resources department providing support.

Resolved: The verbal update was noted.

Chief Executive's Report

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

Health Service Journal Patient Safety Awards – The Trust has been shortlisted again this year in the Health Service Journal Patient Safety awards this time in the governance category for our work on Patient safety huddles.

Unicef Baby Friendly Initiative Gold Award - The Integrated Specialist Public Health Nursing Service (ISPHNS) and the East Riding of Yorkshire Council Children's Centres had their joint assessment for the Unicef Baby Friendly Initiative (BFI) Gold Award during the month. The team were invited to be assessed as the ISPHNS had successfully retained Level 3 on three occasions. The team are the first recipients nationally of a joint Gold Award for Unicef BFI; the assessment has to be ratified by the Unicef Committee.

Director of Workforce and Organisational Development - Steve McGowan has a new title which is Director of Workforce and Organisational Development. This new title is more reflective of the organisation and the developing Proud programme

Health Service Journal Summit – the Chief Executive attended the HSJ summit which also looked at the advances being made with digital technology.

Health Stars – the Impact Appeal continues to gain momentum. The Director of Finance is running a half marathon in June to raise money for the Chief Executive's staff engagement fund which is being accessed by staff for activities.

NHS Confederation - Chief Executive, Sean Duggan visited the Trust and was impressed with services and staff.

Mr Smith asked about the Health Service Journal frequent attenders award and the outcome of this. The Chief Executive will provide an update outside of the meeting.

Professor Cooke felt it was good recognition for patient safety for the organisation in the patient safety awards. He asked about the reduction in out of area placements which was significant and a good achievement for local people who benefit from this service, but wondered whether this would have an effect on waiting times and demand. In terms of the Strategy refresh update, Professor Cooke asked about Board involvement and how this would be done. Mr Beckwith explained that a timetable is in production which will include a workshop involving Non Executive Directors and Governors. The Chief Executive said this will also be picked up at a Board Development session and include the previous strategy work and the outputs from the Think Tank meetings.

Following the Board to Board meeting last month, Professor Cooke asked for an update on the GP access issue in relation to telephone contact with the Mental Health Response Service that was raised. Mrs Parkinson reported that work has been ongoing to resolve the issue. It has become apparent that the system of using the main telephone line for urgent and non urgent referrals is not working. The proposal to change this has the support of both Clinical Commissioning Groups (CCGs) and it will be implemented by the end of June. Dr Fofie said that other contact options such as e mail have also been suggested alongside the telephone calls. A simplified electronic referral form has been finalised which will also help. Professor Cooke was pleased that the issue raised by GPs was being taken forward.

The Chair suggested that an update be provided on all of the actions that have been taken will be included in the next Chief Executive's report.

Ms Bee attended a NHS England Long Term Planning meeting and highlighted that there was no representation from the Integrated Care Services from this patch. She suggested this

might be worthy of further consideration for future attendance within the system.

Ms Bee reflected on a comment made in the patient story where it was said about the red tape and that people had to input on Lorenzo rather than engaging with clients. She said that engagement with staff is co-designed and often when people are stressed they will go to uniform tasks. She felt that only by changing ways of working staff wellbeing and more engagement with patients would be possible and this should link in with the Proud work. Mr McGowan said this is part of the aim of Proud. There is a significant amount of data from the staff survey that shows a need to focus on the health and wellbeing agenda. The patient focus is in the quality work and how services redesign can be done to help staff.

Mr Patton commented on the increase in the Apprenticeship Levy transfer to 25% and looked forward to the presentation at the Workforce and Organisational Development Committee. He felt the new role of Dr Yorke was an interesting concept.

On behalf of the Board, the Chair thanked Dr Lucy Williamson and Dr Reena Roy for their contribution to the roles of the Guardian of Safe Working and Associate Director of Clinical Studies.

Resolved: The report was noted

An update be provided on all of the actions that have been taken with the Mental Health Response Service will be included in the next Chief Executive's report Action LP

74/19 **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

75/19 **Quality Committee Assurance Report & 6 February 2019 Minutes**

The report provided an executive summary of the discussions at the Quality Committee meeting held on 3 April 2019 with a summary of key issues for the Board to note. Professor Cooke reported that a presentation had been received on learning the lessons from deaths by suicide which was well received. Four recommendations were proposed and supported by the Committee. The Patient Safety Strategy will be presented at the May meeting with the Quality Account. The Risk Register was reviewed to look at aligning it around the Budget Reduction Strategy Quality Impact Assessments with the expectation that the Risk Register will show quality issues coming through and any concerns. The Quality Impact Assessment report will be presented to the Executive Team prior to submission to the Quality Committee.

A presentation on the clinical model for the Child and Adolescent Mental Health Services (CAMHS) model was received at the meeting.

The Committee reviewed its effectiveness with the report being presented with other reviews to the May Part II Board. The approved minutes of the meeting held on 6 February 2019 were presented for information.

Mrs Gledhill added that the learning the lessons from deaths by suicide presentation set the scene and was a look back at action plans and how they are embedded into practice with a low recurrence of themes.

Mr Smith asked about the lead in time for the CAMHS development in terms of skilled staff and whether any funding resources would be required. He was informed that the unit will not open to admissions immediately as time has been built into the plan for staff training which has been supported by NHS England. There will be an incremental opening of the unit.

Resolved: The assurance report and verbal updates were noted.

76/19

Finance and Investment Committee Assurance Report

An executive summary of discussions held at the meeting held on 17 April 2019 and a summary of key points for the Board to note was presented.

The Committee noted that the Humber Coast and Vale Sustainable Transformation Partnership (STP) finished the financial year in 2018/19 with a deficit of £104m. The Trust's financial performance at year end of an operational surplus of £0.803m was recognised by the Committee and the finance team congratulated on this achievement. The Primary Care, Specialist and Human Resources were commended by the Committee for their financial management in achieving their targets. In comparison with last year, the Trust has performed better in relation to generating a surplus and for the cash position. However the Budget Reduction Strategy target was not achieved.

Assurance reports were received on the governance and accounting process for the Yorkshire and Humber Local Health Care Record Exemplar (LHCRE), from the Digital Delivery Group and Capital and Estates Group. The Committee also reviewed the annual Trust's Estates Strategy.

Mr Smith commented on the Budget Reduction Strategy and that the trajectory for recurrent savings is not good. He recognised this is a snapshot at a point in time, but felt some assurance is needed on the actions to improve this trajectory. Mr Beckwith explained that all schemes delivered this year totalled £5million which was a significant achievement. There is a shortfall which is partly attributed to the pause of the Wholly Owned Subsidiary which was offset by non recurrent funding. The schemes that were not achieved have been built into the plan for 2019/20 and if progress continues to be made they could be achieved.

Dr Fofie commented that the financial year end position was positive. The Chief Executive agreed and the message will be communicated further to staff. The Chair supported this and added her congratulations to the team, staff and Executives as it was a big task to achieve and a lot of hard work has been done to realise the result.

Resolved: The report and verbal updates were noted.

77/19

Charitable Funds Committee Assurance Report & 17 January 2019 Minutes

The report included discussions held at the meeting held on 25 March 2019 and the minutes of the meeting held on 17 January were presented.

Ms Bee reported that she is pleased with the way that the Committee reporting has improved over recent months and the progress that has been made with incorporating the charity into the overall Trust. There have been some delays with the Whitby and Child and Adolescent Mental Health Services campaigns, but the staff engagement fund is being accessed and is contributing to the Proud campaign.

The Committee Effectiveness review was discussed and will be presented to the May Part II meeting as a full suite of Sub Committee Effectiveness Reviews.

Resolved: The report and verbal updates were noted.

78/19

Trust Strategy Update

Mrs Flack, Transformation Programme Director Mental Health Humber Coast & Vale attended the meeting to provide an update on progress on the Trust Strategy and the plans to refresh this during 2019/20. The report showed the progress that has been made against the 6 key strategic objectives, particularly around patient safety and quality. Plans for how this work will be taken forward based on changes at a national level were included in the report.

Recently there has been a new Director lead for the Trust Strategy and the Operational Plan and also the appointment of a new Strategy Manager. The Executive Lead still remains as the Chief Executive.

The draft Trust's operational plan on a page was included for the Trust board to review and provide comment on. The next update will be provided in September 2019.

Professor Cooke felt that significant progress has been made and the momentum needs to continue. He suggested adding on page 20 the values of partnership and about growing services on page 13 and how there will be synergy between the two. The Chair agreed with his comments and that strategic growth and how we follow up on this should be included. Mr Patton identified that there was no reference to the Workforce and Organisational Development Committee under the appropriate strategic goal. He also felt that under the maximising an efficient and sustainable organisation goal, reference should be made to the Budget Reduction Strategy, Estates strategy and the good job that has been done by the team.

The Chair said more has been achieved that was in the report and this was an opportunity to demonstrate this. She noted that page 12 referred to sickness rates and Personal Development Review (PADRs) figures that needed reviewing. Mr McGowan said there is a time lag with the use of Statistical Process Charts (SPC) and will review sickness and PADRs rates based on the most recent performance report.

Ms Bee noted there was no reference to the work of the Charitable Funds Committee in the update.

As this was a draft any further comments on areas that may have been missed were asked to be submitted to Claire Strawbridge, the new Strategy Manager.

The draft plan on a page was discussed. Professor Cooke felt there was a lot on the page. He asked what was meant by "Organisational Support" and whether the NHS Long Term Plan and Proud were included in this. In terms of the hexagon shapes he felt that in the middle should be patients, service users and carers and Proud rather than the NHS Plan. He recognised there is a lot in the plan, but felt more Trust things could be included. Mr Patton felt there was insufficient detail on partnerships and being a system leader.

It was suggested and agreed by the Board to include last year's achievements on the other side of the plan on a page. When this has been done, the document will be recirculated to the Board.

The Chief Executive thanked Mrs Flack and the team for their hard work in producing the documents.

Resolved: The strategy update was noted. The plan on a page to be revised taking into account comments received. On the reverse, last year's achievements to be added. Document to be recirculated to the Board when completed **Action PBec**

79/19

Freedom to Speak Up Vision and Strategy 2019- 2022

The report provides the Trust Board with an update of the activity taking place and the number of people contacting the Guardians. The Trust now has an approved Speak Up Vision and Strategy (2019) which was approved by the Trust Board in March 2019. The report also provided an update on the recent work programme and further work taking place.

There continues to be sharing of information and close working between the Guardian, the National Guardian's Office and the Regional Network. The Trust is hosting the Regional Network meeting In June 2019. The learning from staff speaking up and how this will continue to be developed. Plans are in place to gather feedback from staff raising concerns.

Mr Baren confirmed that as Senior Independent Director, he meets regularly with the Guardian and Deputy Guardian to go through cases and provide oversight and assurance. It was suggested that this should be included in future reports.

Mr Patton asked about the national packages and about details of the regional leads. He was informed that these roles are still being appointed to presently. Additional support was identified and the leads will focus on the development of the Freedom to Speak Up role across primary care, but will still be a point of contact for the Trust. Details of the roles will be confirmed in the next report.

Discussion to take place outside of the meeting around the regional event in June with the Chair, Chief Executive and Mrs Flack. Details will be circulated to the Board, anyone interested in attending the event to contact Mrs Flack.

Resolved: The report was noted.

Future reports to include the involvement of the Senior Independent Director in overseeing cases. Action AF

Details of the regional event to be circulated to the Board Action AF

80/19

Performance Report

An update on Board approved key performance indicators as at the end of March 2019 was presented. Of particular note were:-

- Waiting times – 52 week waits have increased further in March. Currently 70 patients waiting (excluding ASD).
- One 7 day follow up breach.
- Three admissions of patients aged under 18 to adult wards.

Professor Cooke noted a reduction in the Friends and Family Test scores and felt this should have been highlighted in the exception report as it was outside the accepted trajectory. The Chief Executive agreed with his point and noted that the rates have dipped which could be in relation to the HPV vaccination. The Chief Executive does monitor the number of complaints that are received and there has not been a recent increase. The position is being monitored.

Maister Lodge was shown at 101% bed occupancy and clinical supervision had reduced to 44% which was noted by Mr Baren. The bed occupancy was due to the use of a leave bed which was an appropriate use. Mrs Parkinson confirmed that there is a high occupancy level at Maister Lodge due to the demand for acute beds. Work is taking place to review the dementia pathway. Out of area placements for mental health has significantly improved, but there is work to do for Older Peoples services.

Staff turnover had increased and Mr Baren asked if the reasons were known for this. Mr McGowan said data showed that this was due to people leaving for a variety of reasons. As an exercise, contact will be made with everyone who has left within the month to confirm their reasons for leaving. He informed the Board that some neighbouring organisations are enticing Trust staff with incentives to join their organisations.

Dr Fofie noted the position with waiting times and Autism Spectrum Diagnosis (ASD). Mrs Parkinson said she was disappointed that the core CAMHS and ASD diagnosis figures had increased again this month. The Board is very much aware of the position and it is mainly in Hull. Work is being done to reduce this but the increase in demand continues. Improvement work continues with both Clinical Commissioning Groups (CCGs) and the local authority. A further meeting with Hull CCG is planned as the actions that have been taken are not robust enough as referral rates continue to increase and it is often found when assessing an Individual they do not require ongoing support and treatment suggesting that more needs to be done with the pathway. It was confirmed that the contract is block funded however some additional non recurrent funding has been received. The issue is to make it sustainable going forward and work is taking place with commissioners, local authorities and the voluntary sector.

From a strategic point of view it is an area that the Sustainable Transformation Partnership

(STP) mental health partnership will be looking at to see if there is anything that can be done in the system as it is an issue across the STP. In some schools the SMASH programme is having an impact, but this is not across all schools.

Mr Patton commented that on the quality dashboard, there were eight red and one amber areas for sickness levels. He asked what the reasons were for this. Mr McGowan said these are across different groups of staff and was based on 500 staff out of 2,500. The Chief Executive suggested that the Workforce and Organisational Development Committee review in detail sickness and turnover which will include both short and long term sickness.

The Chair raised the issue of bed occupancy noting an increase in Westlands and Newbridges inpatient units. Mrs Parkinson explained that this was the view from the SPC chart, but bed occupancy remains low across the Trust. It was noted that PICU out of area beds remained a challenge. Bed occupancy on PICU has been reduced to a maximum of ten beds due to the acuity of clients and it has been appropriate to use out of area beds. These cases are rare but there is a clear rationale for when it does happen. Mrs Parkinson said she will include more narrative within the next report of the actions taken.

Resolved: The report was noted.

The Workforce and Organisational Development Committee to review in detail sickness and turnover which will include both short and long term sickness Action SMcG

81/19

Finance Report

The report which provided an update of the financial position of the Trust at month eleven. Of particular note were:-

- An operational surplus position of £0.592m was recorded to the 31st March 2019. The Trust delivered a surplus of £0.803m at year end, compared to the agreed NHS Improvement target of £0.801m
- Expenditure for clinical services was lower than budgeted by £0.296m year to date
- The cash balance at the end of March 2019 was £14.896m, this included £2.154m of Local Health Care Record Exemplar (LHCRE) and £1.518m of Child and Adolescent Mental Health Services (CAMHS) capital funding.
- Capital Spend as at the end of March was £9.911m, mainly related to the CAMHS unit, the LHCRE project, IT hardware and Backlog Maintenance

The Chair asked about the local government pension scheme referred to in the report. She was informed that this was an evaluation in pensions in relation to Section 75 partnership and Granville Court which is charged to the income and expenditure position and falls below the control total line.

Resolved: The report was noted

82/19

Report on the Use of the Trust Seal

In line with Standing Orders this report details the use of the Trust Seal. Over the period 1 April 2018 – 31 March 2019, the Trust Seal has been used twice in relation to the Princes Medical Centre

Resolved: The report was noted.

83/19

Emergency Planning Preparedness & Resilience (EPRR) Annual Report

The annual report provided the Board with assurance that the Trust has met the EPRR duties and obligations as set out in the Health and Social Care Act (2012) as a responder during the period 1st April 2018 to 31st March 2019. The report also provided an overview of EPRR activities and sets out EPRR priorities for 2019/20.

Mrs Parkinson explained there has been a level of activity over the year including the hospital

waste issue. Nationally the bar has been raised and any actions required following the self assessment have been included in the action plan. The Head of Corporate Affairs confirmed that in relation to the 3 trust wide plans due for update, the communications plan had been completed and noted the EPRR group were driving the development and updates of all team plans.

Mr Smith is the Non Executive Director linked to Emergency Planning and it was noted there was no mention of his role or involvement in the report and he had not seen it before submission to the Board. He suggested that he meet with Mrs Parkinson to review the governance arrangements.

Resolved: The report was noted

84/19

Any Other Business

No other business was raised.

85/19

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.

86/19

Date and Time of Next Meeting

Wednesday 22 May 2019, 9.30am in the Conference Room, Trust Headquarters

Signed Date

Chair

**Action Log:
Actions Arising from Public Trust Board Meetings**

Summary of actions from April 2019 Board meeting and update report on earlier actions due for delivery in May 2019						
<i>Rows greyed out indicate action closed and update provided here</i>						
Date of Board	Minute No	Agenda Item	Action	Lead	Timescale	Update Report
24.4.19	73/19	Chief Executive's Report	An update be provided on all of the actions that have been taken with the Mental Health Response Service will be included in the next Chief Executive's report	Chief Operating Officer	May 2019	Included in Chief Executive's report
24.4.19	78/19	Trust Strategy Update	The plan on a page to be revised taking into account comments received. On the reverse, last year's achievements to be added. Document to be recirculated to the Board when completed.	Director of Finance	May 2019	Amendments made to Plan on a Page and circulated.
24.4.19	79/19(a)	Freedom to Speak Up Vision and Strategy 2019-2022	Future reports to include the involvement of the Senior Independent Director in overseeing cases.	Transformation Programme Director Mental Health Humber Coast & Vale	September 2019	Noted will be included in next Trust Board update.
24.4.19	79/19(b)	Freedom to Speak Up Vision and Strategy 2019-2022	Details of the regional event to be circulated to the Board	Transformation Programme Director Mental Health Humber Coast & Vale	May 2019	6 th June at 10 am. Peter Baren as SID to be invited to attend.
24.4.19	80/19	Performance Report	The Workforce and Organisational Development	Director of Workforce and	May 2019	Update provided as part of the May Workforce Insight



			Committee to review in detail sickness and turnover which will include both short and long term sickness	Organisational Development		Report.
Outstanding Actions arising from previous Board meetings for feedback to a later meeting						
Date of Board	Minute No	Agenda Item	Action	Lead	Timescale	Update Report
23.5.18	119/18(b)	Health & Safety Annual Report	2019 report to include the size of the team in the Health and Safety Training rate table	Director of Finance	May 2019	Detailed Training included as an appendix to report, this identifies size of team required to undertake training element
23.5.18	121/18(b)	Annual Fire Safety Report	Next year's report to include all Trust properties	Director of Finance	May 2019	Included as an appendix to the Safety Report
31.10.18	203/18(a)	East Riding Adult Mental Health and Dementia Strategy 2018-23	Updates on progress to be submitted to the Quality Committee and Executive Management Team meetings	Chief Operating Officer	February 2019	Apr 19 – Regular updates are provided to EMT and will agenda item for the Quality Committee in August 2019.
27.3.19	51/19	Chief Executive's Report	A meeting to discuss Recovery will be arranged	MM/LP/MC	April 2019	Meeting took place on 24 April 2019

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

Agenda Item 5

Title & Date of Meeting:	Trust Board Public Meeting - 22 nd May 2019			
Title of Report:	Patient Story – Kirsty’s Poem – ‘Therapy’			
Author:	Name: Kirsty Vessey Title: Patient Name: Claudia Myler Title: Clinical Psychologist, General Liaison Psychiatry			
Recommendation:	To approve		To note	√
	To discuss		To ratify	
	For information		To endorse	
Purpose of Paper:	To inform Board members of Kirsty’s journey with the General Liaison Psychiatry Team through the method of poem.			
Key Issues within the report:	The key messages of the story are: <ul style="list-style-type: none"> To highlight an individual’s experience of receiving services. 			

Monitoring and assurance framework summary:

Links to Strategic Goals				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
	Developing an effective and empowered workforce			
	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			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	



Kirsty's Poem – 'Therapy'

1. Introduction

The purpose of Kirsty's poem is to provide the Board with a story of her experience of receiving services and the General Liaison Psychiatry Team through poem.

2. Attendance at the Board meeting

In attendance will be Kirsty Vessey (patient) and Claudia Myler (Clinical Psychologist).

Kirsty will share her poem with the Board followed by a questions and answers session, supported by Claudia who works in General Liaison Psychiatry where Kirsty receives her care.

3. Key Messages

Kirsty would like to provide the following messages to the Board:

- To highlight her experience of receiving services and her care from General Liaison Psychiatry.

Agenda Item: 7

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Chief Executive's Report			
Author:	Name: Michele Moran Title: Chief Executive			
Recommendation:	To approve		To note	
	To discuss		To ratify	
	For information	✓	To endorse	
Purpose of Paper:	To provide the Board with an update on local, regional and national issues.			
Key Issues within the report:	Identified within the report			

Monitoring and assurance framework summary:

Links to Strategic Goals

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

Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	✓			To be advised of any future implications reports as and when future implications by Lead Directors through Board required
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. Around the Trust

1.1 Humberside Police

I spent a great day working alongside Humberside Police experiencing the work of the community neighbourhood teams and also with their first response patrol. What professionalism and great work. I learnt a lot.

1.2 Child and Adolescent Mental Health Services (CAMHS) Development

Myself and the Care Quality Commission (CQC) Inspection Manager Mental Health (North East) visited our rapidly developing CAMHS unit to see the progress that is being made.

1.3 Proposal for Finding a Name for the New CAMHS Inpatient Service.

Building upon the collaboration we have with our young people in the development of both the building design and the clinical model it is important that we adopt the same approach when naming the service.

A strong sense of identity is important to a young person's mental health and gives them a sense of belonging and self-esteem and supports their overall wellbeing.

In the development of the new Inpatient Service we have the opportunity to change the perception of young people's mental health, more specifically to offer an alternative to the traditional inpatient model and to create a new culture of how an inpatient unit fits in the journey of a young person accessing mental health service.

Getting the name right is crucial and young people feeling that they are an integral part of the naming process is an essential first step to creating something different.

Agreed Approach to the Naming of the Unit:

As part of the Impact appeal campaign all 96 high schools, in the 4 localities, were sent a box containing information about the new service and some suggestions of activities the school could use to start a conversation about young people's mental health.

- We will send a letter asking all 96 schools to get involved in the naming of the unit offering an incentive to the school who suggests the name that we eventually choose. This could be provided by health stars.
- We will go out to members of the public via social media to ask for suggestions, offering the same incentive to be awarded to a school of their choosing. This could include using local media outlets to promote the search for a name.
- Lastly we will use Midday Mail to ask all trust staff for their suggestions.

This will hopefully generate a number of responses, some positive some potentially silly but all will be considered as the new name for the service.

Naming Panel

We will then form a panel of young people, parents, clinicians, members of the Trust senior leadership team who will then work together to agree the name. It is important that the young people feel that this is their process and approve the final name. They will be asked for their top 6-8 names to go forward to the Executive Management Team and the Trust Board for final selection.

1.4 Visits

It was great to spend some time with the staff at the Humber Centre during the month as well as Psychiatric Intensive Care Unit (PICU) and Maister Lodge. Staffing demands remain the key challenge.

1.4 Staff Awards

During the month we held the quarterly staff awards event which recognises the employees of the month awards winners and long service. This was well attended and is really well supported by staff.

1.5 Easter Competition Winners

Thank you to everyone who entered the competition. The winners of the Easter competition were:-

- 1st Place – PICU (submitted by Hayley Vaughan, Rikki Day & Gemma Cheetham)
- 2nd Place – Maister Lodge (submitted by Rielle Dency)
- 3rd Place – Mill View Court (submitted by Derek Peat)

Congratulations to all winners who have received their prizes provided by the Trust Board.

1.6 Hull Yorkshire's Maritime City Project

The Council are moving forward significantly with our very exciting plans for the Hull: Yorkshire's Maritime City project (<https://maritimehull.co.uk/>) which includes the complete refurbishment of our Maritime Museum and adjacent Town Dock Chambers, the renovation and permanent display of our two historic vessels (the Arctic Corsair and the Spurn Lightship) and the development of the historic North End Dry Dock on the River Hull. As mentioned in our media releases on this, we have been giving this a lot of effort, most visibly through our on-going public consultation, and we are now rapidly approaching the submission deadline for the second round of the project funding from the National Lottery Heritage Fund. We have some remarkable plans which will be submitted at the end of May and we hope to hear the outcome of our submission in October.

A successful award will release the balance of the £15M funding and, when combined with Council's capital commitment and funds raised from charities and other sources, this will enable us to implement our plans in full. Ahead of this submission we are now asking all those that support this major development if they will be willing to send a letter of support for the project so that we can submit them along with our round two application. The more external support like this we can get, the better, as local support is an important factor in the final decision making.

2. Around the Region

2.1 Hull Place

Key Highlights from the last meeting included:-

- Governance process agreed.
- Still in development is the Beverley Road Project which is well supported by the Place Board.
- Work is taking place to look at project support for the work of Hull Place.

2.2 East Riding Place Board

Chaired by the Chief Executive the meeting focused upon the annual review and operational plan for the forthcoming year. A couple of key objectives will be set with measurable objectives.

3 National News

3.1 Care Quality Commission (CQC)

The CQC will now be in larger regions North East and North West . The Mental Health team have combined community services, so our usual team will cover both areas. More details will follow.

4 Director's Updates

4.1 Chief Operating Officer Update

4.1.1 Mental Health Response Service – Actions Taken (Board action 73/19)

The Mental Health Response Service (MHRS) service operates 24/7 managing all mental health enquires and referrals for adults and older adults through a Single Point of Access (SPA). It carries out a triage process on all referrals to help define appropriate care pathways; these include advice and signposting to primary care or other appropriate packages of care e.g. third sector services, referral to Improving Access to Psychological Therapies (IAPT). Carrying out face to face non urgent contact where a brief assessment is completed to define if a comprehensive assessment is required, and urgent response (24hrs) or an emergency/crisis response which is with 4 hours.

Besides the referral, triage and assessment (SPA) elements of the service it also manages Mental Health Act requests, the Trust's Section 136 suite at Miranda House and provides intensive home based treatment for those requiring acute and urgent support as an alternative to hospital admission.

Since the establishment of a SPA for mental health services there has been a significant and sustained increase in demand for all services operated through the SPA and capacity to continue to operate the current arrangement is now stretching resources and this has led to increase in the time it takes for calls to be answered. Analysis of the referrals and calls to the SPA demonstrates that it is the non-urgent demand that accounts for this rise and the urgent and crisis demand remains within usual variation. The SPA uses an automated call system which asks callers to determine if their need is urgent or routine, so that wait times can be managed and urgent/crisis calls prioritised. Increasingly however non-urgent calls had been coming through to the routine lines.

Operationally a number of additional measures have been put in place to reduce the call waiting times since October 2018.

- Additional staff were made available to the service to respond to calls – vacancies that existed in the service have been recruited to and this is an ongoing process.
- A new streamlined referral form has been developed with both CCGs to encourage primary care to make referrals, especially non-urgent referrals electronically.
- A Primary Care glossary of services directory and criteria has been developed to support better quality of referrals and the identification of more appropriate services where secondary mental health care is not indicated. This will support the reduction in calls to SPA which are then signposted by us to other services.

These measures are having some impact on managing the call waiting times however further service review work has been undertaken and this has identified a need to change the service model further in order to ensure reduction in call waiting times can be sustained.

A number of alternative service models were reviewed by the Adult Mental Health Care Group, consideration was made though the NHS England Yorkshire and Humber clinical network of SPA and crisis response service of models in place elsewhere. The service has made a proposal based on this review that has been accepted by the Executive Management Team (EMT) to separate the SPA function for routine referrals and enquires from the crisis response service. The new SPA function will be supported by third sector telephone help line capacity which will provide support for those with low level needs or who require advice and signposting elsewhere. The key benefit of this change is that the crisis response service will have sufficient capacity to meet the needs of those with acute and crisis care needs, by staff dedicated to providing crisis care interventions. The SPA will be supported by dedicated staff connected to the community mental health teams with additional capacity being met by the third sector provided help line. The care group are working

toward implementing this change by late June/early July. This proposal has been shared with both CCG's who are supportive of it.

Meanwhile response times to calls to the MHRS continue to be monitored very closely to ensure that urgent and crisis calls are prioritised and that non-urgent calls are responded to as quickly as possible.

4.2 Director of Nursing

4.2.1 Trust Zero Events 2019/20

The Trust introduced zero events as part of the patient safety plan in 2017. Local zero events are one approach to ensuring that we are constantly striving to learn from safety incidents and improving the quality and safety of care we provide to our patients.

The Executive Management Team (EMT) has recently considered and approved the proposed suite of zero events for 2019/20 which were developed following consultation with clinical staff via the Clinical Risk Management Group and the Quality and Patient Safety Group as follows.

Zero events to continue to be reported in 2019/20

- No Grade 3 or above pressure ulcers acquired in our care that were *potentially* avoidable-
- to reflect the new NHS Improvement guidance around Stop the Pressure and the revised reporting, investigation and interpretation/definition of 'avoidable' and 'in our care'
- No failure to recognise and escalate the deteriorating patient in line with trust policy
- No use of blanket restrictions
- No unlawful detentions

Rationale: There is still some improvement to be embedded in respect of unlawful detentions and blanket restrictions.

Further improvement is required in respect of the deteriorating patient and pressure ulcers (incorporating new definitions and standards).

New Zero Events include:

- No sexual safety incidents in our mental health in patient units resulting in moderate harm or above*
- No failure to recognise and manage the risk of Falls as per Trust policy
- No inappropriate urinary catheterisation of a patient in our community inpatient services (commence reporting Q3 to allow System 1 training and reporting process to be established based on national guidance and training)*

*These have been identified as part of nationally recognised areas for patient safety improvement (i.e CQC report of sexual safety incidents and national drive to reduce EColi through inappropriate urinary catheterisation and associated infection)

The rationale for including falls is that local reporting has identified incidents which upon investigation have shown failings to follow trust policy in some cases.

4.2.2 Organisational Learning Conference

Learning the Lessons conferences have been held twice yearly to enable staff from across the Trust to come together and share learning from national and local quality improvements, new initiatives, research, incidents and complaints. Following feedback from staff we recognised it was now time to refresh the purpose of these events which will now be known as *Learning by listening #makingadifference Positive Practice Conferences* which we felt better reflected the successful improvement journey the Trust has undertaken to date.

An event was held 1st May 2019 within the Lecture Theatre at Willerby Hill attended by over 60 members of Trust staff, the CQC and CCG colleagues. This event was extremely well evaluated by the participants.

Presentations included the importance of ensuring co-production remains central in the development of our services and we heard of the positive difference this approach had made upon the patients resident within our learning disability services when considering Always Events. As an organisation we are extremely innovative but do not always publically share our innovations and best practice. The function of The Academy of Fabulous Stuff was presented and will provide a platform to enable us to do this.

As a learning organisation we know there are always opportunities for learning and heard about how we had strengthened our approaches, systems and processes following our learning from serious incidents and Coroner declared suicides. We also heard about the learning identified when working with system partners to ensure the smooth transition for patients between services.

The importance of staff engagement in the development of our strategies is key to our ability to successfully deliver high quality patient focused care. Participants were invited to help us in the development of the refresh of our Patient Safety Strategy and provided us with key information about actions that can be undertaken at team level to support the embedding of a strong patient safety culture.

Bookings are now being taken for the next event which will be held on 13th June at The Rugby Club, Scarborough.

4.3 Medical Director

4.3.1 Award Nomination

The Medical Education team led by Dr Stella Morris and managed by Gillian Hughes have been nominated for award in the annual Hull York Medical School awards event. This is an acknowledgement from the students themselves of the work that's been undertaken in the last year in terms of improving the quality of their learning experience.

4.3.2 Lorenzo ePrescribing

The Pharmacy and Clinical Systems team have been working closely with the Humber Centre and our external supplier and we are going to 'Go Live' with our Lorenzo ePrescribing project starring in the Humber centre on the 4th of June, following a successful period of Early Life Support we will commence the roll out of the Electronic Prescribing and Medicines Administration (EPMA) functionality across all the MH Inpatient and Community Services.

This is extremely important for the Trust as it is the next step on the Trust's journey towards providing a complete electronic record and paper-light processes for our MH services and will help reduce some of the risks associated with manual prescribing including lack of visibility of MAR charts and illegible prescriptions and introduce benefits including remote prescribing and electronic supply.

4.3.3 Patient Experience Team

The Patient Experience team have been asked to present their ground breaking work at the NHSI Improvement directors network as well as a Kings fund event in early June. We are hopeful that the recent filming of our work by NHSE will soon be available for us to share more widely.

4.3.4 3rd Annual City of Research Conference

The Research Team held its 3rd Annual City of Research Conference with over 170 delegates in attendance. Feedback from the conference has been extremely positive and reflects our good fortune in having highly regarded National, Regional and Local researchers keen to present at the event. We have also gathered some significant ideas which will help support the development of our new research strategy.

4.3.5 Veterans Aware Alliance Event

The Medical Director attended the Veterans Aware alliance event for NHS trusts. We have been asked by the the GiRFT (Getting it right first time) team from NHS Improvement to be the lead Mental Health trust in the North of England to achieve the status of Veterans Aware trust. This work will be led by the Medical Director working with the patients experience team, staff veterans, services users and colleagues from our Transition, Intervention and Liaison team.

4.4 Director of Workforce and Organisational Development Update

4.4.1 General Medical Council Survey on Bullying

The General Medical Council (GMC) has launched its first survey of specialty and associate specialist (SAS) and locally employed doctors (LEDs) in the UK. It is seeking the views of these medical professionals on their roles and responsibilities, training and development opportunities, and any experiences of bullying and undermining.

4.4.2 Equality, Diversity & Inclusion Annual Report

The annual report has recently been completed and will be presented to the Workforce and OD Committee on 24th May. The report includes our Workforce Race Equality Standard and Workforce Disability Equality Standard information.

4.4.3 Trust Workforce Plan 2019/2020

The workforce plan for the Trust, compiled from information provided by departments, has been completed and will be presented to Workforce and Organisational Development Committee on 24th May.

4.4.4 Occupational Health

The Occupational Health Service has recently commenced a roll out of health & wellbeing initiatives. This six week programme commenced with a 'know your numbers' campaign, this offers health checks for all staff. Later initiatives will involve amongst other things support with long term stress/anxiety related conditions and menopause awareness.

4.4.5 Bank Investigator Role

The advert for a pool of investigators closed on 16th May. Interest has been high and selection will commence shortly. Once completed, this will give the Trust added capacity to investigate and conclude employee related matters in a more timely manner.

4.4.6 ESR Supervisor Self Service

As part of the organisation wide roll out, both Specialist Services and all of Corporate Services have now gone live.

5 Trust Policies

The policies in the table below are presented for ratification. A document control sheet was provided to the committee to provide assurance to Board that the correct procedure has been followed and that the policy conforms to the required expectations and standards.

Policy Name	Approving Committee	Date Approved	Lead Director
Inpatient Search Policy	Mental Health Legislation Committee	9 th May 2019	Medical Director
Policy for the user of seclusion or Long term Segregation including Restrictive Intervention Procedure	Mental Health Legislation Committee	9 th May 2019	Medical Director

6 Communications Update

A summary poster of 'Communications in Numbers 2018/19' is attached as appendix 1 which provides a summary of the achievements of the communications team - which for much of the year consisted of two members of staff.

The team have supported a number of internal and external initiatives and have supported and delivered a diverse range of activities and support. Where it has not been possible to commit as much time to some projects, the team have supported and advised to their capacity. The outputs achieved in year, not all captured in numbers, are a tribute to the small team.

Plans for the vacant Manager post have been progressed with interviews scheduled for 30th May. The new role - Marketing and Communications Manager - will provide a key focus and lead on strategic marketing and communications aligned to the Trust Strategy.

Communications Update

A summary of communications activity between 12 April and 9th May is summarised below as usual:

External

- 11 stories were posted on the Trust's website between 12 April and 8 May 2019. They included:
 - Trust nominated for national patient safety award
 - Are you having a baby? Have your say!
 - Wear Orange Wednesday!
 - Trust Assistant Director selected to be part of senior leadership programme, GenerationQ
 - Tour De Yorkshire 2019
 - New mental health awareness campaign for new and expectant mums
 - Weight management service shares incredible losses to celebrate its first birthday
 - Experience of Care Week - Blog
 - Save lives: Clean your hands – World Hand Hygiene Day
 - Trust staff member thanks NHS emergency team
 - Pharmacy opening times over 2019 Bank Holiday Weekends

- Between 12 April and 8 May 2019, the Communications team dealt with 5 enquiries from local and national media.
- The communications team have continued to support the CAMHS build and Impact Appeal with the charity being selected as Viking FM's chosen charity for their Cash 4 Kids initiative.
- The communications team ran a social media campaign for the CAMHS recruitment project which produced great engagement rates.
- The team continue to work with partners system wide with Health Expo planning started.
- Work continues on the Social Values Report 2018/19 with the team lending design and copywriting support.
- The team have joined the Redesigning Mental Health Inpatient Services project and have helped draft initial communications to share with the public and stakeholders.
- The team provided live Twitter coverage for the Leadership Forum and the Perinatal Mental Health Service Launch events.
- On Facebook we now have 1,986 followers and our Trust Instagram has 431 followers.
- We have 4,432 followers on Twitter as of 8 May 2019.

Internal

- Prepared and issued the nineteenth edition of *Humber Voice*,
 - the 24th edition of *Board Talk* and
 - the 21th edition of *Team Talk*;

- Filmed and issued the latest video blog from the Chief Executive;
- Managed the Communications and Contact Us inboxes
- Supported:
 - Trust Health and Wellbeing Steering Group
 - The Trust's Brexit Project group
 - The Trust's Event Committee
 - The WOS project group by creating a draft communications plan
 - Sean Duggan's visit by helping to set up the Lecture Theatre and tweeting from the event
- Supported the Trust's Employee of the Month competition; issued Employee of the Month nomination forms to the judging panel and communicated the winner in Midday Mail and the Midweek Global.
- Prepared Trust information leaflets and other materials.
- Managed the Trust's intranet and website
- Prepared and issued Midday Mail and the Midweek Global
- Trained staff on how to manage their intranet pages.
- Progressed and collated Annual Report information content
- Annual Members' Meeting – planning is underway for the AMM which will take place on Thursday, 12 September 2019 at the KCOM Stadium, Hull.
- Annual Staff Awards – planning is underway for the Staff Awards which will take place on Thursday, 17 October 2019 at the Mercure Hotel, Willerby.

7 Health Stars Update

7.1 The Chief Executive's Staff Engagement Fund

The Chief Executive's Staff Engagement Fund has been accessed by several services recently. Staff are encouraged to submit their wishes via the Health Stars website. They need to identify the benefit their wish will have on their team as well as the end benefit to patients and service users. Wishes have been very varied and those granted include team building sessions and group activities outside work. Most wishes fit the criteria and we have been able to grant them, however in some cases where the outcomes are unclear we have stressed the Chief Executive's Staff Engagement fund is to enhance staff experiences and environments and is not to be used as a "top up" to department budgets.

June 20th – Chief Executive's Longest Day Challenge – Update – Due to logistics we have decided to redevelop the event into "The Chief Executive's Longest Carwash". Working with volunteer services and Health Stars, the Chief Executive will wash as many cars as possible at the Willerby Hill site during a 12 hour period. We are approaching our suppliers and contractors for sponsorship and volunteer services will be running a raffle and cake stall.

7.2 Impact Appeal

Fund balance as at 03/5/19 including pledges/pending is £259396.43. Fundraising packs are available to support individuals, organisations and others.

Making A Difference Locally (MADL) are holding a full awareness/fundraising event week comm 14th May. The Operations Manager at Smile and Head of Fundraising will be attending their Head office in Scunthorpe to present about the Impact Appeal and the Clinical Manager, Paul Warwick will be talking about the unit.

ResQ are still fully committed to the impact Appeal and have organised a football match on 6th July at Dean Park. It will once again be 50% Impact and 50% Bradley Lowry Foundation. There will be plenty more info to follow.

School Campaign is going well and we have recently been back in touch with each school to offer support and advice with their fundraising efforts.

Impact Appeal banners are displayed on the perimeter fence of the building and we're using social media and local press to help spread the word.

We were delighted to be chosen by Viking FM as their charity supported by their annual Super Hero Day taking place on 10th May. The Chief Executive, Michele Moran, Clinical Manager, Paul Warwick and some of our fundraisers have all given interviews which have been aired on the radio as part of the campaign. Their target is £25k which will be used to help fund the music studio and ongoing music therapy which is planned.

7.3 NHS Day – 5th July 2019

5th July 2019 is national NHS day. Building on the success of the NHS 70th Birthday party it is hoped that NHS Day will become an annual event, which could potentially rival the super successful Macmillan Coffee Morning.

The marketing tool kits are now available for all those wanting to get involved.

Our main event will be held in the courtyard/conference rooms at Trust HQ, where there will be cakes, craft stalls and food available.

Other sites across the Trust are signing up and will be sent a "Party Pack" so they can hold their own celebrations. There will be lots of national exposure through the media and we will tap into this through our regional TV and Radio Stations. NHS day is a celebration of everything our staff are doing every day. Local fundraisers are holding their own events including raffles, dress down days and a golf day – all to raise funds for Health Stars.

7.4 Circle of Wishes

The Circle of wishes scheme has grown significantly over the past 6 months, with 420 wishes submitted to date.

7.5 Social Media

Health Stars social media profile continues to grow mainly due to more people from outside the Trust wanting to get involved with the charity. It has allowed us to reach a much wider audience. We are aiming to boost our followers over the next few months and with the continued support of Trust Communications Team and high profile re-tweets (Thank you) we are confident to increase our followers, likes and comments. The Charity Champion is working hard to produce video content for Twitter with has great engagement results.

7.6 Health Stars Lottery

As part of the Health Stars Operations plan the team will be encouraging new membership to the scheme. Last week there were 156 active members (this figure fluctuates every month due to leavers/new starters). With greater coverage on social media and internal communications it is hoped this figure will increase significantly.

7.7 New Café Trust HQ

Plans are in place to re-vamp the café area at Trust HQ into a relaxing and welcoming Staff Room and Café Health Stars are working closely with Trust teams to add some sparkle to the project!

HUGE THANK YOU TO EVERYONE SUPPORTING HEALTH STARS

**Michele Moran,
Chief Executive May 2019**

COMMUNICATIONS FACTS & FIGURES

2018 / 19

2.67million
search engine
impressions for the
Trust website

930,800
Twitter Impressions

4,789
people completed
the Family & Friends
Test online

437,019
Facebook reach

61
awareness days the
comms team have
supported

160
news articles have
been published on
the Trust website



138,000
visits to the
Trust website

93
press releases have
shared with media

196
newsletters and
Board round ups
to staff

185
media enquiries the
team have dealt with



21 people have been trained
on the Intranet and Internet
administration systems



We had
Staff 105
Award Nominations
with over 180 guests

18 people have been
trained to Tweet



The Trust was
nominated for
11
National Awards



17/18 vs 18/19

- 86%** Increase In media enquiries
- 43%** Increase In online articles
- 35%** Increase In social media followers



including...

- HSJ AWARDS**
- NHS Sustainability Awards**
- PATIENT SAFETY AWARDS**
- HSJ VALUE AWARDS 2019**
- GENERAL PRACTICE AWARDS**

Agenda Item: 8

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Publications and Policy Highlights Report			
Author:	Name: Michele Moran Title: Chief Executive			
Recommendation:	To approve		To note	√
	To discuss		To ratify	
	For information		To endorse	
Purpose of Paper:	To update the Trust Board on recent publications and policy.			
Key Issues within the report:	<p>I. What gets measured gets done – how can the NHS make the most of the workforce race equality standard?</p> <p>II. System Working in an Uncertain World</p> <p>III. Rise in registered nurses provides optimism but workforce challenges leave staff under substantial pressure</p> <p>IV. Providers welcome “more realistic” 2019/20 financial task but voice two important notes of caution</p> <p>V. Will the NHS long term plan give the community services sector the national focus it deserves?</p> <p>VI. National system leaders right to recognise the scale of workforce challenges facing the NHS</p>			

Monitoring and assurance framework summary:

Links to Strategic Goals

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

Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			
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 on recent publications and policy.

1. What gets measured gets done – how can the NHS make the most of the workforce race equality standard? NHS Providers 17 April 2019

The recent 2018 workforce race equality standard (WRES) update shows that while improvement has been made, there is still much work to do before the NHS can consider itself a global exemplar in equality and diversity standards.

The data shows that trusts have made progress on race equality in some areas. Black and minority ethnic (BME) staff now make up 19.1% of the NHS workforce, with over 10,000 more BME people working in the service than in 2017. The proportion of BME staff in very senior manager roles has increased from 2017 from 5.7% to 6.9%, and there have been year on year improvements in the likelihood of staff from black and minority ethnic backgrounds being appointed from shortlists relative to white applicants. The number of BME board members is increasing gradually. This all represents a step in the right direction and providers will continue to take equality and diversity seriously to sustain this progress. In spite of improvements, the figures shed light on how far the NHS has to go to fulfil its potential to become a global exemplar of diversity and race equality which - as the 5th largest employer in the world – is surely a worthy ambition. Senior BME representation, for example, is slightly lower than the 8% of directors on private sector FTSE 100 boards - a troubling realisation for the NHS. Additionally, the proportion of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months has increased from 26% to 28% in the past year, and the percentage of BME staff believing that their trust provides equal opportunities for career progression or promotion has decreased from 76% in 2017 to 72% in 2018.

In spite of improvements, the figures shed light on how far the NHS has to go to fulfil its potential to become a global exemplar of diversity and race equality which - as the 5th largest employer in the world – is surely a worthy ambition.

White applicants are 1.45 times more likely to be appointed from a shortlist than their BME counterparts, and people from BME backgrounds are radically underrepresented at senior manager levels. The [latest NHS staff survey results](#) show that of those working in the NHS, 15% have experienced discrimination – compared to just 6.4% of white staff. Just 69% of BME staff say that their organisation acts fairly with regard to career progression regardless of ethnicity, compared to 86% of white staff.

If the NHS is to meet the needs of its population, diversity needs to run through its workforce like a stick of rock, from the most senior members of the NHS all the way to porters and healthcare assistants. This includes within NHS arms-length bodies, where BME representation on boards is the same, if not worse, than in the provider sector. If the NHS is to meet the needs of its population, diversity needs to run through its workforce like a stick of rock, from the most senior members of the NHS all the way to porters and healthcare assistants.

The case for improving board diversity extends beyond it simply being the right thing to do. Organisations with more BME representation at senior level tend to benefit from a greater variety of perspectives, helping to avoid 'group think' and supporting effective decision-making. At the front line it ensures that – in a population where 8 million people have a BME background – patients are more likely to receive care that suits their health, social and

cultural needs and preferences. There is evidence that increasing representation of BME staff has a [positive effect on staff engagement](#), and there is a [link between diversity and quality of care](#).

There is evidence that increasing representation of BME staff has a positive effect on staff engagement, and there is a link between diversity and quality of care. Not only do we all need to recognise why diversity is important, we must take greater steps towards supporting diversity well. The experience of BME staff is just as important as their presence in the workforce. Unfortunately the NHS staff survey results echo the WRES findings that BME staff still experience more harassment and bullying than white staff, and feel they benefit from fewer opportunities to progress. Trusts are working hard to improve the experience of BME staff, with many implementing robust staff engagement programmes and forums to ensure their voices are heard and changes are made where needed, and 'reverse mentoring' schemes to improve senior managers' understanding of staff experiences on the front line.

We welcome the national WRES team's work with NHS Improvement focusing on tools and interventions to improve workplace culture across the NHS. This should help build on local efforts in this area, and provide the additional support trusts need in the context of severe staff shortages and threats to the provider leadership pipeline.

Lead: Director of Workforce and Organisational Development

[Our WRES \(workforce race equality standard\) performance is contained in the Equality, Diversity and Inclusion Annual Report which is being considered by Workforce and Organisational Development Committee on 24th May.](#)

2. System Working in an Uncertain World NHS Providers 9 May

On the NHS England website, ICSs are not clearly defined, referring to sustainability and transformation partnerships (STPs), the predecessor of ICSs in the first few lines without clarity on the differences between the two. So it is unsurprising that there is some confusion within STPs over what they need to do to become an ICS.

Definitions notwithstanding, all of England will be covered by ICSs by April 2021, under the commitments set out in the long term plan. This means that no matter where existing local systems are on their journey to integration, they've now just two years to get there.

It's a tall order, especially for areas that have only recently started to work in partnership. These areas will have the longest journey ahead of them, especially considering the variability that exists between local partners. Some of the most advanced ICSs have been working on their transformation for decades, having had considerable time to develop critical relationships. In other areas those relationships can be quite fractured or need time to develop. A lack of funding and capital investment, workforce challenges and organisational and financial performance are all additional factors that could hamper the move to collaboration or distract local leaders from the time and personal commitment they would otherwise give to system working.

A lack of funding and capital investment, workforce challenges and organisational and financial performance are all additional factors that could hamper the move to collaboration or distract local leaders from the time and personal commitment they would otherwise give to system working.

The lack of a statutory underpinning for ICSs is seen by many as the next most obvious challenge. While ICSs are a welcome move to local collaboration, they don't have a basis in law and derive their legitimacy from their component organisations: usually providers, CCGs and local authorities. It is therefore unclear how ICSs will be held to account for their decisions and how they will hold their partners to account for the system goals and performance measures described in the plan. The strength of trusts' autonomous unitary boards, with non-executive directors forming a majority, is that they can practice proper corporate governance, manage risk and be subject to scrutiny and challenge.

However, flexibility in existing legislation allows for ICSs and other collaborative partnerships between providers, and between providers, commissioners and local authorities to form. We know that many providers and their partners have developed governance structures that can support collaboration and integrated services in this environment while managing risk.

ICSs and the move to system working may well mean an enlarged role for providers at a system level. The plan states that commissioners and providers will make shared decisions around population health management, with providers required to contribute to system wide goals on population health.

In fact, ICSs and the move to system working may well mean an enlarged role for providers at a system level. The plan states that commissioners and providers will make shared decisions around population health management, with providers required to contribute to system wide goals on population health. The new integrated care provider (ICP) contract would offer a way for trusts to influence population health, as a single contract through which a number of services (primary, community, acute and mental health care) could be commissioned from a lead provider organisation, responsible for delivering integration of services. This approach is one of many partnership arrangements that are available to STPs and ICSs to achieve the commitments in the long term plan but there remain some unanswered questions around the uptake of the ICP contract and whether it is fit for purpose.

The ultimate uncertainty though, is arguably the broader environment in which the plan was published. Given the key roles that public health and social care play in effective health and care systems, it is unfortunate that the long term plan was published ahead of the expected green papers. Securing sufficient funding for public health, social care, capital spending, education and training is fundamental to the successful delivery of the plan. Indeed, the lack of clarity around these issues has created a very uncertain environment in which systems are being asked to plan and transform.

But it's not all doom and gloom. ICSs are already flourishing, providing joined up, patient-centred integrated care. Developing systems can be supported to overcome these challenges by more advanced "partners" offering tailored support. Any pathway to ICS 'status' will need to incorporate this supportive approach. NHS Providers – working with the Local Government Association, NHS Confederation, and NHS Clinical Commissioners – have developed a [Peer Support programme](#) of bespoke support to local system leaders, using senior, experienced peers who work within the NHS and social care organisations or have very recent experience of leading and supporting local system working in their development. It will take approaches like this as part of a wider programme of support, to identify, and then overcome, the challenges ahead.

Lead: Chief Executive

This will be discussed in the various Humber Coast and Vale Executive meetings

3. Rise in registered nurses provides optimism but workforce challenges leave staff under substantial pressure NHS Providers 8 May 2019

- Around 8,000 more nurses, midwives and nursing associates are now registered to work in the UK compared to 12 months ago, according to latest figures by the Nursing and Midwifery Council (NMC).
- The data reveals a 126% leap in the number of nurses and midwives from outside of the EU registering to work in the UK for the first time.
- Figures also show an overall increase of more than 5,000 UK trained nurses, midwives and, in England only, nursing associates.
- The number of nursing and midwifery professionals from the EU continues to decline, with a 13% drop over two years.
- Findings from that survey show that the top reason for leaving was retirement, however almost a third of the respondents cited too much pressure leading to stress and/or poor mental health.
- Elsewhere in the survey findings, 51% of those nurses and midwives who trained within the EU, left the register and responded to the survey stated Brexit as a reason for encouraging them to consider working outside the UK.

Responding to 'The NMC Register' data for 18/19, the deputy chief executive at NHS Providers, Saffron Cordery said: "Following a concerning fall in the number of nurses registered to work in the UK, these latest figures will provide some optimism for those working to address the shortage of nurses in the NHS. We need to be realistic about the challenges we face. There are now around 40,000 nursing posts currently unfilled in the English NHS alone. This will take time to solve. But we need to be realistic about the challenges we face. There are now around 40,000 nursing posts currently unfilled in the English NHS alone. This will take time to solve. Trusts are already working hard to make sure all staff feel valued and that the NHS is seen as a great place to work. But we will also need to see a mix of short-term and longer-term solutions including the expansion of international recruitment and greater investment in NHS education and training places. Fundamentally while demand continues to rise frontline staff face substantial pressures which can make their roles particularly challenging.

Lead: Director of Workforce and Organisational Development

Vacancies are reported to Board on a monthly basis. Work continues via Workforce Planning and recruitment initiatives to address the vacancies across the Trust.

4. Providers welcome "more realistic" 2019/20 financial task but voice two important notes of caution NHS Providers 26 April 2019

A new report by NHS Providers has found that the majority of trusts are feeling more positive about meeting their financial targets in 2019/20, following the agreement of additional funding for the next five years and a new NHS financial architecture.

The report, the latest in an annual series, looks at initial provider reactions to the 2019/20 task they have been set. 2019/20 is a key year for the NHS as it marks the start of the new five year increased NHS funding settlement. It also heralds the start of the new financial architecture with a strong focus on providers returning to financial surplus.

The report, *the 2019/20 task for providers*, draws on a snapshot survey of trusts focusing on their financial targets for 2019/20. Only a small number of trusts (13%) said they would not be able to sign up to their control total (the financial target set by NHS Improvement for

each trust) and a further 28% were unsure. These numbers are an improvement on last year's results and, together with feedback on progress since the survey, suggest that significantly more providers will agree their control totals than last year.

Providers have also reported that there is an improvement in the level of savings required in 2019/20. The survey shows an average savings level of 3.6% compared to last year's 5% and much larger numbers of trusts with a savings level of less than 3%. 3.6% represents the current level being delivered and it is important to note that many of the savings are on an unsustainable basis. The report highlights two issues of concern. Providers of community services funded by local authorities have not been funded, despite public commitments, to meet the costs of the required agenda for change pay rises for their staff on those terms and conditions. This needs urgent resolution.

There are a number of trusts arguing that their financial task in 2019/20 is significantly more stretching than planned and we need to understand the reasons for this. NHS Improvement are arguing that this is due to trusts failing to deliver sufficient level of 2018/19 savings negatively affecting 2019/20 budgets. The trusts concerned have a different view – that they are being adversely affected by the aggregate impact of some of the micro level changes to the financial architecture.

The report outlines seven ways in which trusts could be more effectively supported to deliver what is needed in 2019/20 and beyond. These include fully funding the Agenda for Change pay rises for those trusts holding local authority community contracts, reviewing the impact of 2019/20 specialist tariff changes and the need to develop a clear, fully funded, plan with the right workforce in place to recover performance in A&E and elective surgery.

Lead: Director of Finance

The outcomes from this report will be reported to the June Finance Committee.

5. Will the NHS long term plan give the community services sector the national focus it deserves? NHS Providers 17 April 2019

NHS Providers has published the fourth edition of its publication series *Provider Voices*, which promotes the views of trust leaders and other parts of the system on some of the key issues facing health and care services today.

In January this year the NHS long term plan was published. This outlined a vision to shift care away from hospitals and closer to people's homes and communities. *Community Services: Our time* explores the opportunities and risks for the sector as a result of the NHS long term plan. National NHS leaders have often promised to give greater emphasis to community services, making them more central and allocating greater investment. Will this now happen?

The report features 10 interviews and found:

- That there is optimism among leaders within the community services sector about delivering the ambitions of the NHS long term plan
- While an opportunity, there are key questions to be addressed about the relationship between community services and primary care networks.
- One of the key challenges faced by community services is securing the right workforce.
- That there are benefits and challenges with adapting to new technologies and ways of working.
- There is a need to change national perceptions and understanding of the role community services play and are accessed by patients.

The report pulls together a broad range of voices from sector representing NHS trust leaders, from the hospital, community, ambulance and mental health sectors, as well as representation from social care, primary care, integrated care systems and the Community Network.

The next report in the series on specialised services will be published in the Autumn.

Lead: Chief Operating Officer

This is an interesting summary report from NHS Providers about the crucial role that community services play in delivering the NHS long term plan. The key points that are being made have formed our considerations already as we participate in the Integrated Care Partnership development work and our ongoing relationships with the emerging Primary Care Networks. It will be useful to continue to reflect on these findings as this work progresses through the Executive Management Team and the Board.

6. National system leaders right to recognise the scale of workforce challenges facing the NHS NHS Providers 25 April 2019

- Health and social care secretary Matt Hancock and NHS Improvement chair Baroness Dido Harding spoke at the event.
- Hancock said the NHS needs a modern working culture where doctors are not expected to cancel important family events because of short-notice shift changes.
- He called for rotas to be fixed a minimum of six weeks in advance and that more part-time, job sharing or home-working roles should be available.
- Baroness Dido spoke ahead of the publication of the Interim NHS People Plan, due to be published soon, which is expected to set out more concrete plans to improve staff retention.

The Royal College of Physicians annual conference, *Medicine 2019*, took place on 25 and 26 April. Responding to the workforce speeches by Baroness Dido Harding and the health and social care secretary at the Royal College of Physicians conference, the chief executive of NHS Providers, Chris Hopson said:

“Trusts leaders tell us that the range of workforce challenges they face, centred on recruiting and retaining the right number of staff, are their number one concern. There is no single, quick solution to these problems. They have developed over several years and will require concerted, purposeful, action over a similar time period to start addressing them. Trusts leaders tell us that the range of workforce challenges they face, centred on recruiting and retaining the right number of staff, are their number one concern. There is no single, quick solution to these problems. The sentiment expressed today by both Dido Harding and Matt Hancock is very welcome recognition about the severity of the workforce challenges the NHS faces. You can’t solve a problem until you honestly and openly acknowledge its existence, scale and size. We agree that solving these challenges isn’t just about future workforce planning and more money, important though these are. We agree that solving these challenges isn’t just about future workforce planning and more money, important though these are. We welcome the emphasis on making the NHS a great place to work by supporting staff wellbeing and promoting flexibility and equality, as set out by the health secretary today. It’s also vital that we address the challenges in changing leadership culture and training a workforce equipped for the future. Trust leaders have a key role to play in each of these areas. You can’t solve a problem until you have the right strategy.

All of the NHS together must get behind a single, clear, approach and develop a unity of purpose which has been sadly lacking for far too long. We welcome the ongoing process to develop the new NHS workforce plan as it's been much more inclusive and moved at a much faster pace than what's gone before. All of the NHS together must get behind a single, clear, approach and develop a unity of purpose which has been sadly lacking for far too long. We welcome the ongoing process to develop the new NHS workforce plan as it's been much more inclusive and moved at a much faster pace than what's gone before. It really has felt different. You can't solve a problem in a system as complex as the NHS until everyone agrees to align behind a single plan and then everyone moves at pace to implement it. But we must also be realistic. There will be no single, quick, magic, fix. We all want to see more money, more staff and solutions to long running problems like pensions and immigration rules as quickly as possible. But given the timing of the spending review and the government's focus on Brexit this was never going to be possible. We should welcome the collaborative work and progress that has been made to develop the forthcoming interim plan, rather than bemoan what it cannot contain at this stage. But these issues must be addressed in time for the final plan. That includes the right outcome for NHS education and training budgets in the forthcoming spending review."

Lead: Director of Workforce and Organisational Development

The Trust Workforce and Organisational Development (OD) Strategy is being refreshed and will be reported in to Workforce and OD Committee in July. It is anticipated that the interim NHS People Plan referred to in the above will have been published and our strategy nudged accordingly.

Agenda Item: 9

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	CQC Inspection Report			
Author:	Name: Michele Moran Title: Chief Executive			
Recommendation:	To approve		To note	√
	To discuss	√	To ratify	
	For information		To endorse	
Purpose of Paper:	To formally present the CQC Inspection report that was published on 14 th May 2019			
Key Issues within the report:	<ul style="list-style-type: none"> • The Trust retained its overall rating of 'Good' • Inspectors awarded a rating of "Good" to the Trust for being well-led, effective, caring and responsive. • Acute wards for adults of working age and psychiatric intensive care units improved from "Requires improvement" to "Good", along with mental health crisis services and health-based places of safety improving to "Good" for being safe and well-led. • The report also highlighted examples of "outstanding practice" in the areas of patient feedback and engagement, self-harm and suicide prevention work and the redesigning of acute pathways to reduce out of area transfers for acute admissions. • The Trust was assessed as 'requires improvement' for safety and this will continue to be an area of focus for improvement. • The CQC noted the rating of 'requires improvement' for community services for adults had brought the overall rating for community down to 'requires improvement' but acknowledged we had taken on additional services since the last inspection - this will be an area of focus as we integrate further the new community services we acquired. 			

Monitoring and assurance framework summary:

Links to Strategic Goals				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
√	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
				Any Action Required?
Risk	√			
Legal	√			



Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Care Quality Commission (CQC) Inspection Report

Introduction

Following inspection by the CQC in February 2019 the Trust has been rated 'Good' overall in its latest inspection.

The Inspection Report is attached and is available on the CQC website with the supporting evidence appendix <https://www.cqc.org.uk/provider/RV9/reports>

Inspectors awarded a rating of "Good" to the Trust for being well-led, effective, caring and responsive. Acute wards for adults of working age and psychiatric intensive care units improved from "Requires improvement" to "Good", along with mental health crisis services and health-based places of safety improving to "Good" for being safe and well-led.

The report also highlighted examples of "outstanding practice" in the areas of patient feedback and engagement, self-harm and suicide prevention work and the redesigning of acute pathways to reduce out of area transfers for acute admissions.

We were disappointed to be assessed as 'requires improvement' for safety and community services and this will continue to be an area of focus as we integrate further the new community services we acquired recently.

As part of the factual accuracy process, we highlighted some areas to the CQC for further consideration and where these were accepted narrative was updated.

Next Steps

The report contained 13 'must dos' in addition to a number of 'should dos'. An action plan for the 'must dos' will be developed and will be signed off by the Executive Management Team in order to provide a response to the CQC by 7th June.

The action plan will be monitored through the existing governance routes to ensure delivery and the report will be discussed at and overseen by the Quality Committee.

May 2019.

Humber Teaching NHS Foundation Trust

Inspection report

Trust HQ
Willerby Hill, Beverley Road
Hull
North Humberside
HU10 6ED
Tel: 01482301700
www.humber.nhs.uk

Date of inspection visit: 07 Jan to 15 Feb 2019
Date of publication: 14/05/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Humber NHS Foundation Trust provides a range of community and inpatients mental health services, community health services, learning disability services, children's and addiction services, and GP services to people living in Hull, the East Riding of Yorkshire, Whitby and Scarborough. The trust serves a large geographical area with a population of 600,000 and it employs approximately 2500 staff at sites at locations across the catchment area.

The trust provides 10 of the core mental health services:

- Community based mental health services for adults of working age.
- Mental health crisis and health based place of safety.
- Community mental health services for people with a learning disability and/or autism.
- Community mental health services for older people.
- Specialist community mental health services for children and young people.
- Acute wards for adults of working age and psychiatric intensive care units.
- Long-stay/rehabilitation wards for adults of working age.
- Wards for older people.
- Forensic/ secure wards.
- Wards for people with a learning disability or autism.

The trust also provides specialist substance misuse services.

The trust provides community health services:

- Community health adult services.
- Community inpatient services.
- Community health services for children and young people.

The trust has seven GP practices:

- Field House Surgery.
- Hallgate Surgery.
- Market Weighton.
- Northpoint Medical Practice.
- The Chestnuts Surgery.
- Princes Medical Centre
- Peeler House Surgery

They also have one adult social care location at Granville Court.

Humber NHS Foundation Trust became a foundation trust in 2010.

Summary of findings

We undertook a well led review at Humber NHS teaching foundation trust on 15, 16 and 17 October 2017. At that inspection we rated the trust good overall and good in effective, caring, responsive and well led and requires improvement in safe.

At that inspection we also issued 15 requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of five legal requirements in nine services.

Regulation 18 – Staffing

Regulation 12- safe care and treatment

Regulation 17 – good governance

Regulation 15- Premises and equipment

Regulation 9 – Person-centred care

We told the trust that it must take action to bring services into line with 15 legal requirements. This action related to nine services and trust wide services.

Trust wide

- The trust must ensure that all staff receive supervision and appraisals in line with trust policy.

Wards for adults of working age and psychiatric intensive care units

- The trust must ensure that staff receive the full range of mandatory training, including immediate life support training and search training.
- The trust must ensure there are enough staff to meet safe staffing levels and provide activities, section 17 leave and engagement with patients on the wards.
- The trust must ensure that staff receive supervision and appraisals in line with trust policy and have time to attend regular team meetings.
- The trust must ensure that it maintains accurate, complete and contemporaneous patient records whereby staff can access results and update patient related information in a consistent manner across the service.

Long stay or rehabilitation mental health wards for working age adults

- The trust must ensure that all patients have a completed and up to date risk assessment and management plan.
- The trust must ensure there is enough suitably qualified staff on duty and that all staff have completed the mandatory training to help them carry out their roles.

Forensic inpatient or secure wards

- The trust must ensure that staff attendance at mandatory training meets their required target, to ensure staff are skilled and competent to perform their role.

Wards for older people with mental health problems

- The trust must ensure that the service has enough suitably qualified staff on duty to fill shifts. Staff must complete mandatory training and receive individual clinical supervision in accordance with trust policy and targets.

Wards for people with a learning disability or autism

- The trust must ensure that staff including temporary bank staff undertake all mandatory training courses.

Summary of findings

Community based mental health services for adults of working age

- The trust must ensure that the compliance for mandatory training courses reaches the 75% target.

Mental health crisis services and health-based places of safety

- The trust must ensure that the rooms used by the rapid response service at Miranda House are properly maintained.
- The trust must ensure that staff know what the freedom to speak up guardian is and who they are.
- The trust must ensure that staff at the rapid response service receive the appropriate training.
- The trust must ensure that an audit schedule is in place for mental health crisis and health based place of safety services to ensure that services can be assessed, monitored and improved.

Substance misuse services

- The trust must ensure that staff regularly review each patient's recovery plan in line with trust policy and best practice.
- The trust must ensure that each patient receives regular clinic reviews in line with trust policy and best practice.

Community health services for adults

- Ensure mandatory training compliance and safeguarding training compliance and targets are met across the services.
- Ensure governance systems and processes are in place across all community health services for adults' areas and embedded within teams.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Good ● → ←

What this trust does

Humber NHS Foundation Trust provides a range of community and inpatients mental health services, community health services, learning disability services, children's and addiction services, and GP services to people living in Hull, the East Riding of Yorkshire, Whitby and Scarborough.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against registered service providers and registered managers who fail to comply with legal requirements, and help them to improve their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Summary of findings

We inspected five complete core services.

- Mental health crisis and health based place of safety.
- Specialist community mental health services for children and young people.
- Acute wards for adults of working age and psychiatric intensive care units.
- Forensic/ secure wards.
- Community health services for adults.

In addition to this two GP practices and Granville Court (adult social care service) have been inspected and rated as good.

These were selected due to their previous inspection ratings or our ongoing monitoring identified that an inspection at this time was appropriate to understand the quality of the service provided.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed Is this organisation well-led?

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as good because:

- We rated well led for the trust as good. We rated effective, caring, responsive and well led as good across mental health and learning disability services. We rated safe as requires improvement.
- We rated nine of the trusts 11 mental health services as good and two as requires improvement, and whilst the rating for acute wards for adults of working age and psychiatric intensive care units remained as requires improvement, the safe key question was now rated as good. In rating the trusts mental health and learning disabilities as good we considered the previous ratings of services not inspected this time, and deviated from the ratings principles.
- We rated two of the core services as good that we inspected this time. Mental health crisis and health based place of safety services were rated as requires improvement at our last inspection in 2017 and was now rated good in all key questions.
- Six GP practices which had been inspected were rated as good in all key questions.
- The adult social care location at Granville court was inspected and rated in January 2018 and was rated as good in all key questions.
- The trust had a clear vision, strategy and vision. Staff knew and understood the trust's vision, values and strategy, had opportunity to be involved of the development of these and understood how achievement of these applied to the work of their team. The trust board and senior leaders had the appropriate range of skills, knowledge and experience to perform its role.
- Staff felt respected, supported and valued amongst their local teams. Staff knew and understood the trust's vision and values and their behaviours reflected these.

Summary of findings

- Staff treated patients with compassion and kindness. They largely respected patients' privacy and dignity and supported their individual needs. Staff understood how to protect patients from abuse and were trained to do so. Feedback we received from patients was positive. Friends and family test results were consistently positive.
- Staff were aware of what incidents they should report as adverse events and were and generally managed them well, they also knew what should be reported, their duty in reporting these and in meeting the requirements of the duty of candour.
- Patients could now access a mental health bed in a timely manner when in crisis. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit.

However:

- We rated community health services for adults as requires improvement in safe, effective and well led. This was the third inspection where this core service has been rated as requires improvement, and at this inspection effective has gone down one rating from good to requires improvement. This has led to an overall rating in community health services as requires improvement.
- There was improvement at our last inspection in the forensic and secure services leading to a rating of good over all. This improvement has not been sustained and has now been rated as requires improvement in safe and well led.
- Despite there being a programme of board visits to clinical areas and board members reporting that significant engagement was undertaken with staff, some staff reported that board members were not visible and staff did not always feel supported or listened to.
- Staff did not feel they were always consulted properly about changes to services. There were not always enough staff in all services.
- The electronic patient records system was slow and staff had developed paper records so they could access details about patients if they could not access the system when needed. The information that teams kept about patients in paper records was not consistent across the service. Staff did not always record details of safeguarding concerns under the designated section of the electronic patient record.
- There were some difficulties with works issues not being completed in a timely manner in the forensic services.
- Children and young people were waiting over 18 weeks to receive treatment in some areas.

Our full Inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website – .

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- In community health services for adults, staff in all teams did not always complete and update risk assessments.
- There was no caseload management tool used in community health services for adults to determine the number of nursing staff required in each locality.
- The electronic patient records system was slow and staff had developed paper records so they could access details about patients if they could not access the system when needed. The information that teams kept about patients in paper records was not consistent across the service. Staff did not always record details of safeguarding concerns under the designated section of the electronic patient record.
- In forensic services visits between patients and their family and friends were always observed by staff. This was a blanket restriction and did not consider risks around visits on an individual basis.

Summary of findings

- Staff had not always ensured that they were recording their responsibilities under the Mental Health Act Code of Practice relating to seclusion. Nursing and medical reviews were not always documented or occurring within the prescribed time frames. Patients in seclusion did not have individualised personal emergency evacuation plans in place.
- Forensic services did not always manage patient safety incidents well. We found that action plans were not always completed in a timely manner.
- Staff were not all following the service protocol for lone working and there were deviances in who staff would inform following a visit.
- There were not always enough staff to maintain safer staffing levels in wards or services.

However:

- Staff assessed and managed risks to patients and themselves well except in community health services for adults. They followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Ward staff participated in the provider's restrictive interventions reduction programme. Trust risk registers accurately reflected the risks of the trust and staff.
- Staff understood how to protect patients from abuse and or exploitation and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and or exploitation and they knew how to apply it. Staff could identify safeguarding concerns and had effective working relationships with the local authority when raising concerns about a vulnerable adult or child.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff knew what should be reported and their duty in reporting these and in meeting the requirements of the duty of candour.
- In forensic services mandatory training rates had improved since our last inspection.
- In community child and adolescent mental health services managers recognised the requirement to improve staffing levels to respond to increases in autism referrals and long waiting lists. This was reflected in a recruitment drive to form a specific team for this care pathway.

Are services effective?

Our rating of effective stayed the same. We rated it as good because:

- Staff provided a range of care and treatment interventions in line with national guidance.
- There were full multidisciplinary team approaches and staff worked closely with members of the mental health response team and external agencies including the police and ambulance service.
- Most ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Generally, managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- In community child and adolescent mental health services staff were experienced and received specialist training to meet the needs of the children and young people using the service.

Summary of findings

- In community child and adolescent mental health services staff from different disciplines worked together as a team to benefit the child or young person. They supported each other to make sure there were no gaps in their care. Teams had effective working relationships with relevant services outside the organisation.

However:

- In mental health crisis and health based place of safety, staff prioritised patient care above the need to receive formal supervision and staff clinical supervision was low. Community health services staff were not always receiving supervision or appraisals.
- In community health services although care and treatment provided appeared evidence based, there were no care pathways for staff to follow to ensure patients were receiving consistency of care. Staff were not always competent.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Feedback we received from patients was positive. Friends and family test results were consistently positive
- We observed staff treating patients with respect and compassion.
- Surveys were conducted to capture the views of patients and carers.
- Staff involved patients and those close to them in decisions about their care and treatment.
- In forensic services patients had been involved in a range of creative activities to improve the wards, including art projects and the creation of a DVD about life in the service.
- Children, young people and their parents or carers had good opportunities to be involved when appropriate in decisions about the service.

However:

- In acute wards for adults of working age and psychiatric intensive care units the measures the trust had taken to protect patients' privacy and personal details was not always effective.

Are services responsive?

Our rating of responsive stayed the same. We rated it as good because:

- Staff helped patients with communication, advocacy and cultural and spiritual support.
- There had been an improvement in the way staff managed patient beds. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The service had clear criteria to support the triage of patients to the most appropriate service.
- The service regularly audited call volumes and adapted staffing to be available at peak times.
- The service ensured patients detained under section 136 of the Mental Health Act received prompt assessments and were detained for the shortest time possible.
- In forensic services staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison.
- Staff worked closely with schools, families and external organisations to establish and maintain engagement and relationships with the wider community.

Summary of findings

However:

- We did not see that staff provided information on wards for patients with lesbian, gay, bisexual and transgender needs, (LGBT). We did not see evidence that staff had links with local LGBT organisations but on the trust website, we saw that staff were involved with the Hull Pride campaign in 2018 and staff and patients from across the trust attended the event.
- Two of the meeting rooms at Miranda House did not have obscure glass to promote privacy and dignity for patients who were completing an assessment.
- There were some difficulties with works issues not being completed in a timely manner which affected privacy and dignity in the forensic services.
- Children and young people were waiting over 18 weeks to receive treatment.

Are services well-led?

Our rating of well-led stayed the same. We rated it as good because:

- The trust board and the senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. Whilst there had been some changes of personnel within the board since our last inspection, the board had the ability to deliver high quality care.
- The trust had a board of directors who were responsible for safe delivery of services and committed to delivering the strategy.
- There was a clear vision, strategy and set of values. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. Processes were in place to support delivery of the strategy. The trust had an operational board, a council of governors and seven committees.
- The trust had started to use statistical process control, which is a method of quality control which employs statistical methods to monitor and control processes. This enabled better evaluation and moved away from cumbersome dashboards for the board.
- There was a board development programme, which was introduced for the senior management team. Board level posts and board members received an annual appraisal where professional development needs were identified and addressed.
- The trust had a distributed leadership plan that supported the overarching workforce and organisational development strategy. Succession planning and development of leaders was a priority for the trust and they had a leadership development programme.
- The trust had an efficient process for management of risk and quality. The trust had recently introduced a daily risk huddle this group reviewed risk items from the previous 24 hours which allowed immediate escalation of any risk issues. The trust also had a weekly clinical risk management group. This group had oversight of briefings, investigations, escalation of issues and commissioning of thematic reviews.
- The trust had an extensive internal and external audit programme and plan to monitor quality and review risks. The trust held its first ever research and development conference in 2018, which was well received by trust staff and external attendees.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust policies described the process for staff to raise concerns about quality and safety of services.

Summary of findings

- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- Staff felt respected, supported and valued by local managers in their day-to-day work. They felt able to raise concerns without fear of retribution. Staff had the opportunity for development and progression. Most managers were compassionate, inclusive and supportive and had the skills knowledge and experience to perform their roles.
- The trust remained part of the sustainability and transformation partnership.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five points had no change and nine had changed negatively.
- Staff treated patients with compassion and kindness. Patients who used the services reported positive and inclusive relationships with the trust. Patients constantly recommended the trust as a place to receive care in the family and friends test between April 2018 and September 2018.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five which had no change and nine that had changed negatively. The trust recognised staff success by staff awards and through ongoing feedback.
- The trust had updated its complaints policy and all complaints were now completed within timescales.
- The trust had appointed a freedom to speak up guardian and a deputy. Both had dedicated time to undertake this role and this included speaking at the induction programme for new staff to highlight the service, training, local and national events and developing the strategy further.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust risk management policy, incident reporting policy, serious incident policy and freedom to speak up policy all described the process for staff to raise concerns about quality and safety of services.
- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- NHS improvements told us that the trust was proactive in using benchmarking data to develop cost improvements programmes. As at the last inspection all cost improvement programmes went through a robust internal assessment process, this process remained the same at this inspection.
- The Trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received.
- The trust was currently involved in 17 National Institute for Health Research projects and 17 non National Institute for Health Research projects.

However:

- At our last inspection in 2017, staff expressed risks and worries around staffing numbers, skill mix and change management. Some staff reported the same at this inspection especially in community health services for adults. Despite the trust board having a comprehensive programme of site visits, there was still a mixed picture from staff who at times felt that the directors were not visible enough.
- The trust had an equality and diversity policy but no strategy, this focused mainly on staff not service users and had no clear statement of what success would look like, this also lacked an operational plan to underpin its delivery. The trust's patient and carer experience strategy included consideration of equality and diversity.

Summary of findings

- The trust were undertaking a shaping the vision – care services structure consultation. This had raised many anxieties in staff who felt that they had not been fully informed or consulted with. This included medical staff.
- There were some difficulties with works issues not being completed in a timely manner in the forensic services. Children and young people were waiting over 18 weeks to receive treatment in some areas. Some information relating to the community child and adolescent mental health services on the trust website was out of date. The risk register had only been implemented two weeks pre- inspection in community health services for adults.
- There were still reported difficulties when working with the trade unions.
- Whilst the trust reached their overall target of 85% for mandatory training, some courses fell below this. Appraisals in all areas did not meet the trusts target. The trust's target rate for clinical supervision was 80%. As at 31 August 2018 the overall clinical supervision compliance was 77%.
- The electronic patient record system remained slow and had varied implementation with some staff creating local records.
- In mental health crisis and health based place of safety services staff informed us despite the service level agreement and patient directives being in place there continued to be difficulties in obtaining medication out of hours.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in acute wards for adults of working age and psychiatric intensive care services, child and adolescent mental health services and trust wide. For more information, see the outstanding practice section of this report.

Areas for improvement

We found areas for improvement including 13 breaches of legal requirements that the trust must put right. We found 27 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued six requirement notices to the trust. Our action related to breaches of thirteen legal requirements in four core services. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information on action we have taken, see the sections on areas for improvement and regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

The trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received. The information showed how the trust were performing at organisation, care group and team level. This live link was available via the trusts internet page and patients, carers and staff could access this immediately. In February 2019 the live link showed that 216 people had responded to the survey and that 94% of them would recommend their services to friends and family if they needed similar care or treatment.

The trust had developed a bereavement package for deaths that occurred because of physical ailments. As part of that bereavement package the charity health stars paid for bereavement cards to be printed. Patients and carers developed the messages inside the card. The bereavement package included a card, advice on how to deal with bereavement for the carers, a card from the clinician who dealt with the loved one, links to funeral homes. This package was developed following the trusts last CQC inspection as the trust recognised that when people were grieving they don't want to be asked lots of questions, so staff don't complete the survey when they are with the carers but do it afterwards to be respectful. The team are hoping to roll these packages out to children and mental health services.

Staff on Westlands had developed a toolkit for use with patients at risk of suicide and self-harm. They were in the process of providing training for staff on other wards.

The trust had reduced their out of area transfers for acute admissions by redesigning the acute pathway including adding five beds, supported by developments of the crisis pad, step down beds and clinical decisions unit.

The Social Mediation and Self-Help (SMASH) programme is a group-based programme which takes referrals from schools. They work with young people aged 10-16 years who may be at risk of developing mental health problems, this is a unique collaboration between Humber Teaching Foundation Trust and the SMASH programme which worked with a wide range of partners across health, social care, communities, education, young people and families. The programme has received national recognition from Thrive, Royal College of Psychiatrists and Young Minds. The programme is a finalist in the HSJ Innovation in mental Health Award. Although referrals to the children and adolescent mental health services continue to rise, consistent with the national picture, the programme has delivered an accessible early intervention programme which has begun to reduce the numbers requiring access to specialist treatment.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services

We told the trust that it must take action to bring services into line with six regulations in respect of thirteen breaches of legal requirements. This action related to four services.

Action the trust MUST take to improve:

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure patient care plans are personalised, holistic and reflect all the identified needs of patients. (Regulation 9).
- The trust must ensure staff act in line with the Mental Capacity Act and code and practice in assessing capacity, making best interest decisions and allowing patients to make unwise decisions. (Regulation 11).

Summary of findings

- The trust must ensure staff complete consent to treatment records for all detained patients. (Regulation 11).
- The trust must ensure staff on the wards feel supported, valued and that they are consulted appropriately on service developments. (Regulation 17).
- The trust must ensure systems and processes designed to monitor and improve the service are implemented consistently across the service and staff have adequate guidance so they understand what is expected of them. Audits must identify and address effectively any areas of concern. (Regulation 17).

Community health services for adults

- The trust must ensure all staff receive supervision and appraisals. (Regulation 18).
- The trust must ensure that accurate and complete patient records are maintained. Risk assessments and care plans should be completed and regularly reviewed. (Regulation 17).
- The trust must ensure regular audits are conducted to assess, monitor and improve the quality and safety of services. (Regulation 17).

Forensic services

- The trust must ensure there are sufficient skilled and competent staff to safely meet the needs of patients. (Regulation 18).
- The trust must ensure that that nursing and medical reviews for patients in seclusion take place and are documented within required timescales. The trust must ensure patients in seclusion must have individualised personal emergency evacuation plans in place. (Regulation 12).
- The trust must ensure there are appropriate systems in place to monitor actions from incident investigations and share learning from incidents amongst the staff team. (Regulation 17).
- The trust must ensure that systems to report, record and resolve maintenance issues in the service are in place and effective. Repairs to essential services such as laundry and shower facilities must be completed in a timely manner. (Regulation 15).

Specialist community mental health services for children and young people.

- The trust must review and reduce the waiting lists for treatment for children and young people to meet national guidance. (Regulation 9).

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider further methods of engagement with staff at ward and service level.
- The trust should review the use and implementation of the Lorenzo electronic patient note system.
- The trust should consider further measures needed to ensure an increase in appraisals and supervision numbers in some core services.
- The trust should ensure participation at all levels when embarking on consultations which affect staff, roles and services.
- The trust should ensure that staff feel communicated with and consulted about trust wide decisions and consultations.
- The trust should ensure that supervision for staff reaches the required target.

Summary of findings

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure they review minimum staffing levels in line with deputy director of nurses safer staffing report.
- The trust should carry out assessments with all patients to determine whether they need access to a personal alarm.
- The trust should ensure there are effective measures in place on all wards to protect patient confidentiality and ensure patients' privacy in bedrooms is not compromised.
- The trust should ensure ward managers receive timely feedback about serious incident investigations and that there is a robust process for sharing lessons learned from wider trust incidents and complaints including between each ward of the service.
- The trust should ensure information for lesbian, gay, bisexual and transgendered people is available and visible for patients and visitors.

Mental health crisis and health based place of safety

- The trust should ensure systems and processes are in place for staff to access medication out of hours.
- The trust should ensure staff record safeguarding concerns under the designated area of the electronic patient records.
- The trust should ensure staff receive regular supervision in line with trust targets.
- The trust should ensure the meeting rooms at Miranda house promote patients right to dignity and privacy.
- The trust should consider staff access to the equipment necessary to complete physical health checks in the community.
- The trust should consider ways to improve senior managers visibility to staff and increase staff confidence in raising concerns.

Community health services for adults

- The trust should consider ways to further engage with staff and improve communication.
- The trust should consider ways to improve cross locality communication between teams.
- The trust should ensure that all staff know how to report incidents.

Forensic services

- The trust should consider the use of individual risk assessments in relation to observed visits within the service.
- The trust should ensure that occupational therapy staff are not routinely used to support safe staffing levels on the wards.
- The trust should consider how to extend opportunities to support and involve families and carers.
- The trust should ensure that patients are able to make telephone calls in a way that does not compromise their privacy.

Specialist community mental health services for children and young people.

- The trust should ensure their website reflects the service's teams and care pathways.
- The trust should consider room space for appointments at the Beverley location in East Riding.

Summary of findings

Is this organisation well-led?

We rated well led good at the trust because:

- The trust board and the senior leadership team had the appropriate range of skills, knowledge and experience to perform its role. Whilst there had been some changes of personnel within the board since our last inspection, the board had the ability to deliver high quality care.
- The trust had a board of directors who were responsible for safe delivery of services and committed to delivering the strategy.
- There was a clear vision, strategy and set of values. Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. Processes were in place to support delivery of the strategy. The trust had an operational board, a council of governors and seven committees.
- The trust had started to use statistical process control, which is a method of quality control which employs statistical methods to monitor and control processes. This enabled better evaluation and moved away from cumbersome dashboards for the board.
- There was a board development programme, which was introduced for the senior management team. Board level posts and board members received an annual appraisal where professional development needs were identified and addressed.
- The trust had a distributed leadership plan that supported the overarching workforce and organisational development strategy. Succession planning and development of leaders was a priority for the trust and they had a leadership development programme.
- The trust had an efficient process for management of risk and quality. The trust had recently introduced a daily risk huddle this group reviewed risk items from the previous 24 hours which allowed immediate escalation of any risk issues. The trust had also implemented a weekly clinical risk management group. This group had oversight of briefings, investigations, escalation of issues and commissioning of thematic reviews.
- The trust had an extensive internal and external audit programme and plan to monitor quality and review risks. The trust held its first ever research and development conference in 2017, which was well received by trust staff and external attendees.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust policies described the process for staff to raise concerns about quality and safety of services.
- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- Staff felt respected, supported and valued by local managers in their day-to-day work. They felt able to raise concerns without fear of retribution. Staff had the opportunity for development and progression. Most managers were compassionate, inclusive and supportive and had the skills knowledge and experience to perform their roles.
- The trust remained part of the sustainability and transformation partnership.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five points had no change and nine had changed negatively.

Summary of findings

- Staff treated patients with compassion and kindness. Patients who used the services reported positive and inclusive relationships with the trust. Patients constantly recommended the trust as a place to receive care in the family and friends test between April 2018 and September 2018.
- The staff survey results for the year 2018 showed a positive increase in 51 points from the previous year, five which had no change and nine that had changed negatively. The trust recognised staff success by staff awards and through ongoing feedback.
- The trust had updated its complaints policy and all complaints were now completed within timescales.
- The trust had appointed a freedom to speak up guardian and a deputy. Both had dedicated time to undertake this role and this included speaking at the induction programme for new staff to highlight the service, training, local and national events and developing the strategy further
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. The trust risk management policy, incident reporting policy, serious incident policy and freedom to speak up policy all described the process for staff to raise concerns about quality and safety of services.
- Central to the trusts risk reporting was the trusts risk management system where staff were encouraged to report all incidents and matters of concern. Managers maintained local risk registers, which generally reflected the concerns of staff.
- NHS improvements told us that the trust was proactive in using benchmarking data to develop cost improvements programmes. As at the last inspection all cost improvement programmes went through a robust internal assessment process, this process remained the same at this inspection.
- The Trust launched a friends and family test live data dashboard in April 2018 which showed the results of the friends and family test surveys received.
- The trust was currently involved in 17 National Institute for Health Research projects and 17 non National Institute for Health Research projects.

However:

- At our last inspection in 2017, staff expressed risks and worries around staffing numbers, skill mix and change management. Some staff reported the same at this inspection especially in community health services for adults. Despite the trust board having a comprehensive programme of site visits, there was still a mixed picture from staff who at times felt that the directors were not visible enough.
- The trust had an equality and diversity policy but no strategy, this focused mainly on staff not service users and had no clear statement of what success would look like, this also lacked an operational plan to underpin its delivery. The trust's patient and carer experience strategy included consideration of equality and diversity.
- The trust were undertaking a shaping the vision – care services structure consultation. This had raised many anxieties in staff who felt that they had not been fully informed or consulted with. This included medical staff.
- There were some difficulties with works issues not being completed in a timely manner in the forensic services. Children and young people were waiting over 18 weeks to receive treatment in some areas. Some information relating to the community child and adolescent mental health services on the trust website was out of date. The risk register had only been implemented two weeks pre- inspection in community health services for adults.
- There were still reported difficulties when working with the trade unions.

Summary of findings

- Whilst the trust reached their overall target of 85% for mandatory training, some courses fell below this. Appraisals in all areas did not meet the trusts target. The trust's target rate for clinical supervision was 80%. As at 31 August 2018 the overall clinical supervision compliance was 77%.
- The electronic patient record system remained slow and had varied implementation with some staff creating local records.
- In mental health crisis and health based place of safety services there continued to be difficulty for the service to access medication out of hour due to the trusts contract with the community pharmacy.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ May 2019	Good ↔ May 2019				

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019	Good ↔ May 2019	Good ↔ May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Mental health	Requires improvement ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019
Overall trust	Requires improvement ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement ↔ May 2019	Requires improvement ↓ May 2019	Good ↔ May 2019	Good ↔ May 2019	Requires improvement ↔ May 2019	Requires improvement ↔ May 2019
Community health services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019	Good ↔ May 2019	Good ↔ May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ May 2019	Requires improvement ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Requires improvement ↔ May 2019	Requires improvement ↔ May 2019
Long-stay or rehabilitation mental health wards for working age adults	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Forensic inpatient or secure wards	Requires improvement ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Wards for older people with mental health problems	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Wards for people with a learning disability or autism	Requires improvement Jan 2018	Good Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018	Good Jan 2018	Good Jan 2018
Community-based mental health services for adults of working age	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Mental health crisis services and health-based places of safety	Good ↑ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↑ May 2019	Good ↑ May 2019
Specialist community mental health services for children and young people	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Requires improvement ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019
Community-based mental health services for older people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Community mental health services for people with a learning disability or autism	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Substance misuse services	Good Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
Overall	Requires improvement ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019	Good ↔ May 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for primary medical services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Field House Surgery	Good Nov 2017					
Hallgate Surgery	Good Jul 2017					
Market Weighton	Good Aug 2017					
Northpoint Medical practice	Good Aug 2018					
Peeler House Surgery	Good Feb 2019					
Princess Medical Centre	N/A	N/A	N/A	N/A	N/A	N/A
Chestnut surgery	Good Aug 2017					

Ratings for adult social care services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Granville Court	Good →← Jan 2019					

Community health services

Background to community health services

The trust provides three community health services these being

- Community health inpatient services.
- Community health services for children and young people
- Community health services for adults

We inspected community health services for adults at this inspection

Summary of community health services

Requires improvement ● ↓

Our ratings of these services went down.

We rated community health services for adults as requires improvement in safe, effective and well led. This was the third inspection where this core service has been rated as requires improvement, and at this inspection effective has gone down one rating from good to requires improvement. This has led to an overall rating in community health services as requires improvement

Community health services for adults

Requires improvement   

Key facts and figures

Humber Teaching NHS Foundation Trust provided community health services for adults to the areas of Whitby, Pocklington, Scarborough and Ryedale. The services for Scarborough and Ryedale had moved from an alternative provider to Humber Teaching NHS Foundation Trust in May 2018.

Services offered included community nursing, physiotherapy, occupational therapy, dietetics, heart failure service, cardiac rehabilitation, respiratory, diabetes, tissue viability, continence, speech and language, stroke services and musculoskeletal (MSK) physiotherapy. A health trainer team supported people to live a healthier lifestyle, working across East and North Yorkshire.

The service was previously inspected in September 2017, when community services were only provided from Whitby and Pocklington.

The previous rating for community services for adults was requires improvement. Safe and well led were rated as requires improvement, effective, caring and responsive was rated as good.

At this inspection, the community health services for adults was inspected.

Our inspection was announced (staff knew we were coming) the day before our inspection, to ensure that everyone we needed to talk with was available.

We visited staff bases at Whitby, Scarborough, Malton and Pocklington. We spoke with 42 members of staff and six patients. We reviewed eight patient records. We accompanied staff on home visits and observed a musculoskeletal (MSK) clinic and dietician's clinic.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- There were inconsistencies in completion of risk assessments and care plans. In Scarborough and Ryedale, the appropriate templates were not yet on the electronic record and staff had not received training. Care pathways were not in place for specific conditions.
- There was no caseload management tool used to determine required staffing levels. Staffing levels at Whitby were low.
- Participation in audits and benchmarking was low. This had been identified at our last inspection and although the team at Whitby had started to introduce audits, others had not.
- Staff were not receiving regular documented supervision and appraisal compliance was low in some areas, particularly Whitby.
- Feedback from staff about leaders was mixed and there were questions about the experience of some leaders who were new in to post. Morale was variable and staff told us communication and engagement from senior management was poor, particularly with regards to the new services.
- Although the community services staff were all employed by Humber Teaching NHS Foundation Trust, staff did not see themselves as part of a wider team and there was little cross team working.

Community health services for adults

- Issues identified at our last inspection had not been fully addressed. Although there had been some changes made in the Whitby team, these were recent changes and needed to be fully embedded.

However:

- Staff provided compassionate care and treatment to patients. Patients and their families were encouraged to be partners in their care.
- The health trainers service had good outcomes and supported people to live healthier lives.
- The service worked closely with commissioners to plan and deliver services to meet the needs of the local population.
- Governance systems were in place, with regular meetings taking place that ensured relevant information was fed down to practitioners and up to board level.

Is the service safe?

Requires improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not always manage patient safety incidents well. We found that action plans were not always completed in a timely manner. We found that following a serious incident investigation in the Whitby team in March 2018, not all the proposed actions had been completed or properly embedded. Target dates for completion were September 2018, but we found that some actions were not completed, such as regular documentation audits. Following our inspection, the provider told us there had been an agreement with the commissioners for extended timescales.
- Staff in all teams did not always complete and update risk assessments. There were inconsistencies in the completion of risk assessments and care plans. Staff told us in some areas were waiting for appropriate templates to be added to the electronic patient record and for training to be provided. The electronic patient record did not contain a prompt to remind staff that assessments needed to be completed and relied on individual practitioners setting themselves a reminder. There was variation in the standard of documentation and record keeping and regular documentation audits had not been completed, despite this being a recommendation following a serious incident.
- Although staff had the right qualifications, skills and experience to provide the right care and treatment; staffing levels were low, particularly in the Whitby nursing and therapy teams. Community nurse staffing levels in Whitby were low due to maternity leave and staff leaving. Therapy staffing levels in Whitby had significantly reduced, over the last few years, since the move from another provider, and this meant that there were some difficulties managing patients who required long term specialist rehabilitation.
- Community nurse staffing levels in Whitby were low due to maternity leave and staff leaving. Therapy staffing levels in Whitby had significantly reduced, over the last few years, since the move from another provider, and this meant that there were some difficulties managing patients who required long term specialist rehabilitation.

However:

- Staff understood how to protect patients from abuse and worked with other agencies to do so.
- The service controlled infection risk well. Staff adhered to arms bare below the elbows policy and followed infection control techniques when seeing patients in clinics or the home environment.

Community health services for adults

Is the service effective?

Requires improvement ● ↓

Our rating of effective went down. We rated it as requires improvement because:

- The effectiveness of care and treatment was not always monitored and findings used to improve. Participation in audits and benchmarking was limited. This had been highlighted as an issue at our previous inspection in September 2017. Although the therapy team at Whitby had started to undertake audits, elsewhere there was no audit plan in place and we saw no evidence of participation in national audits.
- The service did not always make sure staff were competent for their role. Regular appraisals and supervision were not taking place. There were gaps in management and support arrangements for staff, such as appraisal and supervision. Staff did not have regular documented supervision sessions and appraisal rates were low, particularly at Whitby. This had been highlighted as an issue at our last inspection in September 2017.
- Staff of different kinds did not always work effectively together as a team. Despite community teams being multi-disciplinary, consisting of nurses and therapists, some teams still worked as individual teams rather than as an integrated team.
- The service provided care and treatment based on national guidance. However, staff told us there were no pathways in place for them to refer to for the management of specific conditions, for example end of life care, wound care or falls. Senior leaders told us that pathways were available on the trust intranet for the tissue viability team and the falls pathway was under review. However, staff we spoke with could not show us any pathways and there was therefore a risk that patients would not receive consistency of care.

However:

- Staff understood how and when to assess whether a patient had the mental capacity to make decisions about their care. Consent to care and treatment was obtained in line with guidance and where appropriate mental capacity was assessed and recorded.
- The health trainers weight management programme had achieved good outcomes.
- Patients were supported to manage their own health. The health trainers service supported people to live healthier lives.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Staff treated patients with dignity, respect and kindness. They showed compassion.
- Feedback we received from patients was positive. Friends and family test (FFT) results were consistently positive.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their families were involved and encouraged to be partners in their care. Staff spent time talking to patients and their families.

Community health services for adults

- Staff provided emotional support to patients to minimise their distress. Staff communicated and provided information in a way that people understood. Time was given for people to ask questions.

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people. They worked closely with commissioners.
- Specialist services were available for those patients with more complex needs. People's individual needs were considered. The service was meeting the accessible information standards.
- Waiting times were minimal. Therapy services in Whitby had improved their waiting times since our last inspection in September 2017. Although there were 1200 patients on a waiting list for musculoskeletal physiotherapy, this was being appropriately managed and any urgent referrals were being seen within two weeks.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Staff knew how to deal with complaints and leaflets were available to share with patients. Feedback from complaints was shared at team meetings.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- There had been changes in the service since our last inspection in September 2017, with the addition of community services for the Scarborough and Ryedale locality. Several of the service managers, team leaders and clinical leads were relatively new in post. Feedback from staff was mixed, some felt that their leaders did not have the experience to lead effectively. Staff in the central access team in Scarborough were unclear who their manager was.
- The culture did not always make staff feel supported and valued. There did not appear to be any consistencies in practice across the different localities. Despite being part of the same trust, there appeared to be no cross team working due to the commissioning of services by three different commissioners. Staff did not see themselves as part of a wider team.
- The service engaged with patients, but there was limited evidence of change following engagement. Feedback was collected via the friends and family test, but we saw no evidence of changes in practice due to patient feedback. Engagement with staff was variable. Morale was variable and in some areas, was particularly low. Although leaders told us they held ongoing engagement events with staff, some staff felt there had been poor communication from senior management and lack of engagement.
- Issues identified at our last inspection, such as lack of clinical supervision, no programme of internal or national audit, risk register not containing all risks and communication with staff, had not been dealt with in a timely manner as we found similar issues at this inspection.

However:

Community health services for adults

- Governance systems and processes were in place. There were governance structures in place that ensured information was fed up to board level and down to community teams as appropriate.
- There was a new team leader in post in Whitby, who had recognised the work that needed to be done and had started to implement appropriate changes. The therapy team in Whitby had implemented changes following the last inspection.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health services

Background to mental health services

The trust provides 10 of the core mental health services:

- Community based mental health services for adults of working age.
- Mental health crisis and health based place of safety.
- Community mental health services for people with a learning disability and/or autism.
- Community mental health services for older people.
- Specialist community mental health services for children and young people.
- Acute wards for adults of working age and psychiatric intensive care units.
- Long-stay/rehabilitation wards for adults of working age.
- Wards for older people.
- Forensic/ secure wards.
- Wards for people with a learning disability or autism.

The trust also provides specialist substance misuse services.

Summary of mental health services

Good  → ←

We rated nine of the trusts 11 mental health services as good and two as requires improvement, and whilst the rating for acute wards for adults of working age and psychiatric intensive care units remained as requires improvement, the safe key question was now rated as good.

In rating the trusts mental health and learning disabilities services as good we considered the previous ratings of service not inspected at this time and deviated from the ratings principles.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement   

Key facts and figures

Humber NHS Foundation Trust provides inpatient acute and intensive care services for adults of working age with mental health conditions. Patients are admitted informally or detained under the Mental Health Act 1983.

The trust has four acute wards for adults who require hospital admission due to their mental health needs:

- Avondale is an acute assessment ward that provides assessment and treatment for a period of up to seven days for adults experiencing acute episodes of mental ill health who cannot be safely treated in other settings. It has 14 beds and treats both men and women. Patients who require care for more than seven days are transferred to alternative services within the trust.
- Mill View Court provides care and treatment to both male and female patients who are experiencing an acute episode of mental illness and crisis. From April 2018, Mill View increased provision from 10 to 15 beds.
- Newbridges provides care and treatment to males only who are experiencing acute mental illness and crisis. It has 18 beds primarily for males of working age. The ward is a standalone unit located in east Hull.
- Westlands provides care and treatment to females only who are experiencing acute mental illness and crisis. It has 18 beds primarily for women from age 16 to age 65. The ward is a standalone unit located in west Hull.

The trust also has a psychiatric intensive care service for men and women who present with higher levels of risk and require greater observation and support. It has a capacity of 14 beds but at the time of the inspection, due to staffing shortfalls, only 10 beds were available to admit patients.

Both Avondale and the psychiatric intensive care unit are based in Miranda House, which is on the outskirts of Hull city centre.

At the last comprehensive inspection in September 2017, we rated this core service as requires improvement overall, with the caring and responsive key questions rated as good, and the safe, effective and well led key questions as requires improvement.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and sought feedback from patients and staff at focus groups.

We visited all five wards between 8 and 10 January 2019.

During the inspection visit, the team:

- visited the wards, looked at the quality of the environment and observed how staff were caring for patients
- spoke with 17 patients who were using the service
- received 12 comments written on comment cards
- spoke with six carers of patients who were using the service
- looked at the care and treatment records for 19 patients
- spoke with the managers of each ward and a service manager

Acute wards for adults of working age and psychiatric intensive care units

- spoke with 27 other staff including doctors, nurses, pharmacists, modern matrons, healthcare staff, occupational therapy assistants and service managers
- carried out a specific check of the medicines management on the wards
- observed one handover meeting and two multidisciplinary meetings

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not always develop patient care plans which were holistic, recovery-oriented and personalised. Staff did not always carry out an assessment to determine if patients needed a personal alarm. They did not always adhere to the principles of the Mental Capacity Act when patients had capacity to make decisions for themselves and they did not always complete patients consent to treatment in a timely way.
- Staff did not have appropriate information for patients who identified as lesbian, gay, bi-sexual or transgender. Some of the measures the trust had taken to protect patients' privacy and personal details were not always effective.
- Governance processes were not effective in ensuring staff applied policy and practice consistently across the service and it was not always possible to tell from audit reports what improvements were required. The trust had not reviewed minimum staffing levels for the service. Staff did not feel supported or listened to by senior leaders.
- Staff did not always receive timely feedback when the trust investigated serious incidents. They did not have a robust system in place to share lessons learned with staff from incidents and complaints from across the wider trust.

However:

- They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The service provided safe care. Overall, the ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness. They respected their dignity and understood the individual needs of patients. They involved patients and families and carers in care decisions whilst maintaining patient confidentiality.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

Acute wards for adults of working age and psychiatric intensive care units

- Wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. Ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff followed best practice when storing, dispensing, and recording the use of medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. Staff managed patient safety incidents well. They recognised incidents and reported them appropriately. Managers investigated incidents and discussed them frequently. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- Whilst staff assessed and managed risk, staff did not always carry out an individual assessment to determine if patients needed access to a personal alarm.
- On Mill View Court, some medical devices had not been cleaned in line with the cleaning schedule and there were some gaps where we could not see that staff had checked the emergency equipment when they should have done.
- The electronic patient records system was slow and staff had developed paper records so they could access details about patients if they could not access the system when needed. The information that teams kept about patients in paper records was not consistent across the service.
- Whilst the trust had carried out a safer staffing review, they had not reviewed minimum staffing levels for the service following this review.

Is the service effective?

Requires improvement ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always develop individual patient care plans which reflected the assessed needs. They were not always personalised, holistic and recovery-oriented.
- We could not see evidence that staff assessed and recorded mental capacity clearly for patients who might have impaired mental capacity. Staff did not always know where to find information about a patient's capacity in the care record and some clinicians did not record capacity to consent to treatment for patients detained under the Mental Health Act.
- Some staff did not understand the process of best interest decision making and some staff were not clear that patients had the right to make unwise decisions for themselves when they had capacity.
- The trust had not carried out any audits on staff adherence to the Mental Capacity Act and the code of practice

However:

Acute wards for adults of working age and psychiatric intensive care units

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- Teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Patients' access to advocacy was well embedded across all wards.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion, kindness and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately whilst maintaining patient confidentiality.

However:

- The measures the trust had taken to protect patients' privacy and personal details were not always effective.

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- There had been an improvement in the way staff managed patient beds. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, and care needs. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy and separate lounges for female patients.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Acute wards for adults of working age and psychiatric intensive care units

- Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However:

- Staff did not have appropriate information for patients who identified as lesbian, gay, bi-sexual or transgendered.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Some of the systems in place were burdensome for front-line staff. The electronic care records system was slow and not all staff knew where information was stored. Staff had been asked to report all incidents of patients smoking but staff thought this was unrealistic.
- Some systems and processes were not consistent across the service. The service was supposed to be smoke free but some patients continued to smoke unchallenged. Teams had different standard agendas for team meetings and different paper records for patients. Audit reports did not always identify what improvements were required.
- We did not see evidence that leaders shared lessons learned with staff from incidents and complaints which occurred in the wider trust or that staff shared lessons learned with each other across the different wards.

However:

- Managers at ward level had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed. They were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued by local managers in their day-to-day work. They felt able to raise concerns without fear of retribution.
- Staff engaged actively in audit and quality improvement activities.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

Forensic inpatient or secure wards

Requires improvement  

Key facts and figures

Humber NHS Foundation Trust provides forensic inpatients services at the Humber Centre for Forensic Psychiatry, which is a purpose-built hospital at Willerby hill in Hull. The service provides low and medium secure forensic services for mentally disordered or learning disabled male offenders and men with a personality disorder who require assessment, treatment and rehabilitation within a secure environment.

At the time of the inspection, the service comprised of five wards.

- Derwent ward is a medium secure ward providing care for up to 10 patients with complex mental health problems who require high levels of support, assessment and intervention. At the time of our inspection, the ward had nine patients.
- Ouse ward is a medium secure ward providing care for up to 14 patients who require less intensive support. At the time of our inspection, the ward had 13 patients.
- Swale ward is a medium secure ward providing care for up to 15 patients with personality disorders that are functionally linked to their offending and risk behaviours. At the time of our inspection, the ward had eight patients.
- Ullswater ward is a medium secure ward providing care and treatment for up to 12 patients with a learning disability and a diagnosed mental disorder. At the time of our inspection, the ward had 12 patients.
- Darley ward is a low secure ward providing care and treatment for up to eight patients who have not made the anticipated progress within traditional low-secure services, who may have been involved within services for a number of years. At the time of our inspection the ward had eight patients.

At the time of the inspection, the Humber Centre was going through a process of change. The ratio of medium to low secure beds had been subject to review and was due to change, moving to a higher number of low secure beds. Ullswater ward had plans to move from medium to low secure by April 2019. The timescale for completion of Swale ward to move from medium to low secure was unknown.

At the last comprehensive inspection in September 2017, we rated this core service as good overall, with the effective, caring, responsive and well led key questions rated as good, and the safe key question rated as requires improvement.

We visited all five wards between 23 and 25 January 2019. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services. Four carers and eight patients attended focus groups before the inspection and provided feedback on their experiences of the service.

During the inspection visit, the team:

- visited the wards, looked the quality of the environment and observed how staff were caring for patients
- spoke with six patients who were using the service.
- spoke with six family members by telephone.

Forensic inpatient or secure wards

- looked at the care and treatment records for six patients including their positive behavioural support plans and restrictive intervention plans, five seclusion records, two long-term segregation records and six restraint records.
- spoke with ward managers, modern matrons, a service manager and an assistant director.
- spoke with 24 other staff including doctors, nurses, pharmacists, healthcare assistants, occupational therapists, associate practitioners, psychologists, a GP and administrators.
- observed a multi-disciplinary meeting, a reflective practice session and a morning meeting.
- attended and observed three activities with patients and staff.
- looked at policies, procedures and other documents related to the running of the service, including cleaning records, portable appliance testing, health and safety records.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- There were not always enough staff to maintain safer staffing levels on the wards. There was a frequent reliance on occupational therapy staff to support safe staffing levels. Patient leave was often cancelled due to staffing levels.
- There were not always timely responses to carry out maintenance and repairs on the wards. Showers on Ouse ward and one of the laundry rooms within the service had been out of use or awaiting repair since November 2018. Offensive graffiti on a window in Derwent ward had not been reported for repair or replacement.
- Governance processes did not operate effectively at ward level and across the service. There were ineffective systems in place to monitor actions from incident investigations and learning from incidents was not routinely shared with staff.
- Staff did not always document that required reviews had taken place for patients in seclusion. Whilst in seclusion, patients did not have personalised emergency evacuation plans in place.
- Staff observed all visits between patients and their family members and friends. This was not individually risk assessed.
- Carers did not always feel well supported, involved or informed about their loved one's care.

However:

- Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding
- Staff developed holistic, recovery-oriented care plans informed by comprehensive assessments. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Ward teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received supervision and appraisal. Ward staff worked well together as a multi-disciplinary team and with those outside the wards who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Forensic inpatient or secure wards

- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharges were rarely delayed for other than a clinical reason.

Is the service safe?

Requires improvement ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- There were not always enough staff to maintain safe staffing levels on the wards. There was a frequent reliance upon occupational therapy staff to maintain safer staffing levels.
- While staff recognised incidents and reported them appropriately, there was not a robust system in place to disseminate learning from incidents. Staff were unclear about actions arising from incident investigations and did not feel informed. De-brief sessions for staff did not always take place in a timely manner.
- Whilst wards were generally clean and well maintained, there was offensive graffiti etched into a window on one ward. This had been there for some time and had not been reported. Showers on Ouse ward and one of the laundry rooms within the service had been out of use or awaiting repair since November 2018.
- Visits between patients and their family and friends were always observed by staff. This was a blanket restriction and did not consider risks around visits on an individual basis.
- Staff had not always ensured that they were recording their responsibilities under the Mental Health Act Code of Practice relating to seclusion. Nursing and medical reviews were not always documented/occurring within the prescribed time frames. Patients in seclusion did not have individualised personal emergency evacuation plans in place.

However:

- Staff assessed and managed risks to patients and themselves well and generally achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- Mandatory training rates had improved since our last inspection.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.

Is the service effective?

Good ● → ←

Our rating of effective stayed the same. We rated it as good because:

Forensic inpatient or secure wards

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multi-disciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. The care plans included specific safety and security arrangements and a positive behavioural support plan.
- Staff provided a range of care and treatment suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers supported staff with appraisals and supervision. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Staff regularly explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired capacity.
- Staff completed thorough assessments of physical and mental health of all patients on admission and at regular intervals. Patients had access to the full range of specialists required to meet their needs, including physical health care.

However:

- There was a frequent reliance on using occupational therapy staff to support safer staffing levels on the wards. This meant that planned therapeutic activities could not always take place.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood individual needs of patients and supported patients' involvement in their care and treatment.
- Staff involved patients in care planning and risk assessment and sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Patients had been involved in a range of creative activities to improve the wards, including art projects and the creation of a DVD about life in the service.

However:

- Carers did not always feel involved or informed about their loved one's care. Family members did not feel they had been given enough information about the imminent changes to the security status on Ullswater and Swale wards which had caused them anxiety.

Forensic inpatient or secure wards

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison.
- Patients had their own bedrooms and could keep their personal belongings safe.
- The wards met the needs of all people who used the service. Staff helped patients with communication, advocacy and cultural and spiritual support.

However:

- Patients complained that the food quality was not always good and menus were repetitive and had not been changed for many years.
- Whilst concerns and complaints were investigated, there were ineffective systems in place to learn lessons from the results and share these with the staff team and the wider service.

Is the service well-led?

Requires improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Our findings from the other key questions did not fully demonstrate that governance processes operated effectively at ward level. There were ineffective systems in place to ensure actions from incident investigations were completed and a learning from incidents was not routinely shared.
- Processes to share information with staff teams were not well developed. Ward level team meetings had no structured agenda which meant there was a wide variation in the content of the meetings and how these were documented.
- Ward level managers were frequently required to work across the wards as a result of staffing shortfalls. This meant that leadership capacity on the wards was reduced and impacted on the completion of management tasks.
- Two senior management posts were vacant and there were no plans to replace these as the management structures were being reviewed. This impacted upon the leadership capacity at a senior level, although some support was being provided by an assistant director.

However:

- Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the services they managed.
- There were plans in place to implement ward governance meetings, with clear terms of reference and structured agenda format.
- Managers maintained a risk register, which generally reflected the concerns of staff.

Forensic inpatient or secure wards

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Mental health crisis services and health-based places of safety

Good  

Key facts and figures

Humber NHS Foundation Trust provides a mental health response service for the Hull and East Riding areas based at Miranda House in Hull.

The mental health response service is a single point of access into the trust's:

- community mental health services for adults
- inpatient services
- home based treatment
- improving access to psychological therapies
- counselling and psychology services
- early intervention teams
- addiction services
- trauma services
- eating disorder services
- perinatal services.

The service also signposts to third sector organisations and primary care.

The mental health response service works 24 hours a day, seven days per week. They provide home based treatment mainly between 8am and 8.30pm seven days per week and outside of these hours if required. The service aims to provide an alternative to an admission to hospital inpatient wards.

The service triages all referrals and then tailors the service provision to the patients' needs. This includes urgent mental health assessments and Mental Health Act assessments for people who could be a risk to themselves or others, including those at risk of severe self-neglect and those who are being considered for mental health hospital treatment. The service also provides non-urgent mental health assessments at assessment clinics across the Hull and East Riding areas. It also signposts and provides information to people and organisations about other services that can be accessed in the local areas.

The trust provides a health based place of safety at Miranda House for people detained under section 136 of the Mental Health Act.

The service gate keeps access to a crisis pad in Hull. The crisis pad is commissioned by the trust but is provided by an external organisation under a service level agreement.

At the last inspection, the core service was rated as 'requires improvement' overall. We rated the key questions 'safe' and 'well led' as 'requires improvement' and 'effective', 'caring' and 'responsive' as 'good'. At this inspection, we inspected all of the key questions.

Our inspection was short notice 'announced' one working day prior so staff knew we were coming in order to ensure that everyone we needed to talk to were available.

Mental health crisis services and health-based places of safety

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- toured the care environments at the mental health response service and place of safety at Miranda House, and observed how staff were caring for patients
- completed six observations which included initial assessments, multidisciplinary team meetings, a medical review and a team meeting
- interviewed 13 staff members including the service manager, team leader, approved mental health professional, nurses, social worker, and health care assistants
- spoke with one former patients admitted to the place of safety
- spoke with two carers of patients using the mental health response service
- spoke with two patients using the mental health response service
- reviewed four patient records of patients using the mental health response service
- reviewed three patients records of patients who had used the place of safety
- reviewed a range of documents relating to the running of the service.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans and updated them when needed.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Managers made sure they had staff with a range of skills needed to provide high quality care.
- Staff from different disciplines worked together as a team to benefit patients.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.
- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.
- Staff involved patients and those close to them in decisions about their care, treatment and changes to the service.

Mental health crisis services and health-based places of safety

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

However:

- Compliance with clinical supervision was low.
- There continued to be difficulty for the service to access medication out of hours due to the trust's contract with the community pharmacy.
- Staff did not always have access to equipment to enable them to complete physical health monitoring whilst on community visits.
- Two of the meeting rooms at Miranda house did not have obscure glass to promote privacy and dignity for patients who were completing an assessment.
- Staff reported a lack of confidence in the trust to support them in raising concerns.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- Interview rooms and the health based place of safety were clean and well maintained.
- There were robust risk assessment and management processes in place and staff demonstrated a good application of risk management.
- Staff could identify safeguarding concerns and had effective working relationships with the local authority when raising concerns about a vulnerable adult or child.
- Staff were aware of what incidents should be reported and their duty in reporting these and in meeting the requirements of the duty of candour.

However:

- Staff did not always have access to equipment to enable them to complete physical health monitoring whilst on community visits.
- Staff did not record details of safeguarding concerns under the designated section of the electronic patient record.
- Staff were not all following the service protocol for lone working and staff practice varied with respect to who they would inform when they returned from a visit.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff completed detailed assessments of patient needs including their physical health and mental health needs.

Mental health crisis services and health-based places of safety

- Staff completed regular clinical audits including compliance with section 136 of the Mental Health Act and used these to monitor and improve the performance of the service.
- Staff provided a range of care and treatment interventions in line with national guidance.
- There was a full multidisciplinary team approach and staff worked closely with members of the mental health response team and external agencies including the police and ambulance service.

However:

- Staff prioritised patient care above the need to receive formal supervision and staff clinical supervision was low. There were informal methods of supervision available to staff.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- We observed staff treating patients with respect and compassion.
- The service tried to capture the views of patients and carers who had accessed the service through a range of surveys.
- Feedback from the patient and carer surveys was almost entirely positive.

Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service had clear criteria to support the triage of patients to the most appropriate service
- The service regularly audited call volumes and adapted staffing to be available at peak times.
- The service ensured patients detained under section 136 of the Mental Health Act received prompt assessments and were detained for the shortest time possible

However:

- Two of the meeting rooms at Miranda house did not have obscure glass to promote privacy and dignity for patients who were completing an assessment.

Is the service well-led?

Good ● ↑

Our rating of well-led improved. We rated it as good because:

- Managers were compassionate, inclusive and supportive and had the skills knowledge and experience to perform their roles.
- Staff felt respected and supported by service managers and had the opportunities for development and progression.

Mental health crisis services and health-based places of safety

- There were effective process to identify, understand, monitor and address current and future risks.
- Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

However:

- Staff informed us despite the service level agreement and patient directives being in place there continued to be difficulties in obtaining medication out of hours.
- Staff reported senior managers were not visible within the service. Staff reported a lack of confidence in the trust to support them in raising concerns.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

Specialist community mental health service for children and young people

Good   

Key facts and figures

Humber NHS Foundation Trust provide specialist community mental health services for children and young people up to 18 years of age for both East Riding of Yorkshire and Hull. The service is commissioned by two clinical commissioning groups.

The provision provided by Humber Teaching NHS Foundation Trust is made up of the following:

Contact Point

Contact Point provides a single point of access, that has been designed to improve the ease of access and availability of CAMHS for children, young people and their families.

The primary role of the Contact Point is to review and respond to all referrals and contacts by undertaking a robust telephone triage. Staff determine the most appropriate response to meet the needs outlined and if necessary signpost to other relevant services. Referrals accepted to a CAMHS clinical pathway are then passed to the core CAMHS teams for assessment and treatment.

Hull and East Riding have separate contacts points.

Core CAMHS

Following triage, children and young people are allocated to a team depending on their care pathway. Teams are as follows:

Hull team one: low mood, anxiety, early onset psychosis

Hull team two: conduct, Attention Deficit Hyperactivity Disorder, long term conditions, learning disabilities

Hull team three: deliberate self-harm, trauma

Hull autism team: autism assessment and diagnosis

East Riding team one: anxiety, depression, trauma, self-harm early onset psychosis

East Riding team two: conduct, Attention Deficit Hyperactivity Disorder

The service has additional teams specifically for children and young people experiencing eating disorders, involved in the youth justice system and forensics. Teams operate from a variety of locations across Hull and East Riding

CAMHS Crisis Response Team

The crisis response team operates 24 hours a day, seven days a week. This element of the service is for young people (under 18) who are experiencing a mental health crisis, those who:

- are at risk of immediate and significant self-harm,
- are an immediate and significant risk to others due to their mental health,
- are being considered for admission to a mental health inpatient unit,
- are in acute psychological or emotional distress that is causing them to not be able to go about their daily activities, such as going to school and looking after themselves.

Specialist community mental health service for children and young people

This team offers short-term help in the community until there is a resolution of the immediate crisis (usually within 3-7 days). They provide a timely response, working flexibly and tailor the intervention to meet the needs of the individual and family. The aim of this service is to prevent children and young people (under 18) from hospital attendance or admission if no medical intervention is required, keeping them at home with their families.

During this inspection, we visited and spoke with staff from Hull and East Riding contact point and core teams.

We previously inspected this core service between 11 April 2016 and 15 April 2016. The inspection report was published 10 August 2016. We found some areas for improvement. We rated the service as requires improvement in responsive. The service was rated as good for safe, caring, effective and well led.

This inspection was undertaken between 15 January 2019 and 16 January 2019. This inspection was announced on the day prior to attending. We inspected all key lines of enquiry in the five domains (safe, effective, caring, responsive and well-led).

Before the inspection visit, we reviewed information that we held about these services and requested information from the trust.

During the inspection visit, the inspection team:

- visited seven teams within two locations and looked at the quality of the environment
- spoke with five young people who were using the service
- spoke with seven carers of children and young people who were using the service
- spoke with the service manager and responsible clinician
- spoke with ten other staff members including nurses and healthcare support workers,
- looked at the care and treatment records of 13 children and young people
- observed one psychiatrist appointment
- observed one multi-disciplinary meeting and one multi-agency meeting
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Staff identified risks for children and young people from referral, whilst on waiting lists and whilst in treatment. They put plans in place to decrease or mitigate the risks; this included crisis plans where appropriate. Parents, carers, young people and other professionals knew what actions to take if there was a deterioration in health. Staff responded appropriately and promptly if this occurred.
- Staff knew how to protect children and young people from abuse. They recognised when people were suffering from significant harm. Staff had good relationships with external teams to assess holistic needs and if required, knew how to make safeguarding referrals.
- Teams included a full range of specialists required to meet the needs of children and young people. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multi-disciplinary team and with external organisations to provide additional support.

Specialist community mental health service for children and young people

- Staff treated children and young people with compassion, kindness, respected their privacy and dignity and understood individual needs. They actively involved them and their families and carers in care decisions. Children, young people and their parents or carers had good opportunities to provide feedback on the service and be involved in service developments.
- Staff offered flexible times and locations for appointments including weekends and evenings. They responded promptly and appropriately when contacted by children, young people or their parents and carers and took positive steps to encourage those who found it difficult to engage.
- Managers were experienced and had good knowledge of the service. Staff felt supported and valued; they felt able to contribute to service improvements and raise concerns if needed. Governance systems ensured information was shared effectively amongst teams and with external organisations.

However:

- The service had long waiting lists above the NHS constitution of 18 weeks. This was mostly in Hull for the attention deficit hyperactivity disorder pathway.
- Room space was limited in the Beverley location in East Riding.

Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Staff identified and managed risks appropriately. They responded promptly to deterioration in a child or young person's health.
- The environments were clean, had good furnishings and were well maintained.
- Staff were mostly compliant with mandatory training requirements. They were booked onto courses where there had been previous difficulties in dates available.
- Managers recognised the requirement to improve staffing levels to respond to increases in autism referrals and long waiting lists. This was reflected in a recruitment drive to form a specific team for this care pathway.
- Staff recognised safeguarding concerns and the actions they needed to take when needed.
- Staff knew what constituted an incident and how to report these. They knew their responsibilities relating to duty of candour.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff carried out comprehensive assessments to identify the needs of the children and young people. Care plans reflected identified needs and were personalised, holistic and up to date.
- Staff delivered interventions in line with guidance and best practice. They participated in the evidence based Children and Young People's Improving Access to Psychological Therapies Programme.

Specialist community mental health service for children and young people

- Staff were experienced and received specialist training to meet the needs of the children and young people using the service.
- Staff from different disciplines worked together as a team to benefit the child or young person. They supported each other to make sure there were no gaps in their care. Teams had effective working relationships with relevant services outside the organisation.
- Staff had a good understanding of the Mental Capacity Act and Gillick Competency and applied this to ensure children and young people had a sufficient level of understanding to make decisions. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff provided positive support to children, young people and their parents or carers. They treated them with dignity and respect.
- Staff involved children, young people and their parents or carers in decisions around their treatment and their care plans.
- Staff promoted feedback from children, young people and their parents or carers to consider improvements.
- Children, young people and their parents or carers had good opportunities to be involved when appropriate in decisions about the service.

Is the service responsive?

Requires improvement ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Children and young people were waiting over 18 weeks to receive treatment. This was mainly for those referrals for young people diagnosed with a learning disability or autism.
- Staff working from Beverley in East Riding experienced difficulties in finding room space.

However:

- Staff offered children and young people flexibility for their appointments in terms of location and times. They took steps to engage with those who found it difficult or were reluctant attend.
- Staff responded promptly and appropriately when children, young people, their carers or parents contacted the service.
- Staff worked closely with schools, families and external organisations to establish and maintain engagement and relationships with the wider community.

Specialist community mental health service for children and young people

Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Managers had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and supported staff.
- Staff knew and understood the trust's vision and values and their behaviours reflected these.
- Staff felt respected, supported and valued amongst their teams.
- The service had systems and processes in place to ensure information was shared effectively.

However:

- Some information relating to the service on the trust website was out of date.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Our inspection team

Jenny Wilkes, Head of Hospitals Inspection led this inspection. We had access to one executive reviewer on this inspection, one who was a director of people. We also used a specialist advisor who had previous experience as a board level director.

We also used two specialist advisors, who had expertise in safeguarding and equality and diversity.

The inspection team covered five core services and included 10 inspectors, one inspection manager, two Mental Health Act reviewers, an assistant inspector, an analyst, a pharmacist and specialist advisers. Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Agenda Item 10

Title & Date of Meeting:	Trust Board Public Meeting - 22 nd May 2019			
Title of Report:	Performance Report – April 2019			
Author:	Name: Peter Beckwith Title: Director of Finance			
Recommendation:	To approve		To note	✓
	To discuss		To ratify	
	For information		To endorse	
	The Board is asked to note the report.			
Purpose of Paper:	<p>This purpose of this report is to provide the Trust Board with an update on key performance indicators as at the end of April 2019.</p> <p>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.</p>			
Key Issues within the report:	<p>Exception reporting and commentary is provided for each of the reported indicators:</p> <p>EMT have reviewed indicators and targets for 2019/20 the following 3 indicators have been retired from the report but will continue to be reported to the Quality Committee and the Finance and Investment Committee</p> <ul style="list-style-type: none"> • Healthcare Acquired Infections • Budget Reduction Strategy • Staff Cost v Plan <p>The majority of indicators are within normal variation, key areas of performance to note are:</p> <p>The no of Vacancies for the Trust has risen to 327.5.</p> <p>Referral to Treatment for incomplete pathways has fallen to 73.1% in month, performance for completed pathways was 89.5% - both indicators are below target performance (95%)</p> <p>Waiting times – 52 week waits have increased further in April. Currently 159 patients waiting (excluding ASD). 153 relate to CAMHS.</p> <p>CPA Reviews has dropped down below target (95%) and is reporting at 94.3% for Apr-19.</p> <p>One admissions of patients aged under 18 to adult wards.</p> <p>The Trust’s cash position remains strong at £14.335m.</p> <p>Full detailed explanations are included in the exception report.</p>			



Monitoring and assurance framework summary:

Links to Strategic Goals				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
	Maximising an efficient and sustainable organisation			
	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			To be advised of any future implications reports as and when future implications by Lead Directors through Board required
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

Financial Year
2019-20

INTEGRATED BOARD REPORT

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

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



Reporting Month:
Apr-19

Caring, Learning and Growing

Chief Executive: Michele Moran
Prepared by: Business Intelligence Team



Humber Teaching NHS Foundation Trust

Integrated Board Report

For the period ending: **Apr 2019**

Purpose This paper provides a summary on the progress being made against a basket of NHS performance indicators together with executive summary and underpin the Trust's Strategy 2017-2022. A sample of the strategic goals are represented in this report. Particular attention is drawn to the new format and the use of Statistical Process Control (SPC) in the following charts. SPC charts contain upper and lower control limits which are based on 2 standard deviation points above and below the 2 yearly average.

What are SPCs? Statistical process control (SPC) charts can help us understand the scale of any problem, gather information and identify possible causes when used in conjunction with other investigative tools such as process mapping.
 SPC tells us about the variation that exists in the systems that we are looking to improve.
 S – statistical, because we use some statistical concepts to help us understand processes.
 P – process, because we deliver our work through processes ie how we do things.
 C – control, by this we mean predictable.
 SPC should be used to help to get a baseline and evaluate how we are currently operating. SPC will also help us to assess whether service changes have made a sustainable difference. They give an indication as to whether there is relatively stable variation over time or whether there are special causes creating exceptional variance. This is done by analysing the chart looking at how the values fall around the average and between or outside the control limits. The average and control limits do not indicate whether the indicator is achieving the target that has been set, but they allow us to better understand how stable the performance is and whether or not it is changing.

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

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

Dashboard	Safer Staffing	A dashboard to provide overview on a number of clinical indicators for the Trust's inpatient units across all services
Dashboard	Mortality	Learning from Mortality Reviews
Goal 1	Incidents	Total number of incidents reported on Datix
Goal 1	Mandatory Training	A percentage compliance for all mandatory and statutory courses
Goal 1	Vacancies	Variance between the budget (funded) establishment and actual staff in post. Note that not all vacancies are funded
Goal 1	Healthcare Associated Infections	Total number of HCAI cases reported in the Trust for MRSA, C.Diff and E.Coli
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	CPA - 7 day follow ups	Percentage of patients who were on CPA and had a follow up within seven days of discharge from hospital
Goal 2	CPA - Reviews	Percentage of patients who are on CPA and have had a review in the last 12 months

Humber Teaching NHS Foundation Trust

Integrated Board Report

For the period ending:

Apr 2019

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 have been assessed but continue to wait more than 18 weeks for treatment
Goal 2	RTT - 52 Week Waits	Number of patients who have yet to be seen for treatment and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - Adult ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Adult and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - Paediatric ASD	Number of patients who have yet to be seen for assessment and diagnosis in Autism Spectrum Disorder (ASD) Service for Children and have been waiting more than 52 weeks
Goal 2	RTT - 52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks
Goal 2	RTT - Early Interventions	Percentage of patients who were seen within two weeks of referral
Goal 2	RTT - IAPT 6 Weeks and 18 weeks	Percentage of patients who were seen within 6 weeks and 18 weeks of referral
Goal 3	Recovery Rates - IAPT	Recovery Rates for patients who were at caseness at start of therapeutic intervention
Goal 3	Admissions of Under 18s	Number of patients aged 17 and under who were admitted to an adult ward
Goal 3	Out of Area Placements	Number of days that Trust patients were placed in out of area wards
Goal 4	Delayed Transfers of Care	Results for the percentage of Mental Health delayed transfers of care
Goal 4	Staff Sickness	Percentage of staff sickness across the Trust (not including bank staff)
Goal 4	Staff Turnover	Percentage of leavers against staff in post
Goal 4	PADRs	Percentage of staff who have received a Performance and Development Review within the last 12 months
Goal 5	Finance - Cash in Bank	Review of the cash in the Bank (£000's)
Goal 5	Finance - Budget Recovery Strategy	Review of the cost improvement variance against plan
Goal 5	Finance - Use of Resource Score	The Single Oversight Framework assesses the Trust's financial performance across different metrics
Goal 5	Finance - Income and Expenditure	Review of the Income versus Expenditure (£000's) by month
Goal 5	Finance - Staff Costs against Plan	Review of the variance of the planned and actual staff costs (£000's)
Goal 6	Complaints	Two charts showing the number of Complaints Received (1) and the number of Complaints Responded to and Upheld (2)

PI RETURN FORM 2019-20

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

Incidents

Total number of incidents reported on Datix

Executive Lead
Hilary Gledhill

KPI Type

IQ 6

Narrative

Within Control Limits

UCL: 764

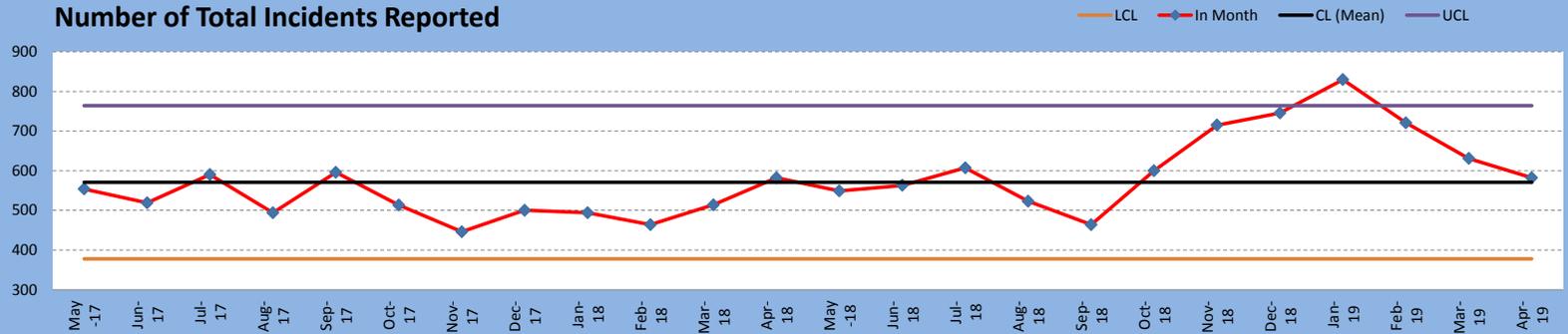
LCL: 378

Current month stands at 582

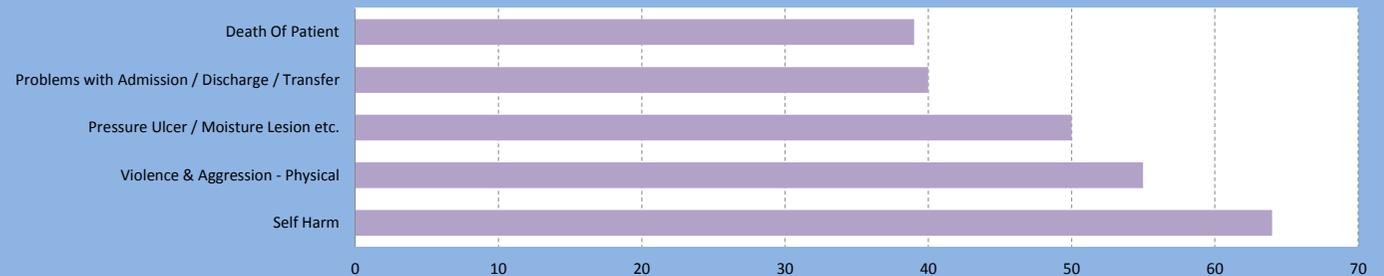
Top 5 Themes

Top five themes of incidents reported in the current financial year (Year to Date)

Number of Total Incidents Reported



Top 5 Themes



Exception Reporting and Operational Commentary

The level of incident reporting has seen a drop of 34% going from a peak of 830 in January 2019 to 549 in April 2019. Self-harm continues to be the highest reported category of incidents although it should be noted that 1 patient accounted for 33 (51%) of those incidents which all resulted in no harm or low harm. The fall in reported numbers appears to be due to two patients who were self-harming who have both been transferred to other providers. It does appear that the numbers now are in line with the incidents reported before these patients started self-harming. Overall the majority of the incidents resulted in no harm or low harm.

Business Intelligence

As the Trust diversifies and acquires business, the number of incidents may increase/decrease to reflect this. Currently the RAG rating is based on the number of incidents outside the Upper and Lower Control Limits. There was an issue with reporting mechanisms for November/December which has now been rectified. This shows an increase in the number of incidents reports in the charts from this point. There are also plans to include data split by level of harm in 2018/19.

PI RETURN FORM 2019-20

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2019**

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

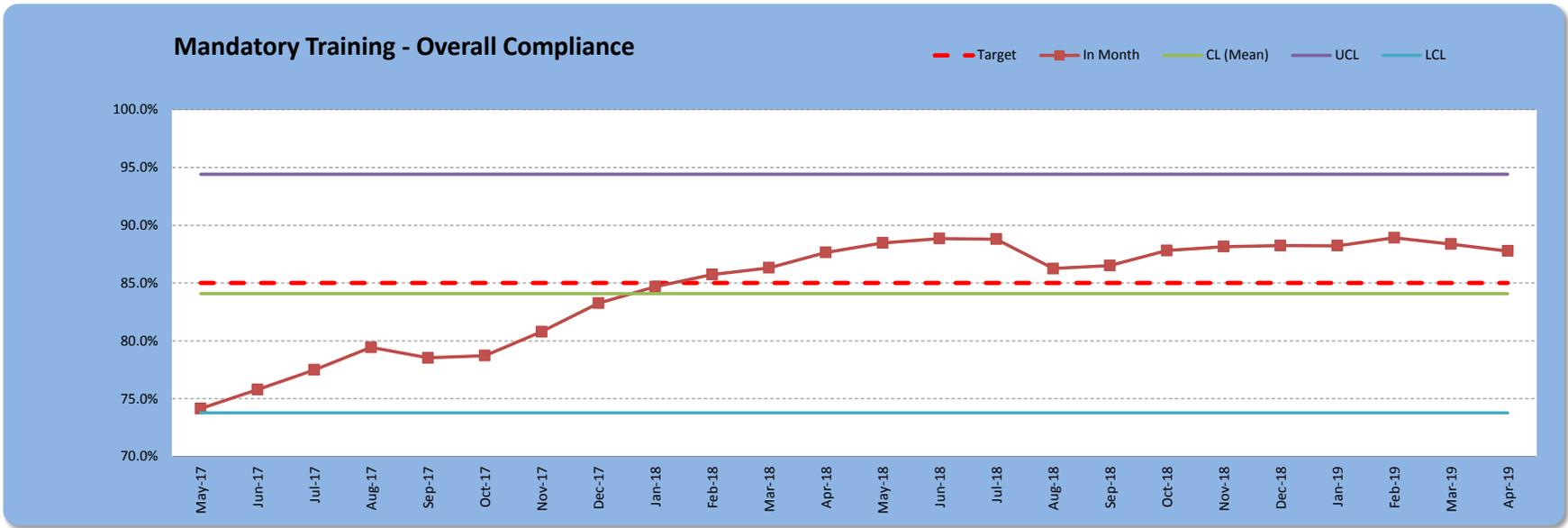
KPI Type
WL 5

Narrative

Above Target

Target: 85%
Amber: 75%

Current month stands at 87.8%



Exception Reporting and Operational Commentary

Performance remains above target. Managers continue to receive information on a fortnightly basis of staff that have not completed their training so that they may take the necessary action. Those managers on ESR supervisor self service can also review performance via the dashboard. Performance is discussed at Operational Delivery Group and EMT.

Business Intelligence

There are 18 individual courses monitored in the IQPT dashboards. We have five courses rated amber (MAPA 80%, IG 94.7%, Moving and Handling 84%, ILS 84% and POVA 85%). With two red (PATS 69.5% and BLS 74.7%)

PI RETURN FORM 2019-20

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2019**

Indicator Title	Description/Rationale	Executive Lead
Vacancies (WTE)	Variance between the establishment and actual staff in post. This information is taken from the Trust financial ledger.	Steve McGowan

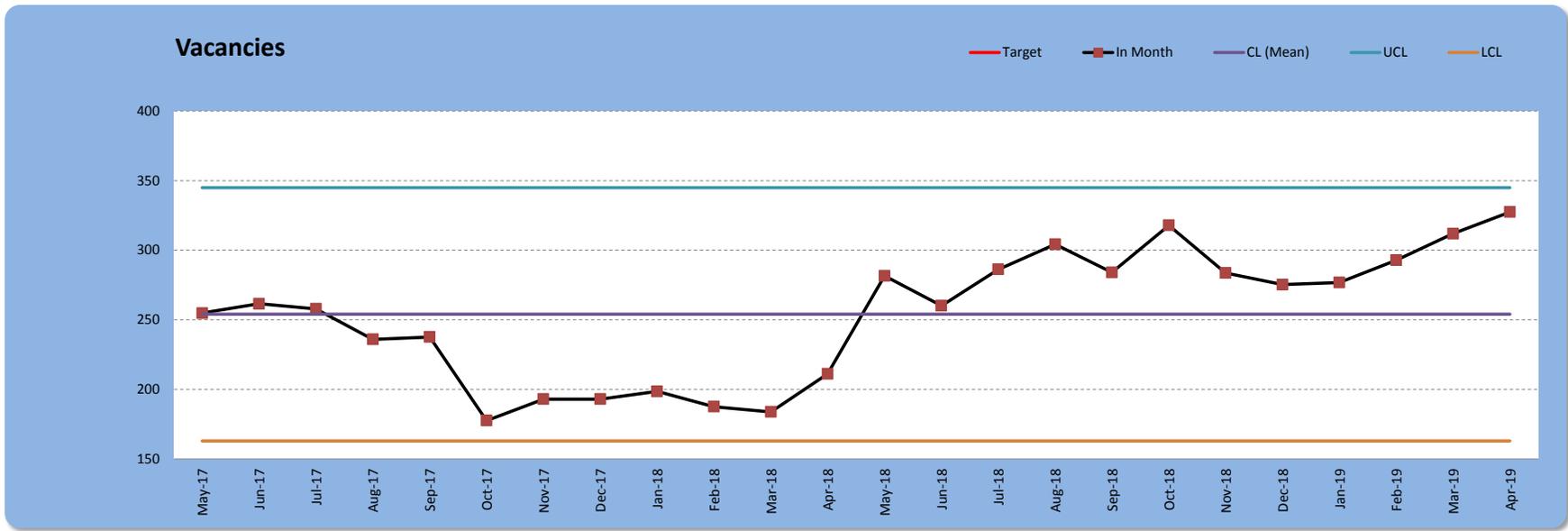
KPI Type
WL 2 VAC

Narrative

within control limits

Target: TBC
Amber: TBC

Current month stands at 327.5



Exception Reporting and Operational Commentary

At the time of writing 51 roles are currently out to advert on NHS jobs covering 74.94 FTE roles. 85 people from outside the Trust have been offered a job and are currently in pre employment screening or notice periods. The highest number of vacancies is qualified Nurses with 104.3 vacancies (12.49%). Consultants vacancies as a percentage of establishment is also high (8.3 vacancies 18.9%) and Occupational Therapists (16.3 vacancies 20.2%).

Breakdown of Vacancies per Care Group

Number of Vacancies as @ 30/04/19
 Corporate 59.5 WTE
 Mental Health Services Care Group 119.7 WTE
 Primary Care, Community, Children's and LD Services 128.1 WTE
 Specialist Services 20.1 WTE
 Total 327.5 WTE

PI RETURN FORM 2019-20

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2019**

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

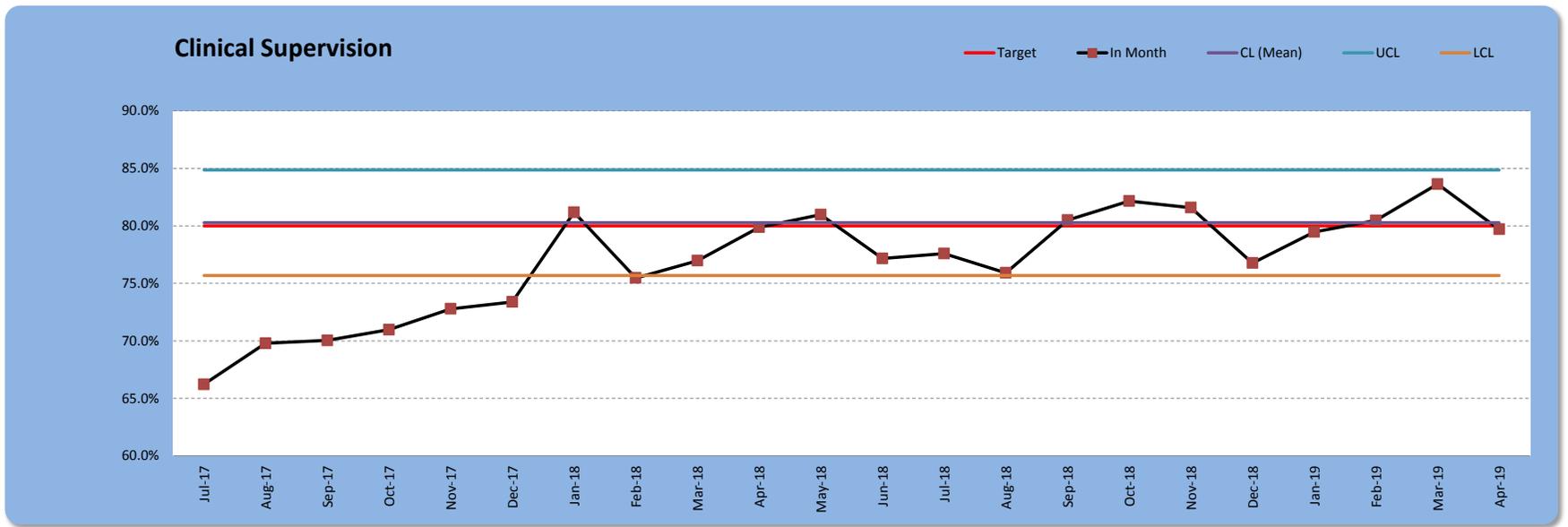
KPI Type
WL 9a

Narrative

Performance below target.

Target: 80%
Amber: 75%

Current month stands at 79.7%



Exception Reporting and Operational Commentary

A slight dip in April. Work continues to encourage a full return from all teams. Scarborough and Ryedale teams now have structures in place for 1:1 supervision and group supervision is also taking place with a programme of training to support full implementation and reporting.

Undergoing external audit as identified as the Trust's Local Indicator

Business Intelligence

Teams who do not provide a return are being actively managed by the Care Group.

HUMBER TEACHING NHS FOUNDATION TRUST SAFER STAFFING QUALITY DASHBOARD

Staffing and Quality Indicators	
Contract Period:	2018-19
Reporting Month:	Mar-19



Speciality	Units				Bank/Agency Hours				Average Safer Staffing Fill Rates				High Level Indicators													
	Ward	Speciality	WTE	OBDs (inc leave)	CHPPD Hours (Nurse)	Bank % Filled	Improvement	Agency % Filled	Improvement	Day		Night		QUALITY INDICATORS (YTD 2018-19)				STAFF QUALITY INDICATORS						Indicator Totals		
										Registered	Un Registered	Registered	Un Registered	Staffing Incidents affecting patient care (All Levels)	Incidents of Physical Violence / Aggression	Complaints (Upheld/ partly upheld)	Slips Trips Falls	Clinical Supervision	Mandatory Training (ALL)	Mandatory Training (ILS)	Mandatory Training (BLS)	PADRs	Sickness Levels (clinical)	WTE Vacancies (RNs only)	Feb-19	Mar-19
Adult MH	Avondale	Adult MH Assessment	26.8	64%	15.45	24.3%	↑	1.6%	↓	70%	85%	86%	121%	1	16	0	4	96.3%	88.0%	100.0%	73.7%	93.5%	2.1%	4.2	1	1
	New Bridges	Adult MH Treatment (M)	39.8	99%	7.84	15.3%	↑	0.3%	↓	88%	91%	93%	105%	2	35	0	3	92.1%	97.0%	100.0%	92.0%	93.0%	7.8%	1.0	2	2
	Westlands	Adult MH Treatment (F)	35.8	97%	8.26	28.4%	↓	3.2%	↑	81%	93%	86%	109%	10	64	0	5	87.5%	89.5%	86.7%	84.2%	97.5%	10.4%	3.0	1	2
	Mill View Court	Adult MH Treatment	28.8	95%	8.53	23.1%	↑	0.0%	↑	103%	94%	98%	98%	1	23	0	10	77.8%	93.8%	81.8%	87.5%	96.7%	4.6%	2.0	2	1
	Hawthorne Court	Adult MH Rehabilitation	29.0	38%	15.01	17.1%	↑	0.0%	→	75%	87%	100%	111%	2	9	0	4	93.1%	88.5%	72.7%	94.4%	66.7%	5.9%	-1.0	4	3
	PICU	Adult MH Acute Intensive	25.1	59%	19.33	43.9%	↑	3.5%	↑	76%	161%	86%	139%	2	180	0	1	100.0%	90.3%	93.3%	84.6%	82.8%	0.9%	5.4	1	0
OP MH	Maister Lodge	Older People Dementia Treatment	33.2	92%	13.59	28.7%	↓	0.7%	↓	54%	126%	129%	102%	14	81	0	74	85.7%	86.7%	72.7%	88.0%	94.7%	2.2%	4.7	3	2
	Mill View Lodge	Older People Treatment	24.2	99%	12.51	13.0%	↑	0.0%	→	88%	88%	100%	104%	0	9	0	27	63.0%	95.6%	100.0%	92.3%	96.6%	5.0%	1.0	1	1
Specialist	Darley	Forensic Low Secure	21.6	100%	10.44	22.8%	↓	0.0%	→	67%	67%	100%	102%	0	10	0	1	78.3%	94.1%	100.0%	82.4%	96.0%	4.8%	3.7	5	3
	Bridges	Forensic Medium Secure	52.0	87%	10.98	2.4%	↓	0.0%	→	69%	84%	100%	105%	7	13	0	0	63.0%	90.2%	85.7%	86.5%	74.6%	10.6%	0.0	3	3
	Swale	Personality Disorder Medium Secure	26.3	55%	17.15	45.7%	↓	0.0%	→	90%	84%	111%	160%	5	8	0	2	95.8%	94.4%	100.0%	80.0%	100.0%	9.7%	2.0	1	1
	Ullswater	Learning Disability Medium Secure	27.6	83%	14.73	39.3%	↓	0.0%	→	57%	123%	98%	100%	3	10	0	9	100.0%	92.5%	88.9%	73.7%	96.4%	9.7%	1.0	2	2
LD	Townend Court	Learning Disability	39.2	21%	64.73	29.6%	↓	0.0%	→	49%	95%	81%	102%	0	104	0	6	91.9%	93.9%	78.6%	100.0%	73.2%	7.2%	3.4	2	3
	Granville Court	Learning Disability Nursing Treatment	37.9	Not Avail	0.00	39.6%	↓	0.0%	→	100%	89%	100%	105%	1	2	0	3	95.7%	88.4%	100.0%	84.8%	70.6%	6.6%	1.0	2	2
CH	Whitby Hospital	Physical Health Community Hospital	33.5	74%	8.49	69.6%	↓	0.0%	→	92%	108%	100%	100%	18	13	0	50	88.6%	87.0%	77.8%	73.7%	86.8%	5.8%	-0.6	1	1
	Malton Hospital	Physical Health Community Hospital	29.7	93%	6.85	Not on eRoster	→	Not on eRoster	→	88%	95%	100%	100%	0	0	0	9	No Ret	78.3%	70.6%	86.4%	75.0%	5.0%	2.6	2	1

Exception Reporting and Operational Commentary

All areas have maintained or improved on the previous months performance with the exception of Westlands, where sickness and bed occupancy have been high. Supervision and overall mandatory training figures are above target for all units and ILS and BLS figures continue to improve. PADR compliance has improved slightly for the worse performing areas in February but overall more teams are below target which is being addressed at team level. Low registered nurse fill rates on Hawthorn Court and Townend Court and are offset by their low bed occupancy- as evidenced by higher CHPPD rates. Ullswater's fill rates are against a demand template that was requesting 3 qualified nurses on during the day- this has now been corrected back to 2 qualified nurses but this will not be reflected in the report until April. Darley and Bridges (Ouse and Derwent) have both had a recent safer staffing review which has confirmed that these are often the areas that have staff moved if clinical activity is high in other areas which will partially account for their fill rates. Additional actions are in place to support the number of vacancies in the Humber centre including the short term use of agency staff. Highest levels of sickness remain in the Humber Centre- A deep dive into this is being undertaken for review in the Workforce and OD committee.

OBD RAG ratings for Safer Staffing are: Less than 87% = Green, 87% to 92% = Amber, More than 92% = Red

Registered Nurse Vacancy Rates

Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
11.62%	12.06%	15.60%	16.60%	15.67%	15.73%	12.40%	11.80%	14.10%	12.50%	13.40%	14.20%

Staffing Incidents include all levels of harm/no harm

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

PI RETURN FORM 2019-20

Goal 1 : Innovating Quality and Patient Safety

For the period ending: **Apr 2019**

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

KPI Type

FFT %

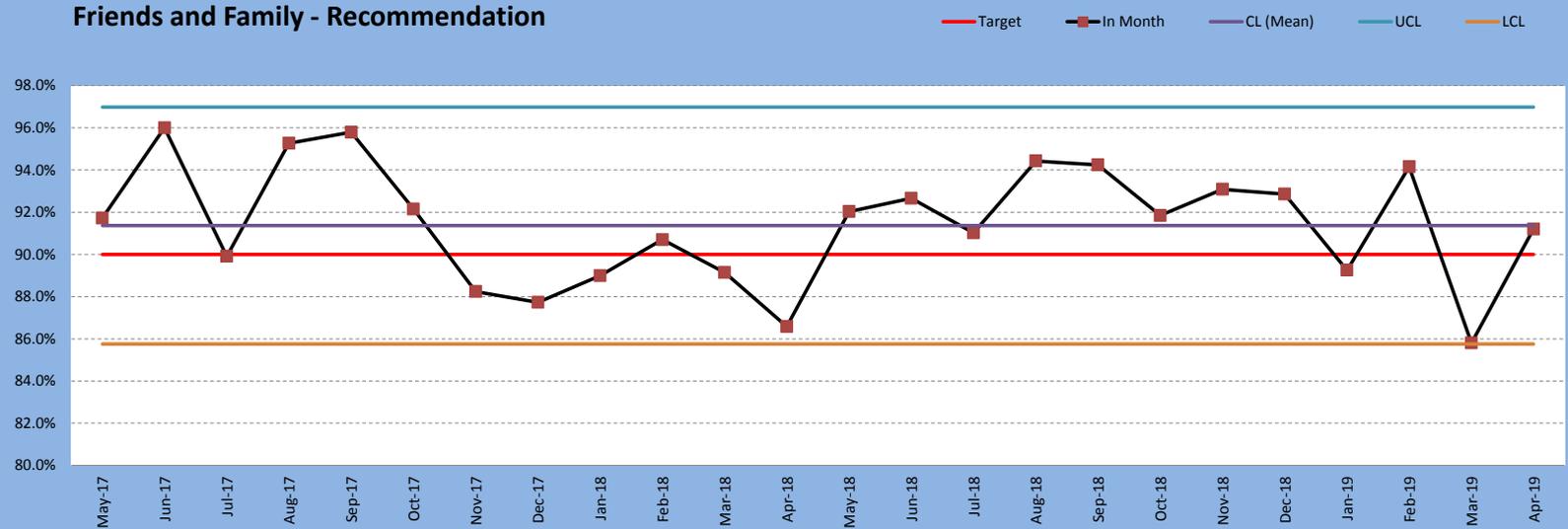
Narrative

In month target achieved.

Target: 90%
Amber: 80%

Current month stands at 91.2%

Friends and Family - Recommendation



Exception Reporting and Operational Commentary

In April 2019 patients likely to recommend our services has increased considerably in comparison to the March score (5.5% increase).

The Patient Experience Team is working with School Nursing to address the feedback received from young people in receipt of immunisations; the process for collecting feedback and the Friends and Family Test survey questions are both being reviewed, however it is recognised that the 'recommend' question must continue and the remaining questions must still be in-line with current Trust questions to align to the Friends and Family Test data dashboard.

NHS England is reviewing the 'recommend' question. It is anticipated that a revised question will be developed and ready to circulate during 2019/20.

Business Intelligence

Calculation based on ALL surveys completed across all service areas including GPs. Significant increase in the number surveys completed for school vaccinations which is likely to have impacted on feedback received.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

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

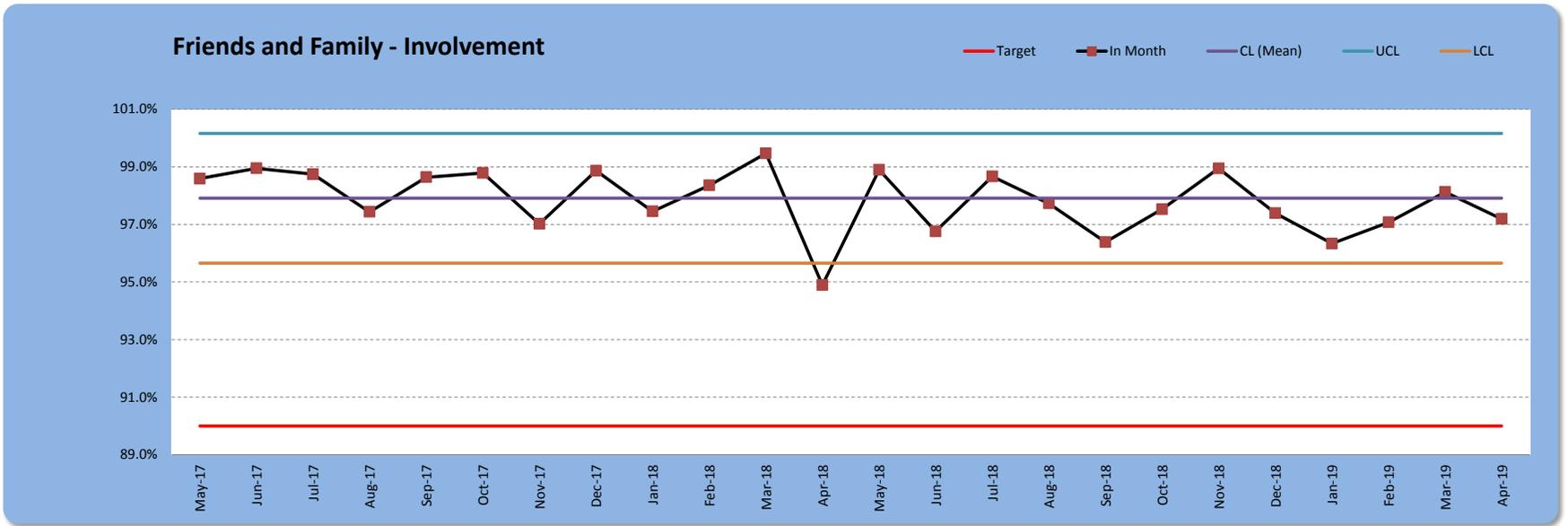
KPI Type
CA 3c %

Narrative

In month target achieved.

Target: 90%
Amber: 80%

Current month stands at 97.2%



Exception Reporting and Operational Commentary

The Trust continues to score high for key question around involvement and remains consistently above the target of 90% with a monthly score of 98.1%. The SPC chart shows normal statistical variation.

Business Intelligence

The results for the two remaining question results are:

Patients Overall FFT Helpful	98.9%
Patients Overall FFT Information	97.5%

The short survey does not include Core Questions. GP Practices use the short survey so are not included in the above results.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

CPA 7 Day Follow Ups

This indicator measures the percentage of patients who were on CPA and had a follow up within seven days of discharge

Executive Lead
Lynn Parkinson

KPI Type

OP 12

Narrative

Within target

Target: 95%
Amber: 85%

Current month stands at 95.3%

CPA 7 Day Follow Ups



Exception Reporting and Operational Commentary

There were three breaches in April. Two patients disengaged with services, despite attempts by the service to contact then within 7 days. One breach was the result of staffing and communication issues. The team and clinical lead have reviewed this breach and action has been taken to address the cause and prevent re-occurrence. The patient was contacted after 7 days.

This indicator is monitored on a daily basis. Directors and operational managers are advised of potential breaches and a timeliness report is updated each day for review and action by teams.

Business Intelligence

64.1% of follow ups achieved within 3 days.

Timescales of Completion
No of Discharges
Patients Seen
BREACHES

May Discharges	Percentage of when patients seen		
	1-3 days	4-5 days	6-7 days
28	19	0	1
20	67.9%	0.0%	3.6%
8			

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

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

KPI Type

OP 7

Narrative

Performance below target but within control limits.

Target: 95%

Amber: 85%

Current month stands at 94.3%

CPA Reviews



Exception Reporting and Operational Commentary

The CPA compliance is below target for Apr-19 but within control limits. The Care Groups continue to focus on ensuring this standard is met. Regular weekly reports are maintained identifying patients who are eligible for a review, this allows Care Coordinators, Team Managers and Service Managers to identify any potential breach of the standard and plan remedial action if required. Where a failure to complete a review within 12 months does occur the Clinical Care Director maintains oversight to identify and share any lessons through the clinical networks.

Business Intelligence

Currently weekly exception reporting is produced to support teams in identifying the overdue and required soon cases. The CPA reviews target was achieved this month.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title	Description/Rationale	Executive Lead
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	Lynn Parkinson

KPI Type

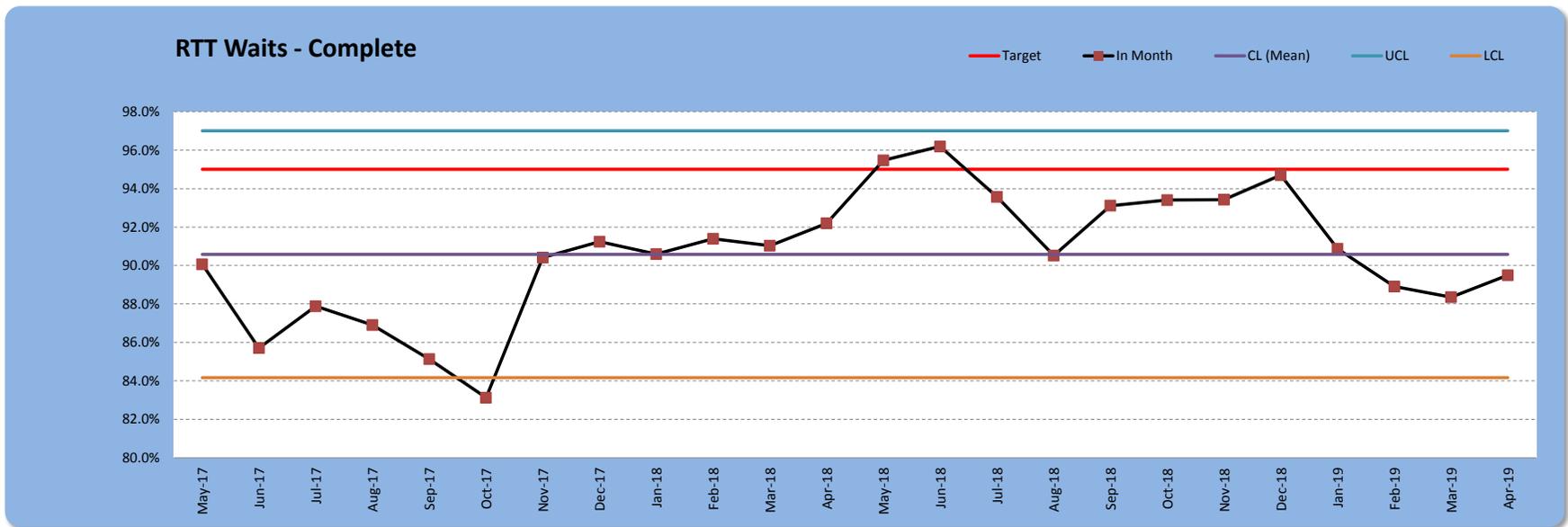
OP 20

Narrative

Below the mean but an improvement on the previous reporting period.

Target: 95%
Amber: 85%

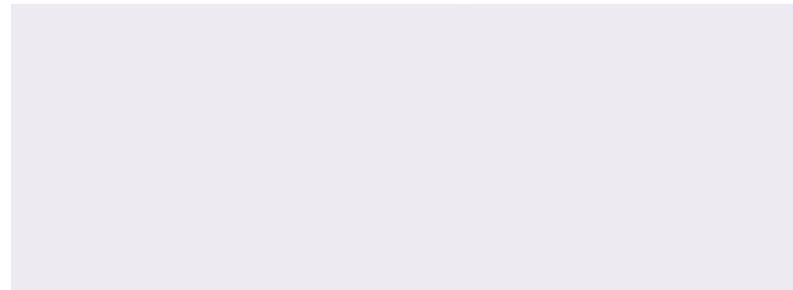
Current month stands at 89.5%



Exception Reporting and Operational Commentary

Waiting times are monitored rigorously by the care groups and oversight is monitored and managed by the Operational Performance and Risk Group chaired by the COO. Where necessary exception reports, remedial action plans and improvement trajectories are required and put in place. Services have an active working Standard Operation Procedures (SOP) in line with the Trusts Waiting List and Waiting Times Policy to manage the referral and waiting list process which sets out that patients are to be contacted regularly whilst they are on a waiting list to mitigate the risks. All teams are encouraged to review their waiting lists at least weekly and resolve any data quality issues which may exist within their clinical system. If a patients need becomes more urgent than the expectation is that their appointment is expedited and they are seen more quickly in line with their presenting need.

Business Intelligence



PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title	Description/Rationale	Executive Lead
RTT Waiting Times (Incomplete Pathways)	Referral to Treatment Waiting Times (Incomplete Pathways) : Based on patients who have been assessed and continue to wait more than 18 weeks for treatment	Lynn Parkinson

KPI Type

OP 21

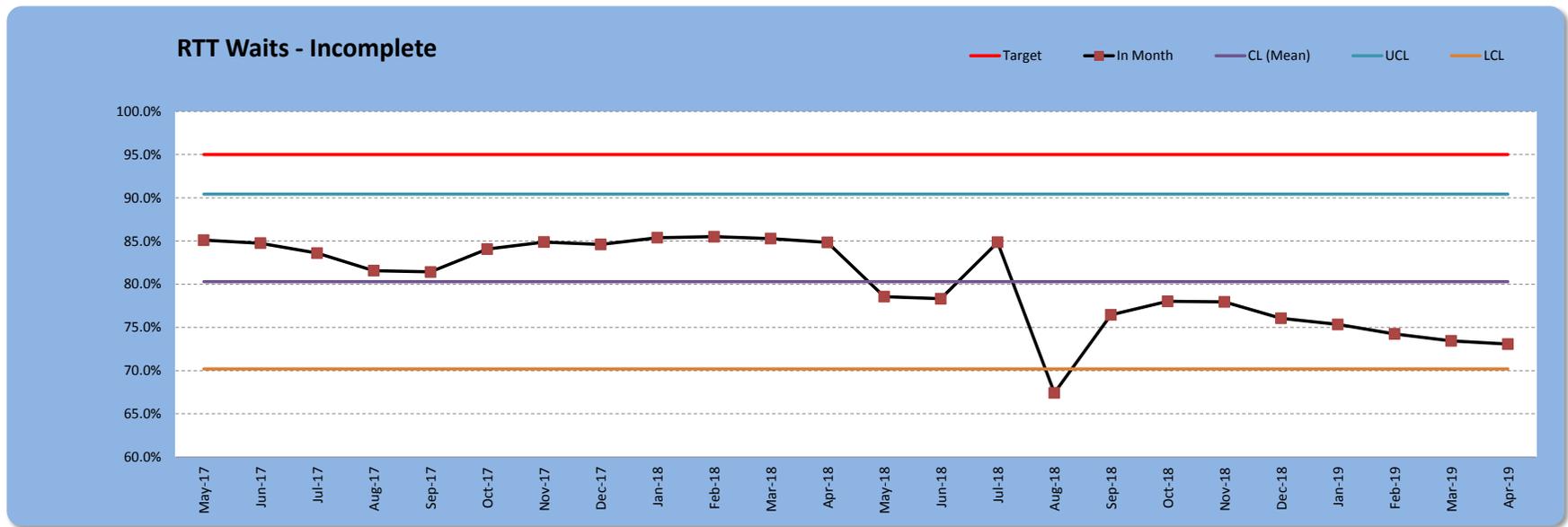
Narrative

slight reduction from previous month

Target: 95%

Amber: 85%

Current month stands at 73.1%



Exception Reporting and Operational Commentary

Waiting times are monitored rigorously by the care groups and oversight is monitored and managed by the Operational Delivery Group chaired by the COO. Where necessary exception reports, remedial action plans and improvement trajectories are required and put in place. Information is provided to patients waiting as to how to contact services if their need becomes more urgent and people are sign posted to other services who can provide support whilst they wait. In order to ensure that this is an active process a patient can be provided with additional support to connect with other services and as part of the regular review and contact made by teams they will check the patient is still in contact with that service and if not discuss the reason with the patient.

Business Intelligence

The drop in performance in Aug-18 relates to data issue following the transfer of existing caseload when Scarborough & Ryedale transferred to the Trust.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

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

KPI Type

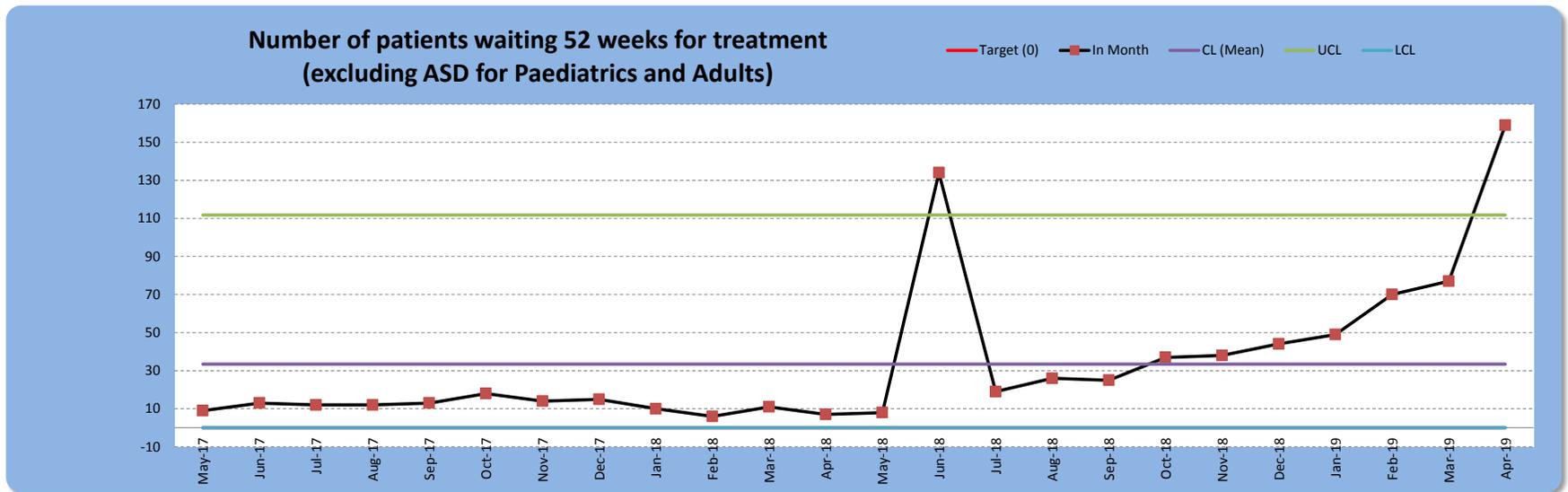
OP 22x

Narrative

Increase of 82 since last month

Target: 0
Amber: 0

Current month stands at 159



Exception Reporting and Operational Commentary

Waiting times continue to be an area for significant operational focus and review. An increased referral rate for Hull CAMHS has been evident for a number of months; this has been appropriately escalated to the Commissioner. The impact of the increased demand on the capacity means that waiting times have been increasing which includes a number of patients waiting over 52 weeks.

Largely, waits over 52 weeks relate service users who have complex needs which include working with families/carers so that the young person is ready to engage in assessment. A detailed review of the patients waiting over 52 weeks in Hull CAMHS has been undertaken in, most of these patients are waiting for ADHD assessments and anxiety assessment/treatment. Additional posts have and are being recruitment to which will ensure that there is increased capacity to meet commissioned service requirements. In relation to Hull CAMHS, the Trust received a further investment of £70k in Q4 2018/19 to improve the waiting list position. Hull CCG is fully aware of the position and they are assured of our progress and transparency, however we are continuing to work with them closely due to the position not yet recovering. We have a further 155k non recurrent monies from commissioners which we will use to sub contract to bring early capacity to the ADHD and anxiety pathways where the waits are over 52 weeks.

Business Intelligence

This indicator excludes Adult & Paediatric ASD patients.

The ASD waiting list information is included in the following two slides.

153 of the >52 weeks waits relate to CAMHS. See additional SPC for further information.

The increased position is Apr-19 was a result of cases transferred from another provider for ADHD.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title	Description/Rationale	Executive Lead
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	Lynn Parkinson

KPI Type

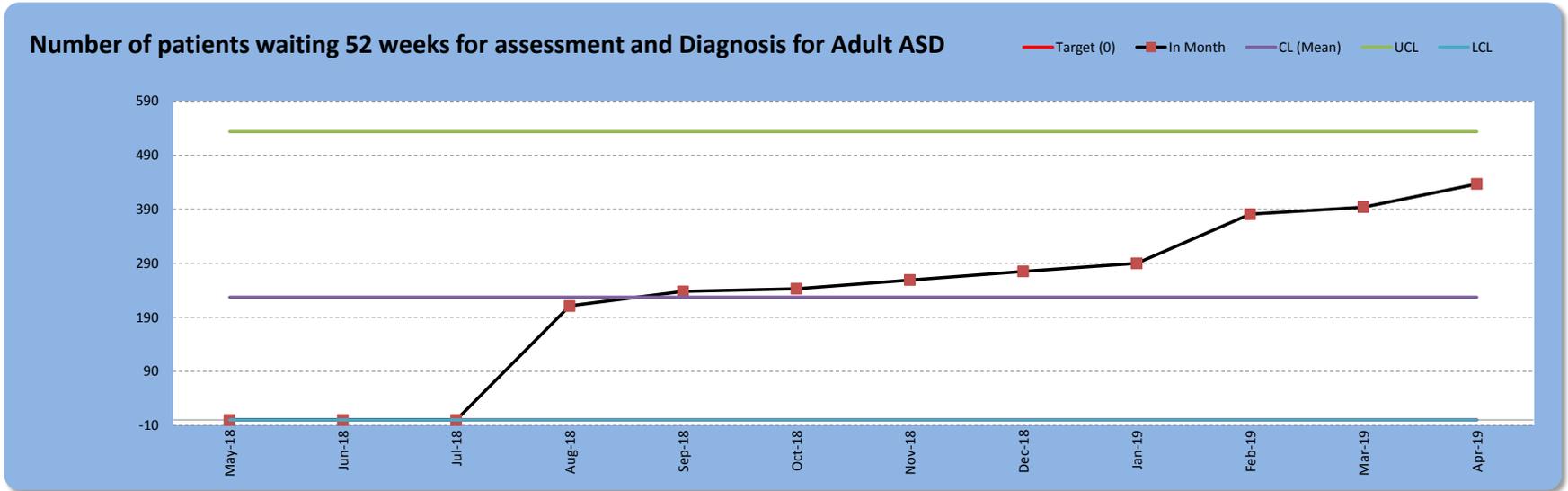
OP 22s

Narrative

Increase of 43 when compared on the previous reporting period.

Target: 0
Amber: 0

Current month stands at 437



Exception Reporting and Operational Commentary

This service is commissioned by both Hull and East Riding CCGs on a cost per case service only – this has meant that assessments have only occurred as core service capacity, demand and staff availability has allowed. The historic referrals were added to Lorenzo in June 2018 when the full waiting list position was validated and incorporated into the operational reporting arrangements which highlighted the need for a more focussed piece of work by the service. Commissioners are fully aware of the historical position and supportive of an approach to address the waiting times. The Care Group has developed a business case which has been considered and approved by the Operational Delivery Group. The additional capacity is expected to be in place from March 2019 which proposes a trajectory for the service to be 18 week compliant within 12 months. The CCGs have confirmed that the priority for assessments is a targeted age range – predominantly those people who are likely to benefit most from a diagnosis, i.e. those in higher or further education, struggling to maintain employment, etc. Further work has been undertaken to refine the diagnosis pathway and this is being supported by additional nursing capacity in order to reduce the waiting times.

Business Intelligence

SPC charts have now been introduced

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

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

KPI Type

OP 22u

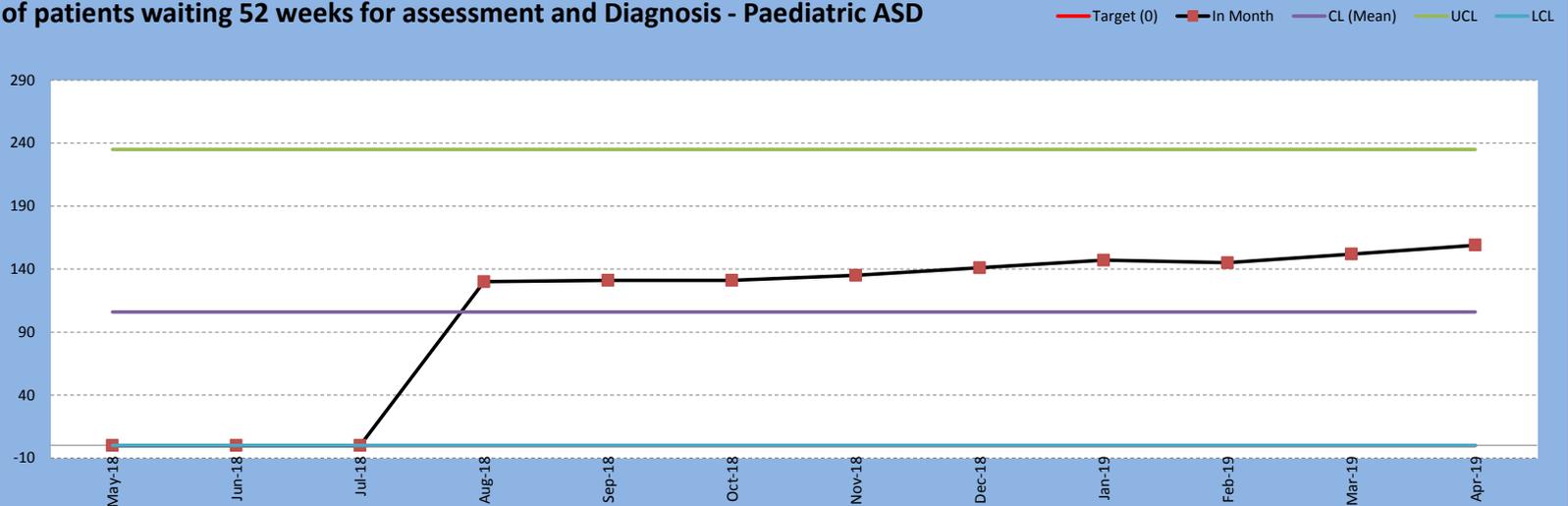
Narrative

Increase of 7 when compared to the previous month.

Target: 0
Amber: 0

Current month stands at 159

Number of patients waiting 52 weeks for assessment and Diagnosis - Paediatric ASD



Exception Reporting and Operational Commentary

From September 2017 referrals for Autism commenced via triage through Hull Contact Point (which includes gathering previous assessments from other agencies, parents & schools) as part of a previously agreed service development. Referrals into the service continue to be high. Historically referrals for children's ASD for the Hull service were significantly over the commissioned activity. The Trust developed a business case and submitted it to Hull CCG in May 2018; following negotiations a revised position was agreed with commissioners in October 2018. Recruitment began ahead of October 2018 – this is progressing well with partial service delivery having commencing in January 2019. There is an agreed trajectory which expects that the service will be 13-week compliant, based on current referral rates, by March 2021. Monthly meetings with commissioners are taking place to assess compliance with the trajectory and that is monitored. Staff are now coming into post; in addition we have secured an agency member of staff who is DOS and ADAiR (Autism Diagnosis Training) to support decrease in the waiting times. In addition the skill mix for the diagnosis pathway has been reviewed and has expanded in line with NICE guidance to include nurses. Discussions have taken place with commissioners about referrers and the plan is to cease GP referrals and accept referrals from SENCO's. This is a development that the CCG are leading on. This will mean that referrals will arrive at Contact Point with a much more comprehensive set of information, cutting down on our assessment time.

Discussions with Commissioners has also taken place regarding securing some on line assessments via HELIOS (a on line support package which has proved successful in the East Riding). To do this the procurement and contractual processes are currently being progressed.(see note in RTT52 - ADHD and anxiety long waiters are a higher risk)

Business Intelligence

SPC charts have now been introduced

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

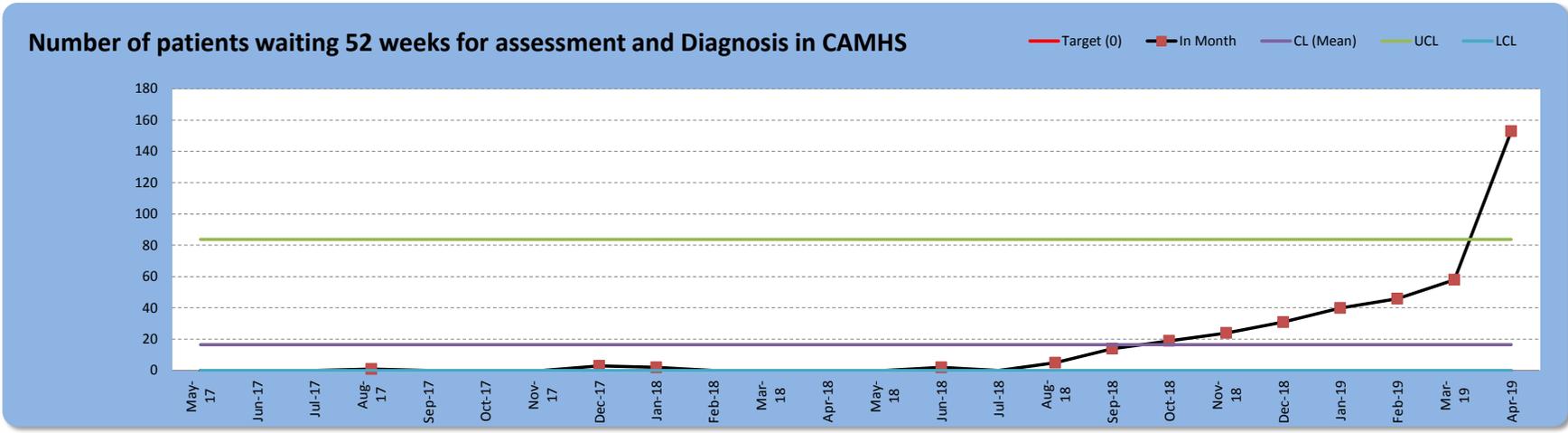
Indicator Title	Description/Rationale	Executive Lead	KPI Type
52 Week Waits - CAMHS	Number of patients who have yet to receive treatment in CAMHS and have been waiting more than 52 weeks	Lynn Parkinson	OP 22j

Narrative

Increase of 95 since last month

Target: 0
Amber: 0

Current month stands at 153



Exception Reporting and Operational Commentary

The number of referrals into Contact Point continue to be high, over 300 per month; all of which need to be triaged and processed. The number that is accepted at Core CAMHS is around one third. We are working with the commissioners to review the 'front door' due to the high number of referrals that need redirecting. These are taking considerable capacity to process which could be redirected to providing treatment and reducing the waiting list. The anxiety and mood pathways have shown slight improvement in waiting times. We have a robust waiting time reduction plan in place and as part of this:

- We continue to refer to Mind for CPWP or counselling input as part of HTFT's sub contract and the counselling service commissioned by the local authority and HeadStart.
- We provide a significant amount of group work into this pathway to increase capacity,
- We are also a placement site for trainee psychologists who under the supervision of Clinical Psychologists can pick up a non-complex caseload and undertake evidence based interventions.
- Temporary bank staff are being used as part of a waiting list initiative as is an Agency CBT therapist

Measures already in place

- CBT Parent Groups (anxiety only) and Young People's CBT groups (anxiety and low mood) continue to run as a way of managing the high volume of anxiety referrals
- Anxiety and Autism Groups continue to run to manage the high level of Autism referrals although there continues to be a number of young people with Autism that need individual work
- Continue to use a Child Psychological Wellbeing Practitioner (CPWP) to provide a waiting list initiative for non-complex cases (10 years and under).

Further discussions are taking place with the commissioners to identify other action we can take to reduce the waiting times. See earlier comment on generic RTT52 re ADHD and anxiety.

Business Intelligence

New referrals for ADHD have now stabilised at a higher rate following the change in Community Paediatricians no longer providing ADHD assessments. Performance waiting lists will see high numbers of referrals but operationally every referral over 18 weeks will have had some form of assessment. It is not until the young person is either assessed by a Consultant Psychiatrist following this comprehensive assessment or assessed as not requiring a Specialist Assessment and is referred on that they are deemed not waiting on performance reports. This is therefore a long assessment process.

The referral rate for Trauma has been growing. Due to the nature of Trauma work there is usually a high level of multi-agency working prior to individual interventions taking place. The waits on performance reports in the past have appeared longer due to this level of preparatory and consultation work. HTFT's activity recording has been changed so this activity can be recorded as intervention.

The 6 session family systemic intervention is working well for the DSH client group. For those young people who are emotionally dysregulated and where systemic practice is not found useful we are exploring models of working with this complex client group and how we link into adult services for transition. Consultation is offered at Contact Point is offered to ensure agencies are provided with advice and early support, referrals requiring face to face intervention are then prioritised on the Trauma pathway.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

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

KPI Type

OP 9

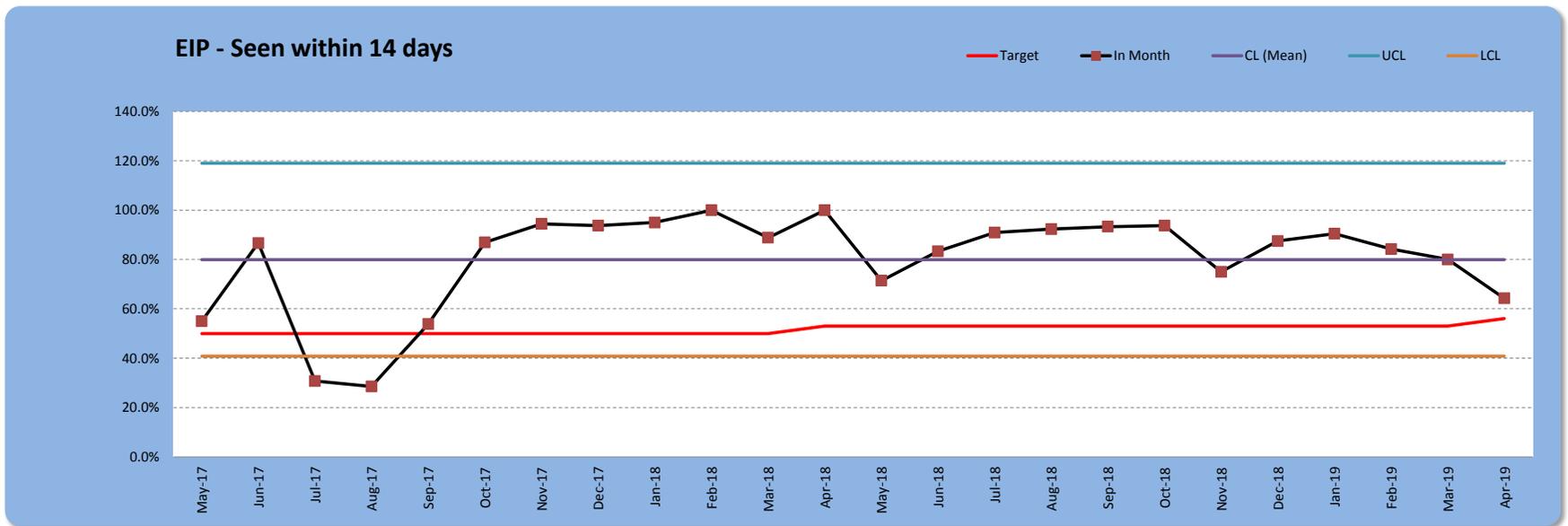
Narrative

Target achieved

Target: 56%

Amber: 51%

Current month stands at 64.3%



Exception Reporting and Operational Commentary

The service has met and exceeded the standard for the month. Rates of referrals vary significantly from month to month and the service continues to work to ensure that it has the capacity match the variation in demand.

Undergoing external audit as identified as a Trust mandated indicator

Business Intelligence

Low numbers of referrals may dramatically affect percentage results. The target increased to 56% from 1st April 2019 and by 2020/21 the target will increase to 60%

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

Improved Access to Psychological Therapies

Two graphs to show percentage of patients who were seen within 6 weeks and 18 weeks of referral

Executive Lead
Lynn Parkinson

KPI Type

OP 10a

Narrative

Target achieved

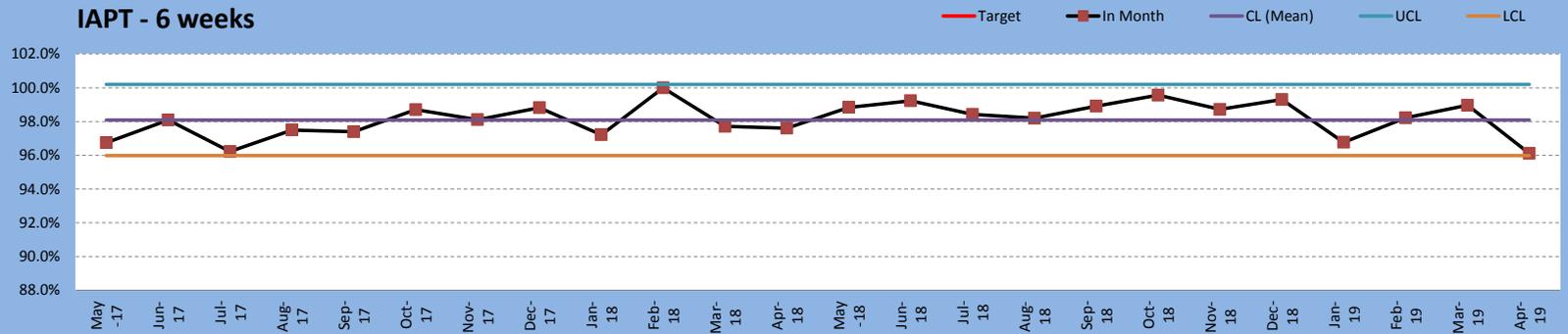
Target: 75%

Amber: 70%

Current month

96.1%

IAPT - 6 weeks



Narrative

Target Achieved

Target: 95%

Amber: 85%

Current month

100.0%

IAPT - 18 weeks



Exception Reporting and Operational Commentary

The service has met and exceeded the standard in the month to see new referrals 6 and 18 weeks. Rates of referrals vary significantly from month to month and the service continues to work to ensure that it has the capacity match the variation in demand.

Business Intelligence

Please note, patients who DNA (Did not Attend) either first and/or second appointment will have their waiting time clock reset (NHSE guidance).

NHS Digital do not factor resetting of waiting times clocks into their published data - so the results will vary.

PI RETURN FORM 2019-20

Goal 2 : Enhancing Prevention, Wellbeing and Recovery

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

Improved Access to Psychological Therapies

This indicator measures the Recovery Rates for patients who were at caseness at start of therapeutic intervention

Executive Lead
Lynn Parkinson

KPI Type

OP 11

Narrative

Target Achieved

Target: 50%
Amber: 45%

Current month stands at 57.8%

IAPT - Moving to Recovery



Exception Reporting and Operational Commentary

The service has met the standard for achieving the recovery outcome measure in the month and remains within the control limits set.

Business Intelligence

Performance continues to exceed the national target of 50% and performance remains within the control limits.

PI RETURN FORM 2019-20

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Apr 2019**

Indicator Title	Description/Rationale	Executive Lead
Under 18 Admissions	Number of patients aged 17 and under who were admitted to an adult ward	Lynn Parkinson

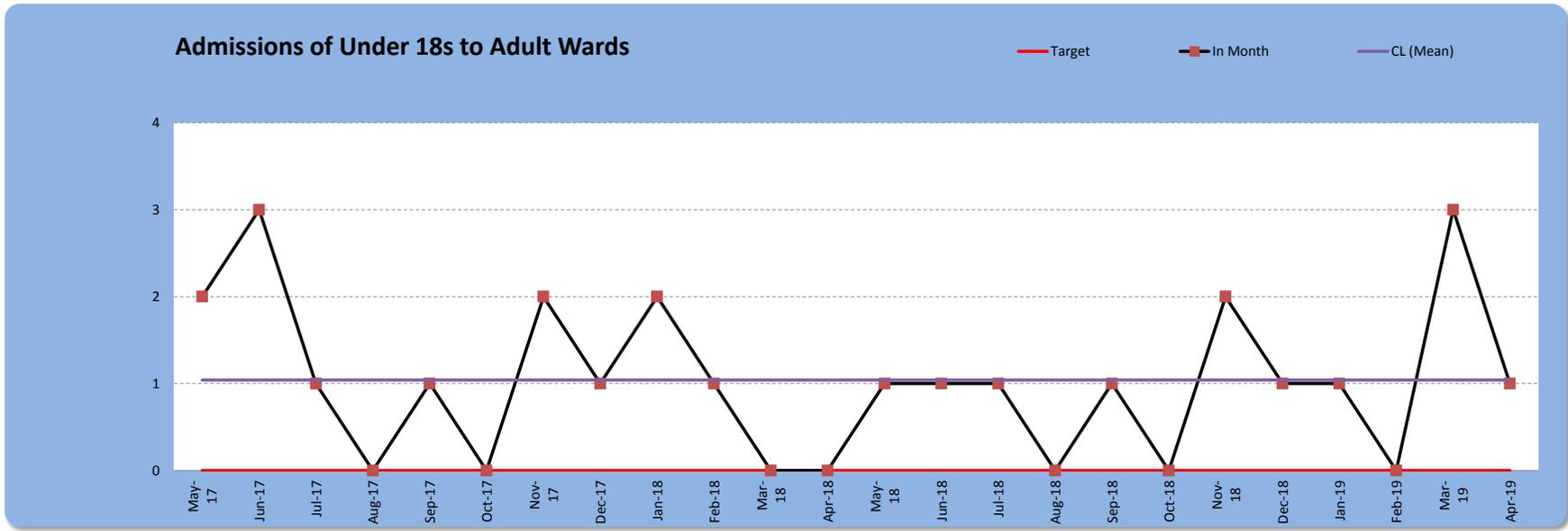
KPI Type
ST 1

Narrative

One admission

Target: 0
Amber: 1

Current month stands at 1



Exception Reporting and Operational Commentary

There was one admission in April which was an emergency due to no CAMHS bed and the patient had been waiting for a bed all day. A CAMHS bed was found the following day.

Business Intelligence

Current Year Summary			
Year	Age 16/17	Under 16	Total
2018/19	10	1	11

PI RETURN FORM 2019-20

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

Executive Lead
Lynn Parkinson

KPI Type

Out of Area Placements

Number of days that Trust patients were placed in out of area wards

ST 4b

Narrative

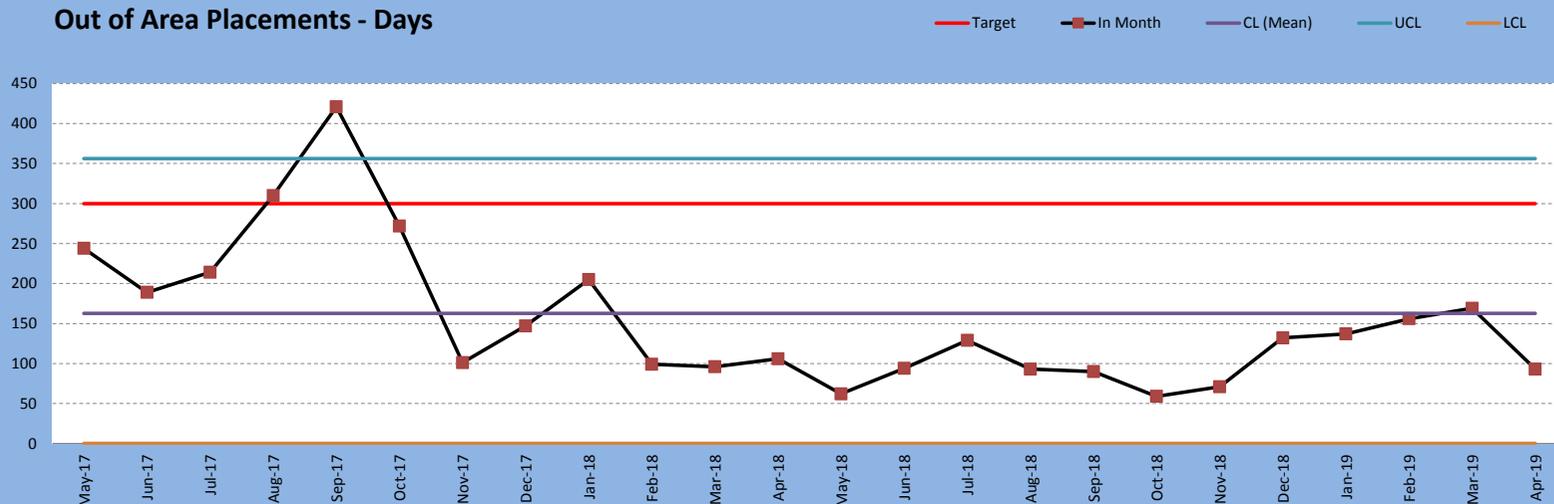
Target Achieved

Target: 300

Amber:

Current month stands at 93

Out of Area Placements - Days



Exception Reporting and Operational Commentary

A rigorous approach to bed management continues to be applied to ensure that out of area placements are avoided. Performance in relation to out of area placements for acute mental health beds continues to demonstrate sustained improvement for mental health beds. However, out of area placement for PICU beds continues to be a pressure. Capacity continues to be impacted by delayed transfers of care to specialist services. Work is underway to review our PICU model and agreement has been reached with commissioners to reduce capacity to 10 beds. Opportunity is being considered within the STP programme to improve flow through these beds. In January there was a further rise in the use of out of area beds for older people, this occurred at the same time that this service experienced an increase in delayed transfers of care, this position has been escalated through our system escalation processes and specifically to Hull and East Riding Councils.

Undergoing external audit as identified as a Trust mandated indicator

Split of Speciality and Reasons in current month

Patients in OoA beds in month

Unavailability of bed	93	Adult	0
Safeguarding	0	OP	78
Offending restrictions	0	PICU	15
Staff member/family/friend	0		
Patient choice	0		
Admitted away from home	0		

An internal data quality audit has been conducted and a subsequent refresh identified. Submissions to NHS Digital have been updated resulting in a reduction of Out of Area Placement Days

PI RETURN FORM 2019-20

Goal 3 : Fostering Integration, Partnership and Alliances

For the period ending: **Apr 2019**

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

KPI Type
OP 14

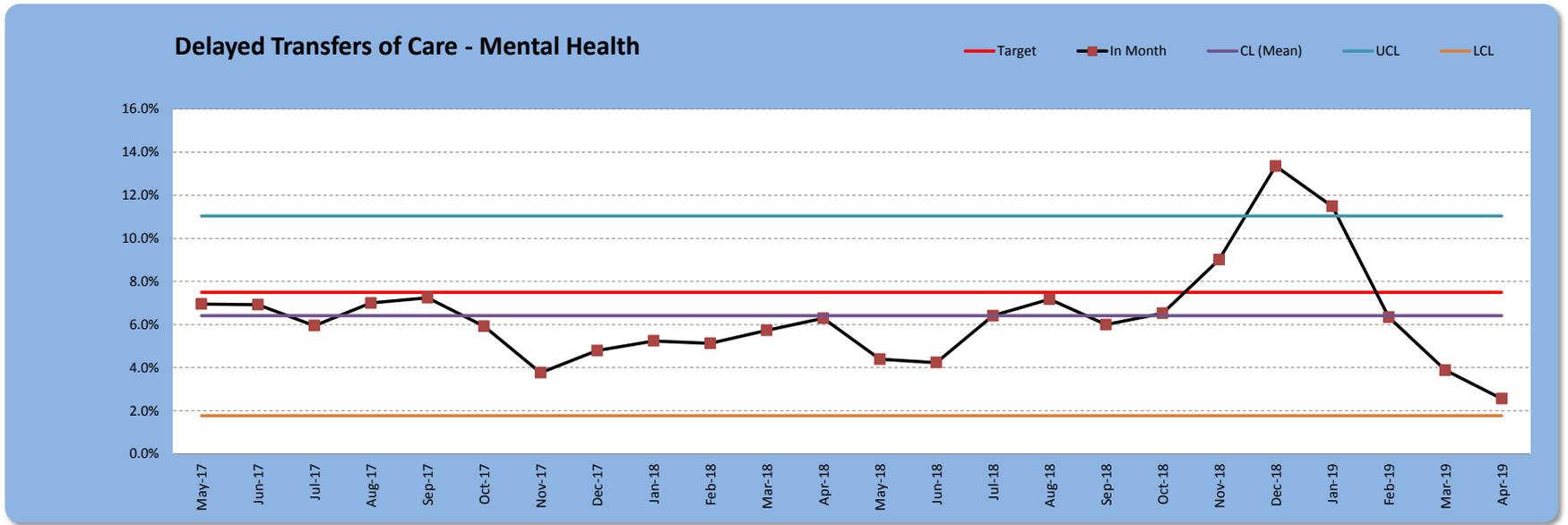
Narrative

Reduced significantly and within target

Target: 7.5%

Amber: 7.0%

Current month stands at 2.6%



Exception Reporting and Operational Commentary

Delayed transfers of care for mental health beds remain within the required standard this month. Delays continue to be managed rigorously through the approaches in place to manage acute bed demand, capacity and flow. Systems are in place to escalate delays to system partners where that is appropriate. Ongoing partnership with Local Authorities continues to be developed. Whilst the position has improved in March, delays continue to be monitored through our system escalation processes with the elected Local Authorities.

Business Intelligence

There were 96 delayed days in mental health during April. A further improvement on the previous month. Six patients in Older People's, 4 patients in Adult services and 1 in Specialist. The top three reasons are:

Awaiting residential home placement	67
Housing - not covered by the Housing Act	42
Awaiting further non-acute NHS Care	42

No delays in Learning Disabilities and 5.7% in Community Hospitals.

PI RETURN FORM 2019-20

Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

Sickness Absence

Percentage of staff sickness across the Trust (not including bank staff). Includes current month's unvalidated data

Executive Lead
Steve McGowan

KPI Type

WL 1

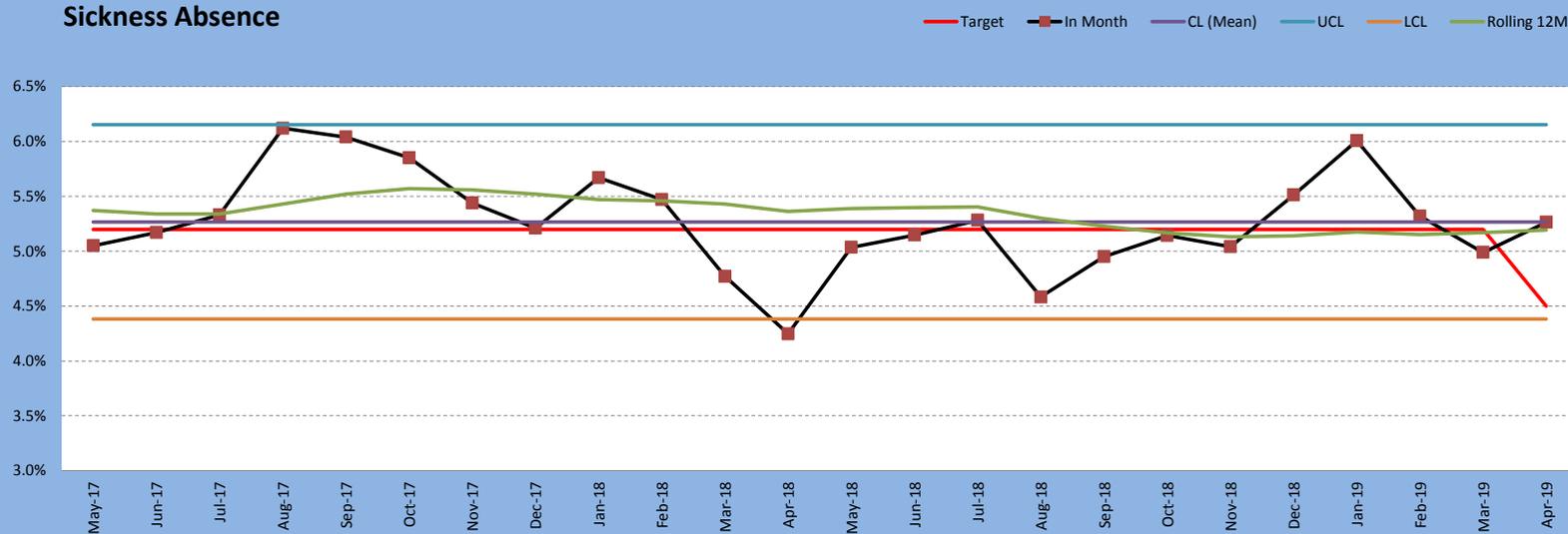
Narrative

In month target not achieved.

Target: 4.5%
Amber: 5.2%

Previous month Refresh
4.9%

Sickness Absence



Exception Reporting and Operational Commentary

Sickness rates are reported to managers on a monthly basis, form part of accountability reviews and feature at Trust Leadership Forum's. The trust recognises good attendance (thank you letters) and has in place a robust policy to help manage sickness absence. The PROUD programme launched in January and this includes various initiatives to help develop managers to be better leaders. Model hospital data shows the median sickness figure for comparable trusts as 4.78%.

Business Intelligence (previous month)

Trustwide - Mar
4.9%
Rolling 12m
5.2%
WTE
2332.13

Care Group Split Below	Mar %	Rolling 12m	WTE
Specialist Services	7.24%	8.34%	213.84
Mental Health Services	5.42%	5.70%	592.04
Older Peoples MH	4.22%	5.63%	176.55
Community Services	5.08%	4.81%	336.63
Children's and LD	4.58%	4.73%	473.39

Corporate Split Below	Mar %	Rolling 12m	WTE
Medical	7.16%	5.97%	31.09
Human Resources	5.40%	4.57%	58.23
Finance	2.21%	3.12%	100.35
Nursing and Quality	4.59%	4.86%	31.33
General Practices	1.77%	2.41%	98.12
Chief Executive	7.80%	8.07%	15.44
Chief Operating Officer	4.33%	3.32%	205.12

PI RETURN FORM 2019-20

Goal 4 : Developing an Effective and Empowered Workforce

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

KPI Type

Staff Turnover

The number of full time equivalent staff leaving the Trust expressed as a percentage of the overall full time equivalent workforce employed. Leavers include resignations, dismissals, retirements, TUPE transfers out and staff coming to the end of temporary contracts. It doesn't include junior doctors on rotation

Executive Lead
Steve McGowan

WL 3 TOM

Narrative

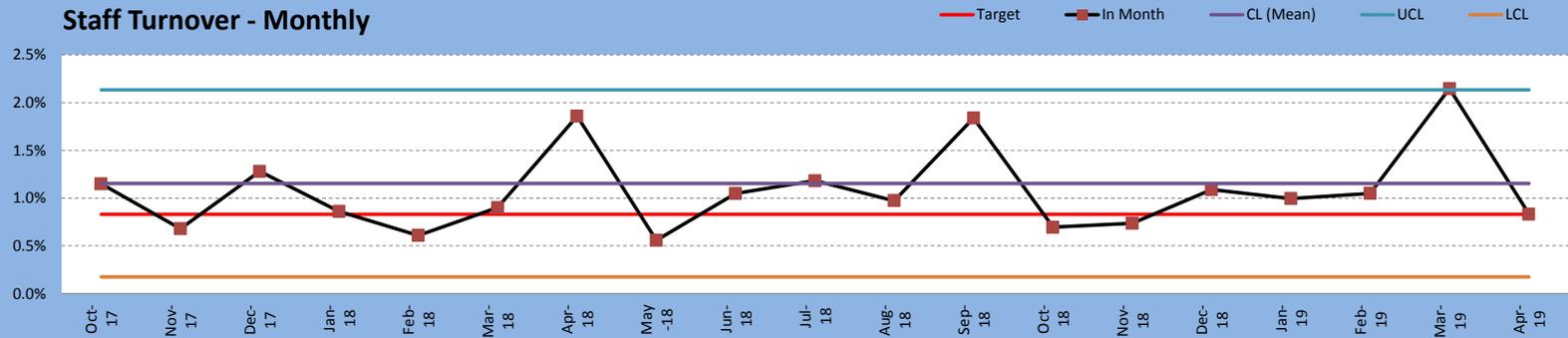
Exceeds Target

Target: 0.83%

Amber: 0.70%

Current month stands at 0.8%

Staff Turnover - Monthly



Narrative

Exceeds Target

Target: 10%

Amber: 9%

Current month stands at 13.9%

Staff Turnover - Rolling 12 months



Exception Reporting and Operational Commentary

The TUPE transfer of staff to CHCP in 2017 largely accounts for the high figures March 17 to March 18. The Trust continues to put in place the actions agreed as part of the retention plan earlier in the year, and is actively trying to recruit to vacant posts within the Trust.

Main Reasons for Leaving - Year to Date

Excludes Students, Psychology Students and Bank

Year to Date	No.
Retirement	10
Voluntary Resignations	11
Work Life Balance	0
End of Contract	1
Other	0
Total	22

PI RETURN FORM 2019-20

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

Performance and Development Reviews

Percentage of staff who have received a PADR within the last 12 months (excludes staff on maternity)

Executive Lead
Steve McGowan

KPI Type

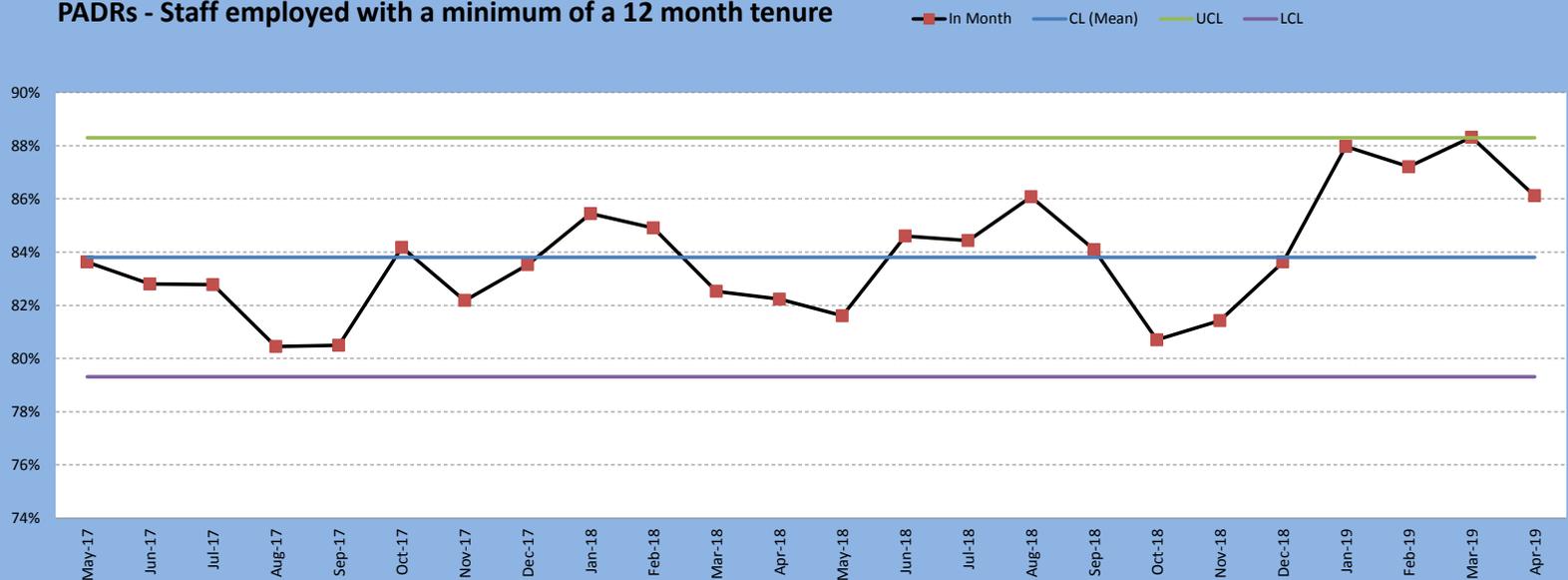
WL 4 (ii)

Narrative

in month target achieved

Current month stands at 86.1%

PADRs - Staff employed with a minimum of a 12 month tenure



Exception Reporting and Operational Commentary

All managers continue to receive monthly updates on their completion rates, together with a list of those that are non-compliant. PADR completion is raised at Operational Delivery Group and discussed at quarterly Leadership Forums. ESR supervisor self service roll out commenced on 1st December, with full roll out due for completion at the end of June 2019. This allows direct entry of a PADR in the recording system (ESR) which will help improve the timeliness of reporting, and sets up a formalised reminder system via self service.

Business Intelligence

Care Group and Corporate Splits Below

CG Reporting	Apr-19
Mental Health	90.3%
Corporate	83.2%
PCCHLD	85.1%
Specialist	81.5%

Chief Exec	83.3%
Chief Operating Officer	75.0%
Finance	94.3%
Human Resources	88.5%
Medical	81.8%
Nursing and Quality	97.1%

PI RETURN FORM 2019-20

Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Apr 2019**

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

KPI Type

F 2a

Narrative

The Trust has not target for cash set, however the Trust has seen an improvement in overall cash and the underlying cash position.

Target:

Amber:

Current month stands at £14,335 ,000

Cash in Bank (£000's)



Exception Reporting and Operational Commentary

As at the end of April 2019 the Trust cash balance was £14.335m.

The cash balance includes central funding for the CAMHS and LICHRE projects were there are timing difference between receipt and expenditure, the underlying balance at the end of the month was £11.114m.

Business Intelligence

The cash figure represents the cash balances held by the Trust (Government Banking Service, Commercial Account and Petty Cash).

PI RETURN FORM 2019-20

Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Apr 2019**

Indicator Title	Description/Rationale	Executive Lead
Resource Score	The Single Oversight Framework assesses the Trust's financial performance across different metrics	Peter Beckwith

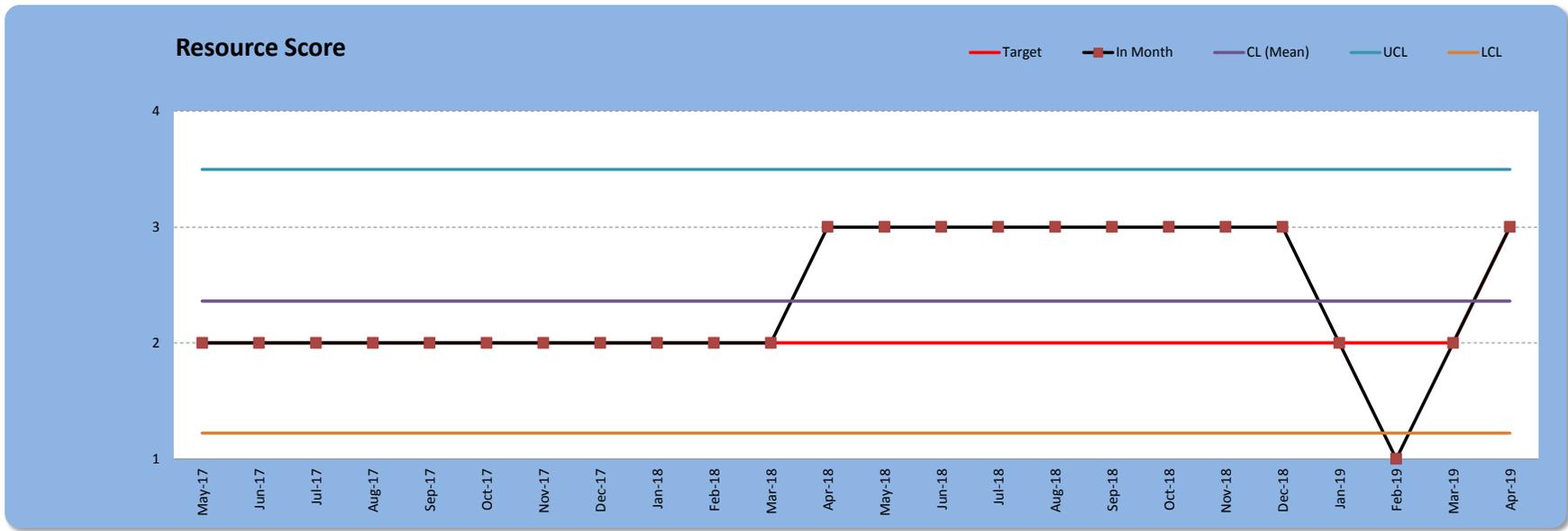
KPI Type
F 2b

Narrative

Use of Resources Score for April 2019 is a 3.

Target: 2
Amber: 3

Current month stands at 3



Exception Reporting and Operational Commentary

The 'Use of Resource' framework assesses the Trust's financial performance across different metrics, the Trust can score between 1 (best) and 4 (worst) against each metric, with an average score across all metrics used to derive a use of resources score for the Trust.

2019/20 is now based on the new NHS I plan. The Trust's Use of Resources score in April 2019 is a 3, dropping from the March score of 2 (which was before the Trusts PSF bonus) and consistent with the Trusts Plan submission.

Business Intelligence

Full two year dataset now available following change to the Resource Score settings

PI RETURN FORM 2019-20

Goal 5 : Maximising an Efficient and Sustainable Organisation

For the period ending: **Apr 2019**

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

KPI Type

F 4b

Narrative

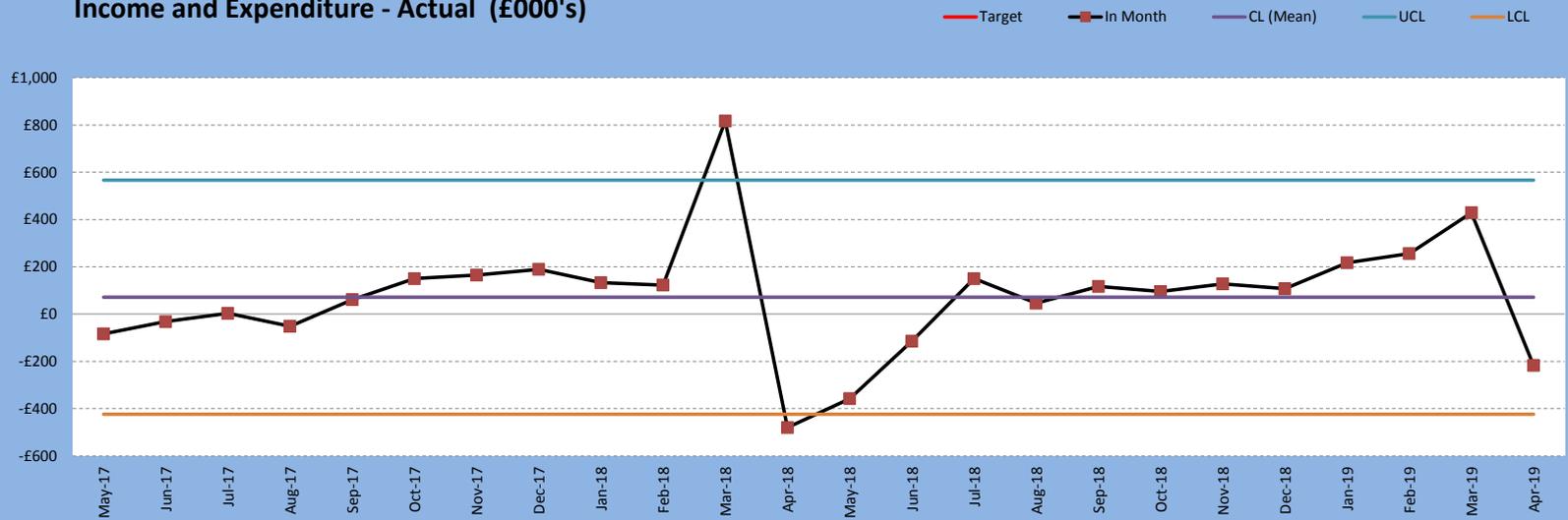
The Trust are reporting a year to date deficit, consistent with its NHSI Plan.

Target:

Amber:

Current month stands at -£217 ,000

Income and Expenditure - Actual (£000's)



Exception Reporting and Operational Commentary

The Trust reported a year to date deficit of £0.117m (excluding BRS contingency). No sustainability funding is included in the position as the Trust has not accepted its Control Total.

The submitted financial plan for the trust is a £2.397m deficit (excluding donated asset depreciation), compared to a control total target of £0.350m deficit from NHS Improvement.

Business Intelligence

The figures above represent the monthly financial position, and report the difference between income received and expenditure incurred in month.

PI RETURN FORM 2019-20

Goal 6 : Promoting People, Communities and Social Values

For the period ending: **Apr 2019**

Indicator Title

Description/Rationale

KPI Type

Complaints

Two charts showing the number of Complaints Received in month (chart 1) and the number of Complaints Responded to and Upheld (chart 2)

Executive Lead
John Byrne

IQ 1

Narrative

within tolerance

Current month stands at 18

Complaints Received



Narrative

98 upheld YTD 45.2%

Current month upheld stands at 6

Complaints Responded to and Upheld



Exception Reporting and Operational Commentary

The Trust responded to 24 complaints in the month of April 2019. Of the 24 complaints, 18 complaints were not upheld (75%) and 8 complaints were partly or fully upheld (25%). The top theme for complaints responded to (year to date) continues to be patient care with 8 complaints.

The Trust received 36 compliments during the same month.

Top 5 Themes of All Complaints Responded to - Year to Date

Patient care	8
Appointments	4
Values and behaviours (staff)	2
Communications	5
Trust admin/policies/procedures including patient record management	0

All Complaints responded to YTD 24



Executive Team:

Chief Executive: Michele Moran
Chairman: Sharon Mays
(Interim) Chief Operating Officer: Lynn Parkinson
Director of Finance: Peter Beckwith
Director of Human Resources: Steve McGowan
Medical Director: John Byrne
Director of Nursing and Quality: Hilary Gledhill

Issue Date: 17/05/2019



Agenda Item: 11

Title & Date of Meeting:	Trust Board Public Meeting – 22 nd April 2019			
Title of Report:	Finance Report 2019/20: Month 1 (April)			
Author:	Name: Peter Beckwith Title: Director of Finance			
Recommendation:	To approve		To note	X
	To discuss		To ratify	
	For information		To endorse	
Purpose of Paper:	The report provides the Board with an update of the financial position of the Trust at Month 1			
Key Issues within the report:	<ul style="list-style-type: none"> • A deficit position of £0.417m was recorded to the 30th April 2019. • Expenditure for clinical services was lower than budgeted by £0.158m. • Expenditure for Corporate Services was £0.175m lower than budget. • A BRS Risk Provision of £0.300m was included in the reported position. • The cash balance at the end of April 2019 was £14.335m, this includes £2.110m of LHCRE and £0.988m of CAMHS capital funding. • Capital Spend as at the end of April was £0.158m. 			

Monitoring and assurance framework summary:

Links to Strategic Goals

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

Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			To be advised of any
Legal	√			To be advised of any
Compliance	√			future implications
Communication	√			reports as and when
Financial	√			future implications
Human Resources	√			by Lead Directors



IM&T	√			through Board Required
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	



FINANCE REPORT – April 2019

1. Introduction

This report summarises the financial position for the Trust as at the 30th April 2019 (Month 1).

2. Income and Expenditure

The Trust has a draft Operating deficit of £0.400m, £0.055m favourable to the month 1 budget of a deficit of £0.455m.

After allowing for donated asset depreciation (£0.017m) the ledger position was a £0.417m deficit. Donated Asset Depreciation does not count against the Trusts NHSI Control Total.

The gross income and expenditure position as at 30th April 2019 is shown in the summarised table below:

Table 1: 2019/20 Income and Expenditure (Gross)

	19/20 Annual Budget £000s	In Month		
		Budget £000s	Actual £000s	Variance £000s
Income	127,557	10,962	10,969	7
	127,557	10,962	10,969	7
Expenditure				
<u>Clinical Services</u>				
Childrens, Learning Disability & Primary Care	46,187	4,031	3,960	70
Specialist Services	11,356	994	1,019	(26)
Adult Mental Health Services	38,763	3,332	3,218	114
	96,307	8,357	8,198	158
<u>Corporate Services</u>				
Chief Executive	1,851	156	153	2
Chief Operating Officer	7,400	772	749	23
Finance	11,506	977	883	94
HR	2,849	243	208	35
Director of Nursing	2,019	176	178	(2)
Medical	2,233	194	231	(38)
Finance Technical items (including Reserves)	784	126	67	59
	28,643	2,644	2,469	175
Total Expenditure	124,949	11,000	10,667	333
EBITDA	2,607	(38)	304	342
Depreciation	2,745	229	219	10
Interest	148	12	8	5
PDC Dividends Payable	2,112	176	176	(0)
BRS Contingency	-	-	300	(300)
Operational Position	(2,397)	(455)	(400)	55
Excluded from Control Total				
Donated Depreciation	216	18	17	1
Ledger Position	(2,613)	(473)	(417)	56
EBITDA %	2.0%	-0.3%	2.8%	
Surplus %	-1.9%	-4.2%	-3.6%	



2.1 Income

Income year to date was £0.007m ahead of budget.

2.2 Expenditure

Expenditure for clinical services was lower than budgeted by £0.158m year to date.

2.3 Clinical Services Expenditure

2.3.1 Children’s, Learning Disabilities, Community Services and Primary Care

Year to date expenditure of £3.960m represents an underspend against budget of £0.070m.

2.3.2 Specialist

An overspend of £0.026m was recorded YTD for Specialist Services. This has been offset by additional income of £0.093m compared to budget.

2.3.3 Mental Health

An underspend of £0.114m was recorded year to date for Mental Health.

2.4 Corporate Services Expenditure

The overall Corporate Services expenditure was £0.175m underspent year to date.

- The Chief Operating Officer directorate has a year to date underspend of £0.023m.
- Within the Finance directorate an underspend of £0.094m is shown for month 1.

3.0 Statement of Financial Position

The Statement of Financial Position in Appendix 1 shows the Trust’s assets and liabilities as at 30th April 2019. In month, the net current asset position decreased by £1.147m to £9.634m. This was related to a decrease in Current Assets due to year end invoice accruals being paid in April.

The Accrued Liabilities figure includes Tax, NI and other payroll deductions, as well as accruals. Offsetting this other current assets which includes income accruals for PSF funding and CQUIN’s.

3.1 Cash

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

Table 2: Cash Balance

Cash Balances	£000s
Cash with GBS	14,242
Nat West Commercial Account	55
Petty cash	38
Total	14,335



In month income of £11.497m was received compared to expenditure of £11.986m.

The main cash expenditure for the month was pay costs, purchase ledger payments and the interim payment for the CAMHS project of £0.524m,

3.2 Capital Programme

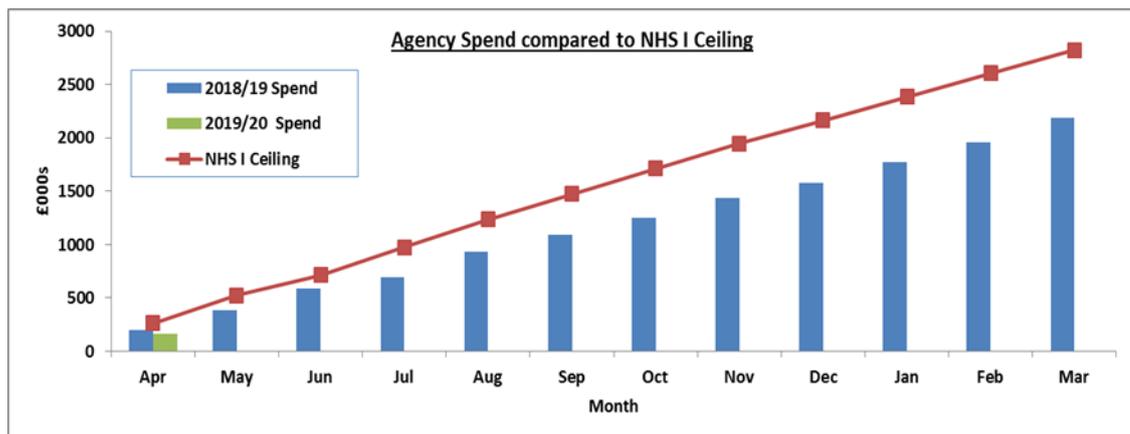
The capital financing limit for the Trust is £12.229m. Year to date capital expenditure of £0.158m comprises expenditure for IT (£0.100m) and Property Maintenance/Acquisitions (£0.058m) as detailed in the table In Appendix 3.

4. Staffing

4.1 Agency

For 2019/20 NHSI has allocated the Trust an agency expenditure ceiling of £2.891m. Actual agency expenditure for April was £0.157m, which is below the ceiling of £0.260m for the month and lower than spend in 2018/19.

Table 3: Agency Spend



5. Recommendations

The Board is asked to note the Finance report for April and comment accordingly.



Appendix 1
Statement of Financial Position

	APR-18 £000	MAR-19 £000
Property, Plant & Equipment	100,917	99,916
Accumulated Depreciation	22,283	22,080
Net Property, Plant & Equipment	78,634	77,836
Intangible Assets	2,175	2,175
Intangible Assets Depreciation	1,588	1,555
Net Intangible Assets	587	620
Total Non-Current Assets	79,221	78,456
Cash	14,335	14,896
Trade Debtors	5,813	6,624
Inventory	138	138
Non Current Asset Held for Sale	2,145	2,145
Other Current Assets	5,386	4,664
Current Assets	27,817	28,467
Trade Creditors	5,749	5,137
Accrued Liabilities	12,434	12,549
Current Liabilities	18,183	17,686
Net Current Assets	9,634	10,781
Non-Current Payables	1,175	1,175
Non-Current Borrowing	4,409	4,392
Long Term Liabilities	5,584	5,567
Revaluation Reserve	13,293	13,293
PDC Reserve	53,902	53,743
Retained Earnings incl. In Year	16,076	16,634
Total Taxpayers Equity	83,271	83,670
Total Liabilities	107,038	106,923



Agenda Item: 29

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Mental Health Legislation Committee Assurance Report following meeting of 09 May 2019.			
Author:	Name: Michael Smith Title: Non Executive Director and Chair of Mental Health Legislation Committee			
Recommendation	To approve		To note	
	To discuss		To ratify	
	For information	√	To endorse	
Purpose of Paper:	<p>The Mental Health Legislation Committee is one of the sub Committees of the Trust Board</p> <p>This paper provides an executive summary of discussions held at the meeting held on 09 May 2019 and a summary of key issues for the Board to note.</p>			
Any Issues for Escalation to the Board:	<p>Items for Communication, Escalation or Inclusion on the Risk Register</p> <p>Items for communication to the Trust Board:</p> <ul style="list-style-type: none"> • Correlation between CQC Monitoring the MHA report and HTFT experience • Discussion required with Hull CC regarding representation and S 117 • Future report / deep dive on S 136, including liaison with Humberside Police 			

Executive Summary - Assurance Report:

- Approved Mental Health Practitioners (AMHPs) - looking at employment terms etc
- 'Publications and Highlights' and "Themes Issues and Partnerships reports now merged into a single 'Insights' report
- Committee effectiveness report and work plan agreed
- Policy revision with consideration to incorporate any additional guidance re the opening of the Child and Adolescent Mental Health Services (CAMHS) inpatient unit and positive input of multiple staff
- Audit plan – move from 'perfect ward' to 'my assure' will give more opportunity for additional audits and wider reporting options
- Policy input – need to involve Hull City Council on the S117 protocol
- Seclusion and segregation policy agreed
- Inpatient search policy agreed

Key Issues:

The key areas of note arising from the Committee meeting held on 09 May 2019 are:

Presentation on monitoring the MHA

Key findings from the report:

- Information provided to patients has improved
- There has been improvement in the quality of care planning and how patients are involved in their care but it is still one of the Care Quality Commission's (CQC) greatest concerns
- The availability and quality of advocacy services is not consistent
- The CQC are concerned about the use of restrictive practices in mental health services
- Services have improved at identifying patient's physical health issues on admission
- The Second Opinion Appointed Doctor service (SOAD) is an important additional safeguard for patients
- Discharge planning has improved

These findings were compared to local performance re HTFT:

- Improvement in quality of care planning:
- Trust has undertaken lot of work to reduce restrictive practices, but should continue to monitor for restrictive practices.
- Physical health assessments – still some challenges in monitoring of physical health in community and inpatient settings.
- Discharge planning has improved and Trust performs better than many other NHS Trusts.
- Information to patients: reading of rights and recording of reading of rights. Ms Nolan considered this may be a recording issue.
- Independent Advocacy is not an issue for Trust. The S132 rights form provides for automatic access to advocacy and it is patient's choice to opt out of this provision.
- Restrictive Practices: CQC Thematic review undertaken at two Trust units: Townend Court and a ward in Humber Centre.
- Complaints and Contacts: there are some challenges around cancelled leave due to staff shortage but some can be due to incidents involving high clinical activity.
- Children and young people accessing appropriate services – national issue.
- 1st Tier Tribunals - Trust has increased detention rates, but numbers of tribunals has reduced.
- Working collaboratively with local authorities – more work to be done
- S132 – frequency of repeating rights should be individualised and not blanket rule
- SOADS – availability is an issue and patients are often waiting a long time to be assessed

Liberty Protection Safeguards video:

The change from Deprivation of Liberty (DoLS) to Liberty Protection Safeguards (LPS) will create new statutory duties and responsibilities on different bodies and care providers.

- LPS will apply to any care setting (not just hospitals and care homes)
- NHS Trusts and Clinical Commissioning Group (CCGs) will become responsible for assessments and authorisations
- Care Home Managers also responsible for assessments and authorisations, which raised some concerns

- LPS extends to young people aged 16 and 17 rather than 18+ under DoLS
- Many new staff groups will be involved in the assessment process
- The role of the BIA changes significantly
- No statutory definition of DoL – still reliant on Cheshire West
- Mental Disorder – Under LPS mental health assessor removed; instead authorities should seek existing evidence of mental disorder written by GPs or other Doctors.
- Implementation details still to be worked out – Code of Practice could take a year and then a year for transition

Board assurance framework for information

Quarterly performance report – main items

- Key themes identified from CQC Mental Health Act (MHA) visits to inpatient units:
 - S132 rights
 - Capacity to consent to treatment
 - S17 leave
 - Patient involvement in care planning

The above issues reflect the national findings in the CQC MHA monitoring report and likely future CQC report.

- S136 - recent 'spike' – to incorporate into progress report re data reliability to next meeting
- S4 improvements sustained

Exceptions – many and varied but not outliers and learning is apparent as is positive reporting culture.

Received Reducing Restrictive Interventions (RRI) report – good quality report including benchmarking 15/16 metrics are positive/green

- Taser report - DB liaising with police re how they operate in practice where their escalation procedure is very different
- DB to attend another meeting with Humberside police and analyse the data

Received annual report on the Associate Hospital Managers (AHM)

- Discussion around recruitment and ensuring a diverse mix of people – Humber often receive enquiries from people interested in becoming an AHM but currently we have a sufficient number.

Agenda Item 13

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Finance and Investment Committee Assurance Report			
Author:	Name: Francis Patton Title: Non-Executive Director and Chair of Finance Committee			
Recommendation	To approve		To note	
	To discuss	√	To ratify	
	For information	√	To endorse	
Purpose of Paper:	<p>The Finance and Investment Committee is one of the sub committees of the Trust Board</p> <p>This paper provides an executive summary of discussions held at the meeting on 16th May 2019 and a summary of key points for the Board to note.</p>			
Any Issues for Escalation to the Board:	<p>The committee recommends that the Board:-</p> <ul style="list-style-type: none"> • Notes the month one financial performance and BRS delivery. • Notes the committee's recommendation of the annual health and safety report. • Notes and accepts the committee's annual effectiveness review. 			

Executive Summary - Assurance Report:

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

A summary of the key areas discussed are that the financial performance was reviewed in detail.

Month one performance showed that in terms of financial performance the Trust had achieved an operational deficit position of £0.100m although there were a number of one off issues which when corrected would result in a £0.209m surplus position. The Trust has a strong cash position and is controlling creditors and debtors well. The committee also received more detailed figures for Primary Care and this will now become a standard item on the agenda.

The committee received an update on Budget Reduction Strategy (BRS) delivery which showed that the overall profiled level of savings stands at £1.086m with achieved savings of £1.050m producing an overall underachievement of £0.036m at Month 1.

The committee received an update on national and regional position.

The committee received the annual Health and Safety report which it recommends to Board plus an update on the Clinical Negligence Scheme for Trusts (CNST) and Mutually Agreed Resignation Scheme (MARS).

Finally the Board received assurance reports from the Digital Delivery Group, the Capital and Estates Group, reviewed and made suggested amendments to the Board Assurance Framework (BAF) and received the committee annual effectiveness report which it recommends to Board.



Key Issues:

The key areas of note arising from the Committee meeting held on 16th May were:

- The Humber Coast and Vale (HCV) year end position represented a £26m adverse variance to plan. This represented a £8.8m improvement from the reported month 11 position. Hull and East Yorkshire improved its position by £8.2m to report a year end surplus of the same amount. York FT reported an improved year end position with a favourable variance to plan. Across the STP £28.0m of sustainability funding was earned (excluding any year end bonus), this was 28.3m short of the total available (£58.3m). The HCV Plan submission is currently £23.5m adrift from control total targets, with a further £34m of risk in plans submitted.
The Trust External Auditors have bid for work on the Local Health Care Record Exemplar (LHCRE) project which could if successful conflict their current audit role.
- As discussed and agreed at the April Board the committee received a more detailed breakdown of Primary Care financial performance showing how the deficit position was made up. The committee requested that this became a monthly update so that the committee had a firm understanding of ongoing performance.
- The Finance team were able to produce a full set of figures for month 1 for which the committee thanked them. These figures showed that in terms of financial performance at month 1 an operational deficit position of £0.100m was recorded to the 30th April 2019. However this position does not include for any sustainability funding, if the Trust signs up to its control total this amounts to £1.343m for the financial year; the Trust has had a reduction in sustainability funding of £0.7m compared to 2018/19 levels; the Pay Award funding built into tariff was insufficient to cover the calculated pay award and left the fund with a £1m cost pressure for 19/20; the timing of pay award payments on increments for the 2019/20 pay award (Non AFC Staff not had award paid in month 1 and consolidate payments for those staff at top of scale). If all of these points were addressed then the Trust would have shown an operational surplus of £0.209m. After BRS contingency has been included, the reported deficit for Month 1 was £0.400m; this represents a favourable variance against the NHSI Plan (£0.537m deficit). Year to Date staff costs of £8.921m are £0.124m lower than budget. Capital Spend as at the end of April was £0.158m. Cash balance at the end of April 2019 was £14.335m, outstanding trade debtors totalled £5.813m at the end of the period (£6.624m March) and the Trust had £5.749m of Trade Creditors at the end of April 2019 (£5.137m March) The Primary Care, Community, Children's and Learning Disabilities Division has a year to date underspend of £0.029m, the Mental Health Division has a year to date underspend of £0.018m, the Specialist Division is showing a year to date underspend of £0.067m and Corporate Divisions are showing an underspend of £0.154m at month 1.
- The committee received an update on BRS delivery which showed that the overall profiled level of savings stands at £1.086m with achieved savings of £1.050m producing an overall underachievement of £0.036m at Month 1. The current Forecast outturn position shows an underachievement of £0.033m Alternative savings to offset the forecast underachievement will be required and are being looked for. Within Corporate Directorates the Chief Executive, Finance and HR have delivered their target savings for the year.
- The committee reviewed the quarter 4 BAF and whilst agreeing with scoring did request that the Executive looked closely at the scoring of the finance elements of goal 5 as it felt that the Trust had improved its financial control and management over the last 12 months. The committee also made some suggestions about the lack of controls mentioned for IT and Estates. On reviewing the individual risks the committee commented that what was in the gaps in controls section needed reviewing as it didn't reflect the title.

- The committee received the Annual Safety report which was extremely detailed. The committee thanked Mr Dent for his work over the year and for both the quality of his report and his excellent summary at the meeting and recommend the report to Board for sign off.
- The committee received and accepted a report showing how the 19/20 CNST figure is calculated and a brief update on the MARS scheme which hadn't closed at the time of the meeting.
- The committee received assurance reports from the Digital Delivery Group and the Capital and Estates Group.
- The committee received the Annual Review of Committee Effectiveness and Terms of Reference 2018/19 Report which was accepted by the committee and recommended to Board.

Agenda Item: 14

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Audit Committee Assurance Report			
Author:	Name: Peter Baren Title: Non Executive Director, Chair of Audit Committee			
Recommendation	To approve		To note	
	To discuss	√	To ratify	
	For information	√	To endorse	
Purpose of Paper:	The Audit Committee is one of the sub committees of the Trust Board.			
	This paper provides an executive summary of discussions held at the meeting held on 14 May 2019 and a summary of key issues for the Board to note.			
Any Issues for Escalation to the Board:	The main area for the Board to note/approve was the generally good or above assurance given through Internal Audit.			

Executive Summary - Assurance Report:

A meeting of the Audit Committee took place on 14 May 2019. It is a requirement of the Terms of Reference and the NHS Audit Handbook for an assurance report to be prepared for the Trust Board as soon as is practical after the meeting takes place, and presented at the next Trust Board meeting.

Key Issues:

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

- Internal Audit Progress Report
- Internal Audit Annual Plan 19/20
- Internal Audit Annual Report
- Counter Fraud Progress Report
- External Audit Update
- Committee Effectiveness Review and review of ToR
- Tender Waiver Update
- Board Assurance Framework
- Risk Register – Board and deep dive Primary Care, Community, Children’s and LD (PCCLD) and Mental Health care group
- Losses and Special Payments Annual Report
- Declarations of Gifts, Hospitality and Sponsorship Annual Report
- Review of the Standards of Business Conduct and Managing Conflicts of Interest for NHS Staff Policy
- Information Governance Group Minutes
- Update on changes to Contracts/Agreements



Risks and Major Items Discussed

Ten Internal Audit Assurance Reports were received and discussed:

Establishment Visit – Field House Surgery	Limited Assurance
Medicines Management/ Safe Handling of Meds	Good Assurance
Cash Management Forecasting	Substantial Assurance
eRostering System IT General Controls	Reasonable Assurance
Bed Management	Good Assurance
Data Security and Protection Toolkit	n/a
Board and Committee Effectiveness	Good Assurance
Follow Up of Patients Property, Valuables and Monies	n/a
Board Assurance Framework	Good Assurance
Communications/Engagement – Carer Inv/ Support	Reasonable Assurance

There was substantial discussion on the reports, concentrated on those reports that were below a Good rating.

The Committee noted a number of medium/high rated risks where the implementation date for completion of the management action was past due in the report. This particularly related to the Field House audit. It was explained that a new system for overseeing the completion of actions was in place, but was still bedding down. An update on these items was requested, to be submitted to members as a post meeting by email as soon as possible. The Committee also noted that the Field House audit had taken place in September 2018, and that in future any delays in reports being finalised should be escalated to EMT.

The Committee queried the relatively long timescale for implementing a few of the recommendations, which would be reviewed by management.

With regard to follow up actions completed within the agreed implementation date, the Committee heard that this had now risen to 87% from 80%.

The Internal Audit Plan for 19/20 was discussed and approved (summary attached for information)

The Annual Report and Head of Internal Audit opinion statement was presented, and the Committee noted that the opinion provides Good assurance (as last year).

The Counter Fraud report contained an update on counter fraud activity and agreed workplan for 19/20. The use of videos produced by AuditOne to highlight to staff counter fraud awareness was welcomed.

Good progress was noted in relation to the External Auditors' work in relation to the 18/19 Accounts. In relation to the audit of indicators in the Quality Accounts, the Auditors noted some areas of work in progress, which are being actively followed through. An update will come at the next Audit Committee.

Some minor amendments were agreed to the report on Committee Effectiveness.

Minor changes to the Board Assurance Framework (BAF) relating to Strategic Goals 2 and 3 were suggested.

In relation to the Trust risk register, the intention to split risk HR32 into two separate risks was noted, with further discussion to come at the Workforce Committee.

The deep dive into the PCCLD care group risks revealed a number of workforce and recruitment issues that were discussed and progress noted, Risk SR4 was highlighted, concerning the number of nurse vacancies in Scarborough, which had also been raised by the CQC. It was agreed that the scoring of this risk be revisited. It was also agreed that the project risk register for the CAMHs project be included in the August committee agenda for a deep dive.

The Adult Mental Health (AMH) risk register was also reviewed and discussed in some detail. It was agreed to cross refer the register for a further discussion at Mental Health Legislation Committee (MH). The good Care Quality Commission (CQC) report for AMH was also noted and thanks given to the team.

In relation to the Information Governance Group assurance report, a sharing information data update is to be prepared for the Board after discussion at the Executive Management team (EMT). In addition, the Committee requested a General Data Protection Regulation (GDPR) update for August and an update on the management of Subject Access Requests.

Agreed Actions

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

Matters Deferred for Future Consideration

While all above reports were received there were a number which require follow up action as noted above

Matters to be Brought to the Attention of the Trust Board

The main areas for the Board to note/approve are

- The follow up report requested in relation to the Field House audit and all outstanding medium/high rated audit risks.
- The Internal Audit Plan for 19/20 (attached for information)
- The Committee's review of Effectiveness and Terms of Reference for Board approval (separate agenda item)
- The External Auditors' progress on the 18/19 Accounts and Quality Accounts.

OPERATIONAL INTERNAL AUDIT PLAN 2019/20 - CORE ASSURANCE TO SUPPORT HEAD OF INTERNAL AUDIT OPINION

Qtr	Audit	Exec Lead	Target Audit Cmte	Days	Scope/Rational/BAF Ref	Strategic Risk	Financial Risk	Patient Safety Risk	Reputational Risk	Compliance Risk
Governance, Risk and Performance										
4	Board Assurance Framework	Director of Nursing, Quality & Patient Experience	May 2020	5	An audit designed to confirm that the Trust meets all relevant national requirements in relation to its Board Assurance Framework and that evidence is available to confirm that the Board is assured of the adequacy of the control environment surrounding its key strategic risks.	✓	✓	✓	✓	✓
1	Humber Primary Care Ltd	Director of Finance	Aug 2019	10	TBC	✓	✓	✓	✓	
1	Healthcare Contract Management	Director of Finance	Aug 2019	7	A risk-based audit of the management of healthcare contracts.	✓	✓	✓	✓	✓
2	Emergency Preparedness	Director of Finance	Nov 2019	5	A risk-based audit of the Trusts' emergency preparedness.	✓		✓	✓	
			Total Days	27						

Finance, Contracting & Capital										
3	Cost Improvement Programme	Director of Finance	Feb 2020	10	A risk-based audit of the arrangements the Trust has in place to deliver the required efficiency savings set out in its operational plan, including how the Trust ensures that QIPP schemes contributing to the overall efficiency plan deliver the required savings and do not have an unacceptable impact on the quality of services provided.	✓	✓	✓	✓	✓
3	Payroll	Director of Finance	Feb 2020	7	A risk-based audit of the Trust's payroll system.	✓	✓			✓
2	Asset Register (deferred from 18/19)	Director of Finance	Nov 2019	7	A risk-based audit of the Trust's asset register system.	✓	✓			
3	Main Accounting System (deferred from 18/19)	Director of Finance	Feb 2020	8	A risk-based audit of the Trust's main accounting system.	✓	✓			✓
			Total Days	32						

Human Resources & Workforce										
3	Sickness Absence Management	Director of HR & Diversity	Feb 2020	10	An audit of compliance with the sickness absence policy.	✓	✓	✓		✓
3	Staff Recruitment	Director of HR & Diversity	Feb 2020	10	A risk-based audit of staff recruitment.	✓	✓			✓
Total Days				20						

IM&T Systems & Projects										
2	Service Business Continuity Follow Up	Director of Finance	Nov 2019	5	To follow up implementation of recommendations from report HTFT 190431 Service Business Continuity Controls (Reasonable Assurance)	✓	✓	✓	✓	✓
3	Network Devices Security and Management Controls	Director of Finance	Feb 2020	8	Risk based audit to review the security and management of the Trust core network devices.	✓	✓	✓	✓	✓
4	Web Filtering Security, Configurations and Monitoring Controls	Director of Finance	May 2020	7	Risk based audit to review the security and monitoring of the Trust's web filtering software			✓	✓	✓
2	Key System IT General Controls (*system still to be agreed)	Director of Finance	Nov 2019	8	Risk based audit of the security and management controls pertaining to one of the Trust's key IT systems (system to be reviewed will be agreed with Trust management during the year)		✓	✓	✓	✓
Total Days				28						

Information Governance										
4	DSP Toolkit	Head of Corporate Governance & OD	May 2020	7	A review of the evidence in place to support the Trust's compliance with Data Security and Protection Toolkit.	✓		✓	✓	✓
Total Days				7						

Data Quality										
2	Performance Reporting and Management	Director of Finance	Nov 2019	10	A risk-based audit of the accuracy and timeliness of reporting of a sample of Trust KPI's.	✓	✓	✓	✓	✓
Total Days				10						

Quality and Clinical Governance										
2	Mental Health Legislation	Director of Nursing, Quality & Patient Experience	Nov 2019	10	A risk-based audit of compliance with mental health legislation (sample TBC).	✓	✓	✓	✓	✓

3	Clinical Audit	Director of Nursing, Quality & Patient Experience	Feb 2020	8	A risk-based audit of the clinical audit arrangements.	✓		✓	✓	✓
Total Days			18							

Follow Up Audits/Contingency										
TBC	Follow Up	TBC	Various	5	All final audit reports with an adverse assurance level will be followed up during 2019/20.	✓	✓	✓	✓	✓
Contingency days to be allocated in year				5						
Total Days			10							

Audit Management										
On-going	Annual & Strategic Planning	N/A	April 2019	5	To undertake an audit planning process, involving meeting with Executive Directors, and senior management to identify assurance needs linked to the achievement of strategic objectives					
As required	Audit Committee Reporting & Attendance	N/A	As required	4	Time to prepare internal audit progress reports and attendance at Audit Committee meetings.					
4	Head of Internal Audit Annual Report & Opinion	N/A	April 2020	1	Production and presentation of the annual report including Head of Internal Audit Opinion.					
On-going	Management & External Audit Liaison	N/A	As required	10	Client liaison including monthly meetings with the Director of Finance, Executive Directors (as required) and External Audit.					
Total Days			20							
Total Number of days overall in plan				172						

Governance, Risk and Performance										
2	GDPR	Director of Finance	Nov 2019	10	Risk based audit of compliance with GDPR requirements.	✓	✓	✓	✓	✓
Finance, Contracting & Capital										
2	Establishment visit one	Director of Finance	Nov 2019	7	An audit of the financial and administration procedures in place at one of the Trust's operational units (to be determined through discussion with senior management).		✓		✓	✓
3	Establishment visit two	Director of Finance	Feb 2020	7	An audit of the financial and administration procedures in place at one of the Trust's operational units (to be determined through discussion with senior management).		✓		✓	✓

Human Resources & Workforce

4	Medical Staff Revalidation/ Professional Registration	Director of HR & Diversity	May 2020	8	A risk-based audit of the Trust's medical revalidation arrangements.			✓	✓	✓
2	Workforce Planning (deferred from 18/19)	Director of HR & Diversity	Nov 2019	8	A risk-based audit of the Trust's workforce planning and management arrangements.	✓	✓	✓		
1	Organisational Learning from Serious Incidents	Director of HR & Diversity	Aug 2019	10	A risk-based audit of the Trust's learning from Serious Incidents (SI's).	✓	✓	✓	✓	
3	Bank, Agency and Locum Staffing	Director of HR & Diversity	Feb 2020	8	A risk-based audit of the usage of either nursing or medical (TBC) bank, agency and locum staffing.		✓	✓	✓	✓
		Total Days		58						

Agenda Item: 15

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019			
Title of Report:	Charitable Funds Committee Assurance Report & 25 March 2019 minutes			
Author:	Name: Paula Bee Title: Non Executive Director and Chair of Charitable Funds Committee			
Recommendation	To approve		To note	√
	To discuss	√	To ratify	
	For information		To endorse	
Purpose of Paper:	<p>The Charitable Funds Committee (CFC) is one of the sub committees of the Trust Board.</p> <p>The report includes details of the meetings held on 14 May 2019, minutes of which are attached to the report for information. Terms of Reference for Charitable Fund Committee are also attached</p>			
Any Issues for Escalation to the Board:	Identified within the key issues			

Key Issues:

A meeting of the Charitable Funds Committee was held on 14 May 2019

Key Issues

- Revise the reporting framework to clearly see objectives years 1 to 3 ensuring that year 2 reflects accurately the activities already undertaking and those that need to be on target for year 3
- Noted as a committee the increased use of Charitable Funds across all fund zones and appeals. Recognise that if we are to maintain such a high level of actively we will have to be proactive in fundraising to maintain levels of fundraising in order to meet future demands.
- Pleased to receive the new Risk reporting framework and agreed to review this every 4 months
- Discussion around social values, return on investment and the contribution Health stars had made to the social value accounting. The committee identified future ideas to draw together SROI activities across the Trust in support of applications to external grant funders.
- Willerby Hill site Café refurbishment Health Stars has worked closely with Trust Estates Team and the Working group to design a delivery model liaising with external partners. New facility due to open 5th July



- Following a comprehensive exercise to scrutinise the legacy information held by the Trust. Positive reporting on the change of usage of charitable funds where apparent restrictions were in place, therefore releasing funds into designated allocations.
- Staff engagement fund is continuing to gain momentum and Michele Moran, CEO is planning the Longest Car Wash on 20th June to help raise funds for staff benefits.
- The Pennies from Heaven scheme will be re-launched to existing and new staff from 1st June. The scheme will change the benefitting charity from Macmillan Cancer Care to Health Stars. Those already taking part in the scheme have been contacted and given the option to opt out. Staff are encouraged to sign up for the scheme as their generosity will enable charitable funds to enhance services for staff across the Trust.
- The Impact Appeal has gone from strength for strength. The current fundraising total is almost £260,000 with high profile supporters such as Viking FM and NISA convenient stores actively fundraising. Positive feedback from supporters

Charitable Funds Committee

Minutes of the Charitable Funds Committee Meeting

held on Monday 25 March 2019, 9.30am – 11.30am in Conference Room B, Trust Headquarters

Present: Paula Bee, Non-Executive Director (Chair)
Peter Baren, Non-Executive Director

In Attendance: Michele Moran, Chief Executive
Peter Beckwith, Director of Finance
Andy Barber, Hey Smile Foundation Charity Director
Clare Woodard, Head of Fundraising, Health Stars
Kerrie Neilson, PA (minutes)

Apologies: Ann Newlove, Smile Health Operations Manager
John Byrne, Medical Director
Mervyn Simpson, Financial Services Manager
Steve McGowan, Director of HR & Diversity

18/19 **Declarations of Engagement**
None declared.

19/19 **Minutes of the Meeting held on 17 January 2019**
The minutes of the meeting held on 17 January 2019 were agreed as a correct record.

20/19 **Action List, Matters Arising and Workplan**
The actions list was discussed and the following was noted:-

16/19 (a) Any Other Business – Mr Barber reported that work is ongoing with the risk register. He agreed to share it with Mr Beckwith prior to submission to the next meeting.

16/19 (b) Any Other Business – Pennies from heaven scheme report on agenda for discussion at today's meeting – complete.

16/19 (c) Any Other Business – Verbal update under AOB at today's meeting – complete.

16/19 (d) Any Other Business – Details of upcoming annual events included in Health Stars update paper at today's meeting.

13/19 Impact Appeal Update – It was noted that a CAMHS Campus Estate Group meeting has been arranged for Thursday 28 March to follow up the sign for the CAMHS inpatient site and various other things relating to CAMHS. Verbal update to be provided at the next meeting.

12/19 Health Stars Annual Review – Board Support / Jenny Jones to arrange time for Mrs Woodard to present to a future Trust Board meeting – closed.

11/19 Staff Engagement Fund Update – The Chief Executive confirmed this was discussed at EMT. Details to be sent to Mrs Woodard later this week.

08/19 (a – g) Trust Accounts – It was noted that all actions relating to Trust Accounts are now complete and can therefore be removed from the actions log. Mr Barber advised that 360 Accountants have been communicating with Annette Clough in relation to next years' timeline. The Chief Executive requested that the timeline be submitted to the next meeting in May.

07/19 (a - c) Mini Bus Fund Zone – All actions relating to the mini bus fund zone are complete. A paper was submitted to EMT for discussion last week, whereby it was agreed that the CAMHS unit do need a minibus and there is enough provision in the Trust.

05/19 (a - c) Costs Allocations – Ongoing. Mr Barber confirmed that cost allocations will be put into place and split from April 2019, as agreed at the last meeting.

04/19 (a & c) Key Operations Plan Highlights including Finances – Complete.

04/19 (b) Key Operations Plan Highlights including Finances – Ongoing. It was noted that this item is on the agenda for discussion today. Mr Baren asked for an update about where the money is invested. Mr Beckwith and Mr Barber both confirmed that this is highlighted as a priority and conversations are ongoing. It will be finalised once year end is out of the way.

78/18 Any Other Business – Mr Barber reported that he did go back to 360 Accountants to progress the year end accounts. This action is now complete.

75/18 Whitby Request – It was noted that the timescale for this action needs to be changed to ongoing as this action is on hold until clarification is received. Mrs Woodard stated that she has not yet heard back from John Byrne.

68/18 Cost Allocations – Action complete. A paper was submitted to the January meeting.

67/18 Key Operations Plan Highlights including Finances – This was discussed at the January meeting so it is now complete.

36/18 (a) Health Stars Update – Action complete. Social Values report will be launched on 5 July 2019.

Mr Baren stated that going forward he would like to see all updates on the actions log and any closed actions to be shaded grey, this will ensure the Committee focus on the main points that are outstanding.

The Chief Executive commented on the draft work plan and noted that the risk register should be submitted on a bi monthly basis, not on an annual basis. Mr Barber is leading the risk register and work is on-going with that.

Resolved: All of the verbal updated were noted by the Committee.
The Committee approved the draft workplan subject to amending the risk register to bimonthly.
The Committee agreed that risk register would come to the next meeting in May. ACTION AB
The actions log will be updated accordingly. ACTION KN

21/19

Health Stars Operations Plan

Mr Barber presented the Operations Plan update report along with the Health Stars 2018 to 2021 Operations Plan tracker, which updates Committee members on the Health Stars performance against the agreed operational plan. The key issues within the report was:

- Performance Tracker
- Highlights and Risks
- Key Pillars of success actions for next quarter
- Review Any additional actions to add to the tracker

Mr Barber updated the Committee on the key risks to note. He advised that income generation is currently £144,575 behind planned income. It was noted that we are £36k behind on legacies, £40k behind on investment into volunteering, and £68,575 behind on Appeals and Wishes income.

Mr Barber reported that a meeting has been arranged for Thursday 28 March with Mr

Beckwith, Vicky Scarborough and Rob Atkinson to go through the grant applications and discuss the timescales challenges with regards to grant applications. There are a wide range of supporters who are committed to support the impact appeal.

It was noted that we are not receiving any funds from Bridlington as they are going to CHCP. In terms of volunteering, Mr Barber had a really positive meeting with Sam Grey, Voluntary Services Manager, and work is currently underway with regards to putting in an application to the Pears Foundation. There are 2 significant pots of money out there at the moment for volunteering within the NHS. One is through Help Force, which is linked to acute Trusts and is linked to the lottery, and the other is the Pears Foundation, which is a family run Trust who are willing to invest into both acute and community MH volunteering. Mr Beckwith asked what the grant would be used for. Mr Barber provided clarity and said it would specifically be used for staffing to resource voluntary services more.

The balance remains in a positive position funds held of £623k as of the end of March, this is a favourable position compared to the previous years position of £517k.

Mr Beckwith stated that for the next meeting do we need to re frame what our objectives are for 2019-20 based on what we know now. Ms Bee said from a charitable point of view she felt that we need to set a 3 - 5 year plan, and set priorities on an annual basis and set annual targets. The Chief Executive asked to see more of a breakdown at the next meeting and then we can review other years and add them on.

Mr Barber informed the Committee about a service user from Forensics, who is very keen to leave all of their assets to that service. A detailed discussion was noted on the challenges around legacies.

Some comments arose around the operations plan tracker. Mr Baren asked if a general review could be done. Ms Bee felt that the narrative and rag rating need to be looked at, and target dates also need to be added.

Resolved: The Committee noted current progress against the Operation Plan. It was agreed that will writing will be discussed in more detail at the next meeting. **ACTION AB/CW.** Mr Barber agreed to do a general review on the Ops Plan and review the narrative, rag rating and add target dates. A more detailed breakdown to be provided at the next meeting. **ACTION AB**

22/19

Financial Report

Mr Barber presented the report, which provides the Charitable Funds Committee with a review of the current finance position of Health Stars Charitable funds. The key issues within the report was:

- Executive summary
- Total fund balance
- Breakdown of funds
- Income and expenditure for the last three month period
- Highlighted risks
- Pledged funds

Mr Barber reported that he is extremely pleased with the development with regards to the broad range of funding that is coming in. Income is being received for the wishes as well as the gifts in kind and a number of corporate relationships are being developed. The current total fund balance for the Health Stars charitable funds is £622,956.12. The key risk is making sure that we have got the right resource for the right delivery. All in all everything is progressing really well.

Ms Bee referred to the CAMHS side of things and asked if there is money pledged but cannot be spent. Mr Barber advised yes we have done the work and now we are starting to receive

some general donations. Ms Bee made reference to the reputational risk and said we need to keep that as a live issue. Mr Baren stated that the admin overspend is in the executive summary but it is not in the detail, so therefore needs to be in both areas going forward.

Ms Bee said from a figures point of view it would be helpful to see it on a summary sheet which shows the figures in and out, and the comments can be put aside the figures, and also where there is a discrepancy against budget, provide an explanation as to why. The Chief Executive would like to see a simple spreadsheet with the income and expenditure on as well as the forecast position.

Ms Bee formally thanked Mr Barber for all of his effort.

Resolved: The report and verbal updates were noted.
Mr Barber agreed to look at treasury management in time for the next meeting. He also agreed to add admin overspend in the executive summary and in the detail going forward. ACTION AB

23/19 **Committee Annual Effectiveness Review**

Ms Bee presented the report, which provides a review of the effectiveness of the Committee during 2018/19. It was noted the report considers the performance of the Committee over the year 2018/19, and assesses its deliver of key functions. She welcomed questions and or comments.

Mr Beckwith commented on the membership and pointed out that he and the Chief Executive are not members of the Committee. The Non-Executive Directors are members of the Committee, as noted from the minutes. Mr Baren referred to the spelling of his name under membership and asked for that to be corrected. The Chief Executive stated that more work is required around how we strengthen the governance process and quality mechanisms.

Ms Bee formally thanked Mr Barber and Ms Woodard for all of their hard work this year.

Resolved: The Committee noted and approved the report.
It was noted that the membership needs to be reviewed and amended after reviewing the ToR and amend the spelling of Mr Baren, and add in a line around Governance and the positive alterations made this year ACTION CW

24/19 **Board Update**

Mrs Woodard presented the report, which provides the Committee with an update on Health Stars and charity activity since the last meeting. It was noted the report was part of the Chief Executives update at the February Trust Board Meeting.

The critical issues within the report were:

- Circle of Wishes
- Impact Appeal
- The Big Tea – NHS Day 5th July
- Health Stars Events

The Chief Executive said that reports should come to this Committee in the first instance not the other way around.

Resolved: The report and verbal updates were noted.

25/19 **Change of Fund Use (Existing Funds)**

Mr Barber presented the report. The Committee was asked to confirm that they are happy to recommend to the Board of Humber Teaching NHS Foundation Trust to make the amendments recommended in the paper to the highlighted funds and agree the recommended

next steps of funds held for the benefit of community hospitals. The key issues within the report was:

A review of funds in relation to community hospitals has taken place. The paper recommends re-designating these funds to enable their use for the benefit of a wider catchment.

It was noted that Health Stars and its Corporate Trustee Humber Teaching NHS Foundation Trust, are not alone in taking action in changing the use of charitable funds held as many Trusts across the UK face similar challenges as services close and delivery evolves. This can be a sensitive issue and many things need to be taken into consideration before formally and or legally (if required) changing the use of historical funds.

Mr Barber asked the Committee if they are comfortable with ring fencing it geographically. The Committee had a lengthy discussion as a number of concerns were raised. It was noted that it cannot go to the Board until CFC receive a complete breakdown.

Resolved: The report and verbal updates were noted by the Committee.

Mr Barber agreed to bring a complete breakdown to the next meeting, prior to it going to the Board for approval. ACTION AB

26/19

Health Stars Update

Yvonne Flynn Fund Guardian / Charge Nurse attended to provide a 10 minute verbal presentation on the positive outcomes Health Stars has and is currently providing to patients in Forensics Services. It was suggested that when the choir comes together a patient story is provided at a future Board meeting.

Yvonne Flynn welcomed a visit from any of the Committee members to go and visit the Humber Centre in the Summer time when the polytunnel will be active.

Ms Bee formally thanked Yvonne Flynn for attending.

Resolved: The Committee noted the positive outcomes Health Stars is providing to the patients in Forensics.

27/19

Circle of Wishes Update

Mrs Woodard presented the report, which updates on the Circle of Wishes (CoW) and to highlight any issues that need approval. The Charitable Funds Committee was asked to note the contents of the paper and discuss and approve the wishes. Particular attention was drawn to the CoW update. It was noted that CoW is going from strength to strength. A lot of work has been done with primary care GP surgeries and the stop smoking campaign that is running with the Health Trainers. All of the Trust guardians know what it is in their funds on a regular basis but also staff are encouraged to talk to their fund guardians and their teams and gifts in kind are constantly coming in.

Mr Baren made reference to the CHCP wish amounting to £355. Mrs Woodard and Mr Barber have both been in touch with CHCP and the ward up at Bridlington but nothing has come from that.

Mr Barber and Mrs Woodward would both really like to see some bigger wishes come through with the help of the Executive team. The Chief Executive suggested a whole article on that in Humber Voice. Mrs Woodard updated on her plans to re-vamp the marketing campaign.

Ms Bee asked if we have got a charitable funds comms strategy. Mr Barber confirmed yes it is within the Ops plan. Ms Bee said that this is something that we might want to put on next years' priority list.

Resolved: The report and updates were noted.

28/19 **Update from PLACE Meeting**

Mr Barber presented the report which was put forward at the recent Big Healthy Link Up meeting. Key issues within the report are as follows:

- Note Health charitable funding across the STP area
- Potential of partnership working
- The role of a partnership for health funding would be collaboration not merger

Across the Strategic partnership area there is approximately £30m of accessible charitable funding for Health across a range of statutory providers and regional and local independent funders. Until now little work has been carried out in how these funds connect, collaborate on our big health challenges and use strength in a partnership to attract further funding nationally to our area.

HEY Smile Foundation works with a range of these funders, both statutory and independents and what strikes us is the huge amount of missed opportunity, should we acknowledge, inform and ignite these funders to a limited number of common goals.

Mr Barber asked for Committee approval for Mrs Woodard to communicate with the group. The Chief Executive reported that she attended the PLACE meeting held on Friday 15 February. She expressed her concern and noted that there are areas that need to be addressed in the first instance and there is a real need to have a tactical discussion at this committee first.

Ms Bee reported that a scoping paper would need to be submitted to the next meeting about what it is we are talking about, the potential and how we manage relationships.

Resolved: The report and verbal updates were noted by the Committee.
It was agreed that Mr Barber would follow this up with the Chief Executive outside of this meeting. Mr Barber agreed to provide a scoping paper to the next meeting. ACTION AB

29/19 **Pennies from Heaven**

Mrs Woodard presented the report, which provides information about the current Pennies from Heaven direct payroll giving scheme and to propose that Health Stars becomes the new charity beneficiary. The critical issues within the report are:

- Pennies from Heaven has been operating in the Trust since January 2008
- Current beneficiary is McMillan cancer relief
- Current donations are between £140/£180 per calendar month
- The Charity can be changed annually

The Pennies from Heaven scheme has been running at the Trust since Jan 2008. Employers choose one charity to which all staff and pensioners donate to – this can be any registered charity and charities can be changed annually.

Every month the Trust sends Pennies from Heaven the donations for distribution to its chosen charity. For the first 2 years Dove House Hospice received a total of £2,000 in donations and since Feb 2011 Macmillan Cancer Care has been the recipient. To date they have received £12,000 – Between £140 /£180 per month.

Approximately just less than 10% of Trust Staff are signed up so there are significant opportunities to expand the scheme further and for the Health Stars CEO Staff Engagement fund to benefit as a result.

Resolved: The report and verbal updates was noted.
The Committee approved that Health Stars becomes the charity for Pennies from Heaven donations and that a marketing campaign is launched to encourage more staff to participate in

the scheme.

30/19

Impact Appeal Update

Mr Barber presented the report on Ms Newlove's behalf, as it was noted she is currently on adoption leave. The report updates on the Impact Appeal supporting the provision of enhancements at the forthcoming CAMHS in-patient unit. The Committees attention was drawn to the following:

- Comms and Marketing
- Fundraising update
- Wish List & Release of Funds

It was noted that a meeting has been arranged for Thursday 28 March to discuss the next levels of processes and approvals with Pete Beckwith, Vicky Scarborough and Rob Atkinson.

Mr Barber stated that he is very confident in achieving the first lot of funds.

Mr Barber took attendees through the Eon Visual Media report and noted that Trust Board approval is required on how we start to go to the next level of communication about the impact appeal and CAMHS itself. Mr Barber asked for Committee approval on a proposal to develop some short social media videos, which will be emotive and hopefully engage the general public, which will hopefully generate further unrestricted funding for that area and help to create more awareness.

The Chief Executive provided her views and noted that it is a good idea and said we will support it from a CFC point of view, as long as the CAMHS Steering Group are happy that it is the right way forward, and providing that we get some suitable and sensible costings through.

The Committee went on to discuss the Faithful Gould CAMHS Facility Playground Garden report. The Chief Executive expressed her concern on item 20 on page 2 (existing Jewish burial ground lawn) and noted that she and the Board have not been sighted on it.

The Chief Executive then referred to item 28 (low lying planting) totalling £20k on the Faithful Gould CAMHS Facility Playground Garden report. She asked to see sight of what was agreed with the contractors (Houltons) in relation to landscaping. The Committee raised some concerns about the overall process and asked for some assurance.

Resolved: The report and verbal updates were noted.

The Committee agreed that the Eon Visual Media report would need to be submitted to the CAMHS Steering Group for approval, following that costings would need to be received then it would need to be submitted to CFC for final approval. ACTION AB/CW

Mr Beckwith agreed to find out more detail about the existing Jewish burial ground lawn on the CAMHS site and provide a briefing note to the Chief Executive. He also agreed to look at what was agreed with the contractors (Houltons) in relation to landscaping and provide an update at the next meeting. ACTION PBec

31/19

Approval of Wish Over £5K - Garden Space

Mr Barber presented the report, explaining that the time sensitive ones are the music room and the cowall.

The Chief Executive noted that she would like to see what was agreed in relation to low line planting. She went to say that it would be useful to know what on the face of it we have asked the contractors to do. She also wants assurance that we are not picking up the work that the contractors would have done.

Resolved: The report and verbal updates were noted. Mr Beckwith agreed to do a second briefing note to ensure it has gone through all of the processes. **ACTION PBec**

Approval of Wish Over £5K – Music Studio

32/19 Mr Barber presented the report. Mr Baren asked whether the equipment is new or second hand. It was noted it is new so will therefore be under guarantee. The Committee would like assurance that this has gone through all of the various process and approvals prior to approval.

The Chief Executive pointed out that these papers need to go to the CAMHS Steering Group in the first instance, as well as the core clinical team. She went on to explain that such requests should come from the CAMHS Executive Board, following that requests will then go to CFC for reassurance and final approval.

Resolved: The report and verbal updates were noted by the Committee.

The Committee support, in principle, the music studio wish and cowall studio wish, subject to those going to the CAMHS Executive Board.

Mr Beckwith agreed to speak to Hilary Gledhill in relation the music studio and the cowall.

ACTION PBec

33/19 **Approval of Wish Over £5K – Cowall Studio**

Mr Barber presented the report and noted that the cowall media wall is critical to the build programme. The Committee had a detailed discussion on this as some concerns were raised relating to the cowall going in to a seclusion room. The Committee felt it would be a good idea to have a cowall in the low stimulus room.

The Chief Executive emphasised the importance to have clinicians involved going forward.

Mr Baren suggested that going forward we need to have sign off boxes which will provide the Committee with the assurance it needs.

Resolved: The report and verbal discussions was noted.

The Committee agreed that a virtual meeting would need to be arranged to approve the cowall before May. Mr Beckwith agreed to speak to Hilary Gledhill, following that he agreed to circulate a post meeting note. ACTION PBec

35/19 **Items for Escalation or Inclusion on the Risk Register**

Ms Bee reported that all of the following should be included in the Board Assurance report.

- Risk Register to come to the next meeting.
- Revised Ops plan with a reduced timeframe.
- Small charities legacy campaign to go to May Board.
- Effectiveness report - add in a line around Governance and the positive alterations we have made this year.
- Have another look at the restricted designated funds allocations and bring a more refined paper to the next CFC meeting.
- Talked about a comms focus and bringing up the marketing plan and thinking about how we are actually going to profile that in 2019-2020.
- Another paper about wider collaborations, STP etc to the next meeting as a discussion.
- To go back to the CAMHS appeals process to ensure we get that right.

Resolved: The verbal updates were noted.

It was noted that all of the above will be included in the Board Assurance report. ACTION PBee/CW/KN

36/19 **Any Other Business**

Mr Beckwith verbally reported that the Trust HQ café will close from the 28 March 2019. A small presentation has been arranged for Friday 29 March. On an interim basis the area will be open for staff to use. Work is ongoing with Health Stars for a more long term solution. A possible launch date of 5 July was discussed. The Chief Executive stated that it will eventually

link in with both recovery college and voluntary services. The Chief Executive sees this ultimately as a social enterprise.

36.1/19 Risk Register

This item was covered in item 20/19.

Mrs Woodard updated the Committee on the two defibrillator requests, following on from the last meeting. It was noted that these would be for use by the GP at the GP surgery. Mrs Woodard has reported back to Julia Mizon about there being funding available for defibrillators but they have to be accessible for the community. Julia Mizon has gone back to the GP's and work is in progress.

Resolved: The verbal updates were noted.

Date and Time of Next Meeting

Tuesday 14 May 2019, 14.45pm - 16.45pm, Meeting Room 2

Signed:Chair: Paula Bee

Date:

Agenda Item: 16

Title & Date of Meeting:	Trust Board Public Meeting – 22 nd May 2019			
Title of Report:	Q4 2018/19 Board Assurance Framework			
Author:	Oliver Sims Corporate Risk Manager			
Recommendation:	To approve		To note	√
	To discuss		To ratify	
	For information		To endorse	
Purpose of Paper:	The report provides the Board with the Quarter 4 2018-2019 version of the Board Assurance Framework (BAF) allowing for the monitoring of progress against the Trust's six strategic goals.			
Key Issues within the report:	<ul style="list-style-type: none"> - Progress against the aligned risks is reflected within the framework to highlight the movement of current risk ratings from the previous position at Quarter 3 2018/19. The format allows for consideration to be given to the risks, controls and assurances which enables focused review and discussion of the challenges to the delivery of the organisational objectives. - Each of the Board Assurance Framework sections has been reviewed by its assigned assuring committee to provide further assurance around the management of risks to achievement of the Trust's strategic goals. <p>Changes to the Board Assurance Framework from Quarter 3 2018-19 to Quarter 3 2018-19.</p> <p>Strategic Goal 5 – Maximising an efficient and sustainable organisation</p> <ul style="list-style-type: none"> - Risks FII206 (<i>If the Trust cannot achieve its Budget Reduction Strategy for 2018-19, it may affect the Trust's ability to achieve its control total which could lead to a significant impact on finances resulting in loss of funding and reputational harm</i>) and FII204 (<i>Inability to achieve the NHS Improvement Use of Resources Score for 2018/19 which may result in reputational harm for the Trust and significant reduction in financial independence</i>) have been removed from this section of the Board Assurance Framework following the closure of the risks in Quarter 4 2018-19. 			



Monitoring and assurance framework summary:

Links to Strategic Goals				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
√	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
√	Maximising an efficient and sustainable organisation			
√	Promoting people, communities and social values			
Have all implications been considered?				
	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			To be advised of any future implications as and when required by the author
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	

BOARD ASSURANCE FRAMEWORK						Trust Board					
ASSURANCE OVERVIEW						22 nd May 2019					
Strategic Goal	Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Risk Appetite	Assurance Rating					Highest current risk
						Q 4	Q 1	Q 2	Q 3	Q 4	
Innovating Quality and Patient Safety	Amber	Trust recognised nationally for development of Patient Safety huddles. A Quality Improvement Strategy has been developed in-year which sets out the Trust's approach to quality improvement. Awaiting the outcome of the 2019 'Well led' CQC inspection.	Director of Nursing	Quality Committee	Open	A	A	A	A	A	12
Enhancing prevention, wellbeing and recovery	Amber	Robust monitoring arrangements developed through monthly operational delivery group to monitor waiting times. Areas of long waits reviewed and monitored through Quality Committee and Trust Board. Standard operating procedures developed across Trust services in line with waiting list policy.	Chief Operating Officer	Quality Committee	Seek	A	A	A	A	A	12
Fostering integration, partnership and alliances	Green	Active engagement continues across all stakeholder groups with demonstrable benefits.	Chief Executive	Audit Committee	Seek	G	G	G	G	G	6
Developing an effective and empowered workforce	Amber	Statutory and mandatory training performance remains above target for year –end position and staff turnover has reduced over the last 12-month rolling period. However, staff sickness rates remain outside in-month targets and turnover has increased for March 2019. The Trust has joined the Institute for Organisational Development to provide further support to teams across the Trust and the PROUD programme has been launched internally to further develop members of staff.	Director of Human Resources and Diversity	Workforce and OD Committee	Seek	A	A	A	A	A	15
Maximising an efficient and sustainable organisation	Amber	Trust has delivered a surplus position as agreed against NHSI target. There are continued risks to the delivery of the overall financial plan going into 2019-20 which continues to have potential to impact on the Trust's overarching financial position. NHSI Control Total for 2019-20 has not been agreed.	Director of Finance	Finance Committee	Seek	R	R	R	A	A	20
Promoting people, communities and social values	Amber	Place plans and Patient Engagement Strategy implemented and positive service user surveys received. Social values' reporting is being further progressed within the Trust and a section has been incorporated into the annual report. More work is to be undertaken to promote service users/ care groups.	Chief Executive	Quality Committee	Seek	A	A	A	A	A	12

ASSURANCE LEVEL KEY		
Green	Significant Assurance	<ul style="list-style-type: none"> - System well-designed / low priority recommendations. - Effective controls in place. - Satisfied that appropriate assurance is available.
Amber	Partial Assurance	<ul style="list-style-type: none"> - System management needs to be addressed/ some actions outstanding. - Effective controls thought to be in place. - Assurances are uncertain and/or possibly insufficient.
Red	Limited/ No Assurance	<ul style="list-style-type: none"> - System not working / actions not addressed. - Effective controls not in place. - Appropriate assurances are not available.

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

Positive Assurance	
Assurance	Source
Quality and Regulations Group has been formed to drive and receive assurances in relation to all aspects of CQC compliance.	QPaS
Continued improvement maintained in relation to clinical supervision.	Quality Ctte Trust Board
Trust shortlisted in HSJ Patient Safety awards for work in developing Patient Safety Huddles.	Trust Board

Negative Assurance	
Assurance	Source
'Must do' actions including safer staffing and supervision required along with a number of areas where the trust should take action to comply with minor breaches that did not justify regulatory action but may prevent future compliance with legal requirements.	Trust Board CQC Report
'Requires Improvement' rating for Safe domain in CQC report.	CQC Report

Gaps in Assurance
What do we not have
Good rating in 'safe' domain for CQC rating. Final Report from 2019 CQC inspection.

Objective	Key Risk(s)	Initial	Current	Target	Movement from prev. Quarter
Deliver high- quality, responsive care by strengthening our patient safety culture.	NQ37 – Inability to meet Regulation 18 HSCA (RA) Regulations 2014 regarding Safer Staffing.	20	12	8	↔
	NQ38 – Inability to achieve a future rating of 'good' in the safe domain at CQC inspection.	12	4	4	↓
Demonstrate that we listen, respond and learn.	NQ45 – Inability to develop robust processes that demonstrate organisational learning from significant event analyses (SEAs).	12	6	3	↔
Achieve excellent clinical practice and services.	NQ44 - Inability to corporately collate clinical supervision compliance across clinical teams to support assurance that teams are delivering high quality care.	12	4	4	↓
Capitalise on our research and development.	No risks identified.				

Key Controls	Sources of Assurance – Reporting Mechanisms
(NQ37) Routine monitoring of staffing establishments and daily staffing levels review by care groups.	6-month safer staffing report.
(NQ37) Validated tool to agree establishments	
(NQ37) Consideration of nursing apprenticeships and nursing associate roles and greater use of the wider multi-disciplinary team in providing clinical leadership to units	Quality Committee Trust Board
(NQ38) Trust self-assessment against CQC standards.	Quality Committee Trust Board
(NQ38) Review undertaken of safety across Trust services.	
(NQ44) Improved compliance with general upward trend across Trust	
(NQ44) Policy has been reviewed to clarify minimum standard of 6 weeks for clinical supervision.	Clinical Risk Management Group
(NQ45) SEA action plans developed in collaboration with teams	

Gaps in Control	Actions
(NQ37) Need to strengthen focus on safer staffing from a multidisciplinary team approach to ensure the Trust has robust systems and processes in place for safer staffing in line with NQB Safe Sustainable and Productive Staffing June 2016.	Development of work plan with focus on safer staffing from a multidisciplinary team approach to ensure the Trust has robust systems and processes in place in relation to safer staffing. (HG / TF 30/06/2019)
(NQ38) Trust identified as requires improvement under 'safe' domain for 2017 CQC inspection.	Continued drive across Trust Care Groups in identified areas for improvement. (HG / TF 30/06/2019)
(NQ44) Timeline for ESR self-service being available to record and report supervision.	Training Lead establishing timeline for ESR self-service being available to record and report supervision. (MB 30/06/2019)
(NQ45) Monitoring of action plans through the DATIX system.	Work to be undertaken to enable SEA action plans to be recorded and monitored through the DATIX system to enable a consistent approach to completion (OS 31/05/2019)
(NQ44) Robust tool for the capture and monitoring of Trust clinical supervision data.	Implementation of Health Assure for recording and monitoring of clinical supervision compliance (TF 30/06/2019)

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

Positive Assurance		Negative Assurance		Gaps in Assurance
Assurance	Source	Assurance	Source	What do we not have
Waiting times continue to be an area of focus as and are reviewed monthly by the Operational Delivery Group. Work is ongoing with Trust partners.	Trust Board ODG	Waiting list challenges continue within the Paediatric ASD (autism assessment), Adult ASD (autism diagnosis), Hull CAMHS and Children speech and language services.	Trust Board Quality Ctte	Recovery-focussed culture within the Trust. Full adherence with Waiting Times policy and associated standard operating procedures.
Waiting list update reported into Quality Committee for oversight and consideration of quality impact.	Quality Ctte			
Development of standard operating procedures in line with Trust Waiting List and Waiting Times Policy for majority of services to manage referral and waiting list process.	Quality Ctte			
Proactive contact with patients on waiting list within challenging services.	Quality Ctte			

Objective	Key Risk(s)	Initial	Current	Target	Movement from prev. Quarter
Ensure patients, carers and families play a key role in the planning and delivery of our services	OPS07 – Inability to equip patients and carers with skills and knowledge needed via social prescribing	12	6	3	
Empower people to work with us so that they can manage their own health and social care needs.					
Develop an ambitious prevention and recovery strategy					
Deliver responsive care that improves health and reduces health inequalities.	OPS05 – Inability to meet early intervention targets (national – IAPT,EIP, Dementia)	12	6	3	
	OPS06 – Inability to meet early intervention targets (local – CAHMS , ASD, CYP)	12	12	3	
	OPS04 – Patients don't have the right level of physical healthcare support and there is not a cohesive alignment of mental health and physical health services to get parity of esteem.	12	9	6	

Key Controls	Sources of Assurance – Reporting Mechanisms
(OPS07) Recovery College	Trust Board reports
(OPS05) IAPT contracts in place with Commissioners	NHS Digital reports Monthly report to commissioners meetings Annual IAPT report.
(OPS05) New IAPT service specifications	
(OPS06) Monthly Waiting List monitoring	Monthly report to Care Group Business Meeting
(OPS06) Ongoing capacity and efficiency demand reviews	Operational Delivery Group
(OPS04) Early Intervention in Psychosis (EIP) CQUIN in place	Monthly progress report to Operational Delivery Group

Gaps in Control	Actions
(OPS07) Monitoring of patient outcomes	Consistent approach to recovery tool and training provided to staff connected to outcomes measure work (LP 30/06/2019)
(OPS05) New national standards in dementia care	Review of GP and IAPT national targets as well as (LP 30/06/2019)
(OPS06) East Riding service under-funded for level of demand	Clarity on future investment for supporting activity (SMASH, MIND, Counselling Services) to be obtained from Commissioners (LP 30/06/2019)
(OPS06) Limited response to increased demand from Commissioners	Contract variations to be agreed (LP 30/06/2019)
(OPS04) Monitoring resource for physical health checks	Physical health group development of physical health monitoring tool for teams to track own compliance (LP 30/06/2019)
(OPS04) Appropriate lead for physical health.	Review of Matron's portfolios. (LP 30/06/2019)

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

Positive Assurance	
Assurance	Source
STP/ ICS partnership events.	Trust Board
Mental Health Partnership Board and MOUs in place.	
Health Expo event and Planned Members meeting.	
High profile visits to Trust.	
Visioning event across Humber Coast and Vale	
Lead provider role within STP Refreshed Operational and Strategic plans shared with stakeholders.	

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

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

Objective	Key Risk(s)	Initial Rating	Current Rating	Target Rating	Movement from prev. Quarter
Be a leader in delivering Sustainability and Transformation Partnership plans.	FII174 - Lack of involvement in Sustainability and Transformation Plans or PLACE plans.	9	6	3	↔
Build trusted alliances with voluntary, statutory/ non-statutory agencies and the private sector.	FII180 - There is a risk to future sustainability and reputation, arising from a failure to compete effectively and build excellent relationships with partners and stakeholders via partnership working, and all communications and marketing activities.	12	6	3	↔
Strive to maximise our research-based approach through education and teaching initiatives.	FII185 - Inability to utilise research to inform and influence service delivery and business development.	9	6	3	↔
Foster innovation to develop new health and social care service delivery models.	No risks identified.				

Key Controls	Sources of Assurance – Reporting Mechanisms
(FII174) Trust Strategy, values and goals aligned with Humber, Coast and Vale STP	Regular STP updates to Trust Board Formal and informal dialogue with Commissioners
(FII174) Alignment clearly demonstrated within two year operational plan	
(FII174) Chief Executive is Senior Responsible Officer for Mental Health Work-stream.	
(FII185) Enhanced staff structure in Business Development team to explore evidence-based practice	Assurance systems for Service Plans/ Strategies Internal Clinical Audit programme R&D programme
(FII185) Formal programme to review and benchmark Trust position.	
(FII180) Marketing and communications activity available and used.	Assurance systems for Service Plan Regular feedback and dialogue to Trust committees.
(FII185) Enhanced staff structure in Business Development team to explore evidence-based practice	Assurance systems for Service Plans/ Strategies Internal Clinical Audit programme R&D programme

Gaps in Control	Actions
(FII174) Feedback arrangements with STPs representing Whitby are currently limited.	Identify Governance Structure within STPs and seek representation at relevant group level (VS 30/06/2019)
(FII185) Showcasing and marketing opportunities not exploited	Recruitment of Communications and Marketing Manager to increase capacity within Trust Communications Team (MH 31/05/2019)
(FII185) Limited internal mechanism in place to support delivery of different models	Develop skills training to support operational and corporate teams (VS 30/06/2019)
(FII180) Trust Communications team not automatically included in external groups	Organisational review required of internal mechanisms to support the delivery of different models of care (VS 30/06/2019)
	Improve Communications sections of Service Plans to ensure opportunities are exploited to showcase/market our services (VS 30/06/2019)

BOARD ASSURANCE FRAMEWORK				Assurance Level	Q4	Q1	Q2	Q3	Q4
STRATEGIC GOAL 4	DEVELOPING AN EFFECTIVE AND EMPOWERED WORKFORCE	Lead Director: Dir. of Workforce and OD	Lead Committee: Workforce and OD Committee		A	A	A	A	A

Positive Assurance	
Assurance	Source
Statutory and mandatory training – Performance remains above target at end of 2018-19 and is regularly monitored through Operational Delivery Group and EMT.	Trust Board
Turnover position – Overall rate reduced for 12 month rolling period at end of 2018-19.	Trust Board
PADR completion rates – At highest rate for 2018-19 in March 2019.	Trust Board
Workforce and OD Committee established.	
PROUD programme launched which includes initiatives to develop managers into better leaders.	Trust Board
Membership of the Institute for Organisational Development to provide support to teams over the Trust as a whole.	Trust Board

Negative Assurance	
Assurance	Source
Sickness levels – Trust sickness rate has reduced for rolling 12-month period but remains outside of in-month target.	Board Report
Turnover position – Increase in staff turnover for March 2019.	Board Report

Gaps in Assurance
What do we not have
Workforce plan for 19-20 has been developed but requires approval by Workforce and OD Committee in May 2019.

Objective	Key Risk(s)	Initial Rating	Current Rating	Target Rating	Movement from prev. Quarter
Develop a healthy organisational culture.	HR26 - Inability to implement the Trust's Workforce Plan and Strategy may result in an inability to achieve the changes to culture and reputation which are aspired to by the organisation.	16	12	4	
Enable transformation and organisational development.					
Invest in teams to deliver clinically excellent and responsive services	HR33 – Inability to retain appropriately qualified, skilled and experienced clinical workforce.	15	15	5	
	HR32 - Significant nursing and consultant staff vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact the credibility/reputation of the organisation.	20	15	5	

Key Controls	Sources of Assurance – Reporting Mechanisms
(HR26) Organisational Development (OD) and Workforce Strategy Implementation Plan	Trust Board performance report including key HR KPIs
(HR26) PADR (Performance and Development Review) process	Workforce Strategy Group monitoring delivery of plan
(HR26) Leadership and management development programmes	
(HR32) Vacancy levels regularly reported to Trust Board through IQPT.	
(HR32) Work commenced on recruitment strategy for nursing staff.	EMT
(HR32) Issues discussed at STP level around place-based recruitment strategies for hard-to-fill roles across the health sector.	Trust Board

Gaps in Control	Actions
(HR26) Inability to release/ backfill staff.	Deploy plan and develop reporting (SM 30/06/2019)
(HR32) Trust-wide workforce plan.	Workforce plan for 19-20 to be approved by Workforce and OD Committee (SM 31/05/2019)
(HR32) National workforce shortages	STP workforce and recruitment initiatives and system-wide work (SM 30/06/2019)
(HR33) Focussed OD programme to ensure our Managers have appropriate skills to lead, motivate and retain staff.	Completion of PROUD programme implementation plan (SM 30/06/2019)

BOARD ASSURANCE FRAMEWORK				Assurance Level	Q4	Q1	Q2	Q3	Q4
STRATEGIC GOAL 5	MAXIMISING AN EFFICIENT AND SUSTAINABLE ORGANISATION	Lead Director: Dir. Finance	Lead Committee: Finance Committee		R	R	R	A	A

Positive Assurance		Negative Assurance		Gaps in Assurance
Assurance	Source	Assurance	Source	What do we not have
Position consistent with financial plan submitted to NHSI. Improved cash position.	Trust Board	Budget Reduction Strategy – gaps in 2019-2020.	Board Report	NHSI Control Total not agreed to date for 2019-2020.
Decrease in agency expenditure in-year (year-end spend 2.189M against ceiling 2.828M)	Trust Board			
Budget Reduction Strategy.	Trust Board Finance Ctte			
Trust delivered a surplus position as agreed against NHS target.	Trust Board			
Secured PSF bonus (1.852 million)				

Objective	Key Risk(s)	Initial Rating	Current Rating	Target Rating	Movement from prev. Quarter
Be a flexible organisation that responds positively to business opportunities.	FII180 – There is a risk to future sustainability and reputation, arising from a failure to compete effectively because we have not maintained and develop strategic alliances and partnerships and not increased our commercial/market understanding.	12	6	3	↔
Be a leading provider of integrated services	FII177– Adverse impact of inadequate IT systems, failing to effectively support management decisions, performance management or contract compliance	16	8	4	↔
	FII186 – Trust IT systems are compromised due to a Cyber Security attack/incident - this could be a malicious attack from an external third party or an accidental attack from inside the trust network due to inappropriate actions taken by staff, patients or visitors that compromise the IT systems security.	16	12	8	↔
Exceed requirements set by NHS Improvement regarding financial sustainability.	FII205 – Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.	25	20	5	↑
	FII200 – The Trust's cash position deteriorates adversely where day to day functioning and financial independence is impacted.	20	10	5	↔
Build state of the art care facilities.	FII158 – Inability to address all risks identified as part of the capital application process due to lack of capital resource.	12	8	4	↔
	FII181 – Inability to improve the overall condition and efficiency of our estate.	12	8	4	↔

Key Controls	Sources of Assurance
(FII205) Budget Reduction Strategy 2019-20 to 2020-21 established which will produce a MTFP, incorporating the CIP process.	Budget Reduction Strategy policy and procedure agreed by Finance and Investment Committee and Trust Board
(FII200) Reporting to board and Finance committee which includes cash-flow projection and sensitivity analysis.	Trust Board reporting. Finance and Investment Committee reporting.
(FII205) Regular reporting of agency expenditure to EMT and Board.	Executive Management Team reporting. Finance and Investment Committee reporting.

Gaps in Control	Actions
(FII205) Insufficient contingency identified.	Budget Reduction Strategy implemented 2019-20 – IO 30/06/2019
(FII205) Agreement of control total with NHSI.	Ongoing discussions with NHSI to agree control total – IO 30/06/2019
(FII200) Trust remaining within its Revenue and Capital budget for 2019/20.	Ongoing monitoring of Trust cash position – IO 30/06/2019

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

Positive Assurance	
Assurance	Source
Patient and Carer Strategy Launched.	Trust Board
Continual development of the Recovery College.	
Health Stars developing	
Wider community engagement developing through changes to constitution and more work with Governors.	
More internal Trust focus on promoting wellness and recovery.	
Positive service user survey results.	
Trust developed in year social values reporting arrangements	

Negative Assurance	
Assurance	Source
Negative media outweighs positive media regarding promotion of communities.	Trust Board
Trust membership base is not fully operational and negative assurance around membership involvement.	

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

Objective	Key Risk(s)	Initial Rating	Current Rating	Target Rating	Movement from prev. Quarter
Apply the principles outlined in the Social Values Act (2013)	OPS07 - Inability to equip patients and carers with skills and knowledge needed via social prescribing.	12	6	3	↔
'Make every contact count' via an integrated approach designed to make communities healthier.	MD05 - Inability to implement the Trust's Equality and Diversity strategy may impact on the Trust's ability to have a workforce trained and engaged with the equality and diversity agenda, limit accessibility to services and prevent achievement of the Trust's E&D aims.	9	6	3	↔
	MD06 - Reduction in patients likely to recommend Trust services to friends and family may impact on Trust's reputation and stakeholder confidence in services provided.	12	8	4	↔
Ensure our human resource priorities and services have a measurable social impact.	HR26 - Inability to implement the Trust's Workforce Plan and Strategy may result in an inability to achieve the changes to culture and reputation which are aspired to by the organisation.	16	12	4	↔
Improve recruitment and apprenticeship schemes and promote career opportunities	No risks identified.				

Key Controls	Sources of Assurance – Reporting Mechanisms
(HR26) Organisational Development (OD) and Workforce Strategy Implementation Plan	Trust Board performance report including key HR KPIs Workforce Strategy Group monitoring delivery of plan
(HR26) PADR (Performance and Development Review) process	
(HR26) Leadership and management development programmes	
(OPS07) Recovery Strategy	Trust Board
(MD05) Supporting forums established for development of equality and diversity work within the Trust.	Quarterly reporting to Quality Committee and Clinical Quality Forum.
(MD05) Equality and Diversity Leads identified for 'patient and carers' and 'staff' respectively.	
(MD06) Task and finish group identified	Reports to QPaS and Quality Committee
(MD06) All clinical teams give out FFT forms and results are fed into services through level 3 reporting system.	

Gaps in Control	Actions
(OPS07) Monitoring of patient outcomes	Consistent approach to recovery tool and training provided to staff connected to outcomes measure work (LP 30/06/2019)
(MD05) Awareness of equality and diversity issues within the Trust.	Development of internal EIA training (MD 30/06/2019)
(MD05) Robust approach to Equality Impact Assessments	Implementation of EIA approval process (MD 30/06/2019)

RISK SCORING MATRIX

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

RISK TERMINOLOGY DEFINITIONS		RISK APPETITE DEFINITIONS	
Initial Risk Rating	The initial risk rating represents the inherent or gross risk. It is the assessment of the risk prior to the consideration of any controls or mitigations in place.	Avoid (No risk)	Avoidance of risk and uncertainty is a key organisational objective.
Current Risk Rating	The current risk rating presents the residual risk level. It is the assessment of the risk after identification of controls, assurances and inherent gaps, reflecting how the risk is reduced in either likelihood of occurrence or impact should it occur.	Minimal (Low risk)	Preference for ultra-safe business delivery options that have a low degree of inherent risk and only have a potential for limited reward.
Target Risk Rating	The assessment of the anticipated score following successful implementation of identified actions to create further controls. Target risk ratings must also be considered with regard to risk appetite and the level of risk the organisation is willing to accept.	Cautious (Moderate risk)	Preference for safe delivery options that have a low degree of residual risk and may only have limited potential for reward.
Control	Risk controls represent any action that has been taken to mitigate the level risk. Controls can reduce the likelihood of a risk being realised or the impact of risk should it occur.	Open (High risk)	Willing to consider all potential delivery options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward (and value for money etc.).
Assurance	Sources of evidence used to demonstrate the effectiveness of identified controls. Assurances sources also allow for monitoring of risk controls to ensure that they are appropriate.	Seek (Significant risk)	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk.

Agenda Item: 17

Title & Date of Meeting:	Trust Board Public Meeting – 22 May 2019																
Title of Report:	Risk Register Update																
Author:	Oliver Sims Corporate Risk Manager																
Recommendation:	To approve		To note														
	To discuss	X	To ratify														
	For information		To endorse														
Purpose of Paper:	The report provides the Board with an update of Trust-wide risk register (15+ risks) including the detail of any additional or closed risks since last reported to Trust Board in March 2019.																
Key Issues within the report:	<ul style="list-style-type: none"> The Trust-wide risk register details the risks facing the organisation scored at a current rating of 15 or higher (significant risks). There are currently 3 risks held on the Trust-wide Risk Register which was last reviewed by the Executive Management Team on xx April 2019. The current risks held on the Trust-wide risk register are summarised below: 																
	<table border="1"> <thead> <tr> <th>Risk Description</th> <th>Initial Rating</th> <th>Current Rating</th> </tr> </thead> <tbody> <tr> <td>FI1205 – Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.</td> <td>25</td> <td>20</td> </tr> <tr> <td>HR32 – Nursing and consultant staff vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact the credibility/reputation of the organisation.</td> <td>20</td> <td>15</td> </tr> <tr> <td>HR33 – Inability to retain appropriately qualified, skilled and experienced clinical workforce.</td> <td>15</td> <td>15</td> </tr> </tbody> </table>					Risk Description	Initial Rating	Current Rating	FI1205 – Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.	25	20	HR32 – Nursing and consultant staff vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact the credibility/reputation of the organisation.	20	15	HR33 – Inability to retain appropriately qualified, skilled and experienced clinical workforce.	15	15
	Risk Description	Initial Rating	Current Rating														
	FI1205 – Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.	25	20														
HR32 – Nursing and consultant staff vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact the credibility/reputation of the organisation.	20	15															
HR33 – Inability to retain appropriately qualified, skilled and experienced clinical workforce.	15	15															

Monitoring and assurance framework summary:

Links to Strategic Goals	
✓	Innovating Quality and Patient Safety



✓	Enhancing prevention, wellbeing and recovery			
✓	Fostering integration, partnership and alliances			
✓	Developing an effective and empowered workforce			
✓	Maximising an efficient and sustainable organisation			
✓	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	✓			To be advised of any
Legal	✓			To be advised of any future implications reports as and when future implications by Lead Directors through Board required
Compliance	✓			
Communication	✓			
Financial	✓			
Human Resources	✓			
IM&T	✓			
Users and Carers	✓			
Equality and Diversity	✓			
Report Exempt from Public Disclosure?	✓		No	

1. Trust-wide Risk Register

There are currently **3** risks reflected on the Trust-wide risk register which records all risks currently scored at a rating of 15 or above and is reflected in **Table 1** below:

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

Risk ID	Description of Risk	Initial Risk Score	Current Risk Score	Target Risk Score
FII205	Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.	25	20	5
HR32	Nursing and consultant staff vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact the credibility/reputation of the organisation.	20	15	5
HR33	Inability to retain appropriately qualified, skilled and experienced clinical workforce.	15	15	5

2. Closed/ De-escalated Trust-wide Risks

There have been no risks that were closed or de-escalated from the Trust-wide risk register since last reported to Trust Board in March 2019.

4. Wider Risk Register

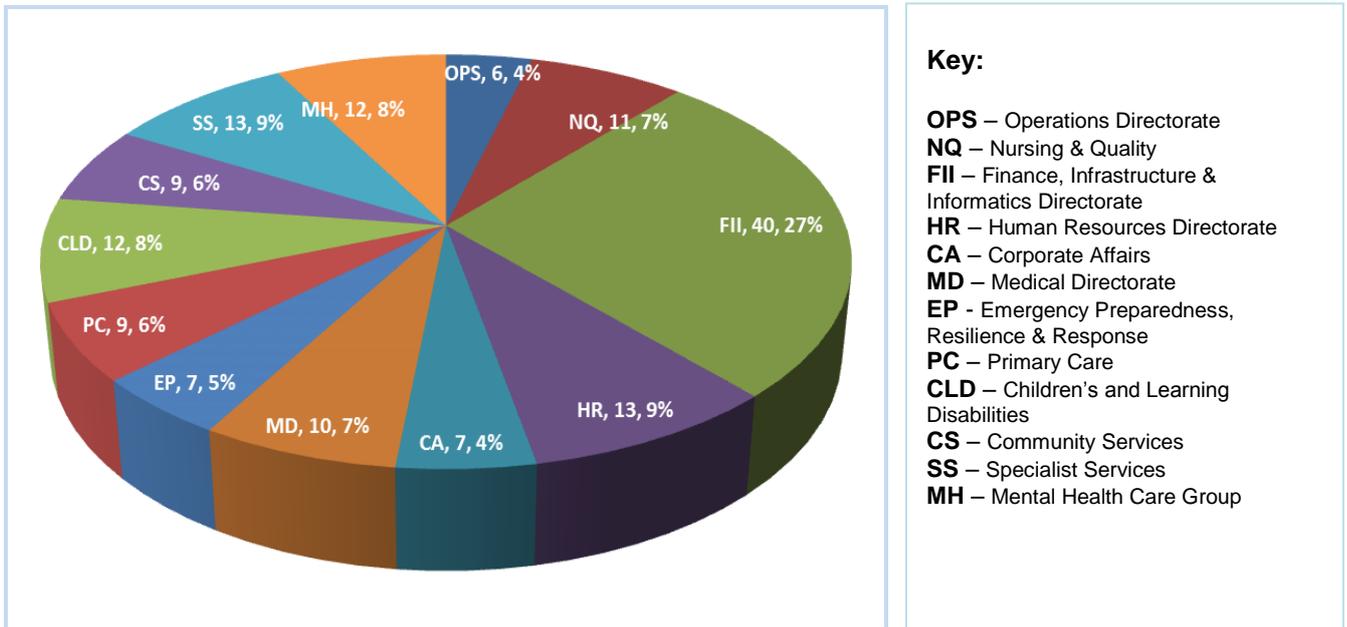
There are currently **142** risks held across the Trust's Care Group and Directorate risk registers. This is an overall decrease of **5** risks from the **147** reported to Trust Board in March. The table below shows the current number of risks at each risk rating in comparison to the position presented to the March 2019 Board.

Table 4 - Total Risks by Current Risk level

Current Risk Level	Number of Risks – March 2019	Number of Risks – May 2019
20	1	1
16	0	0
15	2	2
12	43	38
10	3	4
9	42	32
8	28	21
6	22	35

Current Risk Level	Number of Risks – March 2019	Number of Risks – May 2019
5	1	1
4	4	6
3	0	1
2	1	1
Total Risks	147	142

Chart 1 – Total Risks by Care Group/ Directorate



Trust-wide Risk Register

Row	Risk ID	Description of Risk	Impact/Consequence Type				Key Controls	Sources of Assurance	Gaps in Controls/ Controls currently failing	Gaps in Assurance	Likelihood (Current)				What additional actions need to be completed?	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk		
			Almost Certain	Catastrophic	Initial Risk Score	Initial Risk Rating					Likely	Catastrophic	Current Risk Score	Current risk											
1	FI1205	Risk to longer-term financial sustainability if we are unable to deliver Trust savings targets and income declines through implementation of tariff or commissioner targets.	Objectives	Almost Certain	25	Significant	<ol style="list-style-type: none"> Budgets agreed. Monthly reporting with monitoring and discussion with budget holders. Small contingency / risk cover provided in plan. Project management approach to delivery of BRS MTFP developed to inform plans. Service plans. Finance and Investment Committee. Budget Reduction Strategy 2019-20 to 2020-21 established which will produce a MTFP, incorporating the BRS process. Operational Delivery Group and accountability reviews regarding finance. 	<ol style="list-style-type: none"> Monthly reporting to Board Monthly & Quarterly reporting to NHS 1 and NHS 1 feedback ODG monitoring progress of BRS plans. Standing item on EMT agenda/ ODG agenda. Budget Reduction Strategy policy and procedure agreed by Finance and Investment Committee and Trust Board. BRS reporting to Finance and Investment Committee on a monthly basis. External Audit position. 	<ol style="list-style-type: none"> Insufficient contingency identified. Agreement of control total with NHSI. 	<ol style="list-style-type: none"> MTFP Reporting once plan in place to provide assurance over medium to longer term planning. Risks inherent in 2019/20 BRS plans. 	Likely	Catastrophic	20	Significant	<ol style="list-style-type: none"> Budget Reduction Strategy implemented - 30/06/2019 Review of workforce looking at staffing savings/ agency expenditure - 30/06/2019 Ongoing Accountability review of Care Groups - 30/06/2019 Continued dialogue with NHSI for renegotiation of Trust control total - 30/06/2019. 	Iain Omand	Peter Beckwith	Directorate Business Meeting/ EMT	Trust Board	Rare	Catastrophic	5	Moderate		
2	HR32	Nursing and consultant staff vacancies may impact on the Trust's ability to deliver safe services resulting in increased use of costly temporary staffing solutions and potential impact the credibility/reputation of the organisation.	Objectives	Likely	20	Significant	<ol style="list-style-type: none"> Consultant roles advertised at NHS jobs. Attendance at recruitment fairs. Conversations with a recruitment head-hunter partner to identify consultant resource. Work commenced on recruitment strategy for nursing staff. Issues discussed at STP level around place-based recruitment strategies for hard-to-fill roles across the health sector. Vacancy levels reported monthly to Care Group management and Finance Committee. Vacancy levels regularly reported to Trust Board through IQPT. PROUD programme. Recruitment and retention initiative. 	<ol style="list-style-type: none"> Finance an Investment Committee. Care Group Business Meetings. EMT. Trust Board ODG Workforce and OD Committee. 	<ol style="list-style-type: none"> National workforce shortages Delivery of nursing recruitment strategy. Trust-wide workforce plan. Professional recruitment strategy 	<ol style="list-style-type: none"> Workforce and OD Committee newly established and developing governance processes around workforce. 	Possible	Catastrophic	15	Significant	<ol style="list-style-type: none"> Development of nursing recruitment strategy and roll-out plan (SM 30/06/2019) Workforce plan for 19-20 to be approved by Workforce and OD Committee (SM 31/05/2019) Development of professional workforce strategy (SM 30/06/2019) STP workforce and recruitment initiatives and system-wide work (SM 30/06/2019) 	Julie Hall	Steve McGowan	Directorate Business Meeting/ EMT	Trust Board	Rare	Catastrophic	5	Moderate		

Trust-wide Risk Register

Row	Risk ID	Description of Risk	Impact/Consequence Type		Initial Risk Score	Initial Risk Rating	Key Controls	Sources of Assurance	Gaps in Controls/ Controls currently failing	Gaps in Assurance	Likelihood (Current)				What additional actions need to be completed?	Lead Manager	Lead Director	Risk Monitoring Group	Risk Oversight Group	Likelihood (Target)	Impact (Target)	Target risk score	Target risk		
			Likelihood (Initial)	Impact (Initial)							Likelihood (Current)	Impact (Current)	Current Risk Score	Current risk											
3	HR33	Inability to retain appropriately qualified, skilled and experienced clinical workforce.	Objectives	Possible	15	Significant	<ol style="list-style-type: none"> Organisational Development (OD) and Workforce Strategy Implementation Plan. PADR (Performance and Development Review) process Leadership and management development programmes Staff engagement through TCNC (Trust Consultation and Negotiation Committee), Staff Health & Wellbeing Group and action plan. Trust retention plan as agreed with NHSI. PROUD programme. Recruitment and retention initiative. 	<ol style="list-style-type: none"> Trust Board monthly performance report on turnover and on rolling 12 month basis. Staff surveys. Local Stress Survey. Staff Family and Friends Test. Workforce and OD Committee. EMT HR Insight Report 	<ol style="list-style-type: none"> Trust-wide workforce plan. Lack of career development opportunities indicated through employee exit interviews/questionnaires. 	<ol style="list-style-type: none"> Workforce and OD Committee newly established and developing governance processes around workforce. 	Possible	Catastrophic	15	Significant	<ol style="list-style-type: none"> Workforce plan for 19-20 to be approved by Workforce and OD Committee (SM 31/05/2019) HR Business Partners to review exit questionnaire results and identify any hot spot (SM 30/06/2019) Completion of PROUD programme implementation plan (SM 30/06/2019) 	Julie Hall	Steve McGowan	Directorate Business Meeting/ EMT	Trust Board	Rare	Catastrophic	5	Moderate		

Agenda Item 18

Title & Date of Meeting:	Trust Board Public Meeting – 22 nd May 2019			
Title of Report:	Annual Safety Report 2018-19			
Author:	Name: Peter Beckwith Title: Director of Finance			
Recommendation:	To approve		To note	✓
	To discuss		To ratify	
	For information		To endorse	
	The Trust Board is asked to note the report.			
Purpose of Paper:	This purpose of this report is to provide the Trust Board with assurance regarding the ongoing management of Health and Fire Safety within the Trust			
Key Issues within the report:	This annual report provides analysis of the Trust's Health and Fire Safety activity during 2018-19, outlining key developments and work that has been undertaken during the reporting period.			

Monitoring and assurance framework summary:

Links to Strategic Goals				
✓	Innovating Quality and Patient Safety			
✓	Enhancing prevention, wellbeing and recovery			
	Fostering integration, partnership and alliances			
✓	Developing an effective and empowered workforce			
	Maximising an efficient and sustainable organisation			
	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	✓			To be advised of any future implications reports as and when required by Lead Directors through Board
Legal	✓			
Compliance	✓			
Communication	✓			
Financial	✓			
Human Resources	✓			
IM&T	✓			
Users and Carers	✓			
Equality and Diversity	✓			
Report Exempt from Public Disclosure?			No	



Annual Safety Report 2018 – 2019



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1. Executive Summary

This report provides information relating to key activities undertaken by the Safety Team, with respect to policies, workplace activity safety management reviews, premises Health & Safety and Fire Safety inspections and Safety training provision.

The report provides information on incidents which meet the reporting requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and which have been reported to the Health and Safety Executive (HSE).

In the reference period, a total of 10 reportable incidents occurred compared to 9 in the previous 12 month period. Of these incidents, 6 incidents related to violence and aggression, 3 related to needle stick/sharps and 1 occurred whilst staff participated in a MAPA training session.

During the reporting period, the Trust did not receive any enforcement notices from the Health and Safety Executive.

Throughout the reference period Health & Safety inspections and Health & Safety management reviews have been undertaken to assess compliance with Trust Health and Safety Policies and applicable Health and Safety legislation.

Trust managed premises have been risk assessed and audited during the year to ensure continuing compliance with Fire Safety provisions. Standardised methods of fire safety risk assessment have been adopted across the Trust area.

In order to complement the Regulatory Reform Fire Safety Order 2005 (RRFSO 2005), 'Firecode' a suite of documents, underpins a move away from prescriptive fire safety measures and towards a risk based approach of the Fire Safety Order.

Trust premises conform above the minimum standards required by the Department of Health and a maintenance/improvement programme is in place to maintain standards in accordance with HSC 1999/191 'Achieving Statutory Fire Safety Provisions'.

During the reporting period 6 fire incidences occurred within the Trust. The cause for all of the incidents were malicious ignition of HTFT property.

All fire, false alarm and unwanted fire signals which took place during 2018/19 have been entered onto the Estates database. This information is used to look at trends and develop and implement initiatives to reduce the causation factors of fire alarm signals.

Emergency procedures are continually evolving to ensure protective and preventative measures employed protect all patrons of buildings should a fire occur and evacuation be necessary.

Management have been made aware that they have a duty to ensure staff under their managerial control are aware of their roles and responsibilities as detailed within Articles 8 – 23 of the RRFSO 2005. Failure to comply with this requirement is an offence under criminal law.

Fire Safety Management awareness courses continue to be delivered within the Trust to ensure a generic approach is achieved in the event of an emergency incident occurring within the organisation.

The Risk Assessments of premises are dynamic, and because more emphasis is being placed by inspecting authorities on the management of fire safety, continued support for managers and supervisors has been given during the year 2018/2019.

In order to complement the Regulatory Reform Fire Safety Order 2005 (RRFSO 2005), 'Firecode' a suite of documents, underpins a move away from prescriptive fire safety measures and towards a risk based approach of the Fire Safety Order.

2. Introduction and Purpose

The purpose of this report is to provide the Humber Teaching NHS Foundation Trust Board with assurance regarding the ongoing management of Health & Fire safety within the Trust. It is a requirement that the Board receive annual Safety report (for both Health and Safety and Fire) to assure the Board that sufficient Safety arrangements are in place and those Safety measures being employed is being effectively managed across the Trust.

This report provides analysis of the Trust's Safety performance for 2018/19 and outlines key developments and work that has been undertaken during the reporting period.

The current programme of work, aims to achieve further improvements in Health and Safety, Fire management, whilst also highlighting and mitigating associated risks. An important focus of current activity is to encourage and support a risk based culture towards managing safety hazards, in which a positive and proactive approach to safety management is developed and maintained.

The fire and false alarm statistics in this report cover only premises owned and occupied by Humber Teaching NHS Foundation Trust (HTFT).

3. Reporting Structure and Governance

This report details Trust wide safety performance throughout 2018/19, in order to comply with the Health & Safety at Work Act 1974 and the Regulatory Reform Fire Safety Order 2005 and associated statutory regulations.

The Chief Executive has overall responsibility and accountability for all H&S and Fire Safety matters. The Director of Finance is the designated Executive Director responsible H&S and Fire Safety.

Health and Safety is managed within the Trust's Health and Safety, Fire Safety and Security Team. The Safety Manager reports directly to the Head of Estates.

The Trust's Safety Manager manages all 'non-clinical' aspects of Health and Safety within the Trust. Patient safety risks regarding patient clinical care is overseen by the Clinical Risk Management Group.

The governance structure for Health & Safety and Fire Safety is via the Health and Safety Group, which reports in to the Executive Management Team and provides quarterly reports to the Finance Committee with issues escalated to the Trust Board when appropriate.

The Health and Safety Group has the following responsibilities:

- Receive and review Health & Safety, Fire and Security related policies and recommend where these policies will go next in terms of ratification.
- Review information on Trust Health & Safety and Fire incident reports, collate actions for the action tracker and monitor accordingly.
- Review, monitor and challenge where relevant, reports and action plans received.
- Invite relevant Managers to provide information on incidents or to respond to inspection reports.
- Review the outcomes of external or internal Health & Safety, Fire and Security inspections and make recommendations and representations to others as required.
- Encourage and support the principles of Occupational Health and Infection Control throughout the Trust and any related health surveillance programmes.
- Review upcoming new and amended Health & Safety, Fire and Security related legislation for its impact on Trust's activities.
- Review Health and Safety related civil law cases and relevant Health and Safety Executive prosecutions for their impact on Trust activities.
- Review Health and Safety key performance indicators and findings of Health and Safety audits against Trust Policies and CQC outcomes 10 and 11, collate actions for the action tracker and monitor accordingly.
- Keep records of all proceedings, decisions and activities of the H&S Group.
- Receive and review the quarterly Safety Board update report and recommend ratification to EMT prior to submission to the Board.
- Regular Health & Safety, Fire and Security reports are provided to the Board to ensure they are cited on all statistics and issues relating to safety matters.

There are 2 sub-groups of the Health and Safety Group

3.1 Water Safety Group

Humber Teaching NHS Foundation Trust accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Substances Hazardous to Health Regulation 2002 (as amended), to take all reasonable precautions to prevent or control the harmful effects of contaminated water to residents, patients, visitors, staff and other persons working at or using its premises.

To discharge this duty, a Water Safety Management Group, under the direction of the Trust's Estates Directorate, meets regularly to co-ordinate the water safety management activities.

Issues arising from the above meetings are escalated to the Trust's Health and Safety Group.

During the 2018/19 period, in conjunction with the Trust's externally appointed Authorising Engineer, a Trust Water Safety Plan was formally reviewed, adopted and implemented.

Legionella awareness refresher training, for key Trust staff, will be undertaken in June/July 2019.

3.2 Asbestos Management Group

Humber Teaching NHS Foundation Trust accepts its responsibility under the Health and Safety at Work etc. Act 1974 and the Control of Asbestos Regulations 2012, to take all reasonable precautions to prevent or control the harmful effects of asbestos containing materials (ACMs) to clients, visitors, staff and other persons working at or using its premises.

To discharge this duty, an Asbestos Management Group, under the direction of the Trust's Estates Directorate, meets regularly to co-ordinate asbestos management activities.

During the 2018/19 reference period, in conjunction with the Trust's Asbestos advisors Lucian Services undertook a re-inspection of the Trust's premises to re-confirm the location and condition of ACMs. This information will form the basis of the Asbestos Management Plans for 2019/20.

Asbestos awareness refresher training for key Trust staff was undertaken in January/February 2019.

4. Legal Compliance Overview

4.1 Health and Safety

The foundation of the current management of Health and Safety in the United Kingdom was established by the Health and Safety at Work etc. Act 1974, which remains the principal Health and Safety legislation. The Act and its associated regulations, address the way in which Health and Safety is managed within all organisations.

The Trust fulfils its legal responsibility for Health and Safety by:

Legislation	Description of Actions/Compliance
Health and Safety at Work etc. Act 1974	<p>Maintaining a team of professionals to provide advice and support to managers and staff.</p> <p>Undertaking reviews of local Health and Safety Management processes during Health & Safety review/support visits at Unit/Team level.</p> <p>Undertaking premises Health and Safety inspections to assess the level of safe working conditions and promoting improvements.</p> <p>Continuing to develop a library of template work activity risk assessments and substances hazardous to health assessments for Units/Teams to access.</p> <p>Monitoring Health and Safety incident reports on DATIX, carrying out incident investigations as required and sharing the lessons learned.</p> <p>Facilitating a range of classroom based Health and Safety training courses, in addition to the e-learning training modules.</p>

Legislation	Description of Actions/Compliance
Management of Health and Safety at Work Regulations 1999	<p>Undertaking reviews of Teams/Units work activity risk assessments.</p> <p>Continuing to develop a library of template work activity risk assessments for Teams/Units to access.</p>
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013	<p>Maintaining Sharps devices activity assessments.</p> <p>Restricting purchasing of sharps devices to approved makes and models only.</p>
Control of Substances Hazardous to Health (COSHH) 2005	<p>Undertaking reviews of Teams/Units COSHH assessments.</p>
Personal Protective Equipment at Work Regulations 1992	<p>Undertaking reviews of Teams/Units Personal Protective Equipment risk assessments</p>
Display Screen Equipment Regulations 1992	<p>Undertaking reviews of Teams/Units Display Screen Equipment assessments where applicable.</p>
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013	<p>Reporting incidents to the Enforcement Authority which meet the RIDDOR reporting requirements.</p> <p>Carrying out incident investigations as required and sharing the lessons learned.</p>
Health and Safety Information for Employees Regulations (Amendment) 2009	<p>Displaying Health and Safety information posters in Trust buildings.</p>
Health and Consultation with Employees Regulations 1996	<p>Having in place a number of employee Health and Safety representatives for improved consulting and communication of Health and Safety.</p>
Safety Representatives and Safety Committees Regulations 1977	<p>Liaising with Union appointed Health and Safety representatives for improved consulting and communication of Health and Safety.</p>
Ionising Radiation Regulations 2017 (IRR17)	<p>Notification, registration and consent of use.</p>

4.2 Fire Safety of Humber Teaching NHS Foundation Trust Occupied and Maintained Properties

The following table summarises the schedule of directives and state of compliance in relation to fire safety.

DIRECTIVE	REQUIREMENT	COMPLIANCE	COMMENTS
POLICY AND PRINCIPLES	Clearly Defined Fire Safety Policies	YES	Organisational fire policy in line with requirements as detailed in the HTM suite of documents and the RRFSO 2005.
	Director Appointed Re Fire Safety	YES	Director of Finance
	Fire Safety Manager	YES	Paul Dent
	Firecode Compliance Confirmation	YES	Certificate dated 30.01.2019
	Fire Safety Improvement Programme Instigated	YES	See page 15
	Annual Fire Report To Board	YES	May 2019
	Fire Reporting Procedure	YES	All Fire & False incidents reported through DATIX
	Liaison with Fire Service	YES	Contact maintained through Fire Safety Manager.
	Emergency Fire Procedure Plans	YES	See page 18

4.3 Fire Nominated Officers

The Department of Health requires under FIRECODE Policy & Principals – Fire Safety in the NHS Health Technical Memorandum 05-01: Managing Healthcare Fire Safety, that a Fire Safety Manager be appointed to ensure day-to-day activities in relation to fire safety.

This responsibility has been delegated to the Safety and Information Manager.

In 1997, the Fire Precaution (Workplace) Regulations placed responsibility on every person who has, 'in any extent, control of a workplace to ensure that, so far as it relates to matters within their control', the workplace complies with any applicable requirement of the Regulations.

Non-compliance could, in serious cases, render the responsible person liable to an unlimited fine and/or a custodial sentence.

Such persons who have 'in any extent Control of a Workplace so far as it relates to matters within their control', must be made aware of their responsibilities and of the legal implications if those responsibilities are not carried out. This responsibility has been continued and extended by the RRFSO 2005.

The above requirements are being disseminated through clear distinct training routes, these being the Fire Safety Awareness courses, Fire Warden/Responsible Person Training courses and Management courses.

Evacuation Plans for individual premises are continually reviewed, with Responsible Persons being named and designated duties listed in order to promote a clear understanding of fire safety roles and responsibilities.

The training of Nominated Fire Officer/Fire Wardens has been on-going with both fire refresher and fire warden courses being provided to HTFT staff.

5. Safety Related Policies

Safety policies are regularly reviewed and updated to reflect changes in legislation, service improvements or external agencies' requirements.

The Trust's overarching Health and Safety policy was reviewed in July 2016 and is due for review in July 2019.

The Fire Safety policy was reviewed in October 2018 and was placed on the Intranet as a live document in December 2018, the policy has a manual of procedures to ensure total compliance with RRF50 2005. The Policy is due for renewal Dec 2021.

All Safety related policies are available to staff via the Trust's Intranet site.

6. Incident Reporting

The reporting of incidents across the Trust is key to establishing trends and identifying specific areas where improvements are required.

6.1 Reporting Industrial & Dangerous Diseases Occurrences Regulations (RIDDOR) Incidents

RIDDOR require employers and other people in charge of work premises to report and keep records of:

- Work related accidents which cause deaths;
- Work related accidents which cause certain serious injuries (Reportable injuries);
- Diagnosed causes of certain industrial diseases, and;
- Certain dangerous occurrences (incidents with potential to cause harm).

Table 6.1: Comparison of all RIDDOR reportable incidents

Reporting Period	2016/17	2017/18	2018/19
1 April 2018 to 31 March 2019	14	9	10

There have been 10 RIDDOR reportable incidents during the 2018 -2019 period, brief details of the incidents are summarised in the table below.

Table 6.1: Comparison of all RIDDOR reportable incidents

Incident	Action Taken
May 2018: Injured person was physically assaulted and sustained a facial injury	Staff made aware of patient presentations and personal safety reinforced.

Incident	Action Taken
June 2018: Injured person assaulted with laptop, making contact with head forcefully	laptops are no longer used in long term segregation areas.
June 2018: Individual was sexually assaulted causing bruising to upper torso.	Increased awareness of patient demeanours and behaviour.
Oct 2018: Physical assault to injured person whilst undertaking 'physical' observations of patient. Injured person sustained several blows to the head	Patient moved to another ward, injured person offered welfare facilities.
Dec 2018: Injured person sustained injury whilst performing IM injection to a Hepatitis C patient, safety feature not deployed.	Occupational Health contacted for further advice following bleeding injury for 15 minutes.
Jan 2019: Injured person sustained injury whilst taking bloods from a patient whom consented and allowed for the procedure however upon removing the needle from arm patient moved arm resulting in needle stick injury.	Occupational Health contacted for further advice following bleeding injury for 15 minutes. Awareness raised in relation to unpredictable behaviour when undertaking clinical invasive procedure.
Mar 2019: Injury sustained to fingers whilst cutting up peppers	Awareness raised and reinforced on the correct use of knives in kitchen environments.
Mar 2019: During MAPA training person sustained injury to their rib area.	Injured person sent to A&E, reinforced the need for reporting of fitness for training courses involving physical interventions.
Mar 2019: 2 incidents with individuals who were spat at from a person who was Hepatitis C during a hospital.	Eye areas irrigated and medical advice sought. Awareness raised on patients demeanour and propensity for releasing significant amounts of saliva. <i>(Under legislation this is classed as a physical assault)</i>

6.2 Fire and False Alarm Incidents

In order to monitor and control false alarms and satisfy the Department of Health Estates & Facilities requirement for submission of fire incident details, there is an internal reporting system within the Trust. Six fire related incidents were reported with 65 unwanted fire signals and 43 false alarm activations occurring over the last reporting period.

There has been an increase in both fire and false/unwanted fire alarm signals being reported and this is primarily due to patient interventions by deliberately starting fires in accommodation areas and the use of deodorant sprays or physically damaging the fire detection systems employed.

The reported incidents were as follows:-

6.2.1 Fire Incidents 2018/2019

Over the past reporting period six fire incidences have occurred, all have been malicious ignition with all ignition sources identified as being lighters. Details of each incident have been reported to the Health and Safety Group with appropriate escalation within the Trust.

There remains an ongoing challenges with lighters being introduced into Humber buildings. Management and staff are 'policing' the issue but in some instances as soon as the lighters have been confiscated, family, friends and other patients returning from leave are resupplying patients.

For all of the above incidents if it had not been for their prompt intervention actions the above incidents would have developed.

All fire incidents have been investigated and management and staff debriefed as to their individual actions. Staff have been asked to be more vigilant and policy and procedures reinforced after each incident.

6.2.2 False Fire Alarm Signals 2018/2019

False alarm activations have increased from 30 on last year's figures to 43 this year, an increase of 69%.

False alarm activations have been as a result of predominantly patient interactions whereby fire alarms have been activated by aerosols being sprayed directly into fire detectors, unattended food and the increase in cigarettes being used within buildings since the introduction of the no smoking policy.

Management and staff have been reminded through various communication routes to be more vigilant with patients when these products are being used. Management have also been asked to ensure that smoking materials and ignition sources are surrendered by patients on leave and to reinforce the no smoking policy for visitors to Humber buildings.

6.2.3 Unwanted Fire Alarm Signals 2018/2019

Unwanted fire signals have increased from 33 from last year's figures to 65 this year, an increase of 50.7%. The majority of unwanted fire alarm activations over the past reporting period have been down to client intervention, some contractor issues whereby dust has entered fire detectors and staff testing the fire alarms without the appropriate communications taking place between site and the alarm receiving centre (SCAMP Security).

Staff and management have been reminded to be more vigilant whilst contractual work and alarm testing is taking place. This has been reinforced through all fire related training courses. A monthly report is received regarding alarm activations and causation factors from the alarm receiving company and the report where applicable is sent to managers for them to action accordingly.

Staff are also reminded of their responsibilities under the Regulatory Reform Fire Safety order 2005 through the fire training course that are provided as part of the mandatory training programme.

The percentage of fires to false alarms & unwanted fire signals was 6% actual fires and 94% false alarms/unwanted fire signals. As previously advised, there is significant national concern at the high levels of unwanted fire signal incidents within the Healthcare Industry.

Systems are now in place whereby the Fire and Rescue Service will require Alarm Receiving Centres (ARC's) to confirm that a building has a confirmed report of a fire before they attend. The introduction of the call filter system has proved advantageous in reducing the number of fire service attendances and the 'down time' of the premises whilst the reason for the alarm activation is confirmed.

A reporting system with the Alarm Receiving Centre (ARC) SCAMP security now produces a monthly return of not only the alarm activations but also when the fire service were informed and if they attended HFT buildings.

6.2.4 Call Filter System

The introduction of the call filter system has proved beneficial in reducing the number of fire service attendances due to spurious alarm activations. Staff have embraced the system and are comfortable with the operating parameters of the 3 minute investigatory timeframe. Humberside Fire & Rescue Service have cited HTFT as using best practice in line with the National Fire Chiefs Council (NFCC) and the HTM guides for the reduction of unwanted fire signals for NHS premises.

6.2.5 Emergency Fire Procedure Plans

The arrangements for transmitting emergency calls to the fire service across the Trust has been rationalised for all HTFT premises implementing the call filter procedure. The new procedure is contact between the premises and the ARC to confirm the nature of the alarm activation before contact is made with HF&RS, should this be required (confirmed fire incidents only).

The attendance of HF&RS to premises on the call filter system has been reduced to the minimum amount with attendances being made to life risk premises after normal office hours only, as per the out of hours protocol.

Regular fire drills/exercises to enhance staff awareness of procedures are a statutory requirement and must be arranged by managers to ensure the suitability of the Evacuation Plan for the premises. The approach now is that drills/evacuation exercise should take place twice a year, this approach being deemed best practice from the Department of Communities and Local Government.

All organisational premises have completed at least two evacuation exercises within the last reporting period and a database is held with the Safety Manager to ensure that all premises are complying with the requirements of the RRF50 2005 in relation to this matter.

Procedures are in place for fire evacuation of all organisational premises. Such plans detail how the evacuation will be carried out, who will carry it out and where the patients will be evacuated to. These protocols are in place for all trust premises and as the risk/client base changes then plans are amended accordingly.

All HTFT premises now hold an evacuation strategy in the event of the premises having to completely 'decant' from site to an alternate premises/location. This alternative evacuation plan dovetails in with the resilience measures outlined in the Major Incident Plan as detailed in the Civil Contingencies Act 2004.

7. Safety Assessments

7.1 Health and Safety Risk Assessments

Health and Safety risk assessments are a key tool in ensuring that Health and Safety standards are monitored and managed correctly by Trust staff and/or where Trust services are delivered. The following are completed on an annual or risk based frequency:

- Workplace/activity risk assessments for compliance with the Management of Health and Safety at Work Regulations.
- Control of Substances Hazardous to Health (COSHH) assessments for compliance with the Trust's COSHH Policy.
- Display Screen Equipment (DSE) assessments for compliance with the Trust's DSE Policy.
- Driving at Work assessments for compliance with the Trust's Driving at Work Policy.
- Moving and Handling assessments for compliance with the Trust's Moving and Handling Policy.

As part of the process, line managers are requested to review their Unit/Team's Health and Safety risk assessments against a checklist, to ensure the required assessments are in place and have been communicated to staff.

Where risk assessment reviews identify any non-conformances, e.g. missing activity assessment, assessments requiring review, the relevant line manager is required to take action to rectify the non-conformance.

7.1.1 Themes arising from the assessment reviews in 2018/19

Themes arising from risk assessment completed were;

- Office space and accommodation
- Height of shrubbery causing obstructions for manoeuvring vehicles.
- Lighting in car parking areas.
- Trailing cables.

The shrubbery issues have been dealt with by reducing the heights of shrubs to give a clear view of 'other' traffic on vehicle access roads. Additional lighting in car parks has been installed at sites where the lighting levels were reduced.

Trailing cables have been either re-routed, new sockets have been fitted or office layouts have been changed to accommodate the office users and reduce the amount of trailing cables.

Office space and accommodation plans/layouts are confirmed by the Estates Project Team who plan working spaces on a figure of 5sqm per person floor area.

7.1.2 Template Health and Safety Risk Assessments

The continued rollout of template Health and Safety Assessments over the last 12 months has reduced the length of time needed to undertake the reviews and provides a more consistent approach to the assessment process across services.

Feedback on the template assessments continues to be positive and the introduction and implementation of new template assessments is on-going, with greater co-operation and sharing of assessments actively encouraged across the service areas,

Thirty four Health and Safety activity template assessments are now available for adoption by the Units/Wards.

Sixteen Health and Safety activity template assessments are now available for adoption by Community based Teams.

Twenty one Health and Safety activity template assessments are now available for adoption by the GP Practices.

A new Safety Folder based on the 'Perfect Ward' electronic reporting system has been developed to ensure each Humber premises has a generic safety folder for each building covering Fire, Security and H&S systems and assessment forms available for both internal and external audit purposes. This new system will eradicate the duplication of records and allow staff more time to facilitate clinical service delivery.

The physical condition of some premises has been brought to the attention of the Safety & Estates Teams and where possible remedial works have been and are being programmed in.

All aspects of safety systems within the organisation continue to improve. The new safety team are assessing which areas require addressing to evolve to the next level for audit purposes as it has been identified that staff on site are duplicating recordings.

7.2 Fire Risk Assessments/Audits

The RRFSO 2005 requires an annual fire risk assessment to be carried out in all premises in which people are employed to work.

Within the healthcare industry the risk assessment identifies deficiencies against the mandatory provision of Firecode and details appropriate measures to achieve an acceptable standard.

The purpose of the audit is to monitor compliance with Firecode and statutory requirements, to identify areas of non-compliance and set up remedial programmes.

The risk assessment and audit process are the principal elements of the Firecode Compliance Certificate and the Annual Statement of Fire Safety which has to be submitted annually to the Department of Health Estates and Facilities.

All premises managed by the Trust have a fire risk assessment completed annually but because of its very nature, it is dynamic and fluid and section/departmental heads need to be aware of the implications of the fire risk assessment.

As part of the fire risk assessment all premises have an arson risk assessment completed to ensure the premises are inspected both internally and externally and any arson issues are identified and removed.

A new fire risk assessment template has been introduced to address lone working, personal evacuation plans, sub-compartmentation and an overall evaluation of the risk of a fire occurring.

Interim fire safety inspections are being implemented to enhance the annual inspection and ensure continued compliancy is being maintained.

7.3 Planned Actions for 2019/20

- **Site Specific Risk Cards**
Site specific risk cards have been completed for life risk buildings and the information has been forwarded to HF&RS for inclusion on their mobile data terminals.
- **Safety Folder**
Embed new safety folder which includes reporting measures for Fire, H&S and Security for both internal and external audit purposes.
- **Contractors Safety Folder**
New contractor's induction folder which will incorporate an induction template to be completed and on site procedures to be followed when visiting premises.
- **Safety Inspections**
All premises have annual safety inspections diarised for the period 2019/20 to ensure compliance is being achieved with regulatory requirements and to confirm assurance for the organisation when audited externally.
- **Building Plans & Risk Assessments**
Risk assessments continue to be programmed in to upgrade and increase the information compiled in relation to all Trust properties. As information is collated a final plan will be issued to each property identifying protective and preventative measures that are inherent to the building.

8. Safety Premises Inspections

Safety inspections of Trust buildings and buildings where Trust staff are based are undertaken as part of the incident prevention work and to seek compliance with the Workplace (Health, Safety and Welfare) Regulations. (See Appendix A)

8.1 Services Joining the Trust

The actions outstanding from premises inspections highlights that as services join the Trust and their buildings become the responsibility of the Trust, substantial work is often required to bring the condition of the buildings up to the required Trust standards.

Estates are working closely with the Safety Team to review new services prior to joining the Trust and to ensure that due diligence is completed, so issues with building standards and compliance are addressed prior to the new service buildings becoming the Trust's responsibility.

9. Safety Training

As part of the Trust's mandatory training policy, all staff are required to complete safety training aligned to their role. The Trust monitors compliance on a regular basis.

The table below shows the overall compliance rates for the following Health and Safety related training as of the 31st March 2019. The Trust's target compliance rate for each of the listed training is 85%. A breakdown by Department is summarised at appendix A, the training compliance rates were all above the baseline target at Trust Level.

Table 9: Safety Related Training Rates 2018/19

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Display Screen Equipment Awareness	87.75%	87.95%	89.30%	90.36%	91.18%	89.24%	91.15%	91.51%	91.78%	92.18%	92.61%	93.54%
H&S Awareness	91.65%	91.98%	92.36%	92.42%	92.49%	92.24%	91.77%	90.89%	90.89%	90.18%	89.35%	88.35%
COSHH Awareness	90.94%	91.78%	92.41%	92.67%	92.67%	92.28%	92.58%	92.44%	92.14%	92.52%	92.33%	90.62%
Moving & Handling	86.98%	87.52%	88.11%	87.80%	89.26%	86.97%	83.02%	89.08%	89.08%	81.99%	89.13%	86.73%
Fire Refresher	87.90%	88.20%	82.10%	89.24%	88.35%	88.96%	88.96%	89.56%	90.17%	91.67%	91.56%	88.35%

9.1 Fire Training Plans for 2019/20

All Fire refresher training will be completed online as stated above however when required bespoke site specific fire training will be given on request. There will be a cost saving in employing on line training as staff will not be travelling to training venues, in essence they will be able to complete mandatory training in their workplace. This approach is in line with the Department of Health guidelines and the UK Core Skills Training Framework.

Arson and scene preservation for all fires started maliciously within HTFT buildings forms part of the fire warden training programme.

9.2 Training (Management)

Specific management courses are to be delivered during 2019/20 to ensure management tiers are aware of their responsibilities for arson investigation and scene preservation in line with the RRFSO 2005.

9.3 Fire Warden Training

This training has been enhanced to cover scene preservation, arson reduction, actions post fire and to consider Personal Emergency Evacuation Plans (PEEP's). Also forming part of the course is radio communication procedures. Some HTFT premises are employing hand held radios as part of their evacuation strategy/protocols.

Radios have been used in exercise conditions, live fires and unwanted fire signal incidents and have proven invaluable in speeding up the communication and response times.

Practical training is now completed 'in-house' and at site which is aiding in the ethos of more a bespoke training regime in relation to a local need.

9.4 Regulatory Reform Fire Safety Order 2005

Managers at every level will be encouraged to accept their responsibilities under the RRFSO 2005 and be pro-active in the discharge of those duties. This must include ensuring that all staff members receive fire training as this is an area where the Trust may be deemed to be vulnerable. This is done by face to face training on request or by direct liaison with site when required.

10. E Cigarettes

E-cigarettes are now allowed within unit type premises. The type of e-cigarette being employed is the Generation 2. The chambered types are not allowed. The e-cig will be charged for patients via a six port docking station located within the nurse station. The replacement liquid is also kept in the nurses station but due to some liquids being identified as flammable they are being stored in a flame and waterproof storage box.

Within the forensic unit disposable e-cigarettes are available through a vending machine.

11. Liaison With The Fire Service

Humberside Fire & Rescue Service (HF&RS) continues to focus on local health care premises for audits under their own inspection programme. Contact is maintained via the Premises Managers and the Trust Fire Safety Manager.

A new site specific risk register for fire risk has been implemented in liaison with HF&RS to ensure that the fire service and organisational on-call managers have the most up to date plans and information available. The fire service now have an after the fire team who enter premises to conduct a thorough audit of procedures.

Joint liaison regarding fire investigation with HF&RS and the Police has been completed for fire incidents to ensure a more cohesive approach to fire investigation is conducted and outcomes for internal investigations are prepared.

12. Fire Plans

Firecode requires that an up to date set of drawings is maintained which show alarm and detection systems, means of escape, emergency lighting, containment, first aid firefighting equipment and fire service access. Copies of the fire plans are held in the Estates Department.

Fire plans are displayed at each premises adjacent to the fire alarm panel. These plans will aid staff gain an appreciation of fire safety provisions and also ensures the organisation is compliant with Fire Regulations. New fire and zone plans are being issued to all HTFT premises, both plans being overlaid into one master plan which identifies the fire strategy elements for the building.

13. Summary of Action for 2018/19

Initiatives will continue to reduce fires, false alarms and unwanted fire signals during the next year. The initiatives will combine training, awareness, advice and investigations of incidents.

14. Conclusion

The Trust seeks to ensure that it provides a safe working environment for staff, clients and visitors through risk assessments, inspections, staff engagement, training and advice and guidance and will continue to improve on this.

The 2018/19 period saw an increase in the number of RIDDOR reportable incidents compared to the previous two years and this is a trend we wish to see reduce during the next reporting period.

Changes to the Trust structures and more flexible methods of working, will present fresh challenges for Health and Safety Management within the Trust. However, with continued streamlining of the review and risk assessment process, increased staff Health and Safety representation and more focused training, the Trust will seek to meet these challenges.

APPENDIX A: Risk Assessments Completed 2018/19

April 2018

Sunshine House
Maister Lodge
Princess Medical Centre
Learning Centre
Alfred Bean Hospital

May 2018

Bransholme Northpoint Medical Centre
Lecture Theatre
Coltman Avenue
Four Winds
Newbridges

June 2018

Victoria House
Rank House
Trust HQ
Townend Court (LD)
Westend
Bridlington Medical Centre
Rank House
Clarendon House

July 2018

Rosedale
St Andrews Place
Whitby Hospital
Health House
Skidby House
Market Weighton Group Practice
East Riding Community Hospital
Health Trainers Goole

August 2018

Bartholomew House
Health House
Goole SMSS
Millview Lodge
Millview Court
8 Market Place Driffield
Westlands
Sledmere House
Miranda House
Health Trainers Bridlington

September 2018

Hawthorne Court
Whitby Hospital
East House
Becca House

Chestnuts Surgery
Hallgate Surgery
Baker Street

October 2018

Humber Centre
Peeler House
Cottingham Clinic
Ayton & Snayton Surgery
Brook Square Surgery
Seamer Surgery
Prospect Surgery Scarborough
Malton Hospital
Castle Health Practice Scarborough
Belgrave/Falsgrave Practice Scarborough

November 2018

Hornsea Cottage Hospital
Hornsea Kingfisher Lodge
Waterloo centre
Pocklington Health Centre
Waterloo Centre

December 2018

Health House
Humber Centre (Swale & Ullswater)
Pocklington HC (Beckside)

January 2019

Mary Seacole Building
Fieldhouse Surgery
Hessle HC
Granville Court

February 2019

Coltman Street Clinic
Tennyson Avenue
Scarborough Rugby Club

March 2019

Beverley HC
The Grange
The Surgery Flamborough
Manor House Surgery
Anlaby Clinic

Appendix B
Safety Training Compliance

Org L3	Org L5	Display Screen Equipment			Health and Safety			COSHH			Moving and Handling			Fire		
		Required	Not Compliant	%	Required	Not Compliant	%	Required	Not Compliant	%	Required	Not Compliant	%	Required	Not Compliant	%
Corporate	338 Chief Exec (Service)	15	14	93%	15	11	73%	15	13	87%	15	12	80%	15	14	93%
Corporate	338 Chief Operating Officer (Service)	37	29	78%	37	30	81%	37	29	78%	37	25	68%	37	30	81%
Corporate	338 Finance (Service)	114	112	98%	289	277	96%	289	278	96%	289	274	95%	289	262	91%
Corporate	338 Human Resources (Service)	65	63	97%	70	66	94%	70	69	99%	70	65	93%	70	67	96%
Corporate	338 Medical (Service)	35	35	100%	36	34	94%	36	36	100%	36	33	92%	36	34	94%
Corporate	338 Nursing and Quality (Service)	38	36	95%	38	34	89%	38	35	92%	38	31	82%	38	36	95%
Mental Health Services	338 Adult Inpatient (Service)	169	162	96%	173	161	93%	173	161	93%	22	18	82%	173	151	87%
Mental Health Services	338 ER CMHT (Service)	67	64	96%	67	58	87%	67	58	87%	66	57	86%	67	58	87%
Mental Health Services	338 Hull CMHT (Service)	90	79	88%	90	64	71%	90	66	73%	70	49	70%	90	77	86%
Mental Health Services	338 Medical Staffing (Service)	15	8	53%	15	8	53%	15	8	53%	15	10	67%	15	8	53%
Mental Health Services	338 Mental Health Care Group Management Team (Service)	24	22	92%	24	20	83%	24	20	83%	19	15	79%	24	23	96%
Mental Health Services	338 Older Peoples Mental Health (Service)	194	187	96%	194	176	91%	194	184	95%	44	41	93%	194	170	88%
Mental Health Services	338 Psychological Medicine (Service)	75	68	91%	75	65	87%	75	71	95%	74	64	86%	75	66	88%
Mental Health Services	338 Psychological Wellbeing (Service)	56	54	96%	56	52	93%	56	53	95%	56	49	88%	56	54	96%
Mental Health Services	338 Rapid Response (Service)	86	81	94%	86	75	87%	86	74	86%	85	77	91%	86	63	73%
Mental Health Services	338 Rehab and LTC (Service)	33	29	88%	34	30	88%	34	33	97%	2	2	100%	34	29	85%
Primary Care, Community, Children's and LD Services	338 CAMHS (Service)	155	143	92%	155	123	79%	155	134	86%	146	112	77%	155	137	88%
Primary Care, Community, Children's and LD Services	338 Children's and LD Management Team (Service)	7	7	100%	7	4	57%	7	6	86%	7	5	71%	7	6	86%
Primary Care, Community, Children's and LD Services	338 Community Services (Service)	188	170	90%	189	161	85%	189	172	91%	78	69	88%	189	157	83%
Primary Care, Community, Children's and LD Services	338 General Practices (Service)	109	90	83%	109	91	83%	109	88	81%	109	89	82%	109	96	88%
Primary Care, Community, Children's and LD Services	338 Hull & ER Children's Therapies (Service)	77	73	95%	77	72	94%	77	64	83%	11	11	100%	77	72	94%
Primary Care, Community, Children's and LD Services	338 Learning Disability (Service)	177	167	94%	184	163	89%	184	167	91%	67	60	90%	184	167	91%
Primary Care, Community, Children's and LD Services	338 Universal Childrens (Service)	124	121	98%	124	113	91%	124	115	93%	124	113	91%	124	115	93%
Specialist Services	338 Addictions and Diversion (Service)	26	26	100%	26	23	88%	26	23	88%	26	22	85%	26	25	96%
Specialist Services	338 Forensics / Offender Health (Service)	206	201	98%	207	189	91%	207	197	95%	54	50	93%	207	183	88%
		2,182	2,041	93.54%	2,377	2,100	88.35%	2,377	2,154	90.62%	1,560	1,353	86.73%	2,377	2,100	88.35%

Agenda Item 19

Title & Date of Meeting:	Trust Board Public Meeting - 22 nd May 2019		
Title of Report:	Annual Declarations 2018/19		
Author:	Name: Peter Beckwith Title: Director of Finance		
Recommendation:	To approve	<input checked="" type="checkbox"/>	To note
	To discuss	<input checked="" type="checkbox"/>	To ratify
	For information		To endorse <input checked="" type="checkbox"/>
	<p>The Trust Board are asked to approve the following annual declarations, based on the evidence included in this report:</p> <ul style="list-style-type: none"> • The Board has taken all necessary precautions to comply with its licence, the NHS Act and the NHS Constitution. • The Trust has complied with required governance standards and objectives • That the Trust has complied with section 151(5) of the Health and Social Care Act to ensure that governors are equipped with the skills and knowledge to undertake their role. 		
Purpose of Paper:	To provide the Board with a summary of the annual declarations that are required to be made by the Trust, evidence of how the Trust meets these declarations and to provide assurance that the views of Governors have been taken into consideration..		
Key Issues within the report:	<p>The Trust is required to make annual declarations after the financial year end.</p> <p>Details of declaration and comments/evidence are included within the report.</p>		

Monitoring and assurance framework summary:

Links to Strategic Goals				
√	Innovating Quality and Patient Safety			
√	Enhancing prevention, wellbeing and recovery			
	Fostering integration, partnership and alliances			
√	Developing an effective and empowered workforce			
	Maximising an efficient and sustainable organisation			
	Promoting people, communities and social values			
Have all implications been considered?	Yes	Yes Detail in report	N/A	Comment
		Any Action Required?		
Risk	√			To be advised of any future implications reports as and when future implications by Lead Directors through Board required
Legal	√			
Compliance	√			
Communication	√			
Financial	√			
Human Resources	√			
IM&T	√			
Users and Carers	√			
Equality and Diversity	√			
Report Exempt from Public Disclosure?			No	



**Trust Board (May 2019)
Annual Declarations 2018/19**

1. Introduction and Purpose

This purpose of this paper is to provide the Trust Board with a summary of the annual declarations that are required to be made by the Trust alongside evidence/comments of how the Trust meets these declarations.

2. Views of Governors

All declarations must be signed on behalf of the board of directors, and have regard to the view of governors. A version of this paper was presented and discussed at the Council of Governors meeting held on the 17th January 2019.

3. NHS Licence Conditions

All NHS Foundation Trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and, have complied with governance requirements.

The Trust is required to make the following two declarations:

Declaration	Details
G6 (3)	Providers must certify that their Board has taken all necessary precautions to comply with the licence, NHS Act and NHS Constitution.
FT4 (8)	Providers must certify compliance with required governance standards and objectives

In terms of commissioner requested services the Trusts Contracts currently do not identify any requirements for this declaration however the CAMHS Tier 4 contract which goes live later this year will require this declaration in future years. There has also been a request from Hull and East Riding CCG for services to be included in the contract for the new financial year, this is currently going through the contract governance process.

3.1 Condition G6

Condition G6 requires the Trust to have effective systems and processes in place to ensure compliance with its provider licence, the NHS Act and the NHS Constitution. The Trust should identify any risks to compliance and take reasonable mitigating actions to prevent those risks and a failure to comply occurring.

The previous update to the Trust Board in September 2017 highlighted the evidence available to support the above declarations. At the meeting a request was made by the Chairman for a review of the Trust Licence to ensure the criteria is met and whether any breaches have occurred.

The Trust Licence (No 130053 – Issued 1st April 2013) contains seven sections which details conditions relating to the following areas:

- General Conditions
- Pricing
- Choice and Competition
- Integrated Care

- Continuity of Services
- NHS Foundation Trust Conditions
- Interpretation and definitions

Details of the Trust licence conditions and commentary to support compliance is attached at Appendix A.

Declaration G6 also requires the Board to declare that the Licensee continues to meet the criteria for holding a licence, there are currently 2 conditions:

- The Trust must be registered with the Care Quality Commission
- The Directors and Governors of the Trust must meet the 'fit and proper persons test'

The Trust is compliant with these conditions.

3.2 Condition FT 4

Condition FT4 requires the Trust to apply the principles, systems and standards of good practice which would reasonably be regarded as appropriate for a supplier of health care services to the NHS.

Evidence to demonstrate the Trust's compliance against the six statements is attached at Appendix B, this is not an exhaustive list and has been updated based on feedback from previous board discussions..

4. Additional Declaration – Training of Governors

Whilst not a specific licence condition, the Trust is also required to make an annual declaration in relation to the Training of Governors. It is a requirement of the Health and Social Care Act that requires the Trust to ensure governors are equipped with the skills and knowledge they require. The Trust is required to make the following statement

'The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to Governors, as required by S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they require to undertake their role'

The Council of Governors have considered the above statement in the context of the evidence below:

- Governor Induction Programme
- Governor Development Workshop/Sessions
- Council of Governor Meetings

5. Next Steps

The deadline for annual declarations has yet to be published, it is likely that the following dates will apply:

- Condition G6 31st May 2019
- Condition FT4 and Training of Governors 30th June 2019

When approved by the Trust Board the Annual Declaration on the Trust Website should be updated.

6. Recommendation

The Board are asked to endorse the evidence to support the following annual declarations:

- The Board has taken all necessary precautions to comply with the licence, NHS Act and NHS Constitution.
- The Trust has complied with required governance standards and objectives
- That the Trust has complied with section 151(5) of the Health and Social Care Act to ensure that governors are equipped with the skills and knowledge to undertake their role.

Appendix A
Licence Conditions:

Condition	Explanation	Comments
General licence conditions (G)		
G1. Provision of information	Obligation to provide NHS Improvement/Monitor with any information it requires for its licensing functions.	<ul style="list-style-type: none"> • The Trust complies with any Monitor/NHS Improvement requests for information and complies with the reporting requirements as set out in the Single Oversight Framework. • The Trust has robust data collection and validation processes. • Accurate, complete and timely information is produced and submitted to third parties to meet specific requirements.
G2. Publication of information	Obligation to publish such information as NHS Improvement/Monitor may require.	<ul style="list-style-type: none"> • The Trust Board of Directors meets in public. • Agendas, minutes and papers are published on the Trust's website . • Monthly board meetings include updates on operational performance quality and finance. • The Trust's website contains a variety of information and referral point information should the public require further information. • Published Quality Accounts and Annual Report. • The Trust responds to Freedom of Information requests • The Board Assurance Framework and Trust Wide Risk Register are reported to the board quarterly. • The Council of Governors receives regular communication about the work of the Trust. • The Trust complies with its obligations under Duty of Candor.
G3. Payment of fees to NHS Improvement/Monitor	Gives NHS Improvement/Monitor the ability to charge fees and for licence holders to pay them.	<ul style="list-style-type: none"> • There are currently no plans to charge a fee to Licence holders. • The Trust's financial systems enable it to comply with this requirement in the future.
G4. Fit and proper persons as Governors and Directors	Prevents licences from allowing unfit persons to become or continue as governors or directors.	<ul style="list-style-type: none"> • Governors and Members of the Board of Directors are required to make an annual declarations to ensure that they continue to meet the Fit and Proper Persons Test.



Condition	Explanation	Comments
G5. NHS Improvement/Monitor guidance	Requires licensees to have regard to NHS Improvement/Monitor guidance.	<ul style="list-style-type: none"> • The Trust responds to guidance issued by NHS Improvement/Monitor. • Submissions and information provided to NHS Improvement/Monitor are approved through relevant and appropriate authorisation processes. • The Trust has regard to Monitor guidance and submits self-certifications as required by Monitor
G6. Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	<ul style="list-style-type: none"> • The Trust's Internal Auditors are considering Governance arrangements as part of the 2018/19 internal audit programme. • The Board Assurance Framework and Trust Wide Risk Register are reported to the board quarterly. • Annual Governance Statement • Annual Head of Internal Audit Opinion <p>* This is a signed declaration on behalf of the Trust as part of the annual submissions</p>
G7. Registration with the Care Quality Commission (CQC)	Requires providers to be registered with the CQC and to notify NHS Improvement/Monitor if their registration is cancelled.	<ul style="list-style-type: none"> • The Trust is registered with the Care Quality Commission (CQC). • The Trust's last CQC inspection was in 2017 • The Quality Committee has reviewed all evidence to support submissions made to the CQC • The Trust Board has oversight of CQC Action Plans
G8. Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	<ul style="list-style-type: none"> • Details of Services the Trust provides are published on the Trust's website • Patients referred to the Trust are not selected on any eligibility grounds. • Eligibility is defined through commissioner contracts and patient choice • Treatment decisions are made on clinical grounds and treatment options (risks and benefit) are discussed with the patient through the consent to treatment process.
G9. Application of section 5 (Continuity of Services)	Sets out the conditions under which a service will be designated as a CRS	<ul style="list-style-type: none"> • The Trust are not a provider of commissioner Requested Services
Pricing conditions (P)		
P1. Recording of information	Obligation of licensees to record information, particularly about costs.	<ul style="list-style-type: none"> • The Trust has well established systems for coding, collection, retention and analysis of activity and cost information.

Condition	Explanation	Comments
P2. Provision of information	Obligation to submit the above to NHS Improvement/Monitor.	<ul style="list-style-type: none"> The Trust responds to guidance and requests from NHS Improvement/Monitor.
P3. Assurance report on submissions to Improvement/Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	<ul style="list-style-type: none"> The Audit Committee receives and monitors all internal audit reports.
P4. Compliance with the national tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	<ul style="list-style-type: none"> All Trust contracts are agreed annually and are in line with the national tariff where applicable. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance.
P5. Constructive engagement concerning local tariff modifications	Requires license holders to engage constructively with commissioner and to reach agreement locally before applying to NHS Improvement/Monitor for a modification	<ul style="list-style-type: none"> 2018/19 contracts with the commissioners have been agreed with local CCGs and with NHS England. The Trust has positive working relationships with commissioners. The Trust has adopted a new collaborative commissioning approach to contracting in 2018/19
Choice and competition (C)		
C1. The right of patients to make choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	<ul style="list-style-type: none"> The Trust has in place a service directory setting out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.

Condition	Explanation	Comments
C2. Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	<ul style="list-style-type: none"> The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board decide to consider any structural changes, such as mergers or joint ventures.
Integrated care condition (IC)		
IC1. Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	<ul style="list-style-type: none"> The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care. A number of services provided are done so through partnership working with other local stakeholders.
Continuity of service (CoS)		
CoS1. Continuing provision of Commissioner Requested Services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	<ul style="list-style-type: none"> The Trust is not currently commissioned to provide CRS.
CoS2. Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHS Improvement/Monitor's consent before disposing of these assets IF NHS Improvement/Monitor has concerns about the licensee continuing as a going concern.	<ul style="list-style-type: none"> The Trust is not currently commissioned to provide of CRS. The Trust maintains a full capital asset register.

Condition	Explanation	Comments
CoS3. Standards of corporate governance and financial management	Licenses are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	<ul style="list-style-type: none"> • The Trust has Standing Orders, Standing Financial Instructions and a Scheme of Delegation in place, refreshed November 2018. • The Board of Directors receives monthly performance reports aligned to the Trust Strategic Goals. • The Trust has a Board Assurance Framework and Risk Register • The Trust's Internal Auditors review risk management processes as part of the strategic audit plan. • The Trust has undertaken a Well Led Review with actions from this implemented and monitored.
CoS4. Undertaking from the ultimate controller	Requires licenses to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	<ul style="list-style-type: none"> • The Trust does not operate and is not governed by an Ultimate Controller arrangement so this License Condition does not apply.
CoS5. Risk pool levy	Obliges licenses to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	<ul style="list-style-type: none"> • The Trust currently contributes to the NHS Litigation Authority (NHS Protect) risk pool for clinical negligence and public liability schemes.
CoS6. Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with NHS Improvement/ Monitor.	<ul style="list-style-type: none"> • The Trust would full comply with this condition if required.
CoS7. Availability of resources	Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	<ul style="list-style-type: none"> • The Trust is not currently commissioned to provide of CRS. • The Trust's Financial Use of Resource score is currently 3, consistent with its approved NHSI Plan
Foundation Trust conditions (FT)		
FT1. Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHS Improvement/Monitor.	<ul style="list-style-type: none"> • The Trust has provided NHS Improvement with a copy of its NHS Foundation Trust Constitution • The Trust has provided NHS Improvement a copy of its Annual Report and Accounts.
FT2. Payment to NHS Improvement/ Monitor in respect of registration and related costs	The Trust would be required to pay any fees set by NHS Improvement/Monitor.	<ul style="list-style-type: none"> • If NHS Improvement required fees to be paid by the Trust, the Trust would comply with this condition.

Condition	Explanation	Comments
FT3. Provision of information to advisory panel	NHS Improvement/Monitor has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	<ul style="list-style-type: none"> The Trust would comply with this as required through the provision of any requested information.
FT4. NHS Foundation Trust governance arrangements	Gives NHS Improvement/Monitor continued oversight of the governance of foundation trusts.	* <i>This is a signed declaration on behalf of the Trust as part of the annual submissions. Evidence against this submission is detailed in appendix B.</i>

Condition FT4 (8): the provider has complied with required governance arrangements

	Statement	Sources of Evidence and Assurance
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Scheme of Delegation, Reservation of Powers and Standing Financial Instructions have been updated and refreshed – November 2018 Board. Constitution has been reviewed and updated
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Trust Wide Risk Register Board Assurance Framework Integrated Quality and Performance Tracker Finance Report and Use of Resources Score
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Committee Structures now embedded Workforce Committee to be established Finance and Investment Committee to be amalgamated Clear Accountability through EMT and Executive Directors Portfolios. Level 3 performance reports and ‘ward to board’ reporting.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee’s duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee’s operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee’s ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their	External Audit Opinion on VFM (ISA260) Going Concern review Annual Governance Statement All Statutory requirements met Delivered Financial Position in 2017/18 Use of Resource Score of 3 Trust agreed to its control total for 2018/19 Monthly Performance report to Trust Board Quality Report to Quality Committee Monthly returns to NHS Improvement Risk Register and Board Assurance Framework Annual Report on Fire and Health and Safety presented to Trust Board Annual Accounts Annual Quality Report



	Statement	Sources of Evidence and Assurance
	<p>delivery; and (h) To ensure compliance with all applicable legal requirements.</p>	
5	<p>The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:</p> <p>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</p> <p>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;</p> <p>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;</p> <p>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;</p> <p>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and</p> <p>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.</p>	<p>Board Skill Mix Board Development Programme</p> <p>Standing Items to Board</p> <ul style="list-style-type: none"> • Performance Report • Finance • Chief Executive Update including <ul style="list-style-type: none"> ○ Nursing Update ○ Operations Update ○ Medical Update ○ HR Update <p>Refreshed Trust Strategy</p> <p>Patient Stories reported to Board Programme of Exec Visits Governor Visits Friends and Family Test CQC Action Plan/Improvement Plan Midday Mail/Midweek Global Meet with Michele</p>
6	<p>The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.</p>	<p>Trust Board undertake Fit and Proper Persons Test Board Secretary maintains declarations of interest register Trust has undertaken a Well Led Review Staffing Figures reported to the board regularly. Trust Workforce Strategy Workforce included in Care Group Service Plans The Trust is establishing a Workforce Committee</p>