

Trust Board in Public
Tuesday 13 September 2022

Item	Description/Presenter	Note/Approve	Time	Ref
Business Matters				
1	Apologies and Welcome Sean Lyons, Chair		09:00	Verbal
2	Chair's Opening Remarks Sean Lyons, Chair			Verbal
3	Declarations of Interest 3.1 Changes to Directors' interests since the last meeting Sean Lyons, Chair			Verbal
	3.2 To consider any conflicts of interest arising from this agenda Sean Lyons, Chair			Verbal
4	Minutes of the previous meeting 4.1 Minutes of the meeting held 12 July 2022 Sean Lyons, Chair	Approval		Attached
	4.2 Board Work Programme 2022/23 Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.3 Board Development Framework Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
	4.4 Matters Arising Sean Lyons, Chair			Verbal
	4.5 Action Tracker Sean Lyons, Chair	Approval	Attached	
Patient Story				
5	Patient Story Makani Purva, Chief Medical Officer	Assurance	09.10	Verbal
Governance				
6	6.1 CEO Report/Covid Update Chris Long, Chief Executive Officer	Assurance	09.20	Attached
	6.2 Audit Committee Summary Mike Robson, Non-Executive Director	Assurance		Attached
	6.3 Summary from the Charitable Funds Committee Tony Curry, Charitable Funds Chair	Assurance		Attached
	6.4 Standing Orders Report Rebecca Thompson, Head of Corporate Affairs	Approval		Attached
Strategy				
7	7.1 Trust Strategy Update Michelle Cady, Director of Strategy and Planning	Assurance	09.40	Attached
	7.2 Equality Objectives 2022 - 2026 Simon Nearney, Director of Workforce and OD	Approval		Attached
	Break		10.00	
Quality				
8	8.1 Quality Report Jo Ledger, Acting Chief Nurse/Suzanne Rostron, Director of Quality Governance	Assurance	10.10	Attached
	8.1.1 Maternity Update Lorraine Cooper, Head of Midwifery	Assurance		Attached
	8.2 End of Life Care Report Kristen Saharia – EOL Lead	Assurance		Attached
	8.3 Safeguarding Children and Adults Annual Reports Kate Rudston, Assistant Chief Nurse	Assurance		Attached

	8.4 Summary from the Quality Committee David Hughes, Quality Chair	Assurance		Attached
Workforce				
9	9.1 Our People Report Simon Nearney, Director of Workforce and OD	Assurance	11.00	Attached
	9.2 Workforce Race Equality Standards Simon Nearney, Director of Workforce and OD	Approval		Attached
	9.3 Workforce Disability Equality Standards Simon Nearney, Director of Workforce and OD	Approval		Attached
	9.4 Modern Slavery Report Simon Nearney, Director of Workforce and OD	Approval		Attached
	9.5 Freedom to Speak Up Fran Moverley, Head of Freedom to Speak Up	Assurance		Attached
	9.6 Summary from the Workforce, Education and Culture Committee Una Macleod, Chair of Workforce, Education and Culture Committee	Assurance		Attached
Performance				
10	Performance Report Ellen Ryabov, Chief Operating Officer	Assurance	11.30	Attached
	10.1 Finance Report Lee Bond, Chief Financial Officer	Assurance		Attached
	10.1.1 Premises Assurance Model Duncan Taylor, Director of Estates and Facilities	Approval/ Assurance		Attached
	10.2 Summary from the Performance and Finance Committee Mike Robson, Chair of Performance and Finance	Assurance		Attached
11	Questions from the public relating to today's agenda Sean Lyons, Chair		11.55	Verbal
12	Chairman's summary of the meeting Sean Lyons, Chair			Verbal
13	Any Other Business Sean Lyons, Chair			Verbal
14	Date and time of the next meeting: Tuesday 8 November 2022, 9am – 12pm			Verbal

Attendance 2022/23

Name	10/5	16/06	12/07	03/08	13/09	4/10	08/11	10/01	14/03	Total
Sean Lyons	✓	✓	✓	✓						4/4

S Hall	✓	✓	✓	✓						4/4
T Christmas	✓	✓	✓	x						3/4
T Curry	✓	x	✓	✓						3/4
U MacLeod	x	✓	✓	✓						3/4
M Robson	✓	✓	✓	✓						4/4
L Jackson	x	x	x	✓						1/4
A Pathak	x	✓	✓	✓						3/4
D Hughes	✓	✓	x	✓						3/4
C Long	✓	✓	✓	✓						4/4
L Bond	✓	✓	✓	✓						4/4
M Purva	✓	x	✓	✓						3/4
J Ledger	✓	✓	✓	✓						4/4
S Nearney	✓	✓	✓	✓						4/4
E Ryabov	✓	✓	x	✓						3/4
M Cady	✓	✓	✓	✓						4/4
S Rostron	✓	✓	✓	✓						4/4
S McMahan	✓	x	✓	✓						3/4
R Thompson	✓	✓	✓	✓						4/4

Attendance 2021/22

Name	11/5	10/6	13/7	14/9	9/11	11/1	8/3	Total
Sean Lyons	-	-	-	-	-	Stood down	✓	1/1
T Moran	✓	✓	x	-	-	Stood down	-	2/3
S Hall	✓	✓	✓	✓	✓	Stood down	✓	6/6
T Christmas	✓	✓	✓	x	✓	Stood down	x	5/6
T Curry	✓	✓	✓	✓	✓	Stood down	✓	6/6
U MacLeod	✓	✓	✓	✓	✓	Stood down	✓	6/6
M Robson	✓	✓	✓	✓	✓	Stood down	✓	6/6
L Jackson	✓	x	x	✓	✓	Stood down	✓	4/6
A Pathak	✓	x	✓	✓	✓	Stood down	✓	5/6
David Hughes	-	-	-	-	-	Stood down	✓	1/1
C Long	✓	✓	✓	x	✓	Stood down	✓	5/6
L Bond	✓	✓	✓	✓	✓	Stood down	✓	6/6
M Purva	✓	x	✓	✓	✓	Stood down	✓	5/6
B Geary	✓	✓	✓	✓	✓	Stood down	✓	6/6
S Nearney	✓	✓	✓	✓	✓	Stood down	✓	6/6
E Ryabov	✓	✓	✓	✓	✓	Stood down	✓	6/6
M Cady	✓	x	✓	✓	✓	Stood down	✓	5/6
S Rostron	✓	✓	✓	✓	✓	Stood down	✓	6/6
R Thompson	✓	✓	✓	✓	✓	Stood down	✓	6/6

**Hull University Teaching Hospitals NHS Trust
Minutes of the Board Meeting
Held on 12 July 2022**

Present:	Mr S Lyons	Chairman
	Mr S Hall	Vice Chair
	Dr A Pathak	Non-Executive Director
	Mrs J Ledger	Interim Chief Nurse
	Mr C Long	Chief Executive Officer
	Mrs J Harrison-Mizon	Deputy Chief Operating Officer
	Prof M Purva	Chief Medical Officer
	Mrs S Rostron	Director of Quality Governance
	Prof U Macleod	Non-Executive Director
	Mrs M Cady	Director of Strategy and Planning
	Mr L Bond	Chief Financial Officer
	Mrs S McMahan	Joint Chief Information Officer
	Mr S Nearney	Director of Workforce and OD
	Mrs T Christmas	Non-Executive Director
	Mr T Curry	Non-Executive Director
 In attendance:	 Mrs G Johnson	 Director of Infection Prevention and Control
	Mrs F Moverley	Head of Freedom to Speak Up
	Mrs L Cooper	Head of Midwifery
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	<p>Apologies Apologies were received from Mrs E Ryabov, Chief Operating Officer, Dr D Hughes, Non-Executive Director and Mrs L Jackson, Associate Non-Executive Director</p>	
2	<p>Chair's Opening Remarks Mr Lyons reported that the ICS was now a legal being and the Board was in place.</p> <p>Steve Barclay had been appointed as the new Health Secretary and Mr Lyons wished him well on behalf of the Board.</p> <p>Mr Lyons thanked all staff for their continuing great efforts to look after patients to keep them safe. He said that this was a great achievement with the current Covid challenges and recovery programme.</p>	
3	<p>Declarations of Interest</p> <p>3.1 Changed to Directors' interests since the last meeting There were no declarations made.</p> <p>3.2 To consider any conflicts of interest arising from this agenda There were no conflicts of interest raised.</p>	

The minutes of the meeting held on 10 May 2022 were approved as an accurate record of the meeting.

Mrs Ledger advised that the Midwifery Staffing Report had been scrutinised at the Workforce Education and Culture Committee and would not be presented to the Board unless further assurance was required.

Minutes of the meeting held on 16 June 2022

Mr Bond advised that in item 3 paragraph 2 the adjustment was included in buildings and should have been included in plant and equipment.

Following the above changes the minutes were approved as an accurate record of the meeting.

4.1 Board Work Programme 2022/23

Mr Hall asked if there should be an item relating to inequalities on the work programme and it was agreed that a Board Development Session would be held first to understand the issues and then the Executive Team would review and propose what was required.

Action: RT to include inequalities as a Board Development session.

RT

4.2 Board Development Framework 2022/23

The Board Development Framework was presented and Mrs Thompson advised that Research and Innovation, Wishh and End of Life Care would be added in 2022/23.

4.3 Matters Arising

There were no matters arising.

4.4 Action Tracker

Mrs Thompson advised that the Capital Risk had been split so that the in-year risk would be captured on the Corporate Risk Register and the longer-term strategic risk would remain on the Board Assurance Framework.

The Research and Innovation Strategy would be discussed at the December 2022 Board Development Session.

Mrs McMahon advised that she had reviewed the NED flash report and there were no issues.

All actions to be removed from the action tracker.

5 Patient Story

Prof Purva presented the item which captured 4 patient stories and their experiences whilst in hospital, taking into account the current pressures in the system.

The patients could not thank staff enough and recognised that patients were being moved about due to the operational pressures. The patients also noted how staff were over-worked

and tired. Prof Purva added that problems in Primary Care were captured but once in hospital patients were receiving good care.

Mr Lyons expressed his gratitude for the member of staff who had provided a lap-top so that a gentleman could watch a Rugby match as this was going above and beyond.

Mrs Cooper suggested that the video was put onto Pattie so that members of staff could see it. Prof Purva advised that she would providing the consent allowed it.

Dr Pathak asked about Hospital Radio and Mr Long advised that it was still operating. Mr Bond advised that patients had to pay for TV viewing and Mrs Ledger agreed to speak to the Patient Experience Team to see if there was anything else the Trust could do.

6 CEO/Covid Update

Mr Long expressed his concern regarding the continued pressure in the system and the fact that staff had not had a break from the pressure since October 2019.

Patients with No Criteria to Reside were holding at around 150 and Covid number were increasing.

Mr Long had spoken to Stephen Eames about the continued pressures and a summit was taking place in September with system partners to review what needed to change.

Mr Long was watching the pattern of Flu in the southern hemisphere and advised that Australia was suffering due to people resuming normal behaviours. He added that the UK could expect another wave of Covid that would impact on staff and patients. Along with winter pressures this could result in failure of patient care and patient safety.

Action: It was agreed that the Board would discuss winter pressures further at the August Board Development Session. RT

6.1 Committees in Common Summary

Mr Lyons advised that programmes were beginning to take shape around the Clinical Plan. The Joint Development Board was in place to make the decisions around the 10 vulnerable services, and Chris Long and Peter Reading were chairing the Board.

Mrs Cady added that there had been a positive response to the recruitment campaign and there was a good appetite in both organisations to share best practice. She added that clarity of message and implementation of the decisions was key.

Dr Pathak asked if the team was resourced properly and Mrs Cady advised the resource was being used in the best way to achieve the timescales.

6.2 Audit Committee Summary

Mrs Christmas presented the summary reports and highlighted that the Audit Opinion had been modified due to the closing stock balance as the Auditors had not physically been on the site. There were no other items to escalate.

6.3 Year-end Board and Committee Review

Mrs Thompson presented the year-end Board and Committee review which highlighted the terms of reference, effectiveness reviews and workplans for each of the Board Committees.

The paper proposed removing all Board and Committee meetings in August and January due to operational pressures and annual leave. The Quality Committee could be stood up as a verbal meeting if there were any pressing quality matters.

Resolved: The Board agreed to remove January and August Boards and Committees from January 2023. Mrs Thompson to ensure the Terms of Reference reflect this.

RT

6.4 Register of Gifts and Interests Annual Update

The Register of gifts and hospitality and declarations were presented to the Board for assurance. Mrs Thompson advised that the register was reviewed regularly at the Audit Committee and that she worked closely with the Counter Fraud Team to ensure declarations were in line with the Trust Policy..

6.5 Summary from the Charitable Funds Committee

Mr Curry presented the summary and reported that there was a good level of assurance and no areas to escalate to the Board.

7 7.1 Board Assurance Framework

Mrs Rostron presented the Board Assurance Framework and advised that the Quarter 1 position had been discussed at the Board Committees for scrutiny. The Capital risk had been split and the in-year capital plan placed on the Corporate Risk Register.

Resolved: The Board approved the Quarter 1 risks and ratings.

The agenda was taken out of order

8.2 Infection Prevention and Control Annual Report

Mrs Johnson reported that the Covid pandemic was still challenging from a patient and staffing point of view.

She advised that the Trust had received a visit from NHSEI relating to IPC and had provided advice and guidance to follow.

There had been a number of changes and the role of the Director of Infection Prevention and Control had become more strategically focussed, there had been changes in reporting and a new meeting structure in place.

Healthcare Associated Infections had been relatively steady throughout the year and the Trust was in line nationally with MRSA Bacteraemia and CDifficile. Blood stream infections were down due to reduced elective work.

There had been a number of outbreaks, such as Norovirus during the year but staff are quick to respond and bring them under control.

Mrs Johnson was monitoring the Flu situation in the southern hemisphere and reviewing the new variants of Covid that were creating new challenges.

Antibiotic prescribing was being reviewed and a Task and Finish Group had been set up.

There were a number of Estate challenges and isolating patients but the cleaning standards were in a good position and a new Linen contract was in place.

The IPC Board Assurance Framework was in place and a Task and Finish group in place. Mrs Johnson advised that it was important to note that the BAF was not just for the IPC Team to manage but for all staff.

Mrs Johnson highlighted the risk areas as: patients with no criteria to reside and the risk of developing infection whilst in hospital, digital solutions, Antimicrobial Stewardship and Estate issues.

She added that the improvement areas included a new meeting structure with Operational and Strategic review, the IPC BAF and the roll out of EPMA.

Mr Robson asked if the IPC arrangements were stronger because of Covid and Mrs Johnson advised that they were as attention was much more focussed.

Prof Macleod asked if the NCTR data was being collected around infections that patients wouldn't have had if they had not been in hospital.

Action: Mrs Johnson agreed to review this and bring a further paper to the Board.

GJ

Mr Bond asked about the risks of the ageing Estate and Mrs Johnson advised that outbreaks and infections were more likely in the Tower Block and were more controlled at Castle Hill Hospital. She added that the risk was offset by the new wards as they were significantly better to manage patients safely.

8.3 Infection Prevention and Control – Board Assurance Framework

Mrs Johnson presented the report and advised that the elements were monitored by the IPC BAF Task and Finish Group and rag

rated. Any risks amber or red are escalated at the Strategic Infection Reduction Committee. In 2022/23 there will be a focus on an IPC Quality Improvement programme which will align with the actions on the BAF.

The agenda returned to order at this point

8 Quality Report

Mrs Ledger presented the report and advised that the Quality Accounts had been signed off by the Quality Committee in June 2022.

There had been a CQC IMER visit to the Hull Royal site and also Castle Hill. There had been no concerns raised but an action plan had been put into place following lessons learned.

The internal assurance assessments had commenced using CQC methodology.

There was still an issue around staff burn out but there were support systems in place to help staff.

A Well-led review would be held with the Board in the August Development session.

There had been 19 Serious Incidents in May and June and 1 Never Event. 44 Serious Incidents had been closed and progress was being made into the backlog.

There had been 11 closed falls but work was ongoing to address this and the Falls Team had presented their action plan to the Quality Committee in June 2022.

Work was ongoing with the BI Team to review the Quality Report.

There had been an increase in moderate harms although they were still within the safety parameters. A task and finish group had been set up to look at a Trust-wide action plan.

Mrs Rostron advised that the Quality Strategy had been launched and there had been 150 pledges made. The Trust had also been accredited as a QSIR faculty with a number of staff including consultants ready to train staff.

8.1 Maternity Update CNST – Maternity Incentive Scheme

The scheme had been paused due to the pandemic but had been relaunched on 6 May. Mrs Cooper advised that there were 3 green areas, 6 amber areas and 1 red areas which was linked to medical staffing non-compliance. A recruitment programme was in place for 3 more obstetricians to help achieve the deadline in July.

Mrs Cooper advised that monthly overview is monitored at the Quality Committee.

Avoiding Term Admissions into Neonatal Units (ATAIN)

Mrs Cooper presented the report and advised that the Q4 data was 2.6% which was well within the accepted standard nationally.

The primary reason for admission was for respiratory support requiring continuous positive airway pressure.

CNST – Year 4 Saving Babies Lives

Mrs Cooper presented the report and advised that audits are undertaken quarterly to assess against the service against process indicator 4 and 7 within the SBLCBv2 document. A quarterly newsletter for GAP is produced to highlight any missed opportunities and required learning. Fundal height measurement and GAP training has been reinstated face to face on mandatory training day two for all trained midwives and medical staff. The clinical lead has updated and developed a new LMS pathway/guideline for management and identification of fetal growth restriction.

There was a discussion about the workforce risks and Mr Bond asked if the service was safe. Mrs Cooper advised that the main risk was around the Obstetric Consultant Workforce which was being addressed. Dr Pathak added that there was a national shortage of Obstetricians. Mrs Harrison-Mizon advised the work was being risk assessed and there was additional mutual support for Gynaecology.

8.4 Learning from Deaths, Mortality Update

Professor Purva presented the report and highlighted that the crude mortality figures were now reducing to the levels seen before the pandemic. Common clinical conditions are Pneumonia, Sepsis and Acute Cerebrovascular Diseases (Stroke).

The number of the Trust's Structured Judgement Reviews carried out was higher than the national average and work was ongoing to learn and improve where possible. Three areas of learning highlighted in the report were in Oncology, Renal and Sepsis. Prof Purva stressed the importance of learning across systems and working closely with Primary Care.

The Board discussed the importance of coding flu vaccinations and social deprivation that impacted on secondary care.

8.5 Quality Committee Summary

Mr Hall presented the report and advised that the Quality Accounts were approved and that the Committee received a presentation relating to falls and what actions were in place to reduce them.

9

Workforce Update

Mr Nearney presented the report and advised that staff absence had increased to 6% with 136 staff off with Covid.

On 7th July NHS Employers made national changes to the sickness policy and now all Covid absences would contribute to sickness records.

The vacancy rate had increased but would reduce again in September due to the nurse intake.

The Executive Team had carried out forums with staff asking what stands in the way of great care and the themes coming out of this engagement was being reviewed.

The Barratt cultural survey had been completed. Once analysed the Trust's values will be reviewed.

Mr Nearney advised that new leadership sessions would be taking place to discuss expectations for the future particularly around performance and finance.

The BAME Leadership Conference had taken place and the Zero Tolerance to Racism policy launched.

9.1 New Equality and Diversity Objectives

Mr Nearney presented the 3 new equality and diversity objectives which were:

- To work with our partners and stakeholders to improve health outcomes by developing a better understanding of the local variations in access to and experience of treatment by the Trust.
- To build an inclusive, positive environment for all staff, free from discrimination.
- To ensure our leaders have the capacity and capability to support, empower and enable staff

QR codes will be put into place so that staff can easily report any issues and get immediate support and action.

Leadership and Allyship programmes will be put into place for bands 8 and above to provide solid foundations to grow and develop the organisation.

Prof Macleod asked how the objectives would be measured as most people are not deliberately being racist but do it in ignorance. Mr Long advised that performance would be benchmarked against other Trusts and that partnership working was key.

Resolved: The Board approved the new equality and diversity objectives.

9.2 Trade Union Facility Time reporting

Mr Nearney presented the report and advised that the Trust had a duty to report what Trade Union Facility Time was being spent. The report indicated that the time spent was 0.01% which was the same as last year.

Mr Nearney advised that this was generally in line with other Trusts in the area with the exception of Northern Lincolnshire and Goole who were at 0.03%.

He added that the teams had good relationships with the Trade Union members.

Resolved: The Board approved the report for publication on the Trust's website. SN

9.3 Workforce Education and Culture Committee Summary

Prof Macleod presented the summary and advised that the main area of concern was around the Staff Survey results but there was a lot of work ongoing regarding this matter.

The Committee was also concentrating on what staff views were on working for the Trust.

9.4 Freedom to Speak Up Annual Report

Mrs Moverley presented the Annual Report 2021/22 and advised that the number of contacts had increased from 24 to 71. There were 62 stand-alone enquiries.

The top 3 types of concerns were inappropriate behaviour, bullying and HR Processes.

Mrs Moverley advised that in 2022/23 a network of FTSU Champions would be established. She added that she sat on the Circle Group who were monitoring the Zero Tolerance to Racism Policy and actions.

Mr Curry asked about the HR Processes and Mrs Moverley advised that the Managing Attendance Policy and its trigger points was an example of this issue. It had been escalated to the HR Team.

Dr Pathak asked if there were any trends of staff impacted and Mrs Moverley advised that there wasn't any particular areas and it was widespread across the Trust.

9.5 Guardian of Safe Working Report

The report had been presented to the Workforce, Education and Culture Committee and was received by the Board for assurance.

10 Performance Report

Mrs Harrison-Mizon presented the report and advised that the patients with no criteria to reside was at 150 and there was increasing Covid cases which was impacting on capacity.

The 4 hour standard performance was still challenged and YAS and the Trust had agreed a cohorting procedure using the Fracture Clinic space out of hours.

A Ground Floor pilot for new ways of working had commenced which included a consultant at the front door to undertake rapid

assessment and triage to allow patients to be streamed more efficiently. Mr Robson expressed his support for this initiative.

Dr Pathak asked when the clock started for patients on trolleys and Mrs Harrison-Mizon advised that it was now recorded as time in the department rather than time to admit.

Cancer 2ww referrals had increased but there was no significant increase in confirmed cancers.

There was focussed work being carried out around cancer patient treatment lists to improve delays in the system and increase capacity. Mr Bond asked when the improvements would be seen and Mrs Harrison-Mizon advised that it would be from September onwards. Tumour sites were being monitored and a trajectory was in place. A detailed report would be discussed at the Performance and Finance Committee.

Mrs Harrison-Mizon advised that patients waiting 104 weeks had reduced to 28 patients in June and thanked the teams for the excellent focus and work carried out. She added that the whole Trust was behind the teams achieving this.

Mr Lyons thanked the teams on behalf of the Board.

Mr Hall asked about the plans for the remaining 28 patients and Mrs Harrison-Mizon advised that there was a mix of orthodontic and very complex patients and 2 were patient choice. These patients would be monitored as part of the plan. Work was now ongoing to address patients waiting over 78 weeks and text messaging had begun to assess whether patients still needed to be treated.

10.1 Finance Report

The Trust submitted a financial plan on 28th April 22 with a £19.1m deficit. This was part of an overall Humber and North Yorkshire Health and Care Partnership ICB (HNY ICB) position of £56.2m deficit. Subsequent review of the ICB submission identified that some commissioner expenditure items needed updating and the revised ICB deficit increased to £60.8m. A large element of the Trust deficit (£14.2m) linked to expected high levels of inflation for both utilities and general non-pay costs.

HNY ICB has an indicative share of the above funding at £36.3m, reducing the planned deficit to £24.5m. The CFOs within the ICB have worked through the potential options and have agreed to submit a balanced plan with receipt of the above funding. This has been achieved by release of additional funding from within the overall ICS position and further use of technical flexibilities. It is recognised that some of these assumptions may be challenging and will need further work (for example £3m assumption on Commissioner Independent Sector baselines, transfer of funding between different ICBs).

Once the non-recurrent items have been added back into the plan the 2022/23 underlying position is £41.4m. The Trust will need to develop a recurrent CRES plan for £17.3m.

Risks to the plan are car-parking, catering and unidentified CRES.

The reported capital position at month 2 is gross capital expenditure of £0.96m against a plan of £1.91m. The main shortfall on expenditure is due to delays on the Day Surgery Unit, resulting in spend being below plan. The other main items of expenditure are backlog maintenance and PFI lifecycle costs.

Stock levels are at £16.0m, an increase of £0.1m since year-end.

10.2 Performance and Finance Summary

Mr Robson reported that limited assurance had been given to all aspects of the performance and finance items. Mrs Rostron asked why the BAF had been given limited assurance and it was agreed that this should be changed to reasonable as it was for the BAF process and not the performance within it.

Action: BAF assurance to be changed to reasonable.

RT

Mr Robson advised that he had gained further assurance by attending the Top 12 Elective Recovery Group and seeing the wider view of actions being taken.

11 Questions from the public

There were no questions asked from members of the public

12 Any Other Business

There was no other business discussed.

13 Date and time of the next meeting:

Tuesday 13 September 2022, 9.00am – 12.00pm

Item	Sponsor	Lead	Jan	Mar	May	EO June	Jul	Sept	Nov	Frequency	Purpose of the report	Considered by another Committee	Why is this report required to go to Trust Board	Action
Opening Items														
Declarations of Interest	Chair	Chair	✓	✓	✓	✓	✓	✓	✓	Every Board Meeting	To declare any interests the Board may have	No	Statutory	Nothing
Minutes of the last meeting	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure an accurate record of the meeting is kept	No	Statutory	Nothing
Action Tracker	Chair	Chair	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure actions are completed	No	Statutory	Nothing
Trust Board work programme	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To ensure all statutory items are received	No	Statutory	Nothing
Trust Board Development Framework	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To apprise the Board of future Development sessions	No	Statutory	Nothing
Chief Executive Briefing	Chief Executive	Chief Executive	✓	✓	✓		✓	✓	✓	Every Board Meeting	To update Board members on Trustwide matters	No	The report covers a wider remit of what is happening around the Trust and the wider health economy	Nothing
Regulatory, Compliance and Corporate Governance														
Board Assurance Framework and Corporate Risk Register	Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓		✓	Three times per year	To receive assurance in relation to the management and mitigation of the risks as appropriate and that the BAF remains reflective of the current risks to the achievement of the strategic objectives	Quality/Workforce, Education and Culture/Performance and Finance on a quarterly basis		
Trust Annual Report including Annual Governance Statement and Quality Accounts	Director of Quality Governance	Head of Corporate Affairs				✓				Annually	To seek approval of the Annual Report	Audit Committee	The Trust is required to publish an Annual Report	Approval
Trust Annual Accounts including Going Concern Review and Audit Letter	Chief Financial Officer	Deputy Director of Finance				✓				Annually	To adopt the Annual Accounts	Audit Committee	The Trust is required to adopt and publish the Annual Accounts	Approval
Audit Committee Annual Report	Audit Chair	Head of Corporate Affairs			✓					Annually	To provide assurance to the Trust Board that the Audit Committee is functioning in accordance with its Terms of Reference and in line with the requirements of the NHS Audit Committee Handbook	Audit Committee	In line with the requirements of the Audit Committee Handbook and contributes to the Annual Governance Statement	Approval
Audit Committee summary and minutes	Director of Quality Governance	Head of Corporate Affairs		✓	✓			✓	✓	4 times per year	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Standing Orders	Director of Quality Governance	Head of Corporate Affairs					✓			Every Board Meeting	The report sets out the usage of the common seal of the Trust during the year and is provided for noting	No	Affixation is governed by the Trust's Standing Orders which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board	Noting
Care Quality Commission Registration Report	Director of Quality Governance	Head of Effectiveness and Improvement						✓		Annually	To provide and update on the Trusts current CQC Registration status and outline changes proposed to the system of statutory regulation	Executive Team Meeting	Compliance with the proposed fundamental standards of safety and quality	Assurance
Code of Business Conduct	Director of Quality Governance	Head of Corporate Affairs	✓							Annually	To seek commitment from the Trust Board on an individual and collective basis to comply with the provision of the Code of Conduct and Statement of Responsibilities for the Board of Directors	No	The document demonstrates the Trust's commitment to embedding world class governance and compliance with statutory requirements	Approval
Forward Work Programme	Director of Quality Governance	Head of Corporate Affairs		✓						Annually	To review and support the annual programme of work	No	To approve the annual programme of work	Approval

Timetable of Board and Committee Meetings	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To approve the annual timetable of Board and Committee meetings for the year ahead	No	As part of the overall governance structure for the organisation	Approval
EPRR Self-Assessment Assurance and Annual Report	Director of Strategy and Planning	AD of Strategy and Planning						✓		Annually	To identify the current status of EPRR within the Trust and present the workplan to ensure full compliance within the year	Emergency Planning Steering Group	It is a requirement that the report received executive support and is approved by the Trust Board	Approval
Health and Safety Annual Report and work programme	Director of Quality Governance	Head of Health and Safety			✓					Annually	To provide assurance given the overall responsibility of the Trust Board for Health and Safety and the potential individual and corporate consequences of health and safety breaches	Health and Safety Committee	The Trust Board has overall responsibility for Health and Safety	Approval
Information Governance Toolkit Submission	Director of Quality Governance	Head of Corporate Affairs						✓		Annually	For the Trust Board to approve the annual submission of the Information Governance Toolkit	IG Committee	IG is a key component of the Trust's governance framework	Approval
Register of Gifts and Interests Annual Update	Director of Quality Governance	Head of Corporate Affairs						✓		Annually	To present the register of interests and gifts and hospitality to the Board for approval	Audit Committee	The Trust is required to hold and maintain a register of interests and a register of gifts and hospitality for public inspection	Approval
Freedom to Speak Up	Director of Quality Governance	Head of Freedom to Speak Up			✓				✓	Twice per year	To provide thematic reporting to the Board on the themes and issues that are being reported to the FTSUG	Workforce, Education and Culture Committee	Expectation for all Boards to have a FTSUG following the Francis report.	Assurance
Trust Self-Certification	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To receive assurance	No	To receive assurance	Assurance
Fit and Proper Persons Test	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5 of the Care Quality Commission fundamental standards	No	To provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5	Assurance
Review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation	Director of Quality Governance	Head of Corporate Affairs						✓		Annually	To present proposed amendments to the Standing Orders, Standing Financial Instructions and the Scheme of Delegation	Audit Committee	The document is the Trust's core corporate governance and describes how the Trust Board will conduct its business	Approval
Statement of Elimination of Mixed Sex Accommodation	Director of Quality Governance	Head of Corporate Affairs			✓					Annually	To provide assurance that there have been no MSA breaches	No	To provide assurance to the Board	Assurance
Patient Experience														
Patient Experience Quarterly Report	Chief Nurse	Assistant Chief Nurse	✓		✓		✓		✓	Quarterly	To highlight compliments, complaints, PALs, patient feedback and involvement	Patient Experience	Ensures the Trust Board has oversight of good practice and improvement areas	Assurance
Safeguarding Children and Vulnerable Adults Report	Chief Nurse	Assistant Chief Nurse						✓		Twice per year	To update the Board on Safeguarding activity, issues and risks	Safeguarding	To provide assurance to the Board	Assurance
National Patient Survey	Chief Nurse	Assistant Chief Nurse								Annually	To update the Board of patients views of healthcare experiences	Patient Experience	To provide assurance to the Board	Assurance
Patient Story	Chief Medical Officer	Chief Medical Officer	✓	✓	✓		✓	✓	✓	Every Board Meeting	To highlight patient experience from the patient	No	To align the Trust's values and behaviours	Nothing
Performance														
Integrated Performance Report	Director of Quality Governance	All	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Quality/Workforce, Education and Culture/Performance and Finance on a monthly basis	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Performance Report	Chief Operating Officer	AD of Operations	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Performance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance

Finance Report	Chief Financial Officer	Deputy Director of Finance	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key performance indicators	Performance and Finance Committee	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Covid-19 Recovery Report	Director of Strategy and Planning	AD Strategy and Planning	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on Covid-19 recovery plans	No	To update the Board regarding Covid-19 planning and activity	Assurance
Summary and minutes from the Performance and Finance Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Performance and Finance Committee	As part of overall governance of the Trust	Assurance
Quality														
Quality Report	Chief Nurse/Chief Medical Officer/Director of Quality Governance	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key quality indicators	Quality Committee	The Trust has an obligation to meet operational, financial and contractual targets, including SIs and Never Events	Assurance
Summary and minutes from the Quality Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	Quality Committee	As part of overall governance of the Trust	Assurance
IPC BAF	Chief Nurse	Director of Infection Prevention and Control	✓				✓			Twice per year	To provide an update on the Trust's Infection Prevention and Control activities and information on actions in place	Quality Committee	To provide assurance to the Board	Assurance
Infection Prevention and Control Annual Report and workplan	Chief Nurse	Director of Infection Prevention and Control					✓			Annually	To provide an update on the Trust's Infection Prevention and Control activities and information on actions in place	Infection Reduction Committee	To provide assurance to the Board	Assurance
Medical Revalidation and Appraisal Update	Chief Medical Officer	Senior E-Medical Workforce Officer						✓		Annually	Provides an update on Medical Appraisal and Revalidation within the Trust		Statutory obligation	Assurance
Mortality (SHMI and HSMR) update	Chief Medical Officer	Associate Chief Medical Officer			✓			✓		Twice per year	To monitor the Trust's mortality performance	Mortality and Morbidity Committee/Quality Committee	National Requirement to report mortality to the Trust Board	Assurance
End of Life Care Annual Report	Chief Nurse							✓		Annually	To update the Board on End of Life Care	End of Life Committee	To provide assurance around progress	Assurance
Complaints Annual Report	Chief Nurse	Assistant Chief Nurse						✓		Annually	To provide assurance on key work undertaken by the Patient Experience Team around the management of complaints	Quality Committee	To provide the Board with oversight of the Complaints	Assurance
Cancer Services Annual Report	Chief Operating Officer	Cancer Manager							✓	Annually	To provide assurance of the actions that have been taken to demonstrate improved performance against delivery of the cancer standards to improve patient outcomes and provide a positive experience	Cancer Board	To provide assurance regarding Cancer Services and performance	Assurance
Midwife Staffing Annual Report	Chief Nurse	Head of Midwifery					✓			Annually	To advise the board of the work undertaken over the year and measures in place to ensure safe midwifery staffing	Quality Committee	To provide assurance to the Board that measures are in place to ensure safe staffing for midwifery	Assurance
Guardian of Safe Working Report	Chief Medical Officer	Guardian of Safe Working	✓		✓		✓		✓	Annually	To demonstrate the work carried out to manage safe working hours for doctors	Workforce, Education and Culture Committee	To provide assurance around safe working compliance	Assurance
Summary and minutes from the Ethics Committee	Chair of Committee	Head of Corporate Affairs								If the Committee meets	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Workforce														
Staff Overview Report (Including Nurse Staffing)	Director of Workforce and OD	Deputy Chief Nurse	✓	✓	✓		✓	✓	✓	Every Board Meeting	To inform the Board of the performance against the key workforce indicators	No	The Trust has an obligation to meet operational, financial and contractual targets	Assurance
Summary and minutes from the Workforce, Education and Culture Committee	Chair of Committee	Head of Corporate Affairs	✓	✓	✓		✓	✓	✓	Every Board Meeting	To provide assurance on key work of Board-Committee and escalate matters as appropriate	No	As part of overall governance of the Trust	Assurance
Equality and Diversity Annual Report	Director of Workforce and OD	Head of HR						✓		Annually	To inform the Board of the work of Equality and Diversity throughout the Trust	Workforce, Education and Culture Committee	Equality Act 2010 - progress against eliminating discrimination	Assurance

Staff Survey	Director of Workforce and OD	Director of Communications								Annually	To inform the Board of the Staff Survey results	Workforce, Education and Culture Committee		Assurance
Modern Slavery Statement	Director of Workforce and OD	Head of HR						✓		Annually	The Board to approve the Modern Slavery Statement for publication on the Trust's website	Workforce, Education and Culture Committee	As part of overall governance of the Trust	Assurance
Workforce Disability Equality Standard	Director of Workforce and OD	Head of HR						✓		Annually	To approve progress against the action plan developed to support the WDES reporting template	Workforce, Education and Culture Committee	To ensure disabled staff have equal access to career opportunities and receive fair treatment in the workplace	Assurance
Workforce Race Equality Standard	Director of Workforce and OD	Head of HR						✓		Annually	To approve progress against the action plan developed to support the WRES reporting template	Workforce, Education and Culture Committee	To ensure BAME staff have equal access to career opportunities and receive fair treatment in the workplace	Assurance

Strategy and Planning

Trust Strategy	Director of Strategy and Planning	AD of Strategy and Planning												
Update Digital Strategy	Chief Information Officer	Director of IM&T						✓		Annually	To provide and update to the Board regarding improvements within the IM&T infrastructure	Non-Clinical Quality Committee	Efficient IT infrastructure is critical to delivering high quality clinical care, patient safety and experience and staff access to essential information	Assurance
Operating Framework - Performance and Finance	Director of Strategy and Planning	AD of Strategy and Planning						✓		Annually	To approve the strategy and updates	Performance and Finance	The framework sets out the Trust's performance and finance targets	None
Capital Planning	Chief Financial Officer	Deputy Director of Finance						✓		Annually	To approve the strategy and updates	Performance and Finance Committee	To inform the Board of the annual capital plan	Approval
Winter Planning	Director of Strategy and Planning	AD of Strategy and Planning							✓	Annually	To approve the strategy and updates	Performance and Finance Committee	To inform the Board of the annual winter plan	Approval
Equality, Diversity and Inclusion Strategy	Director of Workforce and OD	Head of HR							✓	Annually	To approve the strategy and updates	Workforce, Education and Culture Committee	The Strategy articulates the Trust's commitment to Equality, Diversity and Inclusion	Approval
People Strategy	Director of Workforce and OD	Head of HR							✓	Annually	To approve the strategy and updates	Workforce, Education and Culture Committee	The Strategy articulates investment in the workforce, through training and development to improve the quality of leaders	Approval
Estates Strategy	Director of Estates and Facilities	Director of Estates and Facilities							✓	Annually	To approve the strategy and updates	Performance and Finance Committee	The Strategy sets out the Trust plans for the estates, facilities and IM&T services	Approval
Clinical Strategy	ICS	Director of Strategy and Planning								Annually	To approve the strategy and updates	Quality Committee	The Clinical Strategy articulates the organisational vision and aims and the desired model of delivery of healthcare	Approval
Quality Strategy	Director of Quality Governance	Associate Director of Quality	✓							Annually	To approve the strategy and updates	Quality Committee	The Quality Strategy sets out the Quality Improvements to ensure high quality care for patients	Approval
Risk Management Strategy	Director of Quality Governance	Head of Corporate Affairs	✓							Annually	To approve the strategy and updates	Operational Risk and Compliance	The Risk Strategy sets out the Risk Management Improvements to ensure risk management is embedded across the organisation	Approval

Research and Innovation

Research and Innovation Strategy	Chief Medical Officer	Director of Research and Innovation			✓					Annually	To approve the strategy and updates	Quality Committee	The Research and Innovation strategy sets out how the service will increase research activities, attract talent, integrate with clinical care and increase collaboration with partners	Approval
Research and Innovation Annual Report	Chief Medical Officer	Director of Research and Innovation			✓					Annually	To provide annual assurance to the Board of the work carried out relating to Research and Innovation	Quality Committee	To inform the Board of the work carried out by the Research and Innovation Team	Assurance

Hull University Teaching Hospitals NHS Trust Board Development Programme 2022/23

Overarching aims:

- The Board to focus on the vision, values and goals of the Trust in all that it does
- The Board to provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2023

Board Development Dates 2022/23	Strategy Refresh	Honest, caring and accountable culture	Valued, skilled and sufficient workforce	High quality care	Great clinical services	Partnership and integrated services	Research and innovation	Financial sustainability	Other
7 June 2022				BAF 3.2 – Patient Harm/Recovery	BAF 4: Risks to recovery plan				Staff Survey
9 August 2022		BAF 1: Board Leadership/ Leadership and culture		Learning from Deaths – SJR Review		BAF 5: Risk that the HCAV and Integrated Care System is not able to collectively make progress on developing and delivering integration due to Covid recovery			CQC – Quality Risk Profile
11 October 2022	Strategic drivers/balanced scorecard review			BAF 3.1: Risk that the Trust is not able to make progress in continuously improving quality	Health Inequalities				Patient Safety
13 December 2022							BAF 6: Research and Innovation		IPC End of Life Care
14 February 2023			BAF 2: Valued, skilled and sufficient workforce					BAF 7: Financial Sustainability	

Principles for the Board Development Framework

Key framework areas for development (The Healthy NHS Board 2013, NHS Leadership Academy) looks at both the roles and building blocks for a healthy board.

Overarching aim:

- The Board to be focussed on the Vision, Values and Goals of the Trust in all that it does
- To provide strategic direction and leadership for the Trust to be rated as 'outstanding' by 2021-22

Area 1 – High Performing Board

- Do we understand what a high performing board looks like?
- Is there a clear alignment and a shared view on the Trust Board's common purpose?
- Is there an understanding the impact the Trust Board has on the success of the organisation?

- Do we use the skills and strengths we bring in service of the Trust's purpose?
- How can we stop any deterioration in our conversations and ensure we continually improve them?

- How can we build further resilience, trust and honesty into our relationships?
Does the Trust Board understand the trajectory that it is on and the journey needed to move from its current position to an outstanding-rated Trust?
- What is required in Trust Board leadership to contribute to an 'outstanding'-rated Trust?

Our recent cultural survey (Barrett Values) gave us a clear blueprint of the culture that our staff desire. This is also embedded within our Trust Values and Staff Charter defining the behaviours we expect from everyone in order to have a culture that delivers outstanding patient care

- Is this reflected at Trust Board level? Do Trust Board members act as consistent role-models for these values and behaviours?

- What else is needed at Trust Board level in respect of behaviours? Towards each other? To other staff in the organisation?

Area 2 – Strategy Development

Strategy refresh commenced

- Outcome: for the Trust Board to have shared understanding and ownership of the Trust's strategy and supporting strategic plans, and oversee delivery of these, to be rated 'outstanding' by 2021-22
- What is the role of the Trust in the communities it serves? What is the Trust Board's role in public engagement?

- How does the Trust Board discharge its public accountability?
- To link this to Area 4 (exceptions and knowledge development) as needed

Area 3 – Looking Outward/Board education

Providing opportunity for Board development using external visits and external speakers, to provide additional knowledge, openness to challenge and support for the Board's development and trajectory

- Outcome: to provide opportunities for Board knowledge development as well as opportunities for the Board to be constructively challenged and underlying working assumptions to be challenged
- To provide an external focus to the Board not just for development but also to address the inward-facing perception reported by the Board itself as well as by the CQC

Area 4 – Deep Dive and exceptions

Internal exceptions that require Board discussion and knowledge development and ownership of issues, as they relate to the Trust's vision and delivery of the strategic goals

- Outcome: Board to challenge internal exceptions
- Board to confirm its risk appetite against achievement of the strategic goals and the over-arching aim of becoming high-performing Trust Board and 'outstanding' rated organisation by 2021-22

**Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (September 2022)**

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
July 2022						
01.07	Board Work Programme	Health Inequalities to be added to the Board Development programme	RT	October 2022		On programme
02.07	Covid Update	Winter pressures to be discussed at August Board Development session	RT	August 2022		Discussed
03.07	Board and Committee Review	Board and Committees to be removed from January/August 2023 – Terms of reference to be changed	RT	November 2022		
04.07	Trade Union Facility Time reporting	Approved reported to be published on the Trust's website	SN	July 2022		
05.07	Performance and Finance Summary	BAF assurance to be changed to reasonable	RT	July 2022		
COMPLETED						
01.05	BAF	Capital risk to be reviewed at PAF	LB/RT	June 2022		Short term risk now on Corporate Risk Register
02.05	R&I Annual Report	Board Development Session to be arranged	RT	Dec 2022		On the workplan
03.05	PAF	SM to review the NED flash report	SM	July 2022		

Actions referred to other Committees

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT

Hull University Teaching Hospitals NHS Trust

Trust Board

13th SEPTEMBER 2022

Title:	Chief Executive Report
Responsible Director:	Chief Executive – Chris Long
Author:	Chief Executive – Chris Long

Purpose:	Inform the Board of key news items during the previous month and media coverage.	
BAF Risk:	N/A	
Strategic Goals:	Honest, caring and accountable culture	✓
	Valued, skilled and sufficient staff	✓
	High quality care	✓
	Great clinical services	
	Partnership and integrated services	✓
	Research and Innovation	✓
	Financial sustainability	
Key Summary of Issues:	Lung health checks, waiting well service, national award nomination, honorary degree for Trust professor.	

Recommendation:	That the board note significant communications items for the Trust and media coverage
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Hull University Teaching Hospitals NHS Trust

Chief Executive's Report

Trust Board 13 SEPTEMBER 2022

Communications strategic objective:

To support the Trust's mission statement, which is: "to be a provider of outstanding treatment and care and contribute to improved population health, by being a great employer and partner, living our values and using resources wisely"

Priority areas 2021-2025:

- Compassionate care of patients and staff
- Equality, diversity and inclusion
- Research, development and innovation
- Sustainability – Zero30

1. KEY MESSAGES FROM JULY/AUGUST 2022

COMPASSIONATE CARE

Staff Team up to Support Ukrainian Children

Staff working at Castle Hill Hospital in Cottingham have teamed up to support disabled children evacuated from the conflict in Ukraine.

Dr Andrzej Frygier, a specialty trainee in haematology, and Lee Ellerker, an engineer who sub-contracts with Hull University Teaching Hospitals NHS Trust, have been working together to raise money and send aid to support over 60 children at a Polish orphanage since April this year.

Ex-military veteran and former UN worker Lee began taking goods and supplies out to refugees at the Polish border at the start of this year as part of the Hull 4 Ukraine effort. Andrzej has also been volunteering his medical skills on regular trips back to his native Poland since the war began.

The aid will support 62 children, some as young as eight and many with severe disabilities, who are struggling to cope with the mental and physical effects of the conflict. A further 30 children are expected to join them soon.

Andrzej has supported the children's medical care from his own monies and with support from colleagues at the Queen's Centre for Oncology & Haematology at Castle Hill Hospital, who have helped him and Lee raise over £2,000 so far to pay for blood tests, personal care and nutrition.

New Service Keeps Patients Well While They Wait

Patients from Hull who are waiting to be treated for heart problems are being offered access to a unique service to support their wellbeing while they wait.

Our Trust has teamed up with Forum to offer the 'Waiting Well' programme to almost 80 people waiting for cardiology appointments. The programme invites patients to take part in activities such as walking or gentle games of football to help maintain their physical health.

Some well-known names in the East Yorkshire health community, such as Tigers Trust, Fitmums and Friends, Hull KR and Hull FC, will be working to deliver group exercise and social activity sessions as part of the Waiting Well project.

Funded by Hull City Council, the Waiting Well programme is open to all eligible patients living within Hull. The nature of the activities have been designed with the specific needs of cardiology patients in mind and will be provided entirely free of charge. There will be general group sessions on offer including football, walking and exercise classes, plus a number of activities aimed at particular groups such as the over 50s and women only, some with childcare included.

Eligible patients have been receiving letters inviting them to take part in the 'Waiting Well – Cardiology' pilot during July.

Lung Health Checks Move to East Hull

A high-tech mobile screening unit, which is helping to save lives through earlier diagnosis of lung cancer and other conditions, has moved to East Hull.

The NHS Targeted Lung Health Check Programme invites past and current smokers aged between 55 and 74 who live in Hull and are registered with a Hull GP to a free lung health check, to identify potential lung problems early so effective and early treatment can be provided.

The unit's relocation from North Hull to Morrisons supermarket on Holderness Road will see approximately 10,000 people in East Hull invited for a lung health check within their local community.

The NHS Targeted Lung Health Check Programme supports the [NHS Long Term Plan](#) ambition of detecting more cancers at an earlier stage when they are easier to treat. Thousands of people have been invited for a lung health check since the programme launched in Hull in January 2020, with around 10,500 assessments and 7,000 scans carried out during this time. In the small percentage where cancer is detected, many have been found at an earlier stage, which is likely to result in better outcomes for the patient.

The lung health check takes place in two stages. The first is an initial phone assessment with a specially trained respiratory nurse. If the assessment finds the person to be at high risk, they will be offered a low dose CT scan of the lungs for further investigation at the mobile unit. Those eligible for a lung health check in East Hull receive an invite from their GP over the coming weeks urging them to take up the offer.

ZERO30

Zero30 In The Running For A National Award

Our Trust is in the running for a prestigious national award based on our efforts to reduce carbon emissions and promote sustainability.

We are one of nine organisations to be shortlisted this week in the 'Towards Net Zero' category of the Health Service Journal Awards 2022.

The Trust has made a bold commitment to achieve net zero by 2030, seeking to become carbon neutral up to 15 years earlier than the targets set by the Department of Health.

The Trust has already made some significant progress towards this aim, such as the replacement of its gas boilers with heat pumps, replacement of some 20,000 traditional light fittings with low energy versions, a reduction in the use of gases such as Entonox, and the creation of Castle Hill Hospital's 'Field of Dreams'; an 11,000 panel solar farm which currently generates enough power to meet the daytime needs of the entire hospital site.

Our Sustainability Team must present its case to the HSJ judging panel in October, before winners are revealed at a special awards ceremony in mid November.

Sheep Are Welcomed Onto Solar Field

The team looking after the solar field at Castle Hill has come up with an innovative way of cutting the grass around the panels.

Thanks to a local shepherding family, they've found the perfect green solution; a flock of 51 hungry sheep. Several breeds including Beltex and Blue Texel are now happily munching away in Field A, which lies adjacent to Castle Road and the A164. The flock is helping to control the growth of grasses and other wildflowers sown on the field when construction finished in February this year.

The sheep are secured within the field with plenty of space to roam, while 21 rows of solar panels and the surrounding trees provide plenty of shade to cool down when the weather gets hot. They are checked on twice a day to make sure they're all okay. And there's no risk of supply cables being nibbled either; the panels are mounted high enough to be out of reach of curious faces and the cables are protected in hard plastic as they reach the ground to keep both the solar farm and its occupants safe.

RESEARCH DEVELOPMENT AND INNOVATION

Honorary Degree for Professor Andy Beavis

Many congratulations to Professor Andy Beavis our consultant medical physicist who was presented with an honorary degree by the University of Hull this month.

A former pupil at Longcroft School in Beverley, Professor Beavis was put forward for the Degree of Doctor of Science, *honoris causa*, by the University of Hull's Dr David Richards.

Dr Richards' nomination described how Andy has excelled throughout his career after discovering his passion and abilities in both physics and maths at a young age. Andy joined Hull University Teaching Hospitals NHS Trust as a clinical scientist in 1992. He progressed through the ranks and eventually took on the role of Head of Radiation Physics at Castle Hill Hospital in 2007.

He is a member of the National Radiotherapy Programme Board, influencing national policy, playing a key role in the future direction of radiotherapy treatment, and helping to establish a £23m Radiotherapy Innovation Fund to modernise radiotherapy throughout the UK.

In 2007 he became co-founder and Chief Scientific Officer of **Vertual Ltd**, a spin off enterprise with colleagues from the University of Hull which uses virtual reality (VR) to train radiotherapy professionals. The system is now in over 160 installations in over 30 countries around the world, helping to shape how care is delivered to millions of people with cancer.

2. MEDIA/SOCIAL MEDIA ACTIVITY

In July 2022 there were 45 articles published about the Trust:

- 29 positive (64%)
- 3 factual (7%)
- 8 negative (18%)
- 5 neutral (11%)

Most negative coverage related to A&E waiting times and ambulance handovers.

Social media

Facebook

Total “reach” for Facebook posts on all Trust pages in July – 237,549

- Hull Women and Children’s Hospital – 78,204
- Castle Hill Hospital – 68,631
- HEY Jobs page – 7,243
- Hull Royal Infirmary – 69,754
- Hull University Teaching Hospitals NHS Trust – 13,717

Twitter @HullHospitals

- 80,200 impressions in July 2022
- 10,287 followers
- Tweets with highest number of impressions related to two ACPs being credentialed by the Royal College of Emergency Medicine and the Trust’s health stand at the Pride in Hull event.

In August there were 17 articles published about the Trust:

- 11 positive (65%)
- 0 factual (0%)
- 5 negative (29%)
- 1 neutral (6%)

Most negative coverage related to ambulance waiting times and hospital visiting policy.

Social media

Facebook

Total “reach” for Facebook posts on all Trust pages in August – 298,612

- Hull Women and Children’s Hospital – 69,186
- Castle Hill Hospital – 56,631
- HEY Jobs page – 23,480
- Hull Royal Infirmary – 127,930

Twitter @HullHospitals

- 65,800 impressions in August 2022
- 10,362 followers
- Tweets with highest number of impressions related to our solar field and shortlisting in several categories for this year's HSJ Awards.

**Report to the Board in Public
Audit Committee July 2022**

Item: External Audit Report	Level of assurance gained: Reasonable
Work was ongoing to complete the annual audit. This would be shared with Committee members once finalised. Mazars were not expecting any significant weaknesses or issues.	
Item: Internal Audit – Junior Doctors Rotas	Level of assurance gained: Limited
Following the audit a comprehensive form had been put into place and processes made more robust. An update regarding the rotas to be received at the November Audit Committee.	
Item: Internal Audit – Waiting List Initiative	Level of assurance gained: Reasonable
In the majority of areas forms are correctly completed and rates could be different due to a points system used in some areas. There was a discussion around standardising rates across the ICS.	
Item: Internal Audit – Linen Contract	Level of assurance gained: Partial
Guidance has been issued to the teams regarding signing off contracts and conflicts of interest. Information regarding conflicts of interest to be added to the quarterly declaration email.	
Item: Counter Fraud Progress/Annual Report	Level of assurance gained: Reasonable
A summary of the work carried out was reported and this included ID verification training, an ethical phishing exercise, conflicts of interest during tendering with sub-contractors and bank staff payment arrangements.	
Item: Review of Credit Card spending	Level of assurance gained: Reasonable
The Committee reviewed the Q1 expenditure and there were no issues to raise. Different ways of purchasing IT equipment was being reviewed and the charity expenditure would be re-charged.	
Item: Review of Debts >£50k and over 3 months old	Level of assurance gained: Reasonable
No issues raised at the Committee. Each of the 4 debts were in hand and due to be settled in the near future.	
Item: National Cost Collection	Level of assurance gained: Reasonable
The 2020/21 return had been submitted in September 2021 and the results had been received 27 th July 2022. There were data quality issues across the NHS and In 2019/20 and 2018/19 HUTH's indices were 92 and 95, respectively. These show that the trust provides care at lower than national average cost. The results from the 2021/22 return would be shared with the Committee once received.	
Item: Board Assurance Framework	Level of assurance gained: Substantial
The process for the BAF was presented. The Board had agreed its 2022/23 risks in July and the Board Committees were discussing the BAF risks as part of the agendas. The process was working well with good engagement from Board members	

**Report to the Board in Public
Charitable Funds Committee August 2022**

Item: Financial Report including Fund Balances	Level of assurance gained: Reasonable
<p>The financial report and balance was provided to the committee the funds continue to decrease as income has been diverted to the WISH charity, only investment movement and charges noted. The £2m Allam donation is expected shortly which will be repaid to the hospital as per agreement.</p> <p>Year end accounts have not yet been completed due to the finance systems being taken off line due to a cyber attack, these will be completed once the systems restored.</p> <p>No risks were highlighted with the remaining balance.</p>	
Item: Project Director's Report	Level of assurance gained: Reasonable
<p>The committee received a comprehensive overview and update on various fundraising and related charitably funded activities.</p> <ul style="list-style-type: none">• Molecular Imaging Research Centre And Radiopharmacy• Pet/Ct Scanning Capacity• Hospital Arts Strategy <p>The Project Director of Fundraising also provided an update on existing benefactor funded developments.</p> <ul style="list-style-type: none">• Allam Diabetes Centre – Hull Royal Infirmary• Endoscopy/Digestive Diseases Development – Castle Hill Hospital• Twin Robotic Theatre – Castle Hill Hospital	
Item: Legacy Update	Level of assurance gained: Reasonable
<p>The committee received an update on the current position in respect of legacies and actions being taken to manage down balances held within the General Purposes funds and the next steps.</p> <p>The committee approved the following;</p> <ul style="list-style-type: none">• Updated authorised signature list for bank mandates• Spending Proposal – BARD Ultrasound System	

Hull University Teaching Hospitals NHS Trust

Agenda Item	Meeting	Trust Board	Meeting Date	13.09.22
Title	Standing Orders			
Lead Director	Suzanne Rostron, Director of Quality Governance			
Author	Rebecca Thompson, Head of Corporate Affairs			
Report previously considered by (date)	The report was previously considered at the May 2022 Trust Board			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	✓	Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	
Assurance		Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	✓

Key Recommendations to be considered:
<p>The Trust Board is requested to:</p> <ul style="list-style-type: none"> • Authorise the use of the Trust's seal • Approve the change to the Scheme of Delegation as detailed above. • Approve the updated Standing Orders including the updated OJEU thresholds.

Hull University Teaching Hospitals NHS Trust

Trust Board

Standing Orders September 2022

1 Purpose of the Report

To approve those matters reserved to the Trust Board in accordance with the Trust's Standing Orders and Standing Financial Instructions.

2 Approval of signing and sealing of documents

The Trust Board is requested to authorise the use of the Trust seal as follows: This paper summarises all use of the Trust seal since September 2022.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2022/12	HUTH and Lloyds Pharmacy Ltd – Lease agreement for Pharmacy Units at Hull Royal Infirmary and Castle Hill Hospital	04/07/22	Suzanne Rostron, Director of Quality Governance
2022/13	HUTH and Martin Patrick May, John Ingram May, Keith Ingram May – Deed of surrender re: Farm business tenancy regarding the land South of Castle Road, Cottingham	04/07/22	Suzanne Rostron, Director of Quality Governance and Lee Bond, Chief Financial Officer
2022/14	HUTH and Martin Patrick May, John Ingram May, Keith Ingram May – Deed of surrender re: to the playing fields to the land South of Castle Road, Cottingham. TA2319174	04/07/22	Suzanne Rostron, Director of Quality Governance and Lee Bond, Chief Financial Officer
2022/15	HUTH and Helix Construction Management Services – fit out of ICU, Hull Royal Infirmary x 2	05/07/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/15.1	HUTH and Leisure Technique Ltd, Saltgrounds Road, Brough – Fit out of ward 37, Hull Royal Infirmary x 2	05/07/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/16	HUTH and Northern Powergrid (Yorkshire) PLC – Lease – sub station accommodation and easements at Castle Hill Hospital, Castle Road, Cottingham	26/07/22	Suzanne Rostron, Director of Quality Governance and Chris Long, Chief Executive Officer
2022/17	HUTH and IPM Personal Pension Trustee's Ltd – Counterpart lease related to Unit D, Venture Business Park, Witty Street	08/08/22	Suzanne Rostron, Director of Quality Governance and Chris Long, Chief Executive Officer
2022/18	HUTH and Hull and East Yorkshire Medical Research Centre (The Daisy Appeal) – Development agreement for lease and underlease in respect of the construction and letting of premises known as the new	18/08/22	Chris Long, Chief Executive Officer and Ellen Ryabov, Chief Operating Officer

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
	Cyclotron and radio-pharmacy facility at CHH		
2022/19	HUTH and Roger Waudby, John Kemp, George Hinchcliffe and Angela Waudby – Lease relating to: premises known as two sports fields at the former De La Pole Hospital Land	24/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/20	HUTH and Leisure Technique Ltd, Saltgrounds work, Brough – CT4 Refurbishment, HRI	24/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/21	HUTH and Helix Construction Management Services – GF West – Phase 3 (Old Pharmacy into EAU, Hull Royal Infirmary)	24/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/22	HUTH and Leisure Technique Ltd, Saltgrounds Work, Brough – Front Entrance enabling works	24/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/23	HUTH and IPM Personal Pension Trustees Ltd – Counterpart lease relating Unit D Venture Business Park, Witty Street, Hull	25/08/22	Chris Long, Chief Executive Officer and Ellen Ryabov, Chief Operating Officer
2022/24	HUTH and Capsticks – Licence for alterations (minor works) relating to Pharmacy unit at Hull Royal Infirmary, Anlaby Road, Hull	25/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/25	HUTH and Lloyds Pharmacy Ltd – Lease relating to Pharmacy Unit, the front entrance, Hull Royal Infirmary, Anlaby Road, Hull	25/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer
2022/26	HUTH and Lloyds Pharmacy Ltd – Lease relating to Pharmacy Unit, Queens Centre, Castle Hill Hospital, Cottingham	25/08/22	Chris Long, Chief Executive Officer and Lee Bond, Chief Financial Officer

3 Scheme of Delegation

The Trust Board is asked to consider the updated Scheme of Delegation attached. The change highlighted is to add the Chief Financial Officer to enable authorisation of CNST invoices from NHS Resolution up to the value of £2.5m. This change will required authorisation by the Board as well and the Chairman and Chief Executive signatures.

4 Standing Orders and Standing Financial Instructions

There has been a slight change to Standing Orders to update the Official Journal of the European Union (OJEU) thresholds. These have been confirmed with the Head of Procurement. The Board is asked to approve this change. Once approved the updated document will be added to the Trust Website and Pattie.

5 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal
- Approve the change to the Scheme of Delegation as detailed above.
- Approve the updated Standing Orders including the updated OJEU thresholds.

Rebecca Thompson
Head of Corporate Affairs
September 2022

Hull University Teaching Hospitals NHS Trust
Financial Scheme of Delegation (made under CP105 Standing Orders)

The attached financial scheme of delegation and authorisation procedure for revenue expenditure, capital expenditure and tenders has been approved by the Chief Executive and the Chairman.

.....
Christopher Long
Chief Executive

.....
Sean Lyons
Chairman

Date signed

Version control

The current version of this Financial Scheme of Delegation will be the version published on Pattie and available to all staff. This Financial Scheme of Delegation is a sub-set of the Trust's Standing Orders and Standing Financial Instructions and is delegated by the Trust Board. As such, updates and amendments require signature by the Chief Executive and Chairman and will be received at the next meeting of the Audit Committee for good governance. The Head of Corporate Affairs will work with the Chief Executive to enact the publication of the Financial Scheme of Delegation and receipt by the Audit Committee.

Version control table

Version	Date	Change/amendment
1.0	April 2016	New Financial Scheme of Delegation under Standing Orders and Standing Financial Instructions
1.1	March 2018	Delegation to Chief Executive £1m for code 129999 Statement of Financial Position Weekly Liaison/Tempre invoices delegated up to £25,000 and up to £200,000 and clarity on Director-level responsibilities for monthly Liaison /Tempre invoices
1.2	April 2018	Director of Operations Medicine Health Group – Fresenius expenditure up to £200,000
1.3	April 2019	Chief Financial Officer, PFI & NHS Supply Chain invoices up to £1.1m
1.4	July 2019	Changes to EU tender threshold and programmes of work amounts
1.5	January 2020	Changes to EU tender threshold and programmes of work amounts
1.6	October 2020	To amend the Scheme of Delegation to allow the Chief Executive to sign orders for NHS Blood and Transplant up to the value of £2,500,000
1.7	September 2022	To amend the Scheme of Delegation to allow the Chief Finance Officer to

		sign off invoices from NHS Resolution for the Clinical Negligence Scheme for Trusts up to the value of £2,500,000
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Scheme of Delegation

The Trust's scheme of delegation makes the following provisions:

- The Chief Executive and the Chief Financial Officer are accountable for financial control but will, as far as appropriate, delegate their detailed responsibilities.
- The Chief Executive will delegate budget to budget holders
- The Chief Financial Officer will devise and maintain systems of budgetary control
- The Chief Executive and the Chairman will sign amendments to this Financial Scheme of Delegation, as the document forms a schedule to Trust Standing Orders and Standing Financial Instructions

Revenue Expenditure

For orders, invoices, cheque requests petty cash and contract amendments:-

<i>Updated Scheme of Delegation</i>	<i>Typical Grade</i>	<i>Authorisation Limit</i>
Chief Executive	VSM	over £500k
Corporate Directorates		
Chief Finance Officer	VSM	Up to £500k
Other Corporate Directors	VSM	Up to £150k for own budgets
Assistant Directors	Band 8d	Up to £25k own budgets
Other Managers	Band 8a+	Up to £10k own budgets
	Band 7	Up to £5k own budgets
	band 6	Up to £500 own budgets
Health Groups		
All Directors (ie Operations, Nursing and Medical Directors)	Band 9/VSM	Up to £100k own budgets
Divisional Triumvirates	Band 8b	Up to £25k own budgets
Business Managers /Heads of Departments/Matron (or equivalent role)	Band 8a	Up to £10k own budgets
Ward Managers, Dept Managers, Deputies to the above	Band 7	Up to £5k own budgets
Senior Nurse, Deputy Department Managers	Band 6	Up to £500 own budgets

Exceptions (record of agreement at Chairman and Chief Executive Level) :-

High non pay clinical expenditure only - for practical reasons

Cardiology/Radiology/Vascular labs - lead technicians/AHP/sister (at least B7) £25k
(Clinical Lab/ECG supplies only)

Chief Pharmacist/Deputy Chief Pharmacist £100k (drugs only)

Clinical Manager Orthotics/Prosthetics £25k

Departmental Manager Prosthetics £10k

Chief Executive over £500k for code 129999, Capital Expenditure

Director of Operations Medicine Health Group Fresenius up to £200k

Chief Financial Officer, PFI & NHS Supply Chain invoices up to £1m

Chief Executive to sign orders for NHS Blood and Transplant up to the value of £2,500,000

Agency

Monthly Liaison/Tempre invoices, one of the following up to £500,000:

- Chief Executive
- Chief Financial Officer
- Chief Nurse

Weekly Liaison/Tempre invoices up to £25,000 requires 1 Deputy Director (Finance) approval

Weekly Liaison/Tempre invoices up to £200,000 require 2 Deputy Director (Finance) approval

These agency exceptions are as at 8.3.18 and are subject to review and amendment only with evidence of Director level agreement

Clinical Negligence Scheme for Trusts (CNST)

Chief Financial Officer up to £2,500,000 for NHS Resolution for CNST.

Capital Expenditure

The approval process for the agreement of capital expenditure is summarised below:-

Capital Cost	Approval Required
£5m to £15m	Trust Board
£2m to £5m	Performance and Finance Committee (PAF)
£0.5m to £2m	Executive Management Committee (EMC)
£5k to £0.5m	Capital Resource Allocation Committee CRAC)

Note: any business case deemed to be a high financial risk will also require approval at the next level of authority.

The authorisation for orders and invoices etc, following the approvals process above, is as follows and is regardless of whether or not the VAT is reclaimable:-

Capital Expenditure	Orders/Invoices
Chief Executive	All commitments/invoices > £500k
Chief Finance Officer	Up to £500k including VAT
Other Corporate Directors	Up to £100k including VAT
Heads of Service (I&D)	Up to £50k including VAT
Senior Project Manager/Estates Operations Manager	Up to £10k including VAT
Project Officer/Manager	Up to £5k including VAT

Tenders

The full details of the formal tendering requirements are included in the SFIs, but the table below summarises the general requirements:

Value	Requirement
Less than £10k	In line with procurement procedures approved by the Chief Financial Officer and using NHS Supply Chain, where applicable.
£10 - £50k	Quotations
£50k- to £118,133	Local Tenders
£118,133*	EU Tenders

*Programmes of “works” have an EU tender threshold of £4,551,413 – further defined in SFIs

Formal authorisation and the award of a contract may be decided by the following, to the value of the contract as follows:

Budget Holder	Up to £50k
Chief Executive or Chief Financial Officer	Up to £500k
Chief Executive or Chief Financial Officer or Chairman/vice Chairman (2 signatures of the 3 required)	£500k to £1m
Performance and Finance Committee	£1m - £3m
Trust Board	Over £3m
All lease tenders must be authorised by the Chief Executive only	All

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS AND STANDING FINANCIAL INSTRUCTIONS

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SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

- 1.1 Save as otherwise permitted by law, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive and/or Trust Secretary).
- 1.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:
- 1.2.1 **"Accountable Officer"** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
- 1.2.2 **"Trust"** means the Hull University Teaching Hospitals NHS Trust.
- 1.2.3 **"Board"** means the Chairman, officer and non-officer members of the Trust collectively as a body.
- 1.2.4 **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- 1.2.5 **"Budget holder"** means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.
- 1.2.6 **"Chairman of the Board (or Trust)"** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.
- 1.2.7 **"Chief Executive"** means the chief officer of the Trust.
- 1.2.8 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
- 1.2.9 **"Committee"** means a committee or sub-committee created and appointed by the Trust.
- 1.2.10 **"Committee members"** means persons formally appointed by the Board to sit on or to chair specific committees.
- 1.2.11 **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
- 1.2.12 **"Funds held on trust"** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.
- 1.2.13 **"Member"** means officer or non-officer member of the Board as the context permits. Member in relation to the Board does not include its Chairman.
- 1.2.14 **"Associate Member"** means a person appointed to perform specific statutory and non-statutory duties which have been delegated by the Trust Board for them to perform and these duties have been recorded in an appropriate Trust Board minute or other suitable record.
- 1.2.15 **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations (SI 1990/2024) and subsequent amendments.
- 1.2.16 **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
- 1.2.17 **"Non-officer member"** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
- 1.2.18 **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.
- 1.2.19 **"Officer member"** means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1(3) (i.e. the Chairman of the Trust or any person nominated by such a Committee for appointment as a Trust member).
- 1.2.20 **"Secretary" (Trust Secretary)** means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, NHS Improvement and Department of Health guidance.

- 1.2.21 **"SFIs"** means Standing Financial Instructions.
- 1.2.22 **"SOs"** means Standing Orders.
- 1.2.23 **"Vice-Chairman"** means the non-officer member appointed by the Board to take on the Chairman's duties if the Chairman is absent for any reason.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

Hull and East Yorkshire Hospitals NHS Trust is a statutory body which came into existence on 1st October 1999 under Hull and East Yorkshire Hospitals NHS Trust Establishment Order 1999 No 2675.

On 1st March 2019, the organisation changed its name to Hull University Teaching Hospitals NHS Trust as a result of The Hull and East Yorkshire Hospitals National Health Service Trust (Establishment) (Amendment) Order 2019 No. 346.

- (1) The principal place of business of the Trust is Hull Royal Infirmary. Patient care is also provided at Castle Hill Hospital.
- (2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, Health Act 1999, the National Health Service Act 2006 and the Health and Social Care Act 2012.
- (3) The functions of the Trust are conferred by this legislation.
- (4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.
- (5) The Trust also has statutory powers under Section 28A of the NHS Act 1977, as amended by the Health Act 1999 and 2006, to fund projects jointly planned with local authorities, voluntary organisations and other bodies.
- (6) The Code of Accountability requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of Standing Orders setting out the responsibilities of individuals.
- (7) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

1.2 NHS Framework

- (1) In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.
- (2) The Code of Accountability requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board members.
- (3) The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.3 Delegation of Powers

The Trust has powers to delegate and make arrangements for delegation. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the Trust is given powers to "make arrangements for the exercise, on behalf of the Trust of any of their functions by a committee, sub-committee or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust

thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). This document has effect as if incorporated into the Standing Orders.

2. THE TRUST BOARD: COMPOSITION OF MEMBERSHIP, TENURE AND ROLE OF MEMBERS

2.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

- (1) The Chairman of the Trust
- (2) Up to 6 non-officer members
- (3) Up to 5 officer members (but not exceeding the number of non-officer members):
 - the Chief Executive;
 - the Chief Financial Officer;
 - the Chief Medical Officer;
 - the Chief Nurse;
 - the Chief Operating Officer

The Trust shall have not more than 12 and not less than 8 members (unless otherwise determined by the Secretary of State for Health and set out in the Trust's Establishment Order or such other communication from the Secretary of State).

2.2 Appointment of Chairman and Members of the Trust

- (1) Appointment of the Chairman and Members of the Trust - Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chairman is appointed by the Secretary of State (through NHS Improvement), but otherwise the appointment and tenure of office of the Chairman and members are set out in the Membership, Procedure and Administration Arrangements Regulations.

2.3 Terms of Office of the Chairman and Members

- (1) The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations. The period of tenure is notified by NHS Improvement for Non-Executive Directors.

2.4 Appointment and Powers of Vice-Chairman

- (1) Subject to Standing Order 2.4 (2) below, the Chairman and members of the Trust may appoint one of their numbers, who is not also an officer member, to be Vice-Chairman, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him.
- (2) Any member so appointed may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The Chairman and members may thereupon appoint another member as Vice-Chairman in accordance with the provisions of Standing Order 2.4 (1).
- (3) Where the Chairman of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Vice-Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Vice-Chairman.

2.5 Joint Members

- (1) Where more than one person is appointed jointly to a post mentioned in regulation 2(4)(a) of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 2.1 as one person.
- (2) Where the office of a member of the Board is shared jointly by more than one person:

- (a) either or both of those persons may attend or take part in meetings of the Board;
- (b) if both are present at a meeting they should cast one vote if they agree;
- (c) in the case of disagreements no vote should be cast;
- (d) the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 3.11 Quorum.

2.6 Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer Members will be full and equal members. Their role as members of the Trust Board will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

(2) Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

(3) Chief Financial Officer

The Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

(4) Non-Executive Members

The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(5) Chairman

The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall work with NHS Improvement over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.7 Corporate role of the Board

- (1) All business shall be conducted in the name of the Trust.
- (2) All funds received in trust shall be held in the name of the Trust as corporate trustee.
- (3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 3.
- (4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State.

2.8 Schedule of Matters reserved to the Board and Scheme of Delegation

- (1) The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters

Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

2.9 Lead Roles for Board Members

The Chairman will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement

3. MEETINGS OF THE TRUST

3.1 Calling meetings

- (1) Ordinary meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.
- (2) The Chairman of the Trust may call a meeting of the Board at any time.
- (3) One third or more members of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

- (1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member, or sent by email or by post to the usual place of residence of each member, so as to be available to members at least three clear working days before the meeting. The notice shall be signed by the Chairman or by an officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.
- (2) In the case of a meeting called by members in default of the Chairman calling the meeting, the notice shall be signed by those members.
- (3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 3.6.
- (4) A member desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least ten working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten working days before a meeting may be included on the agenda at the discretion of the Chairman.
- (5) Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

Agendas and papers will be available on the Trust's website 3 working days before the public meeting of the Trust Board.

3.3 Agenda and Supporting Papers

The agenda will be sent to members at least three clear days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency. Papers can be electronically transmitted, if requested, by the Board member.

3.4 Petitions

Where a petition has been received by the Trust Chairman, the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

- (1) Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a member of the Board wishing to move a

motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

- (2) The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.6 Emergency Motions

Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

i) Who may propose

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

ii) Contents of motions

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) Amendments to motions

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

iv) Rights of reply to motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

v) Withdrawing a motion

A motion, or an amendment to a motion, may be withdrawn.

vi) Motions once under debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;

- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that a member/director be not further heard;
- a motion under Section I (2) or Section I (8) of the Public Bodies (Admissions to Meetings) Act 1960 resolving to exclude the public, including the press (see Standing Order 3.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a member of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

- (1) Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of three other members, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.
- (2) When any such motion has been dealt with by the Trust Board it shall not be competent for any director/member other than the Chairman to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of meeting

- (1) At any meeting of the Trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Vice-Chairman (if the Board has appointed one), if present, shall preside.
- (2) If the Chairman and Vice-Chairman are absent, such member (who is not also an Officer Member of the Trust) as the members present shall choose, shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

- (i) No business shall be transacted at a meeting unless at least half of the whole number of the Chairman and members (including at least 3 Executive Directors and 3 Non Executive Directors) are present.
- (ii) An Officer in attendance for an Executive Director (Officer) but without formal acting up status may not count towards the quorum.
- (iii) If the Chairman or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No. 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

- (i) Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding (ie: the Chairman of the meeting) shall have a second, and casting vote.

- (ii) At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.
- (iii) If at least one third of the members present so request, the voting on any question may be recorded so as to show how each member present voted or did not vote (except when conducted by paper ballot).
- (iv) If a member so requests, their vote shall be recorded by name.
- (v) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote.
- (vi) A manager who has been formally appointed to act up for an Officer Member during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Officer Member.
- (vii) A manager attending the Trust Board meeting to represent an Officer Member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Officer Member. An Officer's status when attending a meeting shall be recorded in the minutes.
- (viii) For the voting rules relating to joint members see Standing Order 2.5.

3.13 Suspension of Standing Orders

- (i) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum (SO 3.11), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present (including at least one member who is an Officer Member of the Trust and one member who is not) and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.
- (ii) A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chairman and members of the Trust.
- (iii) No formal business may be transacted while Standing Orders are suspended.
- (iv) The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

These Standing Orders shall not be varied except in the following circumstances:

- upon a notice of motion under Standing Order 3.5;
- upon a recommendation of the Chairman or Chief Executive included on the agenda for the meeting;
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's Non-Officer members vote in favour of the amendment;
- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State.

3.15 Record of Attendance

The names of the Chairman and Directors/members present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.17 Admission of public and the press

(i) Admission and exclusion on grounds of confidentiality of business to be transacted

The public and representatives of the press may attend all meetings of the Trust Board, but shall be required to withdraw upon the Trust Board as follows:

- 'that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest', Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

(ii) **General disturbances**

The Chairman (or Vice-Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- 'That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public'. Section 1(8) Public Bodies (Admissions to Meetings) Act 1960.

(iii) **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Board.

Members and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private/Part 2' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(iv) **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, tweeting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

3.18 Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

The Trust Board will permit questions at the public Board meeting on agenda items discussed at that Board meeting.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Trust Board may appoint committees of the Trust Board.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.2 Joint Committees

- (i) Joint committees may be appointed by the Trust by joining together with one or more other bodies, or other Trusts consisting of, wholly or partly of the Chairman and members of the Trust or other health service bodies, or wholly of persons who are not members of the Trust or other health bodies in question.
- (ii) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees consisting wholly or partly of

members of the committees or joint committee (whether or not they are members of the Trust or health bodies in question) or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

- 4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees**
The SOs and SFIs of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public.)
- 4.4 Terms of Reference**
Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the SOs.
- 4.5 Delegation of powers by Committees to Sub-Committees**
Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.
- 4.6 Approval of Appointments to Committees**
The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.
- 4.7 Appointments for Statutory functions**
Where the Board is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and directions made by the Secretary of State.
- 4.8 Committees established by the Trust Board – The Schedule of delegation (Section C)**
sets out the duties delegated:
- 4.8.1 Audit Committee
 - 4.8.2 Remuneration and Terms of Service Committee
 - 4.8.3 Charitable Funds Committee
 - 4.8.4 Performance & Finance Committee
 - 4.8.5 Quality Committee
 - 4.8.6 Workforce, Education and Culture Committee
 - 4.8.7 Covid-19 Ethics and Clinical Policy Prioritisation Sub-Committee

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

- 5.1 Delegation of Functions to Committees, Officers or other bodies**
- 5.1.1 Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an officer of the Trust, or by another body as defined in Standing Order 5.1.2 below, in each case subject to such restrictions and conditions as the Trust thinks fit.
- 5.1.2 Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trust’s to be carried out by third parties. In accordance with The Trusts (Membership, Procedure and Administration Arrangements) Regulations 2000 the functions of the Trust may also be carried out in the following ways:

- (i) by another Trust;
- (ii) jointly with any one or more of the following: NHS trusts, NHS Improvement or CCGs;
- (iii) by arrangement with the appropriate Trust or CCG, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies;
- (iv) in relation to arrangements made under S63(1) of the Health Services and Public Health Act 1968, jointly with one or more NHS Improvement, NHS Trusts or CCG.

5.1.3 Where a function is delegated by these Regulations to another Trust, then that Trust or health service body exercises the function in its own right; the receiving Trust has responsibility to ensure that the proper delegation of the function is in place. In other situations, i.e. delegation to committees, sub-committees or officers, the Trust delegating the function retains full responsibility.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.9) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

5.3 Delegation to Committees

5.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint-committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.3.2 When the Board is not meeting as the Trust in public session it shall operate as a committee and may only exercise such powers as may have been delegated to it by the Trust in public session.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or Department of Health requirements. Outside these statutory requirements the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

5.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by Hull University Teaching Hospitals NHS Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- Declaring gifts and external interests policy for Hull University Teaching Hospitals NHS Trust staff;
- the staff Disciplinary Policy adopted by the Trust shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of SO 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Members

- i) The NHS Code of Accountability requires Trust Board Members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

- (i) The interests which are regarded as "relevant and material" are set out in the Trust's Declaring Gifts and External Interest Policy.
- (ii) Any member of the Trust Board who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Board member shall declare his/her interest by giving notice in writing of such fact to the Trust as soon as practicable.

7.1.3 Advice on Interests

If Board members have any doubt about the relevance of an interest, this should be discussed with the Chairman of the Trust or with the Director of Corporate Affairs.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in Trust Board minutes

At the time Board members' interests are declared, they should be recorded in the Trust Board minutes.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 **Publication of declared interests in Annual Report**

Board members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 **Conflicts of interest which arise during the course of a meeting**

During the course of a Trust Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. (See overlap with SO 7.3)

7.2 **Register of Interests**

7.2.1 The Director of Corporate Affairs will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive Trust Board members.

7.2.2. These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 **Exclusion of Chairman and Members in proceedings on account of pecuniary interest**

7.3.1 **Definition of terms used in interpreting 'Pecuniary' interest**

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- (i) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
- (ii) "contract" shall include any proposed contract or other course of dealing.
- (iii) "Pecuniary interest"
Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-
 - a) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
 - b) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.
- iv) Exception to Pecuniary interests
A person shall not be regarded as having a pecuniary interest in any contract if:-
 - a) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or
 - b) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
 - c) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (c) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 **Exclusion in proceedings of the Trust Board**

- (i) Subject to the following provisions of this Standing Order, if the Chairman or a member of the Trust Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- (ii) The Secretary of State may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability should be removed. (See SO 7.3.3 on the 'Waiver' which has been approved by the Secretary of State for Health).
- (iii) The Trust Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest is under consideration.
- (iv) Any remuneration, compensation or allowance payable to the Chairman or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 (pay and allowances) shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- (v) This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee (whether or not he/she is also a member of the Trust) as it applies to a member of the Trust.

7.3.3 **Waiver of Standing Orders made by the Secretary of State for Health**

(1) Power of the Secretary of State to make waivers

Under regulation 11(2) of the NHS (Membership and Procedure Regulations SI 1999/2024 ("the Regulations"), there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 (which prevents a chairman or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which he has a pecuniary interest) is removed. A waiver has been agreed in line with sub-sections (2) to (4) below.

(2) Definition of 'Chairman' for the purpose of interpreting this waiver

For the purposes of paragraph 7.3.3.(3) (below), the "relevant chairman" is –

- (a) at a meeting of the Trust, the Chairman of that Trust;
- (b) at a meeting of a Committee –
 - in a case where the member in question is the Chairman of that Committee, the Chairman of the Trust;
 - (ii) in the case of any other member, the Chairman of that Committee.

(3) Application of waiver

A waiver will apply in relation to the disability to participate in the proceedings of the Trust on account of a pecuniary interest.

It will apply to:

(i) A member of the Hull University Teaching Hospitals NHS Trust, who is a healthcare professional, within the meaning of regulation 5(5) of the Regulations, and who is providing or performing, or assisting in the provision or performance, of –

- (a) services under the National Health Service Act 1977; or
- (b) services in connection with a pilot scheme under the National Health Service Act 1997;

for the benefit of persons for whom the Trust is responsible.

- (ii) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which he is present:-
 - (a) arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons;
 - (b) has been declared by the relevant chairman as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who:-
 - (i) are members of the same profession as the member in question,
 - (ii) are providing or performing, or assisting in the provision or performance of, such of those services as he provides or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.
- (4) Conditions which apply to the waiver and the removal of having a pecuniary interest
The removal is subject to the following conditions:
- (a) the member must disclose his/her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes;
 - (b) the relevant chairman must consult the Chief Executive before making a declaration in relation to the member in question pursuant to paragraph 7.3.3 (2) (b) above, except where that member is the Chief Executive;
 - (c) **in the case of a meeting of the Trust:**
 - (i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
 - (ii) may not vote on any question with respect to it.
 - (d) **in the case of a meeting of the Committee:**
 - (i) the member may take part in the consideration or discussion of the matter which must be subjected to a vote and the outcome recorded;
 - (ii) may vote on any question with respect to it; but
 - (iii) the resolution which is subject to the vote must comprise a recommendation to, and be referred for approval by, the Trust Board.

7.4 Standards of Business Conduct

7.4.1 Trust Policy and National Guidance

All Trust staff and members must comply with the Trust's Declaring Gifts and External Interests Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff' (see SO 6.2).

7.4.2 Interest of Officers in Contracts

- i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust Secretary as soon as practicable.
- ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.
- iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Members in Relation to Appointments

- i) Canvassing of members of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

Members of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a member from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.4 Relatives of Members or Officers

- i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.
- ii) The Chairman and every member and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive to report to the Trust Board any such disclosure made.
- iii) On appointment, members (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other member or holder of any office under the Trust.
- iv) Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and members in proceedings on account of pecuniary interest' (SO 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Trust Secretary.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed by the Chief Executive and Chairman, or their nominated deputies (Chief Financial Officer, Chief Operating Officer and Trust Secretary), and shall be arrested by them.

8.3 Register of Sealing

The Trust Secretary shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive, any Executive Director or Director of Corporate Affairs.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

9. MISCELLANEOUS (see overlap with SFI No. 21.3)

9.1 Joint Finance Arrangements

The Board may confirm contracts to purchase from a voluntary organisation or a local authority using its powers under Section 28A of the NHS Act 1977. The Board may confirm contracts to transfer money from the NHS to the voluntary sector or the health related functions of local authorities where such a transfer is to fund services to improve the health of the local population more effectively than equivalent expenditure on NHS services, using its powers under Section 28A of the NHS Act 1977, as amended by section 29 of the Health Act 1999.

See overlap with Standing Financial Instruction No. 21.3.

SECTION C - SCHEME OF RESERVATION AND DELEGATION

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	<p>General Enabling Provision The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.</p>
NA	THE BOARD	<p>Regulations and Control</p> <ol style="list-style-type: none"> 1 Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2 Suspend Standing Orders. 3 Vary or amend the Standing Orders. 4 Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 5.2 5 Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6 6 Approve a scheme of delegation of powers from the Board to committees. 7 Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 8 Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto as recommended by the Chief Executive. 9 Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 10 Receive the recommendations of the Trust's Board committees where the committees do not have executive powers and in line with the terms of reference 11 Receive annual management letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 12 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13 Approve the terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14 Authorise use of the seal. 15 Discipline members of the Board who are in breach of statutory requirements or SOs.
NA	THE BOARD	<p>Appointments/ Dismissal</p> <ol style="list-style-type: none"> 1. Appoint the Vice Chairman of the Board. 2. Appoint and dismiss committees that are directly accountable to the Board. 3. Appoint the Senior Independent Director

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
		4. Appoint, discipline and dismiss Executive Directors (subject to SO 2.2). 5. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
NA	THE BOARD	Strategy, Plans and Budgets 1. Set the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust 3. Approve annually the Trust's organisational development proposals (People Strategy) 4. Approve the 5 year plan and annual operating plan 5. Approve financial strategies and plans, budgets (including capital) 6. Approve Outline and Final Business Cases for capital investment in line with the scheme of delegation. 7. Approve investments of new activity or any disinvestments (in line with NHS Improvement's significant transactions guidance) 8. Ratify proposals for acquisition or disposal of land and/or buildings. 9. Approve PFI proposals. 10. Approve the opening and closing of bank accounts. 11. Approve applications for loans 12. Approve proposals for new areas of business to the Trust amounting to £5,000,000 or more (further detail on timings relating to tender processes for new work are set out in Standing Financial instructions) 13. Approve the use of the NHS risk pooling schemes or arrangements to self-insure 14. Approve arrangements in relation to spin off companies 15. Approve the Trust's R & D Strategy
	THE BOARD	Policy Determination 16. Approval of Risk Management Policy 17. Approval of Performance Management Policy 18. Approval of Investment Policy
	THE BOARD	1. Approve the appointment (and where necessary dismissal) of External Auditors. 2. Approve external auditors' arrangements for the separate audit of funds held on trust, and the submission of reports to the Audit Committee meetings. 2 Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.

REF	THE BOARD	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD	<p>Annual Reports and Accounts</p> <ol style="list-style-type: none"> 1. Receive and approve the Trust's Annual Report and Annual Accounts. 2. Receive and approve the Annual Report and Accounts for funds held on trust.
NA	THE BOARD	<p>Monitoring</p> <ol style="list-style-type: none"> 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from the Chief Financial Officer on financial performance of the Trust

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	AUDIT COMMITTEE	<p>Duties and Responsibilities of the Committee</p> <ul style="list-style-type: none"> • Governance, Risk Management and Internal Control The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives. <p>In particular, the Committee will review the adequacy of:-</p> <ul style="list-style-type: none"> • All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board. • The structures, processes and responsibilities for identifying and managing key risks facing the organisation in particular the Board Assurance Framework—including the link with the corporate risk register • The underlying control and assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the disclosure statements. • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service. • Consider and review the Annual Information Governance Toolkit (and any replacement scheme) and the Data Quality Reports. • Trust arrangements to meet the requirements of the General Data Protection Regulations that apply from 25 May 2018 <p>Power to seek reports and assurances In carrying out this work the Committee will primarily utilise the work of Internal Audit, Anti-Fraud, External Audit and other assurance functions, but will not be limited to these audit functions. It may also seek reports and assurances from Directors and managers as appropriate,</p>

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<p>concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. The Committee will receive the minutes of the Board's Performance and Finance Committee, Quality Committee and Charitable Funds Committee to inform its assurance work. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.</p> <p>Internal Audit The Committee shall ensure that there is an effective internal audit function established by management; that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee.</p> <p>It will:-</p> <ul style="list-style-type: none"> • Recommend the appointment of the Internal Auditors to the Board, approve the annual fee and consider any questions of resignation and dismissal • Review and approve the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework and Strategic Plans. • Consider the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources. • To review progress on implementing internal audit recommendations. • Ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation. • Monitor the effectiveness of internal audit through their annual review <p>External Audit The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work.</p> <p>This will be achieved by:-</p> <ul style="list-style-type: none"> • Recommending to the Trust Board the appointment of the External Auditor . • Discussion and agreement with the External Auditor, before the audit commences, of the

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<p>nature and scope of the audit as set out in the Annual Plan.</p> <ul style="list-style-type: none"> • Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee. • Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken alongside the annual audit plan together with the appropriateness of management responses. • Review and monitor the external auditor's independence and objectivity, taking into account relevant UK professional and regulatory requirements. • To develop and implement a policy on the engagement of the external auditor to supply non audit services. <p>Financial Reporting</p> <p>The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focussing particularly on:-</p> <ul style="list-style-type: none"> • The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee. • Changes in, and compliance with, accounting policies, practices and estimation techniques. • Unadjusted mis-statements in the financial statements. • Letter of Representation. • Significant judgements in preparation of the financial statements. • Significant adjustments resulting from the audit. <p>Other Assurance Functions</p> <ul style="list-style-type: none"> • The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by Department of Health Arms-Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<ul style="list-style-type: none"> • In addition, the Committee will consider the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This Committee also needs to be review the assurances gained from clinical audit activities in the organisation. • The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of anti-fraud work. • The Committee will seek annual assurance that a current, clear and effective Whistleblowing or Protected Disclosures Policy is in place and that all Trust staff have access to this policy. One Non-Executive Director under the current policy (reference CP169) will be one of a number of internal contacts available to consult and be the "Whistleblowing Champion" of the Trust. <p>Reporting</p> <ul style="list-style-type: none"> • The minutes of the Audit Committee meetings shall be approved by the Chairman of the Audit Committee and submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. • The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and effectiveness of risk management in the organisation, the integration of governance arrangements and produce an annual work plan. <p>Other Matters</p> <p>The Committee shall undertake reviews of:</p> <ul style="list-style-type: none"> • Risk register • Write offs and compensations • Outstanding debtors over £50,000 and 90 days or more outstanding. • Decision to waive tender procedures • Offers of hospitality/gifts and sponsorship • Review of Standing Orders and Standing Financial Instructions and approval of proposed changes

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<ul style="list-style-type: none"> • Waiver of Standing Orders • Going Concern Reviews • Corporate credit card expenditure • Legal expenditure
	<p>REMUNERATION AND TERMS OF SERVICE COMMITTEE</p>	<p>Duties and Responsibilities of the Committee</p> <p>Remuneration</p> <ul style="list-style-type: none"> • To approve the terms and conditions of the Board Directors (detailed below) in accordance with Trust policies and following consultation with the Chief Executive, including; <ul style="list-style-type: none"> • Salary, including any performance related pay or bonus • Provision for other benefits, including pensions • Allowances <p>The Board Directors are the Chief Executive, Chief Financial Officer, Chief Nurse, Chief Medical Officer, Chief Operating Officer, Director of Workforce and Development, Director of Strategy and Planning and Director of Corporate Affairs.</p> <ul style="list-style-type: none"> • To receive benchmarking information on Board Directors salaries in order to determine the overall market positioning of the remuneration package • The Chief Executive is responsible for putting in place effective and fair appraisal arrangements for his/her direct reports and for reporting his/her decisions formally by a paper to the Committee at least annually. In making his/her decision on the level of overall performance, Committee Members will have had the opportunity to provide feedback on individuals to inform the Chief Executive's overall assessment • To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Board Directors whilst remaining cost effective. • To approve any changes to the standard contract of employment for Board Directors • To agree and review the extent to which a full time Board Director takes on a Non-Executive Director or Chairman role of another organisation. • To approve any payments to staff which are outside of Trust policy. • To monitor the level and structure of remuneration for Very Senior Managers and note

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<p>annually the remuneration trends across the Trust</p> <ul style="list-style-type: none"> • To approve severance payments in line with NHSI guidance • To approve MAR schemes and ensure that NHSI guidance is followed for individual staff applications. • To receive information on: <ul style="list-style-type: none"> • Any Trust post where there is a termination clause of more than 6 months • Highest paid employees in the Trust (20 individuals) annually • Any special pension arrangements for any employee • All bonus schemes (ie Trust earnings not paid in to salary) in operation in the Trust <p>Nomination</p> <ul style="list-style-type: none"> • To review the structure, size and composition of the Board and make recommendations for changes as appropriate • Before an appointment is made evaluate the balance of skills, knowledge and experience on the Board and its diversity and on the basis of the evaluation prepare a description of the role and capabilities required for appointment of Executive Directors. • To give full consideration to and make plans for succession planning for the Chief Executive and other Board Directors (Chiefs) taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. • Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the Trust to operate effectively in the health economy. • Ensure that a proposed executive directors, other significant commitments (if applicable) are disclosed before appointment. • Consider any matter relating to the continuation in office of any Executive Director (Chief Executive, Chief Financial Officer, Chief Nurse, Chief Medical Officer, and Chief Operating Officer) including the suspension and termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract. • To receive assurance on the succession plans for Very Senior Managers.
	CHARITABLE FUNDS COMMITTEE	<p>Duties and Responsibilities of the Committee</p> <ul style="list-style-type: none"> • To ensure that the Trust's charitable funds are established and operated in

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<p>accordance with Charities Law.</p> <ul style="list-style-type: none"> • To ensure that any fund raising activity carried out by or on behalf of the charity is properly undertaken and that all funds are properly accounted for in line with the Trust policy. • To ensure that funds not needed for immediate expenditure are invested or deposited to earn interest to protect the real value of the asset whilst generating a reasonable level of income. • To ensure that audited accounts, as laid down in the 2011 Charities Act are submitted to the Trust Board and to the Charities Commission annually and made available for the public.. • To manage and monitor expenditure from charitable funds in accordance with Standing Financial Instructions and the Scheme of Delegation • To receive information on grants against general funds which are less than £10,000K. To approve bids of £10,000 or greater in line with the Scheme of Delegation. • To oversee the relationship and governance arrangements between the Trust's Charitable Funds and the Working Independently to Support Hull Hospitals (WISHH) Charity (registered charity no. 1162414 Hull University Teaching Hospitals Health Charity). • To oversee the Trust's hospital arts strategy, specifically the use of charitable funds in the delivery of this strategy. • To oversee the Trust's broader Corporate Social Responsibility role, in particular the Trust's role to support the well-being of the local community, which may be supported through charitable funds
	PERFORMANCE AND FINANCE COMMITTEE	<p>Duties and Responsibilities of the Committee <u>NHS Constitution standards (access)</u></p> <ul style="list-style-type: none"> • To gain assurance that the organisation has, at all times, robust and effective operational planning systems in place (including demand and capacity) for delivering contract levels of activity • To gain assurance that the organisation has, at all times, robust and effective performance management systems in place relating to delivery of the access targets.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<ul style="list-style-type: none"> • To seek assurance that controls are in place, and operating effectively to mitigate the risks to the successful delivery of access targets • Review the plans for winter and make recommendations to the Board for adoption. Monitor delivery of the plans. • To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken • To seek assurance that agreed recovery plans are being implemented in a timely fashion and delivering the required outcomes <p><u>Financial Performance</u></p> <ul style="list-style-type: none"> • To seek assurance that the organisation has a robust and effective financial planning and performance management systems in place. • To seek assurance on the production and implementation of long term financial plans (including capital) having regard to relevant national guidance, commissioning plans, and resource availability both internally and within the local health economy in order to support the Board in its decision making. • To consider loan applications prior to recommending approval by the Trust Board • To seek assurance that controls are in place and operating effectively to mitigate the risks to the successful delivery of financial performance, including cash releasing efficiency schemes (CRES) and agency caps. • To ensure that the Board is informed of significant issues, underperformance, deviation from plans and to provide assurance on action being taken • To seek assurance that agreed recovery plans are implemented in a timely fashion and resulting in improved outcomes • To receive assurance that Service Line Management is in place and Patient level costing is being developed and used to support delivery of the Trust's financial objectives • To receive assurance on the work being undertaken in relation to the Lord Carter review • To receive regular assurance on the People Strategy, the Trust's current workforce figures and the Trust's agency spend position, to flag up any financial or delivery issues impacted by workforce

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<p><u>Overall Financial & Operational Planning</u></p> <ul style="list-style-type: none"> • To provide overview and scrutiny to the development of the Trust’s annual and longer term plans (as required by relevant National Guidance) for financial and operational performance and is line with the Trust Strategy, ensuring that the Trust’s financial plan is consistent with the Trust’s operational plan and reflective of the Trust’s goals • Ensure that the annual plans (operations, revenue and capital) are consistent with, and supportive of, relevant Trust wide strategies - Clinical Services, IM&T and Estates • To recommend to the Trust Board the approval of the Annual Operating Plan in relation to operational performance and financial plans. • Review the risks on the Board Assurance Framework relevant to the remit of the Committee (NHS Constitution Standards and Finance) to ensure that controls are in place and mitigating action is effective <p><u>Investment</u></p> <ul style="list-style-type: none"> • In line with the Trust’s approved scheme of delegation scrutinise all business cases for proposed capital investment that require either Performance and Finance Committee or Trust Board approval, ensuring that outcomes and benefits are clearly defined, are measurable and support delivery of the Trust’s goals • Evaluate, scrutinise and approve investment (and dis-investment) proposals within delegated limits, making recommendations to the Board in line with Standing Orders, Standing Financial Instructions • To receive assurance from the Capital Resource Allocation Committee that in year capital investment is being spent as planned and delivering planned benefits.
	QUALITY COMMITTEE	<p>Duties and Responsibilities of the Committee</p> <p>The Committee is responsible for providing the Board with assurance concerning all aspects of quality and safety relating to patient care and identifying quality improvement measures. The specific responsibilities are to:</p> <ul style="list-style-type: none"> • Monitor delivery of Trust strategies as delegated by the Board to this committee. • Advise the Board on appropriate quality and safety indicators and benchmarks for

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<p>inclusion in the Trust's Corporate Performance Report and keep these under regular review.</p> <ul style="list-style-type: none"> • Propose Quality Accounts priorities for consideration by the Board and maintain oversight of delivery. • Scrutinise performance against quality targets, highlighting risks and exceptions to the Board. • Regularly review compliance with Care Quality Commission requirements and receive assurance that agreed actions are being progressed. • Regularly review progress with the Trust's Quality Improvement Plan, as the Trust's over-arching plan on driving improvement in quality of care, including any issues highlighted by the Care Quality Commission • To assure the Board that where there are risk and issues that might jeopardise the Trust's ability to deliver excellent quality care that these are being managed in a controlled and timely way. • Receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality. • Monitor the information being received from patient feedback and adverse incidents to demonstrate that the Trust is learning and making improvements. • Learning and compliance from national and local reviews. • Regularly review outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths • To receive regular updates on the delivery of the People Strategy and its link with quality and safety
	<p>WORKFORCE, EDUCATION AND CULTURE COMMITTEE</p>	<ul style="list-style-type: none"> • To gain regular assurance on the People Strategy, including key workforce metrics as well as the key objectives and strands within the Strategy • To gain regular assurance on the Trust's current workforce position as it relates to the People Strategy and plans for delivery, as well as the Trust's agency spend position, to flag up any financial or delivery issues impacted by workforce • To gain regular assurance on the results of the Trust's Staff Surveys, the annual staff survey and Staff Engagement, and to link this to the delivery and outputs required of the People Strategy, particularly with regard to inclusion and wellbeing

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
		<ul style="list-style-type: none"> • To support the Trust's organisational development and work on leadership, staff engagement, staff culture and becoming a learning organisation, through review, action planning and assurance processes • To gain regular assurance on the quality of medical and non-medical education and training within the organisation, including staff satisfaction, the delivery of action plans to address any gaps identified through feedback, and feedback on quality of placements. • To review items of workforce planning and statutory workforce compliance on behalf of the Board, including lessons learned and action plans, for recommendation to be approved at the Trust Board • To ensure that the Board is informed of significant issues, underperformance, and deviation from plans that would constitute a particular risk to the delivery of the Trust's People Strategy, and to provide assurance on action being taken • To seek assurance that agreed delivery plans are being implemented in a timely fashion and delivering the required outcomes • To provide oversight of progress against the Trust's Research and Innovation strategy, including key enablers and risks • Review the risks on the Board Assurance Framework relevant to the remit of the Committee ensure that controls are in place and mitigating action is effective, and that positive assurance is received where appropriate
	COVID-19 ETHICS AND CLINICAL POLICY PRIORITISATION SUB-COMMITTEE	This is a sub-committee formed on 31 March 2020 in response to the Novel Coronavirus pandemic in the UK. This is a temporary board sub-committee. The aim of this sub-committee is to help guide service leaders and clinicians on ethical issues and clinical prioritisation during this challenging period. The intention is to promote the highest standards of ethical and clinically responsible conduct, monitor compliance with organisational conduct with this regard and identify good practice and opportunity for improvement. This sub-committee is chaired by a Trust Non-Executive Director.

HULL UNIVERITY TEACHING HOSPITALS NHS TRUST

STANDING FINANCIAL INSTRUCTIONS

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HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

The purpose of these Standing Financial Instructions is to regulate the conduct of the Trust and **all** of its employees, directors, officers and agents with regards to financial matters.

These Standing Financial Instructions explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in the use of public resources. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust and the financial policies and procedures on the Trust intranet site.

These do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial Officer.

Where other guidance or policies appear to conflict with these instructions, these instructions will override those policies or procedures. Any conflicts should be brought to the attention of the Chief Financial Officer. If there are any doubts regarding the application or interpretation of these Standing Financial Instructions the advice of the Chief Financial Officer should be sought.

All members of staff, including the Trust Board, have an obligation to disclose any non-compliance with these Instructions to the Chief Financial Officer as soon as possible. All non-compliance will be reported to the Audit Committee for review and action.

For the avoidance of doubt, where the Title of Chief Executive or Chief Financial Officer is used it is also deemed to refer to officers or employees that have been duly authorised to represent them. Officers and employees of the Trust include nursing and medical staff and consultants practising on Trust premises.

These standing financial instructions have been compiled under the authority of the Trust Board and have been fully approved by the Trust Board. The Audit Committee has also reviewed and approved the content. It is expected that all staff, including contractors and agency staff, will comply with these instructions at all times. **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

2. DELEGATION AND AUTHORITY

Certain Powers and obligations exist for the following in relation to financial matters.

2.1 The Trust Board

Specific powers and decisions that are reserved to the Board are set out in the document "Reservation of powers to the Board." Other specific powers, decisions and obligations have been delegated to Trust Board committees.

By virtue of their size or nature certain financial transactions will require Board approval, these are detailed in the financial scheme of delegation.

The Trust Board will exercise financial supervision and control by ensuring:

- Approval of annual financial strategies and plans
- Approval of annual capital strategies and plans
- Approval of annual accounts
- Approval of the high level scheme of delegation.
- Approving the opening and closing of bank accounts
- Approving use of seal
- Approving loans

2.2 The Chief Executive

All executive powers are vested in the Chief Executive. The Chief Executive will delegate some of those powers as appropriate to relevant Executives and Officers, and also delegate detailed responsibilities to them as appropriate. This includes the delegation of financial management powers to the Chief Financial Officer, however, the Chief Executive remains accountable for financial control.

The Chief Executive is specifically accountable as Accounting Officer to the following for ensuring that the Board meets its obligations within its available financial resources

- to the Board
- to the Chairman
- to the Secretary of State

The Chief Executive is also responsible for:

- maintaining a sound system of internal control.
- ensuring that all staff and Board members are aware of and in a position to understand their obligations in relation to these instructions.

2.3 The Chief Financial Officer

The Chief Executive delegates powers to the Chief Financial Officer to facilitate his/her role in relation to managing the financial affairs of the Trust.

Using these powers the Chief Financial Officer is required to:

- formulate and implement the Trust's financial policies and strategy
- ensure that all financial systems and records are sufficiently detailed to allow the determination and explanation of the Trust's financial position at any time.
- determine and maintain detailed financial procedures and systems that incorporate the principles of separation of duties and internal assurance and control
- determine and maintain an effective scheme of financial delegation that will set out the required level of authorisation for transactions based on their nature and value.
- determine the form of financial records and approve the method of discharge of duties for financial functions not under the direct control of the Finance department.
- provide financial advice to the Board / Board members

- Ensure that all financial and procurement processes are compliant with the law
- interpret the meaning of standing financial instructions where there is uncertainty.

2.4 All Trust Employees

The Trust is accountable to Parliament to ensure that the services it provides are efficient, economic and effective and therefore these principles must be incorporated into the daily business of all staff. All employees should have regard to the principles set out in HM Treasury guidance "Managing Public Money.

All staff are individually and collectively responsible for safeguarding the interests of the Trust at all times. In practice this will include ensuring the security of Trust property, actively avoiding loss, ensuring that all actions have a basis in law and are in line with internal policy and procedures.

All employees are expected to uphold the public service values of accountability, probity and openness in all they do.

Without exception all staff should comply with these Standing Financial instructions, Standing Orders and the Scheme of Delegation.

2.5 Contractors and their employees (including Agency staff)

Any contractor, employee of a contractor, or agency worker who is empowered by the Trust to commit resources or obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive and engaging officer to ensure that such persons are made aware of this.

The following provides specific guidance in relation to the specific functions and services

3. AUDIT and ANTI-FRAUD

The following have roles and responsibilities in relation to Audit and anti fraud

3.1 Audit Committee

In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference that are in line with guidance contained within the most current version of the NHS Audit Committee Handbook.

The committee will provide an independent and objective view of risk management and internal control across clinical and non clinical services. They will do this by oversight and review of the work of internal and external audit services and anti-fraud services, the work undertaken by other risk related committees and clinical audit, and by ensuring compliance with Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

The Audit Committee will also review the annual accounts, significant financial judgements therein, and make recommendations to the Trust Board.

The internal auditors, external auditors and local anti-fraud specialist should ordinarily attend Audit Committee

Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters

that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS Improvement (to the Chief Financial Officer in the first instance.)

It is the responsibility of the Chief Financial Officer to ensure adequate internal and external audit services are provided. The Audit Committee shall be involved in the selection process when internal and external Audit service providers are changed. When appointing external Auditors the Audit Committee will be the “audit panel”

The Audit Committee should ensure that measures are in place to ensure both internal and external audit and the provider of anti-fraud services, provide an effective and cost efficient service.

3.2 Chief Financial Officer

The Chief Financial Officer will:

- (a) ensure there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
- (b) ensure that the internal audit function is adequate and as a minimum meets the NHS mandatory audit standards;
- (c) decide at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;
- (d) ensure that for each meeting an internal audit report is prepared for the consideration of the Audit Committee [and the Board]. The report must cover:
 - (i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
 - (ii) major internal financial control weaknesses discovered;
 - (iii) progress on the implementation of internal audit recommendations;
 - (iv) progress against planned work
- (e) Ensure that strategic a 3 year internal audit plan and an annual audit plan are prepared for review by the Audit Committee before the start of each financial year
- (f) Appoint a competent and suitable Local Anti-Fraud Specialist in line with Secretary of State and NHS Protect guidance
- (g) Ensure effective counter fraud arrangements that are in line with the regulatory requirements set out by the Secretary of State and NHS Protect, are in place and monitored.
- (h) Ensure that a report is prepared for the Audit Committee at least twice annually and should cover:
 - Progress against the agreed annual plan
 - Progress in respect of fraud referrals noted on the fraud log

The Chief Financial Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

- (a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- (b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
- (c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and
- (d) explanations concerning any matter under investigation.

3.3 The Role of Internal Audit

Internal Audit will review, appraise and report upon:

- (a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- (b) the adequacy and application of financial and other related management controls;
- (c) the suitability of financial and other related management data;
- (d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - (i) fraud and other offences;
 - (ii) waste, extravagance, inefficient administration;
 - (iii) poor value for money or other causes.
- (e) Internal Audit shall also independently verify the Annual Governance Statement in line with guidance from the Department of Health.

Whenever Internal Audit discovers any matter which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, or fraud, the Chief Financial Officer must be notified immediately.

The Director of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

The Director of Internal Audit shall be accountable to the Chief Financial Officer. The reporting process for Internal Audit shall be agreed between the Chief Financial Officer, the Audit Committee and the Director of Internal Audit. The agreed process shall comply with the guidance on reporting contained in the NHS Internal Audit Standards and be reviewed at least every three years.

3.4 Role of the Local Counter Fraud Specialist (LCFS)

The Local Counter Fraud Specialist shall report to the Trust's Chief Financial Officer and shall work with staff in the NHS Protect and the Regional Counter Fraud and Security Management Services (RCFSMS) in accordance with the Department of Health and NHS Protect Guidance.

The Local Counter Fraud Specialist will provide written reports on counter fraud work within the Trust to the Audit Committee at intervals agreed with the Chief Financial Officer, but at least twice annually.

3.5 Appointment of the External Audit Function

The External Auditor is appointed by the Trust. In line with national guidance, the Audit Committee will act as the “panel” responsible for the selection process of the External Auditors. The Audit Committee will advise the Board of Directors of the recommended External Audit appointment. The Board will approve the appointment.

4. FINANCIAL PLANNING, BUDGETARY CONTROL AND MONITORING

4.1 Board

The Board will approve an annual financial plan setting out key financial targets and milestones.

The Plan will be submitted to the Trust’s Regulatory body.

The financial plan will involve the formal devolution of financial budgets to health groups and directorates

4.2 Chief Executive

As Accountable Officer the Chief Executive delegates powers to Officers in their role as first line budget holders

The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- (a) the amount of the budget;
- (b) the purpose(s) of each budget heading;
- (c) individual and group responsibilities;
- (d) authority to exercise virement;
- (e) achievement of planned levels of service;
- (f) the provision of regular reports.

Delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

The Chief Executive (in conjunction with the Chief Financial Officer) is responsible for identifying a programme of cash releasing efficiency savings and productivity gains for inclusion in the annual financial plan

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the appropriate monitoring organisation.

4.3 Chief Financial Officer

Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

- (a) be in accordance with the aims and objectives of the local health and social care economy;
- (b) Be consistent with workforce and activity assumptions;
- (c) be produced following discussion with appropriate budget holders;
- (d) be prepared within the limits of available funds;
- (e) identify potential risks.

The Chief Financial Officer shall monitor financial performance against allocated budgets and the annual plan, regularly review them and report appropriately to the Board.

The Chief Financial Officer will devise and maintain robust systems of budgetary control. These will include:

- (a) monthly financial reports to the Board in a form approved by the Board containing:
 - (i) income and expenditure to date showing, trends and year end forecasts;
 - (ii) movements in working capital;
 - (iii) movements in cash and capital;
 - (iv) capital programme spend and projected outturn against plan;
 - (v) explanations of any material variances from budget or plan;
 - (vi) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officers view of whether such actions are sufficient to correct the situation;
- (b) the issue of timely, accurate and comprehensive financial reports to each budget holder, covering the areas for which they are responsible;
- (c) investigation and reporting of variances from financial, activity and workforce plans and targets;
- (d) monitoring of management action to correct variances
- (e) sound arrangements for the authorisation of budget virements.

The Chief Financial Officer has a responsibility to ensure that there is adequate provisions for financial training for budget holders in order to facilitate robust budget management.

4.4 Budget Holders

4.4.1 General Principles

All budget holders will sign up to their allocated budgets at the commencement of each financial year

All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Financial Officer, subject to any authorised use of virement.

Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Financial Officer.

4.4.2 Budgetary Control and Reporting

Each Budget Holder is responsible for ensuring that:

- (a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Financial Officer.
- (b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

- (c) no permanent employees are appointed without the approval of the Chief Financial Officer other than those provided for within the available resources and manpower establishment as approved by the Board.

4.4.3 General

The general principles applying to delegation and reporting shall also apply to capital.

4.4.4 Monitoring Financial Performance

The Chief Finance Officer will provide regular reporting of the overall Trust financial position for the current financial year and for future financial periods.

For the purposes of monitoring performance against budget as part of the overarching financial framework. The Board will look to the following Board members for assurance regarding financial performance:

- Individual corporate directors for their own individual portfolios (corporate directorates)
- Chief Operating Officer for the overall performance of the clinical Health Groups within the Trust.

5. ANNUAL ACCOUNTS AND ANNUAL REPORT

The following have responsibilities in relation to the Annual Accounts and Annual Report

5.1 Chief Executive

The Chief Executive will:

- (a) ensure that an Annual Report is published and presented to a public meeting by the prescribed deadline
- (b) ensure the Annual Report shall be compliant with The NHS Manual for accounts guidance on the content of Annual Reports

5.2 The Chief Financial Officer,

The Chief Financial officer will:

- (a) By the prescribed date, prepare and submit annual accounts and financial returns in accordance with the Trust's accounting policies, generally accepted accounting principles, and guidance given by the Department of Health and HM Treasury,
- (b) Ensure that annual accounts are audited by the external auditors and the accounts are approved by the Board before submission to the NHS Improvement and the Department of Health.
- (c) Ensure that audited returns and accounts are submitted to the NHS Improvement together with any relevant audit reports, in line with nationally agreed deadlines.
- (d) A copy of the Annual Accounts will be made available to the public and presented at a public meeting

6. BANK ACCOUNTS

6.1 Trust Board

The Trust Board is responsible for approving banking arrangements, including authorising the opening and closing of new accounts.

6.2 Chief Financial Officer

The Chief Financial Officer will:

- (a) Manage the Trust's banking arrangements
- (b) Advise the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health, NHS Improvement or other regulatory body
- (c) Be responsible for the operation of all bank accounts held by the Trust (commercial and Government Banking Service accounts), including those used for charitable funds.
- (d) Ensure accounts do not fall into overdraft other than where proper arrangements have been agreed and approved.
- (e) Report to the Board arrangements made for overdraft facilities
- (f) Monitor compliance with Department of Health and NHS Improvement guidance on the level of cleared funds permitted within commercial bank accounts.
- (g) Set out the conditions under which each bank account is to be operated;
- (h) Detail those authorised to sign cheques or other orders drawn on the Trust's accounts or make changes to the banking mandates
- (i) Report changes to banking arrangements to the Trust Board for approval

The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each bank account will be operated.

The Chief Financial Officer will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by market testing at least every 8 years. The results of the tendering exercise should be reported to the Board.

7. INCOME, FEES & CHARGES AND DEBT RECOVERY

7.1 All Employees

All staff shall follow the Department of Health's advice in the "Costing for contracting" Manual and "Payment by Results" guidance in setting prices for NHS service agreements.

All employees must inform the Chief Financial Officer promptly, and in accordance with procedure, of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

Only officially prescribed stationery and receipts should be used to record monies receivable/received

7.2 Chief Financial Officer

The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. This includes prompt banking of all monies received.

The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in

the Department of Health's Commercial Sponsorship – Ethical standards in the NHS - shall be followed. Actions should also be in accordance with the Trust's policies on business and professional conduct.

The Chief Financial Officer is responsible for ensuring appropriate recovery action on all outstanding debts, such actions should be cost effective. Income considered uncollectable should be dealt with in accordance with debt collection, write off, and losses procedures.

Systems and processes should be designed to minimise overpayments however where they do occur appropriate recovery action should be initiated by the Chief Financial Officer. Such actions should be cost effective

8. CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

8.1 All Employees

All receipts of cash, cheques and other negotiable instruments, including those in respect of charitable funds should be banked as soon after receipt as is practicable.

All cash received should be banked intact. i.e. as received. Disbursements should always be made from separate cash floats unless expressly authorised by the Chief Financial Officer

Those responsible for cash floats should never use Trust money for the encashment of private cheques

The holders of safe keys shall not accept unofficial funds for depositing in their safes other than those in the scope of the patient's property and money procedures.

8.2 Chief Financial Officer

The Chief Financial Officer is responsible for:

- (a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- (b) ordering and securely controlling any such stationery;
- (c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
- (d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

9. TENDERING AND CONTRACTING PROCEDURE

9.1 General

The procedure for making all contracts by or on behalf of the Trust will encompass the requirements of these Standing Orders and Standing Financial Instructions

Directives by the Council of the European Union promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

The Trust shall comply as far as is practicable with the requirements of the Department of Health, other regulatory bodies, the requirements of “Estate code” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

The table below summarises the requirement in relation to tenders and quotations and should be viewed in conjunction with the detailed guidance below.

Value of Goods/Services	Tender/quotation requirement
Less than £10k (including VAT)	Use NHS supply chain and established contracts where possible otherwise obtain a quotation (see guidance below)
Between £10k and up to £50k (including VAT)	Obtain a quotation (see guidance below)
£50k to £138,760 (including VAT)	Undertake a local tender exercise (see guidance below)
More than £138,760 (Including VAT)	Tender exercise using EU procurement procedures

Programmes of “works” have an EU tender threshold of £5,336,937, including VAT

*The table below shows the 2 OJEU limits, including VAT

Goods and Services – central procurement including NHS Trusts	£138,760
Works	£5,336,937

9.2 Formal Competitive Tendering

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the tendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.
- Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

9.3 Exceptions and instances where formal tendering need not be applied

Tenders exceeding the OJEU limit can never be waived or not applied, however formal tendering procedures (for contracts expecting to be under the OJEU limit) need not be applied where:

- (a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000 over the life of the contract. In these circumstances formal quotes should be requested
- (b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;
- (d) regarding disposals as set out in Standing Financial Instruction number 9.17.

Items estimated to be below the £50,000 limit set out above which subsequently prove to have a value in excess of £50,000, shall be reported to the Chief Financial Officer and recorded by the Head of Procurement. That record should be reported to the Audit Committee at least annually.

9.4 Formal tendering procedures may be waived in the following circumstances:

- (a) in very exceptional circumstances where the Chief Executive or Chief Financial Officer decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record (with the exception of tenders over the OJEU limit).
- (b) where the requirement is covered by an existing contract;
- (c) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
- (d) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender; *(This only applies if the value of the contract does not exceed the OJEU limit)*
- (e) where specialist expertise is required and is available from only one source; *(This only applies if the value of the contract does not exceed the OJEU limit)*
- (f) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; *(This only applies if the value of the contract does not exceed the OJEU limit)*
- (g) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases it should be clearly demonstrated that the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; *(This only applies if the value of the contract does not exceed the OJEU limit)*
- (h) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at least twice annually.

The Trust shall always ensure that invitations to tender or quote are sent to a sufficient number of companies/individuals to provide fair and adequate competition. In no circumstances should this be less than two firms/individuals, and accounts should be taken of their capacity to supply the goods or materials or to undertake the services or works required.

9.5 Detailed Tendering Procedure

9.5.1 Invitation to tender

- (i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.
- (ii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable at the time
- (iii) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

9.5.2 Acceptance/Evaluation of formal tenders

- (i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.
- (ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be explicitly recorded in the contract file.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

- (a) experience and qualifications of team members;
- (b) understanding of client's needs;

- (c) feasibility and credibility of proposed approach;
- (d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

- (iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or the Chief Financial Officer.
- (iv) The Trust must demonstrate that the award of the contract was:
 - (a) not in excess of the going market rate / price current at the time the contract was awarded;
 - (b) that best value for money was achieved.
- (v) All tenders should be treated as confidential and should be retained for inspection by the procurement department or the Infrastructure and Development directorate.

Reports on tender activity to the Audit Committee will be made on an exceptional circumstance basis only

9.6 List of approved firms for building engineering and construction work

- (i) Invitations to tender shall be made only to companies included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).
- (ii) Companies included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of Age, Race, Religion and Belief, Disability, Gender, Gender Reassignment, Sexual Orientation, Pregnancy and Maternity, Marriage and Civil Partnerships and will comply with the provisions of the Equality Act 2010, Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.
- (iii) Companies shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

9.7 Financial Standing and Technical Competence of Contractors

The Chief Financial Officer may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

If in the opinion of the Chief Executive and the Chief Financial Officer or the Board member with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Financial Officer should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list. –

9.8 Quotations: Competitive and non-competitive

General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £50,000. The purpose of a quotation is to provide comparison and achieve best value for money.

9.9 Competitive Quotations

- (i) Quotations should be obtained from at least 3 companies/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
- (ii) Quotations should only be in writing
- (iii) All quotations should be treated as confidential and should be retained for inspection.
- (iv) The Chief Financial Officer or his nominated officer(s) (see table 9.12) should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

9.10 Non-Competitive Quotations (ie single quotes)

Non-competitive quotations in writing may be obtained in the following circumstances:

- (i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
- (ii) the supply of goods or manufactured articles of any kind which are required urgently and could affect a service provision if not purchased and are not obtainable under existing contracts;
- (iii) miscellaneous services, supplies and disposals;
- (iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

9.11 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Chief Financial Officer.

9.12 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the total value of the contract as follows:

Budget Holder	Up to £50,000
Chief Executive or Chief Financial Officer	Up to £500,000
Chief Executive or Chief Financial Officer and Chairman/vice Chairman	£500,000 up to £1M
Performance and Finance Committee	£1M up to £3M
Trust Board	£3M and over
All lease tenders must be authorised by the Chief Executive or Chief Financial Officer	All

These levels of authorisation may be varied or changed from time to time and therefore need to be read in conjunction with the Trust Board's Scheme of Delegation.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board and the Performance and Finance Committee this shall be recorded in the minutes.

Where competitive tendering or a competitive quotation is not required (i.e. where expenditure is less than £10,000) the Trust should adopt one of the following alternatives:

- (a) the Trust shall use the NHS Supply Chain for procurement of all goods and services, where applicable, unless the Chief Executive or nominated officers deem it inappropriate or impractical. The decision to use alternative sources must be documented and retained by the requisitioner.
- (b) If the Trust does not use the NHS Supply Chain, or any other agreed contracts the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer.

9.13 Private Finance funded procurements (see overlap with SFI No. 24)

On consideration of a PFI funded procurement the following should apply

- (a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
- (b) The proposal must be specifically agreed by the Board of the Trust.

- (c) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

9.14 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and/or regulatory body and shall comply with:

- (a) The Trust's Standing Orders and Standing Financial Instructions;
- (b) EU Directives and other statutory provisions;
- (c) any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;
- (d) such of the NHS Standard Contract Conditions as are applicable.
- (e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.
- (f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.
- (g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Financial Officer shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

9.15 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into temporary contracts for services with agencies or personal service companies. Such contracts are not covered by these procurement rules, however, officers and employees should use agencies with whom national and local contracts have been negotiated wherever possible. Officers and employees should have regard to pay regulations governing the payment to and rates paid to temporary and agency workers.

9.16 Healthcare Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefit Corporation, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

9.17 Disposal of Equipment

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- (a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;
- (b) obsolete or condemned articles and stores, which may be disposed of in accordance with the disposal policy / guidance,
- (c) items with an estimated sale value of less than £100, this figure to be reviewed on a periodic basis;

- (d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- (e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

9.18 Tendering of In-house Services

The Chief Financial Officer shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

- (a) Specification group, comprising the Chief Financial Officer or nominated officer/s and specialist.
- (b) In-house tender group, comprising a nominee of the Chief Financial Officer and technical support.
- (c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Financial Officer or representative.

All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Board.

The Chief Financial Officer shall nominate an officer to oversee and manage the contract on behalf of the Trust.

9.19 Charitable Funds

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's Trust funds and private resources.

9.20 Trust submission of bids for new areas of work

It is part of the Chief Executive's executive powers to approve tender submissions. The Chief Executive discharges this responsibility through the Chief Operating Officer who will sign off the final tender response and the Chief Financial Officer who will sign off the final financial model.

Within the procurement timeline sufficient time will be allowed for a final review of the Invitation to Tender (ITT) response or bid submission by the appropriate Trust Committee and, where required, for any necessary alterations to be made to the final submission. The Chief Operating Officer and Chief Financial Officer are required to sign off this final version prior to submission.

The Committees providing relevant sign-off based on the total value of the contract bid for are:

- Health Group Triumvirate/Directorate sign off – value up to £100K
- Executive Management Committee for £100k - £2m
- Performance and Finance Committee (value £2m - £5m)
- Trust Board (value over £5m)

In the event that there is insufficient time within the tendering process to enable sign off at the appropriate committee, authority will be given to the Chief

Operating Officer and Chief Financial Officer (or in their absence another member of the Executive Team) to sign off the final ITT for submission. If it is a bid of a value of more than £2m, this will also require the signature of the Chairman (or in their absence another Non-Executive Director).

10. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

10.1 Service Level Agreements (SLAs)

10.1.1 Chief Executive

The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners and providers for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within local strategies and plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways
- That SLA's are clear on costs, volumes and outcomes.

The Chief Executive will ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the services required to ensure all parties are appropriately involved in planning and management of risks.

The Chief Executive will ensure that the SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

The Trust's main activity is to provide healthcare services. Guidance should be sought from the Chief Financial Officer where commissioning activities are necessary.

10.2 Remuneration of Staff and Payment of expenses

10.2.1 General

In accordance with Standing Orders the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined

terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

The Committee shall report in writing to the Board the basis for its decisions.

The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health and other regulatory bodies as appropriate.

10.2.2 Chief Financial Officer

The Chief Financial Officer is responsible for:

- (a) specifying timetables for submission of properly authorised time records, expense claims and other notifications;
- (b) the final determination of expenses pay and allowances;
- (c) making payment on agreed dates;
- (d) agreeing method of payment.

The Chief Financial Officer will issue instructions regarding:

- (a) verification and documentation of data;
- (b) the timetable for receipt and preparation of payroll and expense data and the payment of employees and allowances;
- (c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- (d) security and confidentiality of payroll and related information;
- (e) checks to be applied to completed payroll and expenses before and after payment;
- (f) authority to release payroll and expenses data under the provisions of the Data Protection Act;
- (g) methods of payment available to various categories of employee and officers;
- (h) procedures for payment to employees and officers;
- (i) procedures for the recall of cheques and bank credits;
- (j) pay advances and their recovery;
- (k) maintenance of regular and independent reconciliation of pay and expense control accounts;
- (l) separation of duties of preparing records and handling cash;
- (m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.
- (n) specifying the arrangements for accepting deductions from employees gross/net pay
- (o) specifying the arrangements to be put in place to recover overpayment of salary and expenses.

The Chief Financial Officer will:

- (a) Reject or refer payments in whole or in part where they contravene Trust policies, contracts or employment/terms of service and liaise with the Chief Executive where appropriate
- (b) Reject in whole or in part expense claims where they contravene agreed policies procedures, contracts of employment/terms of service

Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of authorised payroll deductions and payment of these to appropriate bodies.

10.2.3 Appropriately nominated managers (budget holders)

Appropriately nominated managers (budget holders) have delegated responsibility for:

- (a) submitting time and expense records, and other notifications in accordance with agreed timetables;
- (b) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;
- (c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.
- (d) In so far as they are able, ensuring that all claims for remuneration and expenses are genuine and reasonable.

11. NON-PAY EXPENDITURE

11.1 General Principles

Those placing requisitions for goods and services should always ensure that they obtain the best value for money. The Trust's Head of Procurement is able to offer advice in relation to obtaining best value for money.

Payments for goods or services will only be made where it can be proven that those goods or services have been received, and that the price charged is correct and as agreed.

Payment for goods and services should not be made in advance of receipt those goods or services other than with the express agreement of the Chief Financial Officer. See conditions for making prepayments below

On an annual basis, the Board will approve the level of non-pay expenditure as part of the agreement of the financial plan and budgets. The annual plan will delegate the level of non- pay expenditure to budget holders.

The financial scheme of delegation will set out the delegated level of approval for non-pay transactions depending on the nature and value of the transaction and will be determined by the Chief Financial officer. The scheme of delegation will also set out the levels at which competitive quotes and tenders should be sought

Prepayments for goods and services are only permitted where exceptional circumstances apply. In such instances:

- (a) Prepayments are only permitted where the financial advantages outweigh the disadvantages

- a) (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).-The opportunity cost / availability of cash is considered
- b) The budget holder must provide to the Chief Financial Officer a written report setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
- c) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
- d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Chief and Chief Financial Officer.

11.2 Chief Financial Officer

The Chief Financial Officer will:

- (a) Advise the Board on the threshold above which quotations or formal tenders will be required for goods and services.
- (b) devise procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds
- (c) set out procedures on the seeking of professional advice regarding the supply of goods and services, ensuring they are in accordance with relevant guidance.

The Chief Financial Officer will set out and maintain:

- (a) a list of those who are authorised to place requisitions for the supply of goods and services;
- (b) the maximum level of authority for those authorised to requisition goods and services.
- (c) detailed procedures for the ordering of goods and services which will include verification procedures, legal compliance, authorisation, official stationery requirements and will incorporate adequate internal controls
- (d) detailed procedures covering the approval and verification of accounts for payment. These shall include controls on the verification of invoices including confirmation of prior receipt of goods and services, prices charged, discounts applicable, and, arithmetic accuracy.

The Chief Financial Officer will authorise all prepayments.

11.3 Budget Holders, Managers and Officers

Budget holders, Managers and Officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

- (a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;
- (b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

- (c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health or Regulator;
- (d) no order shall be issued for any item or items to any firm or company which has made an offer of gifts, reward or benefit to directors or employees, other than as set out in the Declarations Policy.

(This provision needs to be read in conjunction with the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff”);

- (e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;
- (f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
- (g) verbal orders will only be issued exceptionally and will be confirmed by an official order and clearly marked "Confirmation Order";
- (h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- (i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
- (j) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Financial Officer within a reasonable timescale following the change;

The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE, OGC, and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

12. EXTERNAL BORROWING AND INVESTMENT

12.1 Borrowing

All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health and regulatory body.

Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Board must be made aware of all short term borrowings at the next Board meeting.

Applications for capital investments or loans will be subject to approval by the Department of Health and the Trusts regulatory body.

Capital Investment loans and receipt of Public Dividend Capital (PDC) must be consistent with the Trust's financial strategy and should always be approved by the Board

12.1.1 Board

The Board must approve all capital investment loans and receipts of PDC

The Board will agree the list of employees (including specimens of their signatures) who are authorised to take short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer

12.1.2 Chief Financial Officer

The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on, and repay any proposed new borrowing

The Chief Financial Officer is also responsible for reporting to the Board at least annually the position of all borrowings. (loans, PDC, and overdraft facilities).

The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.2 Investments

Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and regulatory bodies. The Trusts Investment policy sets out the nature of organisation the Trust will invest in.

12.2.1 Board

The Board should authorise the investment policy

12.2.2 Chief Financial Officer

The Chief Financial Officer is responsible for advising the Board on investments within the boundaries of the investment policy and shall report periodically to the Board concerning the performance of investments held.

The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13. FINANCIAL FRAMEWORK

The Chief Financial Officer should ensure that members of the Board are aware of the Financial Framework. This document contains the financial directions which the Trust must follow. The Chief Financial Officer should also ensure that the direction and guidance in the framework is followed by the Trust.

14. CAPITAL INVESTMENT

14.1 Capital Investment in Property plant and Equipment

14.1.1 Board

The Board should approve the quantum and content of the capital investment programme before the start of each financial year. The approval of a capital investment programme does not constitute approval to incur costs.

The Board should oversee capital investment by receiving progress reports at least quarterly

All projects considered under a PFI initiative should be approved by the Board.

14.1.2 Chief Financial Officer

The Chief Financial Officer:

- (a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- (b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- (c) shall ensure that the capital investment is not undertaken without confirmation of Commissioners support where applicable and the availability of resources to finance all revenue consequences, including capital charges.

For every capital expenditure proposal the Chief Financial Officer should see it.

- (a) that a business case (in line with the Trusts business case guidance) is produced setting out:
 - (i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
 - (ii) the involvement of appropriate Trust personnel and external agencies;
 - (ii) appropriate project management and control arrangements;
- (b) that the business case has certified professionally to the costs and revenue consequences of the proposal.

For capital schemes where the contracts stipulate stage payments, the Chief Financial Officer will issue procedures for their management, incorporating the recommendations of "Estate code".

The Chief Financial Officer is responsible for the maintenance of an asset register recording all items of capital investment (as defined within the Trusts accounting policies). The register should be in a format that identifies where the asset is located, and includes a data set that facilitates recording the value of the asset in line with accounting policies

The Chief Financial Officer will ensure that there are adequate arrangements in place to confirm the existence of assets. Discrepancies should be reported to the Chief Financial Officer

The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Financial Officer is responsible for devising processes to regulate capital expenditure within approved limits of the approved capital programme, including a scheme of delegation that is in line with the instructions and limits issued by the Trusts regulatory

body. The current scheme of delegation for capital investment is set out below.

Total Value	Approver
£3M and above	Trust Board & NHS Improvement
£1M up to £3M	Performance and Finance committee
£100K up to £1M	Executive Management Committee
Up to £100K	Capital Resource Allocation Committee

The Chief Financial Officer shall ensure adequate arrangements for the regular reporting of expenditure and commitments against authorised capital budgets.

Where PFI funding is being considered the Trust Chief Financial Officer will ensure compliance with the requirements of its regulatory body. All PFI initiatives need Board approval prior to proceeding.

The Chief Financial Officer should offer advice in respect of capital investment to the Board.

14.1.3 All Staff

All staff have a duty to ensure that property, plant and equipment assets are used, safe guarded, and maintained responsibly. Wherever possible all should be marked clearly as Trust property.

15. INVENTORY AND CONSUMABLES RECEIPT OF GOODS

15.1 General Principles

Inventory should always be kept to the minimum level possible and should always be the subject of an annual stock take as set out in the Chief Financial Officers stock take instructions. Material holdings of inventory should be checked at least twice annually.

Inventory should be valued in accordance with the prevalent accounting policies, the appropriate methodology is set out in the Chief Financial Officers stock take instructions.

15.2 Chief Executive

The Chief Executive, through the scheme of delegation, shall delegate responsibility to individuals for the management and safe keeping of inventory and consumables.

15.3 Chief Financial Officer

The Chief Financial Officer has delegated responsibility for ensuring adequate systems of financial control. The Chief Financial Officer shall therefore set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, losses, stock counting and valuation.

The Chief Financial Officer will authorise systems of stores and control, where the value held is greater than £750k

The Chief Financial Officer will ensure that systems are in place to ensure he can satisfy himself that the goods have been received

The Chief Financial Officer will authorise all bulk purchases of inventory.

15.4 Designated staff

The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated Estates Manager.

The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated Manager/Pharmaceutical Officer. Wherever practicable, inventory should be marked as health service property.

The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.

The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also Losses and Special Payments guidance). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Any proposed bulk purchases of inventory should be notified to the Chief Financial Officer and be authorised by him before a purchase is made.

15.5 All Staff and Budget Holders

For goods supplied via the NHS Logistics central warehouses, the Chief Financial Officer shall identify those authorised to requisition and accept goods from the store and this will be set out within the financial scheme of delegation. The authorised person shall check receipt against the delivery note and satisfy themselves that the goods have been received before accepting the charge.

Any proposed bulk purchases of inventory should be notified to the Chief Financial Officer and be authorised by him before a purchase is made.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 Disposal and Condemnation of assets

16.1.1 Chief Financial Officer

The Chief Financial Officer must prepare detailed procedures for the disposal or condemnation of property, plant equipment and other assets such as inventory. These procedures should be notified to managers

16.1.2 All Staff

All staff have a responsibility to safeguard the interests and assets of the Trust at all times

Assets should only be condemned or disposed of if deemed unserviceable and the decision to condemn must be taken by an

employee authorised by the Chief Financial Officer to make such decisions

The procedure for disposals sets out the decision making and authorisation process.

Staff should report negligent use of Trust assets to the Chief Financial Officer

16.2 Losses and Special Payments

16.2.1 The Chief Financial Officer

The Chief Financial Officer must prepare procedural instructions on recording losses, and special payments. Such instruction should include the maintenance of a register, the content of the register should be reported to the Audit Committee twice annually.

The Chief Financial Officer must notify NHS Protect and the External Auditor of all frauds.

For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify the Board and External Auditors.

Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved

The Chief Financial Officer should ensure that the Trust follows the losses and special payments guidance issued by the Department of Health and other regulatory bodies, and acts within the delegated limits from those authorities. The Chief Financial Officer should seek authorisation and advice from the regulatory body and/ or the Department of Health where payments are expected to fall outside the Trust's delegated limits

The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

16.2.2 All Staff

Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive or the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss – for example the Local Counter Fraud Specialist or the Local Security Management Specialist

This notified officer will then appropriately inform the Chief Financial Officer and/or Chief Executive.

Where fraud or corruption is suspected the employee must inform the Local Counter Fraud Specialist (LCFS) or Chief Financial Officer, the matter will then be dealt with under the Local Anti-Fraud Bribery and Corruption Policy.

17. INFORMATION TECHNOLOGY

17.1 Chief Financial Officer

The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

- (a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programmes and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;
- (b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
- (c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
- (d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.
- (e) ensure that the Trust complies with the obligations and principles set out in:
 - Data Protection Act 1998
 - NHS Information Governance Standards
 - NHS Code of Practice: Confidentiality
 - NHS Code of Practice: Information Security Management
 - The Caldicott Review

The Chief Financial Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

The Chief Financial Officer (in conjunction with the Trust Secretary) shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

17.2 Other Directors and Officers

Each proposed new computer systems must have a Project Sponsor. Whether the intention is to procure a solution as part of a consortium or to procure a system by the Trust for its sole use, Directors and Officers involved in the planning of such systems must:

- (a) take due regard of, and ensure compliance with, national IM&T Strategy, particularly regarding the procurement of clinical systems and the development of unified, electronic patient records;
- (b) notify the Director of IT & Innovation of the outline requirements of the system and design requirements prior to any procurement commencing
- (c) ensure that Trust IM&T staff are involved in all stages of the planning, procurement and installation of new systems and upgrades;

- (d) ensure compliance with Trust IM&T Policies and Technical Standards. Systems and hardware must not be procured, or applications developed, which do not comply with relevant Trust technical standards;
- (e) ensure that new clinical systems are technically able to connect to the Trust's infrastructure and, where applicable, are able to connect to and share data with, existing clinical systems
- (f) in the case of packages acquired either from a commercial organisation, from the NHS or from another public sector organization, ensure that Trust technical standards are complied with

Financial support for, and approval of, IM&T procurements will be regulated in accordance with the committee structure and scheme of delegation pertaining to investment.

It is the responsibility of the Project Sponsor to ensure that, before any commitment to procure or develop a system is made a Proof of Concept is submitted to the appropriate authorising body for approval in principle. All procurements will be supported by Business Cases.

17.3 Contracts for Computer Services with other health bodies or outside agencies

17.3.1 Chief Financial Officer

The Chief Financial Officer shall ensure that contracts for computer services and/or applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

The Chief Financial Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate Business Continuity and Disaster Recovery plans.

17.3.2 General

For non-financial applications it is the responsibility of the appropriate Trust Director to ensure that the contracts with the suppliers clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

For any services and systems hosted and managed by third parties, evidence of appropriate controls should be periodically obtained for audit purposes.

17.4 Computer Systems which have an impact on corporate financial systems

17.4.1 Chief Financial Officer

Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that:

- (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy & Trust Technical Standards;
- (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- (c) Chief Financial Officer staff have access to such data;
- (d) such computer audit reviews as are considered necessary are being carried out.

18. PATIENTS' PROPERTY - check this fits with new procedures

The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.1 Chief Executive

The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.2 Chief Financial Officer

The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.3 All staff

All Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

All staff shall abide by the policies and procedures for managing patients money at all times.

19. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

19.1 General

Section C of Standing Orders outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust. Trust funds should always be managed in accordance with the law and Charities Commission requirements and the Charities own internal policies

The discharge of the Trust's Corporate Trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety as set out in these Standing Financial Instructions.

19.2 The Board

The Trust discharges its operational duties through the Charitable Funds Committee however the Board remains fully responsible and accountable for funds held on trust as the physical embodiment of the Trust.

19.3 Charitable Funds Committee

The committee shall, on behalf of the Board, manage the strategic and policy decisions relating to funds held on trust.

The charitable funds committee shall oversee the operational management of funds held on trust as provided by the Chief Financial Officer.

19.4 Chief Financial Officer

The Chief Financial Officer shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

The Chief Financial Officer will discharge the duties of the Charitable Funds Committee in terms of the daily operational management of charitable funds, and legal and financial reporting requirements

The Chief Financial Officer is responsible for devising policies and control mechanisms (both financial and non financial) for ratification by the charitable funds committee

19.5 All staff

The funds held on Trust's Financial Scheme of Delegation makes clear where decisions regarding the exercise of discretion regarding the use of the funds are to be taken and by whom. Decisions should not be taken outside of that scheme of delegation.

All staff authorised by way of the scheme of delegation should always have regard to its limitations and the policies and procedures governing the use of funds held on trust.

20. ACCEPTANCE OF GIFTS AND HOSPITALITY

The Chief Executive shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff (see the Trust's Declarations Policy). **All staff, Officers and contractors** should comply with the provisions of these policies.

21. RETENTION OF RECORDS

21.1 Chief Executive

The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines and various statutory requirements.

21.2 Chief Financial Officer

The Chief Financial Officer shall provide advice on the retention of financial records.

The records held in archives shall be capable of retrieval by authorised persons.

Records should only be destroyed in accordance with best practice guidance, and at all times have regard to information governance principles.

22. RISK MANAGEMENT

22.1 General

The Trust should maintain a programme of risk management which must be approved and monitored by the Board.

The programme of risk management shall include:

- a) a process for identifying and quantifying risks and potential liabilities;
- b) engendering among all levels of staff a positive attitude towards the control of risk;
- c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- d) contingency plans to offset the impact of adverse events;
- e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
- f) a clear indication of which risks shall be insured;
- g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make Statements on the effectiveness of Internal Controls within the Annual Report and accounts as required.

22.2 Board

The programme of risk management should be approved by the Board

23. INSURANCE

23.1 General

The Trust will use the NHS Risk Pooling Scheme, including the Clinical Negligence Scheme, unless otherwise agreed by the Board.

Insurance arrangements with commercial insurers should not be entered into other than those below

- (1) **Insuring motor vehicles** owned (or lead) by the Trust including insuring third party liability arising from their use;
- (2) **Private Finance Initiative contract** or similar arrangements where the agreements stipulates commercial insurance arrangements should be used.
- (3) **Income generation activities** not covered by the risk pooling scheme
- (4) **Fidelity guarantee** – insuring the Trust against financial losses incurred through theft or fraud of senior officers of the Trust

23.2 Chief Financial Officer

Where there is any doubt about the Trust's powers to enter into commercial contracts of insurance, the Chief Financial Officer will consult the Trust's regulatory authority.

The risk pooling scheme requires Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Document Control			
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Consultation Process			
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All staff			

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Date	Version	Author	Revision description
September 2016	14	Trust Secretary	Updated
February 2017	15	Trust Secretary	Additional information on European limits added (Section 9 SFIs)
February 2018	16	Trust Secretary	Updates to Audit Committee scheme of delegation New paragraphs on bidding for new work (new paragraph 9.20 to SFIs)
May 2018	17	Trust Secretary	Updates to Quality Committee scheme of delegation Updates to Performance and Finance Committee scheme of delegation Replacement of all references to Director of Governance to Director of Corporate Affairs All approved by May 2018 Trust Board
September 2018	18	Trust Secretary	One change to the Remuneration Committee terms of reference in the scheme of delegation (Sept 18 Trust Board approval) Additional three clauses to Charitable Funds Committee in the scheme of delegation (July 2018 Trust Board approval)
May 2019	19	Trust Secretary	Insertion of additional sentence at paragraph 1 to reflect the Establishment Amendment Order that brought about the Trust's name change to Hull University Teaching Hospitals NHS Trust
July 2019	20	Trust Secretary	Amendment to Standing Financial Instructions for changes in OJEU thresholds
September 2019	21	Trust Secretary	Amendment to Standing Financial Instructions for clarity on proposals for new business and sign-off values
January 2020	22	Trust Secretary	Amendment to Standing Financial Instructions for changes in OJEU thresholds Formation of the Trust Board Workforce, Education and Culture Committee
April 2020	23	Trust Secretary	Addition of the temporary Covid-19 Ethics and Clinical Policy Prioritisation Sub-Committee in Standing Orders and the Scheme of Delegation
January 2022	24	Head of Corporate Affairs	Reviewed. Minor changes to the document control panel. Director of Governance and Head of Corporate Affairs added

September 2022	25	Head of Corporate Affairs	Amendment to Standing Financial Instructions for changes in OJEU thresholds.
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Hull University Teaching Hospitals NHS Trust

Trust Board Meeting

Agenda Item	Meeting	Trust Board Meeting	Meeting Date	13/09/2022
Title	Trust Strategy 2022-25 HUTH Strategic Delivery Framework Year 1 Objectives, progress as at 31.8.22 (mid-year report)			
Lead Director	Michelle Cady, Director of Strategy and Planning			
Authors	Michelle Cady, Director of Strategy and Planning Jackie Railton, Deputy Director, Strategy and Planning			
Report previously considered by (date)				

Purpose of the Report	Reason for submission to the Trust Board private session	Link to CQC Domain	Link to Trust Strategic Objectives 2021/22			
Trust Board Approval	Commercial Confidentiality	Safe	<table border="1"> <tr> <td>✓</td> <td>Honest Caring and Accountable Future</td> <td>✓</td> </tr> </table>	✓	Honest Caring and Accountable Future	✓
✓	Honest Caring and Accountable Future	✓				
Committee Agreement	Patient Confidentiality	Effective	<table border="1"> <tr> <td>✓</td> <td>Valued, Skilled and Sufficient Staff</td> <td>✓</td> </tr> </table>	✓	Valued, Skilled and Sufficient Staff	✓
✓	Valued, Skilled and Sufficient Staff	✓				
Assurance	Staff Confidentiality	Caring	<table border="1"> <tr> <td>✓</td> <td>High Quality Care</td> <td>✓</td> </tr> </table>	✓	High Quality Care	✓
✓	High Quality Care	✓				
Information Only	Other Exceptional Circumstance	Responsive	<table border="1"> <tr> <td>✓</td> <td>Great Clinical Services</td> <td>✓</td> </tr> </table>	✓	Great Clinical Services	✓
		✓	Great Clinical Services	✓		
		Well-led	<table border="1"> <tr> <td>✓</td> <td>Partnerships and Integrated Services</td> <td>✓</td> </tr> </table>	✓	Partnerships and Integrated Services	✓
✓	Partnerships and Integrated Services	✓				
	<table border="1"> <tr> <td></td> <td>Research and Innovation</td> <td>✓</td> </tr> </table>		Research and Innovation	✓		
	Research and Innovation	✓				
			<table border="1"> <tr> <td></td> <td>Financial Sustainability</td> <td>✓</td> </tr> </table>		Financial Sustainability	✓
	Financial Sustainability	✓				

Key Recommendations to be considered:

The Board is asked to receive the mid-year update, and to note the areas of progress against the Year 1 objectives of the refreshed Trust Strategy 2022-25.

Members of the Board are invited to provide any feedback, indicate where further information or assurance is required and to note that the full progress report for Year 1 of the 2022-25 Strategy will be presented in March 2023.

Our strategic ambitions 2022-25

	Goal	Element	Strategic ambition	
1	Great staff	Honest, caring and accountable culture	We will have a strong culture of inclusion, diversity and equality	
2			We will have a strong culture of learning and team led continuous improvement	
3		Valued, skilled and sufficient workforce	We will have a strong focus on the well-being of our staff	
4			We will have one of the most engaged and satisfied staff in the NHS	
5			We will have fewer vacancies and lower turnover	
6	Great Care	High Quality Care	We will receive an outstanding rating by our quality regulator	
7			We will increase harm free care	
8			We will improve patient experience and outcomes	
9		Great Clinical Services	We will improve access to our urgent and emergency care services	
10			We will improve our outpatient services, using technology to enable better access	
11			We will develop our specialist clinical services portfolio	
12			We will recover and improve access to elective services as part of our pandemic recovery programme	
13		Partnership and integrated services	We will develop effective partnerships with other providers	
14			We will play a key role in the reform of health and care systems and provision of services closer to home	
15			We will support the developing ICS structure and play a lead role in the Collaborative of Acute Providers and Place Partnerships	
16		Great Future	Financial sustainability	We will secure the long term financial health of the Trust
17				We will work with partners across the system in the aim of financial balance at system and ICS level
18			Environmental sustainability	We will further reduce our energy consumption and waste
19				We will become a greener organisation
20			Research and innovation	We will create a well-led 'research active and aware' workforce enabling high quality care for every patient through research opportunities
21	We will lead collaborative partnerships in the region to realise the full potential of research and innovation			
22	We will create a positive reputation through our research, increasing R&I capability and demonstrably improving patient care and experience			
23	Estates and infrastructure		We will agree an ambitious estates plan that delivers our clinical strategy and replaces our oldest clinical facilities	
24	Digital development		We will become a digital first organisation	
25			We will play a key role in the development and delivery of the Humber and ICS Digital strategy and plans	
26			We will work in partnership with neighbouring organisations and systems to develop more streamlined digital capability	
27			We will become a digitally mature, secure and resilient organisation	

Progress in delivering our strategic ambitions – Year 1 Objectives

Section 1: Great Staff

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
1	Great staff	Honest, caring and accountable culture	We will have a strong culture of inclusion, diversity and equality	Refreshed Equality Objectives plan and governance arrangements.	Equality Objectives (Public Sector Equality Duty)	Achieved Equality objectives 2022-26 agreed at July 2022 Trust Board.		SN
				Establish a new Exec led ED&I development group.	Workplace Race Equality Standard (WRES) Gender Pay Gap Workforce Disability Equality Standard (WDES) % of BAME staff in leadership roles	Achieved EDI Steering Group established – Chaired by CEO Revised governance arrangements include key ED&I projects and reports being standard agenda items on Workforce Transformation Committee, Workforce Education and Cultural Committee. The refreshed ED&I Steering Group has recently established a process to review standard reporting frameworks/requirements to ensure these actively influence ED&I projects and initiatives.	The make-up of the ED&I steering group including the staff network chairs has provided a direct connection for the staff representative groups to the senior leaders and has resulted in an increased focus on the delivery of initiatives that promote inclusivity for employees with protected characteristics. The ED&I Steering Group recognised the absence of any standard national reporting frameworks related to LGBTQ+. The Trust's Equality, Diversity and Inclusion Manager is currently working with the Chair of the LGBTQ+ Network to develop key	

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
							objectives for the 2022/23 year to be signed off via the LGBTQ+ Network and the Workforce Transformation Committee.	
				<p>Complete self-assessment against Anchor Institution standards.</p> <p>Contribute to HNY Anchor Institution work programme.</p>	Inclusive Anchor Organisation Framework	<p>February 2022 Anchor Institution self- assessment – HUTH as an Inclusive Anchor organisation: average score of Level 2 (Basic start point (level 1) to best practice (level 4)</p> <p>HUTH is working in partnership with HNY via the CAP work on Anchor development</p>		
				Completion of the inclusion development programme for all senior leaders.		First part completed with Exec and Triumvirates. Anti-racism training to restart autumn 2022	Programme paused due to Omicron Wave. Focus on anti-racism next to support Zero Tolerance Framework	

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Commit to lower paid staff reaching their potential		Creation of a widening participation team within learning and development to ensure access to development such as Maths and English and study skills for higher education for unqualified roles. New Level 2 apprenticeships in the pipeline. We also have a clear conditional pathway through the apprenticeship level to support staff from Healthcare Assistant through to Nurse Associate or Registered Nurse status. Internationally educated staff with nursing degrees, but working as Nursing Assistants, are supported to complete their OSCE examinations and a number now have their PINs and are working as qualified nursing staff.	Overall there is a raised profile of the EDI culture within the Trust due to increased communications activity promoting the positive work that the Trust is undertaking, which in turn fosters the importance of inclusion and equity amongst staff.	

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
2			We will have a strong culture of learning and team led continuous quality improvement	Become an accredited QSIR faculty/academy.	Confirmation of status as a QI Faculty/Academy. % of staff trained.	Achieved May 2022		SR
				Establish training programme for QI, including human factors training.		On track for March 2023.	Plans to implement a Human Factors hub to deliver training trust-wide. Training programme will be confirmed by this hub in line with PSIRF.	
				Implement Quality Strategy with supporting improvement programme.		Board approval March 2022, formal launch June 2022.		
				Introduce 'celebration events' to share service successes.		On track for October 2022.	Dates in diary.	
				Work with partners on joint QI programmes, particularly NLaG and Humber.		Complete	Joint training delivered with NLAG. Regular meetings between quality leads.	
				Agree a patient safety incident response plan.		PSIRF published nationally August 2022. On track for March 2023.		

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Implement 'making data count' at all levels of the organisation.		On track	Board training provided. SPC charts used in quality and performance reports. Training required for operational teams.	SR
				QI embedded with solution focussed thinking techniques in all Leadership Programmes.		Completed.	All Trust leadership programmes have elements of QSIR training embedded.	
3		Valued, skilled and sufficient workforce	We will have a strong focus on the well-being of our staff	A full programme of mental and physical programmes in place every quarter.	Take up of well-being and support services.	The Trust offer a number of programmes which support the mental health and wellbeing of staff and have recently appointed a new assistant psychologist to design and deliver programmes in collaboration with the mental wellbeing MDT.	The W&OD Team actively promotes and encourages attendance at ICB led programmes including Humber Recovery College and Resilience Hub. These ICB programmes compliment, rather than duplicate, the programmes offered by the Trust.	SN

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Staff will have had the opportunity to take part in a health and wellbeing conversation at least once per year.		Health and wellbeing conversations are now a core part of appraisal with a clear template embedded into the system which both appraisee and appraiser are prompted to complete.	Appraisal to be reviewed in 22/23 and any improvements to the conversation will be identified and acted upon. Currently staff member feeds back on the quality and usefulness of the conversation.	
				Trauma Risk Incident Management (TRIM) in place in key areas e.g., ED and ICU		TRIM Coordinator role in place within OD Team with 4 TRIM managers trained. 28 TRIM practitioners are also trained and ready to deploy. TRIM will be available in ED and ICU from September 2022. Rolling out to the wider Trust late Autumn/Early Winter 2022	TRIM principles are now embedded in the Trust's Critical Incident Stress Management (CISM) policy and the MAJAX Plans.	
				A reduction in stress related sickness. An increased in effective stress risk assessment in departments.	Stress related sickness absence	In progress		SN

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Overall score for Health and Wellbeing Is 6.2	Staff survey results on Health and Wellbeing	The Trust's overall score for the theme of "We are safe and healthy" is 5.8/10.	The Trust provides free yoga, mindfulness and walking groups every week for staff. The Staff Lottery funds a running club and a football team. Staff can participate in the gardening club and we have built a vegetable plot at Hull Royal Infirmary. There is a country walk route which has been constructed at Castle Hill. Free coaching is available via the coaching network	SN
4			We will have one of the most engaged and satisfied staff in the NHS	Overall score for engagement of 7.0. Staff reporting that they are able to make improvements happen 6.4 (this is one of the most critical elements of the overall score for engagement and the one we perform least well on)	Staff survey results on Engagement and Making Improvements	The Trust overall score for engagement is 6.7/10	The Trust has held a series of engagement events with staff to understand the challenges they face and developed a key four point plan - increased autonomy, ability to make improvements, clarity on strategy and vision, improved recruitment and retention. In this endeavour the Trust has set up a series of manager briefings with all Trust managers to set out the strategy for the next three years and encourage them to move away from a command and control approach to management of services. The Trust has launched a month-long Improvement Month to encourage and support staff to suggest ideas for	SN

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
							improvement and provide the support for them to deliver on their ideas. The ThinkTank received 84 suggestions in less than one week.	
				<p>Increase in use of online training via e-learning and live webinar services.</p> <p>Increase in access to IT via facilities in Suite 22, MEC and libraries.</p>	% of statutory and mandatory training compliance.	<p>Q1 82.6% compliance</p> <p>Review being completed of the hours needed to complete training online. Big Blue Button live webinars continue to remain popular with all key theoretical statutory and mandatory training available via this approach.</p> <p>Pilot of individual learning pods being available in clinical areas currently being trialled at CHH, Queen's Centre, Cardiology and Main Corridor wards allows easier access to IT based training facilities for clinical and medical staff.</p>	<p>Full review and training needs analysis taking place for all statutory and mandatory courses to ensure appropriate capacity to deliver is in place.</p>	SN
				<p>Appraisal to be fully reviewed and redesigned to have a more talent, performance and wellbeing focus.</p> <p>Increase in quality of the appraisal with</p>	<p>Appraisal review and redesign.</p> <p>Quality scores related to appraisal.</p>	<p>New Talent Management Group in place and Appraisal Focus Groups taking place in September and October 2022 to engage managers and staff on new appraisal design.</p>	<p>HEY247 is due to be upgraded to increase its capability significantly to deliver more user friendly and meaningful appraisals. This includes the exploration of bespoke appraisal templates to suit roles at</p>	SN

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				improvement in staff survey scores on all related questions around appraisal and development.		Development of success profiles for key roles to allow staff to have clear goals and career pathway plans. These will support appraisal discussions.	every level in the organisation.	
5			We will have fewer vacancies and lower turnover		Vacancy and turnover rates by profession and all staff groups.	<p>Overall, the Trust adjusted vacancy rate has reduced from 5.3% as at 30/6/21 to 4.1% as at 30/6/22. Nursing particularly reduced from 5.7% to 3.8%, as had Admin and Clerical from 6.1% to 0.4%. Estates and Ancillary staff have increased their vacancy rate from 6.2% to 14.2%.</p> <p>Turnover however has increased from 11.5% to 12.1% over the same period. This is largely across all staff groups, but particularly, the turnover rate in nursing has increased from 8.5% to 10.4%. Estates and Ancillary have risen from 8.3% to 12.5%.</p>	<p>The success of overseas recruitment and the apprenticeship to registered nurse and associated pathways have contributed to the improved vacancy rate.</p> <p>The doubling of vacancies in Estates is largely in Catering owing to short shift patterns, redeployment issues and uncompetitive pay rates. It has been a difficult year post Covid, and retention of staff has evidently suffered, however there is still a number of temporary staff brought in to support Covid efforts affecting this figure. In addition, a number of staff chose to retire and return (this affects turnover data) and a number of employees chose to stay longer than planned until the pressures of Covid eased and then left/ permanently retired.</p>	SN

Section 2: Great Care

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
6	Great Care	High Quality Care	We will receive an outstanding rating by our quality regulator	Develop and embed a Quality Strategy and associated improvement programme	Care quality ratings from our regulator (CQC Safe, Effective, Caring, Responsive, Well Led)	Quality Strategy Board Approved in March 2022. Launched officially June 2022/	Over 150 pledges made by staff in the first week of the Strategy launch. Improvement month Sept 22.	SR
				Implement assurance visits, including external representatives, for core services.		Completed – trialed in November 2021, implemented fully March 2022.	Improvements identified via visits, focus groups, interviews and data reviews being implemented across core services.	
				Become an accredited QSIR faculty.		Achieved in May 2022.	Trust now providing QSIR training – fundamentals and practitioner. QSIR also included in Trust leadership programmes.	
				Undertake risk maturity baseline.		Added to the Internal Audit programme for Q4 22/23.		

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
7			We will increase harm free care	Implement Patient Safety Incident Response Plan.	Increase in reporting of patient safety incidents	Q1 = 4,511 Q1 = 3,793		MP
				Align processes to the National Patient Safety Strategy	Increase in proportion of incidents reported as no or low harm	In progress		
				Have a robust programme of improvement for patient safety initiatives, as identified in above plan.		In progress		
				Agree patient safety indicators for services and obtain baseline information		In progress		
8			We will improve patient experience and outcomes	Implementation of Ockenden review changes.	Clinical outcome data. Patient feedback.	In progress and closely monitored via Quality Committees and Trust Board oversight. End of year report will summarise progress against the strategic ambition.		JL
				Improvements in Better Births indicators vs 2021 baseline.	Better Births indicators	In progress and closely monitored via Quality Committees and Trust Board oversight. End of year report will summarise progress against the strategic ambition.		JL

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Improvement in accessible information standards vs 2021 baseline.	Compliance with accessible information standards for booking appointments.	Patient preferences and AI needs recorded in EPR and alerts in place to assist with determining whether additional time, quiet waiting areas or sign language interpretation required		LB
					Use of patient preferences and accessible information needs for contacts/bookings. Accessible information needs recorded in patients' EPR to be used for future patient contacts	Refresh of AIS information on external website in coming months will include electronic patient contact form to enable clinical admin teams to be notified of patient preferences and AI needs. Process in place for recording preferences in EPR and instigating alert system.		LB
			We will improve access to our urgent and emergency care (UEC) services	New UTC will be operational on the HRI site.	Non-admitted UEC pathway efficiency. ED attendances seen within 4 hours	Q1 – 48.70%	On-site UTC was piloted Nov 21 – Mar 22; refreshed Urgent Care stream and team being put in place in ED in Q3 2022-23	ER
9		Great Clinical Services		Streaming function will be fully operational in line with exemplar ED services.	Streaming/signposting effectiveness.	RAT & Streaming model piloted in ECA July 22	Plan to put in place 12 hours of RAT & Streaming in ECA in Q3; new triage model for ECA being piloted Q3 – adopting national standards on triage	ER

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Increased use of SDEC pathways vs 2021 baseline.	Proportion of UEC work undertaken via SDEC measured against SDEC 100 and national AEC standards.	Part of Ground Floor pilot work July 22	Increased SDEC provision build in to Business As Usual plan from Ground Floor pilot review; for Q3-Q4	ER
				Increased use of UEC direct admission pathways vs 2021 baseline.	Proportion of specialty UEC work arranged on a direct admission basis.	Q1 = 1,710		ER
10			We will improve our outpatient services, using technology to enable better access	25% of OPA delivered via virtual route.	% of OP activity delivered virtually.	Q1 = 18.8%		ER
				5 specialities operating PIFU system.	Number of specialities delivering OP contact via PIFU	Q1 = 1.3%		ER
				Implementation of partial booking system in all specialties. 2% overall reduction in DNA and patient cancellation rates.	Wasted POA appointment slots. Use of information about patients, needs, preferences and capabilities and agreement of dates and times to ensure that more patients can fulfil their appointments.			ER

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Measurable reduction in the median wait for first OPA	Median waits for first OPA	Q1 = 15.81		ER
11			We will develop our specialist clinical and day surgery services as a tertiary provider	New strategic development objectives and action plans/projects in place. Development and agreement of a vascular SDIP with NHSEI Spec Com.	National standards for Vascular services	Vascular services strategy developed with two key areas: Vascular hybrid operating suite at HRI Production of a strategic assessment and case for change with regard to the longer term future	Key risk is being able to secure capital investment to develop and expand the service in line with current standards.	MC
				HUTH DSC first phase will be operational. Minimum 4 new theatre suites delivering 72 sessions per week.	Proportion of day surgery undertaken in dedicated day case facilities	Capital development programme on track to deliver phase 1 of new DSC in Q4 of 22/23		MC
				100	Volume of mechanical thrombectomy procedures undertaken in neuro/vascular Interventional Radiology	25 (Apr – July 2022)	Proposal for hours extension in mechanical thrombectomy service under consideration, aims to extend hours to 8-8 x 5 days from October 2022	MC
				Improve overall performance with TARN standards	National standards for Major Trauma	In progress via MTC Board		MC
				HUTH Regional Hand Unit model will be operational on the CHH site.	National standards for Hand Trauma	Development in progress, on track for Q4		ER

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
					National standards for Stroke services			ER
				Acute model on HRI site	National standards for Cardiac services	Medical and nursing staff recruited; fit out of H39 completed – looking at Q3 start as Cardiology ward	Need to overcome NCTR capacity on H39	ER
				Review and redevelopment of the Humber Cancer Board and associated Cancer Development Programme.	National standards for Cancer services development			ER
				Case accepted by NHSE Spec Com and NEY ODN for expansion of the HUTH Neonatal Unit	National standards for Neonatal Care	Expansion case has been developed and submitted to NHSEI, awaiting feedback		MC
			We will recover and improve access to elective services as part of our pandemic recovery programme	70% of P2 cases waiting less than 28 days.	Patient waiting times. Waiting list volume.	Q1 = 58.4%		ER
		<5000 patients waiting over 52 weeks on an incomplete pathway		Sept 22 forecast position = 5,551			ER	
		Total WLW < 60k		Q1 = 68,545			ER	
12								

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
				Average RTT incomplete waiting time < 14 weeks				ER
13		Partnership and integrated services	We will develop effective partnerships with other providers	Evidence of 3 clinical services and 1 support service operating a single model across the Humber partnership.	Evidence of joint approach to service design and delivery. Completion of ICP programme	Neurology – single service across the Humber. Oncology and Haematology – progressing towards single services, joint PTL unlikely to be achieved until 2023/24 Working towards joint PTL for Dermatology by December 2023		MC
				Development of an outline HASR group strategy for Humber Acute providers and oversight by a Joint Development Board	Progression of HASR programmes 2 and 3.	HASR PCBC on track for public consultation starting in November 2022 or Summer 2023 subject to ICB approval, strategy to be developed as this progresses		MC
				Implementation of a GP Expanded Role development scheme in 2 specialties.	Partnership for the development of GPs with Expanded Clinical roles to increase HUTH medical workforce capacity.	Ongoing engagement with Modality, HUTH element of the programme maintains readiness subject to GP recruitment by our partner.		MC

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
14			We will play a key role in the reform of health and care systems and provision of services closer to home	Set up and operation of a mobile MR/CT service for the ICS.	Volume and % of planned diagnostic activity delivered in a CDH service.	In progress		TBC
				Set up and operation of one CDH in the Humber area.				
				Establish HUTH as a CDH provider via the national framework.				
				Establish a three year plan that delivers increased delivery of services not requiring an acute setting in alternative settings, eg community and primary care	Volume of services delivered in non-acute hospital settings			ER
				Establish a three year delivery plan for the Connected Health programme for the Hull and East Riding area.	Progress on implementation of the Connected Health programme. Referrals to key specialties. Hospital follow up in key specialties.			ER
				Deliver improved quality and volume of referrals				

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
15			We will support the developing ICS structure and play a lead role in the collaborative of acute providers and Place Partnership Boards	Delivery of high volume, low clinical complexity pathways in 2 specialties at CAP level	Elective delivery through CAP schemes	Participation in CAP meetings and collaborative working to develop joint approach to elective recovery		ER
				<p>HUTH contributes to the development of the Health and Well Being strategies for Hull and ERY Places, and the new Trust Strategy is aligned with the vision of both places.</p> <p>HUTH response plan in place for Hull Place based Levelling Up and Community Wealth Programmes.</p> <p>Place priorities are reflected in the CAP work programmes.</p>	Membership and providing consistent presence/support as part of the two Hull and ERY Place Partnership Boards and ICS Place Partnership Steering Group.	Director of Strategy and Planning attendance at Hull and ERY and ICS meetings and has contributed to the transition phase to the new ICS model and Place arrangements		MC

Section Three: Great Future

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
16	Great Future	Financial sustainability	We will secure the long term financial health of the Trust			In progress		LB

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
17		Environmental sustainability	We will work with partners across the system in the aim of financial balance at system and ICS level			Financial planning as part of 2022/23 planning round included ICS-wide discussions in relation to individual Trust allocations of funding		LB
18			We will further reduce our energy consumption and waste			LED lighting replacement scheme in place Replacement of gas boilers with heat pumps Reduction in anaesthetic gas emissions		DT
19			We will become a greener organisation and produce zero carbon emissions by 2030	Increased use of low carbon energy sources	Carbon Neutral by 2030	Zero30 Plan in place Solar panel scheme at CHH Exploration of micro wind farm technology		DT
			Reduction in the volume of waste to landfill	Waste disposal methods/ volume of waste to landfill			DT	
			Reduction in the use of single use plastics and packaging	Use of packaging			DT	
20		Research and innovation	We will create a well-led 'research active and aware' workforce enabling high quality care for every patient	Refreshed Research Website Rebranding launch of RDI Directorate	Developing a research communications and engagement strategy. Actively pursue the integration of research and innovations			MP

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
			through research opportunities	'Research Celebration' Conference Establish a combined Trust and University partner annual review of current PA levels for and job planning for research components of our staffing groups.	activities into clinical services at all levels			
21			We will lead collaborative partnerships in the region to realise the full potential of research and innovation	Become a strategic leader in the HCV ICS Research Collaborative (formal research alliance with NLAG and Humber). Appointment of Hull Innovation Hub Manager with UoH. Create Industry Engagement Document. Increase income from commercially funded research by 20% year-on-year from baseline.	Strategic and co-ordinated investment in research capacity and supporting the creation of major investment in clinical and translational research across UoH/HYMS and HC&V Development of an industry engagement document highlighting our facilities, expertise and capabilities.			MP
22			We will create a positive reputation through our research,	Seek to establish research programmes with the potential to positively impact our	Develop mechanisms to ensure every patient is offered the opportunity			MP

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
			increasing R&I capability and demonstrably improving patient care and experience	<p>key performance and quality indicators (i.e. A&E and cancer waiting times).</p> <p>Support the establishment of Hull as a national centre of excellence for research on PET-CT imaging and the development of radiopharmaceuticals.</p> <p>Achieve all Department of Health and NIHR research performance metrics</p> <p>Overseas simulation fellowship opportunities-to commence</p>	<p>to participate in research.</p> <p>Development of educational resources facilitated by an overseas exchange programme of staff and resources</p>			
23		Estates and infrastructure	We will agree an ambitious estates plan that delivers our clinical strategies and replaces our oldest clinical facilities	Develop a refreshed Estates Strategy	<p>One public space plan with system partners.</p> <p>Residential services plan.</p>	Review underway via the Strategic Development Group.	Linked to development of Clinical Strategy	DT
24		Digital development	We will become a digital first organisation	Complete rollout of ePMA, eObservations and electronic nurse assessments	Successful implementation of Digital solutions for key operations and systems	In progress		SM

	Goal	Element	Strategic ambition	Year 1 objectives	Measures	Progress to date	Comments	AEO
25			We will play a key role in the development and delivery of the Humber and ICS Digital strategy and plans	Support the transition of services as part of Interim Clinical Plan to enable shared service models across the Humber region	Develop digital solutions that encompass all elements of the patient pathway, and align with Humber and ICS wide objectives	In progress		SM
26			We will work in partnership with neighbouring organisations and systems to develop more streamlined digital capability	Shared PAS with NLAG; Shared Data Warehouse and analytics team; Shared LIMS and Pathology service; Integration with regional shared care record to support patient pathways	Implement digital solutions that support shared working with neighbouring organisations	NLaG to transition to Lorenzo in Spring 2023		SM
27			We will become a digitally mature, secure and resilient organisation	Meet DSPT standards and work towards Cyber Essentials plus compliance; Complete a baseline assessment of What Good Looks Like (WGLL) and continue improvement work against HIMSS digital maturity framework	Compliance with National Cyber Security guidance on current and new systems and show improvement in our Digital Maturity	The Trust's compliance with the DSPT toolkit has been rated as 'Approaching Standards'. An Improvement plan is in place (agreed with NHS Digital)		SM

Hull University Teaching Hospitals NHS Trust

Agenda Item	Meeting	Trust Board	Meeting Date	13.09.22
Title	Equality Objectives 2022-26			
Lead Directors	Michelle Cady, Director of Strategy and Planning Simon Nearney, Director of Workforce and Organisational Development			
Authors	Jackie Railton, Deputy Director, Strategy and Planning Helen Knowles, Head of HR Services Lucy Vere, Head of Learning and Organisational Development			
Report previously considered by (date)	Equality objectives agreed at Equality Diversity and Inclusion Steering Group (09.06.22)			

Purpose of the Report		Reason for submission to the Trust Board private session	Link to CQC Domain	Link to Trust Strategic Objectives 2021/22
Committee Approval	✓	Commercial Confidentiality	Safe	Honest Caring and Accountable Future ✓
Committee Agreement		Patient Confidentiality	Effective	Valued, Skilled and Sufficient Staff ✓
Assurance		Staff Confidentiality	Caring	High Quality Care ✓
Information Only		Other Exceptional Circumstance	Responsive	✓ Great Clinical Services ✓
			Well-led	✓ Partnerships and Integrated Services
				Research and Innovation
				Financial Sustainability

Key Recommendations to be considered:

The Trust Board is asked to receive the progress against the Equality Objectives and decide if any further information or assurance is required.

Hull University Teaching Hospitals NHS Trust

Equality Objectives 2022-26

1. Purpose

The purpose of this paper is to present the Board with the progress against the Equality Objectives for 2022-26 and to clarify that Professor Purva will take on the role of Health Inequalities Lead.

2. Background

The Equality Act 2010 (Specific Duties) Regulations 2011 (Section 3) requires listed bodies to prepare and publish one or more specific and measurable equality objectives that they think will achieve the aims of the general equality duty and thereby:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

The purpose of setting equality objectives is to strengthen the Trust's performance of the general Equality Duty and to ensure that we are making year on year progress in advancing equality and human rights for all groups and beyond, with our patients and carers and those who work in the organisation.

The Trust's equality objectives (2016-2020) were approved by the Trust Board in April 2016. They are:

- To improve our evidence base for patient equality of access to services
- To make information more accessible to better meet the needs of people who have a disability, impairment or sensory loss
- To build an inclusive environment for all staff
- To demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES)

The Trust's equality objectives were linked to the achievement of the goals and outcomes within the NHS Equality Delivery System, ie:

- Goal 1 - Better health outcomes
- Goal 2 - Improved patient access and experience
- Goal 3 - A representative and supported workforce
- Goal 4 - Inclusive leadership.

In accordance with the general equality duty, the Trust is required to review and refresh its equality objectives every four years. The review should be informed by:

- Progress against our current equality objectives
- The requirements of the NHS Equality Delivery System.
- Engagement with stakeholder groups, including staff and patient/service users.
- The findings and recommendations of key reports such as the Care Quality Commission Inspection Reports

- Results of national and local surveys, including NHS Patient Surveys, NHS Staff Surveys
- Compliance with the Accessible Information Standard
- Benchmarking against the NHS Workforce Race Equality Standard and NHS Workforce Disability Equality Standard
- Gender Pay Gap reporting
- Analysis of patient and workforce equality data.

Due to the Covid-19 pandemic it had not been possible to undertake the wider engagement with the public, patients, service users and staff that is a requirement of the NHS Equality Delivery System. In March 2021, the Executive Management Committee agreed to extend the Equality Objectives for 2016-20 to cover the financial year 2021/22 and allow time for the development of refreshed/new equality objectives for 2022-2026.

3. Progress Update

The Trust's Equality Diversity and Inclusion Steering Group has reviewed the Trust's progress against the current Equality Objectives. To date:

- 9 measures have not been achieved
- 4 measures have been partially achieved
- 1 measure achieving as per plan
- 4 measures have been achieved.

A detailed update on achievement against each of the goals and supporting measures is attached at Appendix 1.

The Trust's Equality, Diversity and Inclusion Steering Group has considered the progress against the existing Equality Objectives, the impact that the Covid-19 pandemic has had on the local community, staff and patients and how it has widened existing health inequalities.

The Group has also taken into consideration the ambitions set out in the NHS Long Term Plan, the NHS People Plan and the role that the Trust can play as an Anchor Institution within the local community.

4. Proposed Equality Objectives

The following proposed equality objectives for 2022-26 have been developed in consultation with the adult and youth patient councils and the Trust's Staff Networks. They build on our previous equality objectives and the ongoing areas for improvement and reflect the required outcomes of the NHS Equality Delivery System.

The proposed equality objectives are:

- To work with our partners and stakeholders to improve health outcomes by developing a better understanding of the local variations in access to and experience of treatment by the Trust.
- To build an inclusive, positive environment for all staff, free from discrimination.
- To ensure our leaders have the capacity and capability to support, empower and enable staff.

Detailed information on each of the objectives, the context, actions and key performance measures is attached at Appendix 2.

5. PERFORMANCE MONITORING

Delivery of the key actions and achievement of the proposed Equality Objectives will be monitored through the Trust's Equality Diversity and Inclusion Steering Group, which will submit half yearly reports to the Workforce Transformation Committee and the Executive Management Committee, with an annual report on progress being presented to the Trust Board.

6. HEALTH INEQUALITIES LEAD

In August 2020, NHS England published an update to its July 2020 paper: *Implementing phase 3 of the NHS response to the COVID-19 pandemic*. The document set out a series of actions, in collaboration with local communities and partners, to increase the scale and pace of progress in reducing health inequalities. These included:

- Protecting the most vulnerable from Covid-19
- Restoring NHS services inclusively
- Developing digitally enabled care pathways in ways which increase inclusion
- Accelerating preventative programmes which proactively engage those at greatest risk of poor health outcomes
- Supporting those who suffer mental ill health
- Strengthening leadership and accountability
- Ensuring datasets are complete and timely
- Collaborating locally in planning and delivering action.

There was a specific requirement that all systems and every NHS organisation should identify a named executive board-level lead for tackling inequalities. Professor Purva is the Trust's named lead.

7. RECOMMENDATIONS

The Trust Board is asked to receive the progress against the Equality Objectives and decide if any further information or assurance is required.

Jackie Railton
Deputy Director, Strategy and Planning

Helen Knowles
Head of HR Services

Lucy Vere
Head of Learning and Organisational Development

September 2022

Progress Against Trust Equality Objectives 2016-22

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
<p>1. To improve our evidence base for patient equality of access to services</p>	<p>Year on year percentage increase in the number of patients/service users for whom the Trust holds data by protected characteristic</p>	<p>Gender – 100% achieved Marital status – 88% compared to 77% (2015) Religion or belief – 47% compared to 62% (2015) Age – 100% achieved Ethnic group – 80% compared to 84% (2015)</p>	<p>Partially Achieved</p>	<p>Demographic details updated via national spine with ongoing opportunities via face to face and virtual contacts to check patient details. Potential opportunity through Patient Knows Best to enable patients to update their demographic profiles.</p>
	<p>Improvement in the capture and recording of protected characteristic data on Datix</p>	<p>Gathering of protected characteristics data reviewed at PALS team training session on with a view to improving data capture and recording. Data collected in relation to age, gender and ethnicity.</p>	<p>Partially Achieved</p>	<p>Data not collected on all protected characteristics.</p>
<p>2. To make information more accessible, to better meet the needs of people who have a disability, impairment or sensory loss</p>	<p>Trust compliance with the conformance criteria specified within the Accessible Information Standard Specification (July 2015)</p>	<p>Process established to ensure recording of patient preferences within Lorenzo and alerting system in place on patient record. Process in place to provide clinical correspondence in line with patient preferences. Interpretation services include increased access to British Sign Language interpretation. Reachdeck software on Trust website to improve access to information. Functionality with Patients Know Best enable users to receive information digitally AIS training and information available to all staff via Pattie.</p>	<p>Achieved</p>	<p>Work ongoing with Synertec to address communication support preferences relating to paper-based correspondence eg braille, large print, easy read.</p> <p>Work ongoing to maintain compliance and continuously improve with the AIS.</p>

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	Number of PALs issues/complaints raised by patients/service users whose information/communication support needs have not been met	2015/16 – 0.15% 2016/17 – 0.04% 2017/18 – 0.10% 2018/19 – 0.78% 2019/20 – 0.32% 2020/21 – 0.58%	Partially Achieved	Whilst a minor improvement has been seen, it is noted that this relates only to reported issues. Discussion with members of the Hull Deaf Club highlighted a number of areas of concern in relation to timely and consistent provision of British Sign Language interpreters. The new interpretation contract includes provision of online BSL services, as well as face-to-face provision. Additional ipads have been purchased to increase online access.
	Year on year improvement in the Trust's performance in national patient surveys in relation to communication with professionals	Inpatient survey satisfaction score – communication with doctors and nurses) 2015: 8.0/8.1 2019: 8.0/8.1 2020: 8.9/8.9	Achieved	Improvement seen in 2020 survey results
3. To build an inclusive environment for all staff	NHS Staff Survey KF7 – Year on year improvement in the percentage of staff able to contribute to improvements at work, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by 2020.	Baseline 2015 = 68% below, (worse than) average 2020 = 55.8% (just above average) 2021 = 49.5% (below average)	Not achieved	Whilst the Trust saw improvement in 2020, the Trust was below the peer average (53.3%) in the 2021 survey results. Nationally results were lower in the last two years as a result of the Covid-19 pandemic.
	NHS Staff Survey KF10 – Year on year improvement in the number of staff receiving support from their immediate managers, with a view to achieving a score of 'above (better than) average by April 2018 and 'highest' (best) 20% of acute Trusts by April 2020.	Baseline 2015 = 3.70 (average for acute Trusts) 2018 = 67.7% compared to average of 68.5% 2019 = 67.8% (70.2%) 2020 = 68.0 (69.2) 2021 = 65.8% (69.0) below average	Not achieved	Trust has not achieved above average performance when reviewed against the 2018 near equivalent question (Q9a)

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	<p>NHS Staff Survey KF21 – Year on year improvement in the percentage of staff believing the Trust provides equal opportunities for career progression or promotion, with a view to achieving a score of average by April 2018 and better than average by April 2020.</p>	<p>Baseline 2015 = 85% worse than average 2016 = 88% above (better than) average 2017 = 64.1% above average 2018 = 62.5% above average 2019 = 58.6% above average 2020 = 56.3% average 2021 = 57.0% above average</p>	<p>Partially achieved</p>	<p>Closest mapped question in new 2017 survey results shows the Trust is above the average score. (Q15) However, year on year improvement not achieved.</p>
	<p>NHS Staff Survey KF26 – Year on year improvement in the percentage of staff experiencing harassment, bullying and abuse from staff in the last 12 months, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by April 2020.</p>	<p>Baseline 2015 = 38% worst 20% of acute Trusts 2017 – 20.0% worse than average (18.6%) 2018 – 27.0% worse than average 2019 – 20.4% worse than average 2020 – 21.5% worse than average 2021 – 20.5% worse than average</p>	<p>Not achieved</p>	<p>2017 survey – closest question used as comparison</p>
	<p>CQC Well led domain – Trust achieves and maintains an overall rating of 'good' or higher for this domain</p>	<p>Baseline 2015 = requires improvement 2016 = requires improvement 2018 = good 2019 = good 2020 = good</p>	<p>Achieved</p>	
<p>4. To demonstrate progress against indicators within the NHS Workforce Race Equality Standard (WRES)</p>	<p>To increase the proportion of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) by 2% per annum over the next 4 years</p>	<p>Baseline 2015 = 1.43% 2016 = 2.25% 2017 = 3.90% 2018 = 4.13% 2019/20 = 5.05%</p>	<p>Not Achieved</p>	<p>Whilst the proportion of BME staff in Bands 8-9 and VSM has been increasing year on year compared to white staff, the 2% pa increase has not been achieved.</p> <p>The Board did not have a BME member until 2018/19.</p>

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	To increase the relative likelihood of BME staff being appointed from shortlisting so that BME candidates are just as likely as White candidates to be appointed from shortlisting by April 2020.	Baseline 2015 = 1.98 (white staff almost twice as likely to be appointed as BME staff) 2016 = 1.67 2017 = 1.39 2018 = 1.38 2019 = 0.88 2020 = 1.30 2021 = 1.43	Not Achieved	Year on year improvement to 2019 when BME staff were more likely to be appointed than white staff. However this position changed from March 2020.
	To ensure that the relative likelihood of BME staff entering the formal disciplinary process is not disproportionate to that of White staff by April 2020.	Baseline 2015 = 2.13 (BME staff twice as likely to enter formal disciplinary compared to white staff) 2016 = 1.67 2017 = 1.59 2018 = 0.94 2019 = 0.69 2020 = 0.66 2021 = 0.52	Achieved	Performance has moved from BME being twice as likely to enter the formal disciplinary process to BME being less likely in 2021..
	NHS Staff Survey KF25 – Reduction in the percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months with a view to achieving 'the lowest (best) 20% of acute Trusts' by April 2018	Baseline 2015 = 27% 2016 = 21% 2017 = 21% 2018 = 24% (better than average of 29.8%) 2019 = 24.1% 2020 = 25.3% 2021 = 26.5%	Not Achieved	
	NHS Staff Survey KF26 – Reduction in the percentage of BME staff experiencing harassment, bullying and abuse from staff in the last 12 months, with a view to achieving a score of 'average for acute Trusts' by April 2018 and being in the 'better than average for acute Trusts' by April 2020.	Baseline 2015 = 57% 2016 = 30% 2017 = 27% 2018/19 = 29.6% (worse than average of 28.6%) 2020 = 30.1% 2021 = 34.1%	Not Achieved	

Equality Objective	Measure	Position at May 2022	RAG Rating	Comments
	NHS Staff Survey KF21 – Increase in the percentage of BME staff believing the Trust provides equal opportunities for career progression or promotion, with a view to achieving a score of average by April 2018 and better than average by April 2020.	Baseline 2015 = 73% 2016 = 87% 2017 = 81% 2018/19 = 81.7% (better than average of 72.2%) 2019/20 = 78.9% 2021 = 77.0%	Not Achieved	
	NHS Staff Survey Q17b – Reduction in the percentage of BME staff who, in the last 12 months, have personally experienced discrimination at work from their manager/team leader or other colleagues, with a view to achieving better than average for acute Trusts for both White and BME staff	Baseline 2015: White 8% BME 16% 2016 = White 6% BME 13% 2017 = White 5% BME 11% 2018/19 = White 6.1% BME 13.2% 2019/20 = White 5.5% BME 14.5% 2020/21 = White 7.3% BME 18.2%	Not Achieved	2020/21 national averages: White = 6.7% BME = 17.3%
	The Board meets the WRES requirement on Board membership (ie broadly representative of the population it serves)	Baseline 2015 = No BME rep 2016 = No BME rep 2017 = No BME rep 2018 = BME CMO appointed 2021 6.3% of Board from BME background	Achieving	Local population: Hull 10.3% BME East Riding of Yorkshire 3.9% BME (2011 Census)

Key:		Not achieved	9
		Partially achieved	4
		Achieving as per plan	1
		Achieved	4
Total number of measures:			18

Equality Objective One	To work with our partners and stakeholders to improve health outcomes by developing a better understanding of the local variations in access to and experience of treatment by the Trust.	EDS2 Goal(s) Goals 1 and 2
<p>Context:</p> <p>Based on the Index of Multiple Deprivation 2019, Hull is the fourth most deprived local authority in England (out of 317). Half of Hull's 166 geographical areas on which the IMD is based, are in the most deprived fifth nationally. There are also large variations in deprivation scores across Hull's 21 electoral wards. Hull has a high percentage of children living in absolute and relative poverty, and the percentages differ markedly across Hull's wards. There is also a high percentage of children who are eligible for free school meals. Life expectancy in Hull is lower than in England, and the inequalities gap has been increasing. The largest contributions to the gap in life expectancy comes from excess deaths from circulatory disease, cancer and respiratory disease.</p> <p>The health profile for the East Riding of Yorkshire shows that the health of people in the East Riding is generally better than the England average, as is life expectancy. However, this masks a range of inequalities. Some areas, (especially in Bridlington, Goole and Withernsea), have some of the highest levels of poverty in England. These areas are characterised by low incomes, high unemployment, poor health, higher levels of crime and anti-social behaviour and low educational achievement. ERoY residents live in towns which range from the wealthy, with good access to services and opportunities, to those living in relative poverty in remote areas. There is also a large gap between life expectancy and healthy life expectancy. This means a proportion of ERoY residents live with preventable, multiple long term conditions for a large part of their lives.</p> <p>Waiting for treatment can affect other aspects of people's lives, with impact depending on someone's life circumstances. For example, it can make it harder to maintain independence or continue to work or attend school. Long waits before accessing planned care can have life-long consequences on the development of children and young people, impacting their ability to access education and lead full and active lives. For older people, it can make recovery longer and harder, leading to loss of independence.</p>		
<p>Actions:</p> <ul style="list-style-type: none"> • Continue to build upon and develop the Trust's Business Intelligence reports which have been established to monitor health inequalities in its patient population. • Restore NHS services inclusively by: <ul style="list-style-type: none"> ○ Utilisation of ONS statistical data, data and information within the local JSNAs and health profiles ○ Utilisation of the National Health Inequalities Improvement Dashboard ○ Establishing a clear understanding of the extent to which the elective waiting list is made up of certain groups (eg Black, Asian and Minority Ethnic, top 20% of socially deprived electoral wards) and ensuring that they are not further disadvantaged. ○ Proactive engagement with communities at risk of health inequalities eg: HUTH Bowel Screening Centre work with GP practices, agencies, mental health services, prisons, learning disabilities groups and the homeless to increase opportunities for these groups to participate in the programme. • Working in partnership with the Integrated Care System, NHSE/I commissioners, Place-based Partnerships and other health and social care providers to develop 		

Ethnicity

Ethnicity	Asian	Black	Mixed	Other	White
A&G	0.7%	0.4%	0.7%	2.5%	95.7%
PIFU	0.0%	0.8%	2.4%	0.8%	96.0%
Virtual	0.8%	0.4%	0.4%	1.2%	97.1%
ED Attends	1.1%	0.6%	1.2%	5.3%	91.8%
NEL Admits	0.9%	0.6%	1.0%	2.3%	95.2%
Catchment	1.8%	0.7%	1.0%	0.5%	95.9%
Median Weeks (RTT)	17	18	13	14	14

- Year on year improvement in the first outpatient DNA (Did Not Attend) rates for those patients and service users from a BAME background when compared to the British % New OP DNA rate.

Baseline: Q4 2021/22 British 8.3% New OP DNA rate

Ethnic Group

Description	OUTPATIENTS	% of New OP DNA Rate
British	75,867	8.3%
Any other white background	2,539	11.0%
Any other ethnic group	1,601	13.7%
African	404	8.0%
Any other Asian background	370	6.6%
Any other mixed background	296	14.5%
Indian	261	5.1%
Pakistani	186	12.7%
White and Asian	180	8.7%
Irish	155	10.6%
White and black African	124	9.6%
Any other black background	138	11.0%
Bangladeshi	128	10.5%
Chinese	120	8.6%
White and black Caribbean	52	26.3%
Caribbean	49	14.7%
Total	104,805	8.9%

Equality Objective Two	To build an inclusive, positive environment for all staff, free from discrimination.	EDS2 Goal(s) Goal 3																				
<p>Context: The Trust is committed to developing an organisational culture that encourages every member of staff, whatever their role or background to succeed and work in a positive environment free from discrimination.</p>																						
<p>Actions:</p> <ul style="list-style-type: none"> Actively explore, understand and publish specific outcomes from the National Staff Survey by protected characteristics working with Staff Networks to embed actions which reduce differentials and support the continued development of an inclusive workforce characterised by dignity and mutual respect. Reduce inequalities in employment by ensuring clear routes to allow staff to speak up when they face discrimination due to one of their protected characteristics by developing and embedding a zero tolerance reporting and action culture. Ensure robust monitoring arrangements are in place to identify themes to support evidence base for change as well as increasing staff confidence that the organisation will address concerns when raised. Continue to build on the partnership approach with already staff networks (BAME, Enabled & LGBTQ+) to ensure the voices and lived experiences of staff are heard and used to influence future change. 																						
<p>Expected Outcomes:</p> <ul style="list-style-type: none"> To have a continual and incremental improvement in the NHS Staff Engagement Score aiming to be equal to or above the national average Across all protected characteristics* aim for the staff engagement score to be equal to or above the 2021 Trust average To have a continual and incremental reduction in the number of staff reporting that in the last 12 months they have personally experienced harassment, bullying or abuse at work from managers and colleagues across all protected characteristics, aiming to be equal to or below the 2021 Trust average. Close the gap of staff reporting that if they spoke up about something that concerned them they were confident that the organisation would address their concern so they are equal to or above the 2021 Trust score 																						
<p>Measures: <u>Staff Engagement</u></p> <ul style="list-style-type: none"> To have a continual and incremental improvement in the NHS Staff Engagement Score aiming to be equal to or above the national average <table border="1" data-bbox="245 1585 871 1659"> <thead> <tr> <th></th> <th>HUTH</th> <th>National Average</th> </tr> </thead> <tbody> <tr> <td>2021</td> <td>6.7</td> <td>6.8</td> </tr> </tbody> </table> <ul style="list-style-type: none"> Across all protected characteristics aim for the staff engagement score to be equal to or above the 2021 Trust average <table border="1" data-bbox="245 1794 871 2033"> <thead> <tr> <th>2021</th> <th>Score</th> </tr> </thead> <tbody> <tr> <td>Trust Average</td> <td>6.7</td> </tr> <tr> <td>Gender – Male</td> <td>6.8</td> </tr> <tr> <td>Gender – Female</td> <td>6.8</td> </tr> <tr> <td>Gender – prefer not to say</td> <td>5.3</td> </tr> <tr> <td>Long term conditions</td> <td>6.4</td> </tr> <tr> <td>Ethnicity – Non white</td> <td>6.9</td> </tr> </tbody> </table>				HUTH	National Average	2021	6.7	6.8	2021	Score	Trust Average	6.7	Gender – Male	6.8	Gender – Female	6.8	Gender – prefer not to say	5.3	Long term conditions	6.4	Ethnicity – Non white	6.9
	HUTH	National Average																				
2021	6.7	6.8																				
2021	Score																					
Trust Average	6.7																					
Gender – Male	6.8																					
Gender – Female	6.8																					
Gender – prefer not to say	5.3																					
Long term conditions	6.4																					
Ethnicity – Non white	6.9																					

Sexuality – Gay/Lesbian	6.8
Sexuality – Bisexual	6.8
Sexuality – Other	5.9
Sexuality - prefer not to say	6

People Promise: We are safe and healthy

- To have a continual and incremental reduction in the number of staff reporting that in the last 12 months they have personally experienced harassment, bullying or abuse at work from managers and colleagues across all protected characteristics, aiming to be equal to or below the 2021 Trust average.

2021	Score	
	Managers	Colleagues
Trust score	13.8%	20.5%
Gender – Male	13.0%	19.10%
Gender – Female	13.00%	20.70%
Gender – prefer not to say	28.00%	30.00%
Long term conditions	17.90%	27.90%
Ethnicity – Non white	16.60%	26.10%
Sexuality – Gay/Lesbian	15.70%	24.10%
Sexuality – Bisexual	14.90%	29.80%
Sexuality – Other	14.30%	21.40%
Sexuality - prefer not to say	18.70%	28.60%

People Promise: We each have a voice that counts

- Close the gap of staff reporting that if they spoke up about something that concerned them they were confident that the organisation would address their concern so they are equal to or above the 2021 Trust score

2021	Score
Trust Score	45.7%
Gender – Male	48.10%
Gender – Female	45.60%
Gender – prefer not to say	18.10%
Long term conditions	38.40%
Ethnicity – Non white	42.80%
Sexuality – Gay/Lesbian	54.10%
Sexuality – Bisexual	62.50%
Sexuality – Other	13.30%
Sexuality - prefer not to say	27.50%

Equality Objective Three	To ensure our leaders have the capacity and capability to support, empower and enable staff.	EDS2 Goal(s) Goal 4
<p>Context: In our Trust Vision of Great Staff, Great Care, Great Future the hidden statement before Great Care is Great Leaders. The Trust has been working for the last three years to embed a compassionate and inclusive leadership approach. All programmes commissioned and delivered both internally and externally are planned to equipped leaders and managers at all levels, to not only develop themselves but to gain the skills that allow them to create a healthy working culture that embraces diversity in all its forms. The COVID-19 Pandemic has seen the need to return to a more command and control style due to the nature of the demands on our people and system. We now need to reset the compassionate and inclusive approach as the norm. As we move to “living with Covid” we are now asking our staff again what are the values of our current culture and do they match what we want here at HUTH? Our 2021 Staff Survey results also show that we can do significantly more to support staff in their careers and make knowing how to success available to all.</p>		
<p>Actions:</p> <ul style="list-style-type: none"> • A complete review and redesign of our current appraisal systems that ensures our leaders take a talent management approach to managing staff and successful outcomes. This will also aim to include a way to give helpful and development feedback from staff to their managers. • Development of an effective, helpful and supportive Talent Management approach for HUTH that ensures we have inclusive and positive approach to our succession planning at every level • Positive action self-development and leadership programmes for our range of protective characteristics. This in partnership with the respective Staff Networks, to co-create programmes that make a difference. • Compassionate and Inclusive leadership and its approach embedded in all internal and externally commissioned leadership development programmes • To engage with staff on what matters to them with Focus Groups and wider staff engagement activities • To review our Trust Values and the Current Culture using Barrett Values Cultural Barometer to understand our staff personal values, the current culture values and the future values they want to see at HUTH. To the review our results • To adapt our Values and Staff Charter based on the results of our focus groups and Barrett Values Survey and ensure its built into how leadership and personal development activities are role modelled by staff at all levels 		
<p>Expected Outcomes:</p> <ul style="list-style-type: none"> • To see staff reporting a continual and incremental increase in opportunities to develop their careers through having leaders with the skills to support, empower, enable their staff to access, and make great choices. • To have a continual and incremental increase in the number of staff reporting that we have a compassionate and inclusive culture with leaders and staff role modelling our values and behaviours in all their everyday activities. 		
<p>Measures: <u>People Promise: We are always learning</u></p> <ul style="list-style-type: none"> • To have a continual and incremental increase in staff reporting opportunities to develop their career aiming to be equal to or above the 2021 Trust average 		

2021	Score
Trust Average	52.10%
Gender – Male	57.20%
Gender – Female	52.20%
Gender – prefer not to say	28.60%
Long term conditions	41.30%
Ethnicity – Non white	62.90%
Sexuality – Gay/Lesbian	58.80%
Sexuality – Bisexual	77.10%
Sexuality – Other	46.70%
Sexuality - prefer not to say	40.10%

People Promise: We are compassionate and inclusive

- To have a continual and incremental increase in the number of staff reporting we are a compassionate and inclusive organisation aiming to be equal to or above the 2021 Trust average (Compassionate Culture Sub-Score)

2021	Score
Trust Average	6.9
Gender – Male	7
Gender – Female	6.9
Gender – prefer not to say	5.7
Long term conditions	6.7
Ethnicity – Non white	7.1
Sexuality – Gay/Lesbian	7
Sexuality – Bisexual	7.1
Sexuality – Other	6.4
Sexuality - prefer not to say	6.3

Agenda Item		Meeting	Trust Board	Meeting Date	13/09/22
Title	Quality Report				
Lead Director	Suzanne Rostron – Director of Quality Governance				
Author	Business Intelligence Analytics Team, Donna Pickering – Head of Patient Safety and Improvement and Leah Coneyworth – Head of Quality Compliance and Improvement				
Report previously considered by (date)	This report has not previously been considered				

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval		Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	✓

**Quality Indicator Report
August Performance 2022**

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1. Executive Summary

Areas for escalation		
Domain	Indicator	Update
Safe	Patient Safety Incident Reporting	<p>The Trust has a positive patient safety reporting culture (high volume, low harm)</p> <p>There has been a reduction in the incidents that are being reported. However, these have reduced proportionately with the bed occupancy per 1000 bed days as we have moved through the Coronavirus pandemic waves.</p> <p>Incidents causing moderate harm or above have increased but remain within control limits.</p> <p>The learning from incidents is shared through various avenues in the Trust to communicate key information and key learning and to share and celebrate success.</p> <p>Key quality improvement programmes are informed by incident data.</p>
Safe	Serious Incidents	<p>There been an increase in the number of serious incidents declared.</p> <p>There continues to be a backlog of serious incidents overdue investigation as a result of the pandemic.</p> <p>To aim be in a stable position within agreed tolerance limits, by October 2022 with a sustainable case load of open serious incidents</p>
Effective	HSMR and SHMI	<p>The Trust continues to highlight as an outlier for the HSMR and SHMI mortality indicators. The Mortality and Morbidity Task and Finish Group is undertaking a significant amount of work to really understand the reasons why the HSMR and SHMI continues to be above the England average, as part of this the Trust is also challenging CHKS on its data and the reasons for undertaking a rebasing exercise. The group is also working with the clinical teams to increase the number of staff trained to undertake Structured Judgement Reviews (SJRs), in turn increase the number of SJRs completed to understand the quality of care provided at end of life and where lessons can be learned to improve.</p>
Caring	All	Indicators are under review, this will be reflected in future IPR reports.

2. Performance Review – Safe

2.1 Patient safety incident reporting and incidents causing harm

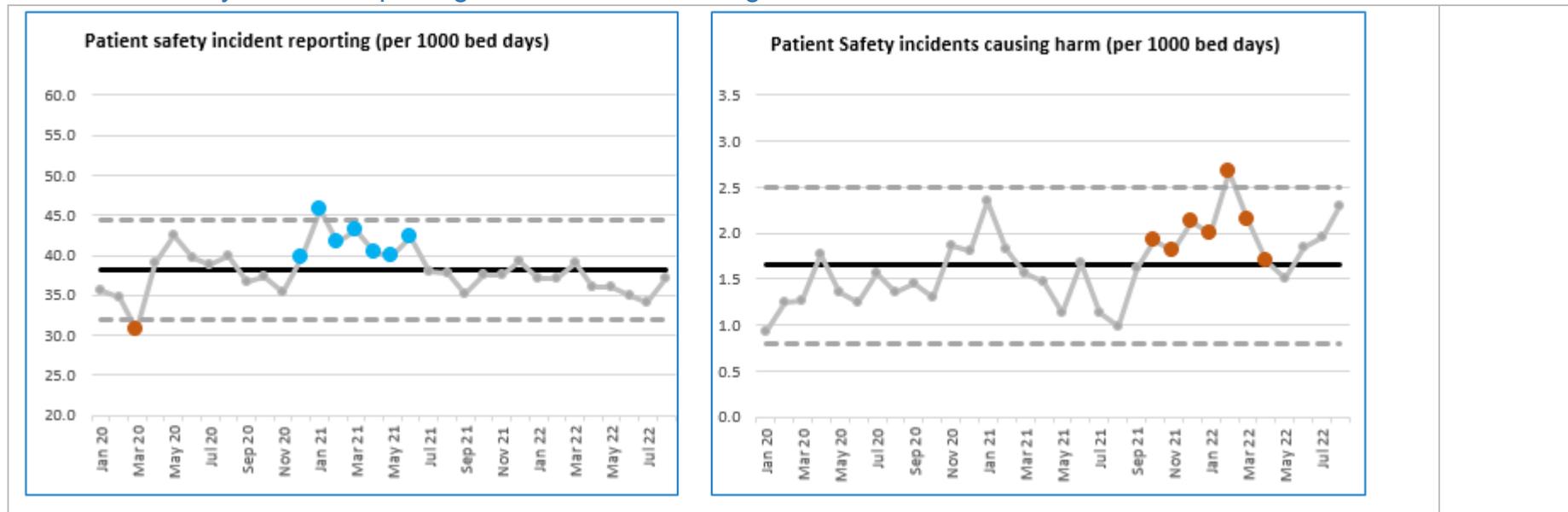


Chart Says:	<ul style="list-style-type: none"> • There were 37 patient safety incidents per 1000 bed days recorded in August 2022 (n=1635); 2.3 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient. • The number of incidents causing harm to patients is showing an upward trend over the last 4 months • The Trust has a positive patient safety reporting culture (high volume, low harm)
Issues:	<ul style="list-style-type: none"> • The highest proportion of incidents causing harm to patients are hospital acquired pressure ulcers (category 2 and above) and inpatient falls • Orthopaedics (Trauma) reported the highest number of pressure ulcers with Chest Medicine reporting the highest number of inpatient falls within the month
Actions:	<ul style="list-style-type: none"> • Immediate learning from incidents causing harm to be identified and actioned and shared throughout the Governance Structures in line with the Lessons Learned Framework. • To embed the Trust Quality Strategy to focus on learning from excellence in addition to incidents. • To develop and encourage a Quality Improvement approach to learning from incidents at the earliest opportunity
Mitigations:	<ul style="list-style-type: none"> • To continue to review patient harms at the Weekly Patient Safety Summit • Monitoring of the strategic ambitions for Safe Care outlined in the Trust Quality Strategy 2022/2025 for all patients to receive harm free care measured by six harms

2.2 Serious incidents

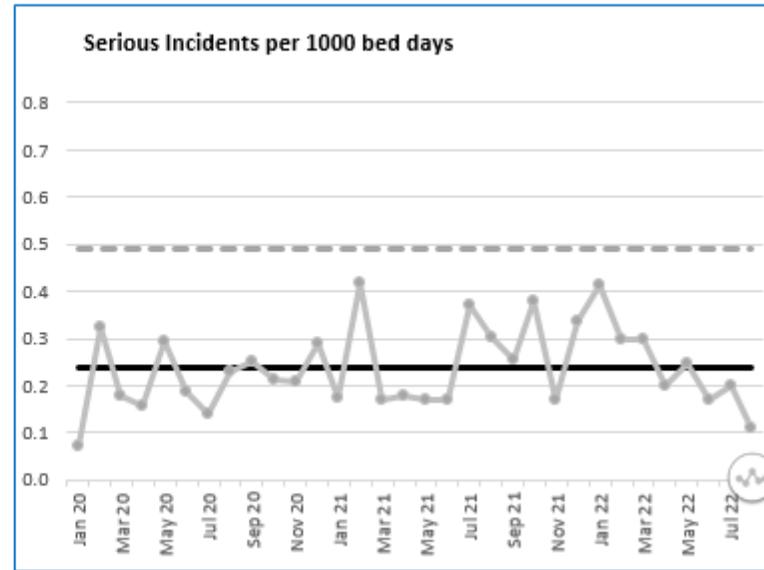
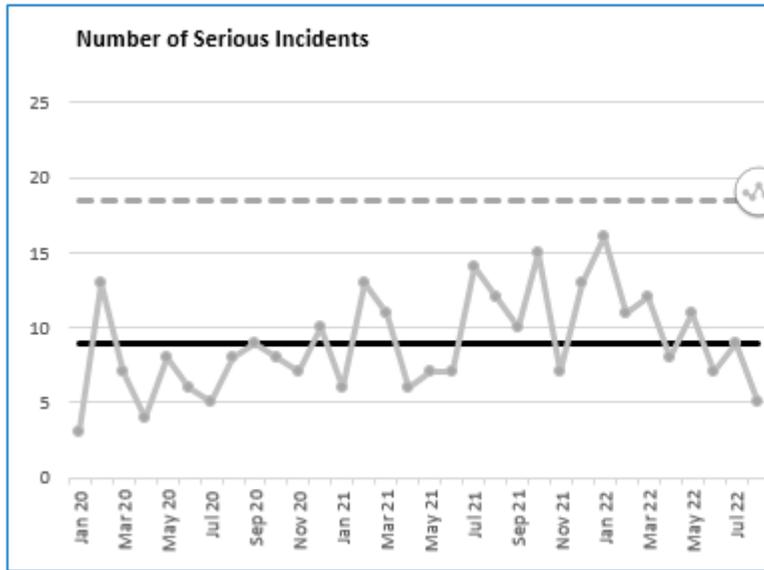


Chart Says:	<ul style="list-style-type: none"> The Trust declared 5 serious incidents in August 2022 equating to 0.11 serious incidents per 1000 bed days The graphs above show common cause variation with no cause for concern with a downward trend since January 2022.
Issues:	<ul style="list-style-type: none"> Two Never Events were declared in August 2022 relating to wrong site surgery (a repeat event) and the incorrect implant being inserted. One serious incident on the ICU was as a result of a patient's tracheostomy becoming dislodged leading to hypoxic cardiac arrest. August saw the lowest number of serious incidents declared in a month for two years At the end of August there were 54 serious incidents under investigation (a significant reduction in the 100+ cases in March 2022) 18 investigations were completed in August
Actions:	<ul style="list-style-type: none"> Aim to be in a stable position, within agreed tolerance limits, by October 2022 with a sustainable case load of 35 open SIs at any time For no serious incident investigation to take more than 100 days Utilise the wider Governance team members to facilitate investigations Undertake thematic reviews where possible
Mitigations:	<ul style="list-style-type: none"> Development of the Trust Patient Safety incident Response Plan (PSIRP) following the publication of the new national framework (August 2022) A task and finish group has commenced this piece of work and will provide progress updates to the Quality Committee.

2.3 Hospital Acquired Pressure Ulcers causing harm

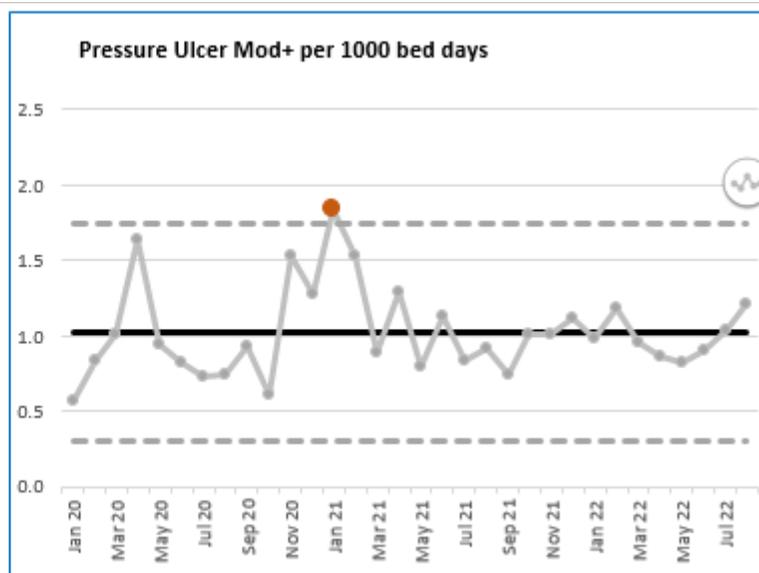
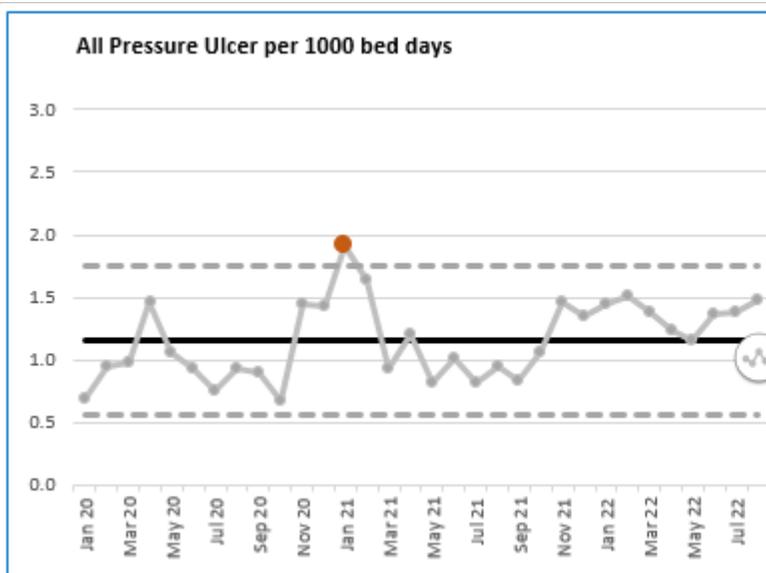


Chart Says:	<ul style="list-style-type: none"> • There were 1.48 hospital acquired pressure ulcers per 1000 bed days recorded in August 2022 (n=65). • 1.21 (per 1000 bed days) hospital acquired pressure ulcers resulted in moderate, severe or catastrophic harm to the patient.
Issues:	<ul style="list-style-type: none"> • There were 53 Category 2 pressure ulcers reported (10 as device related); 19 Deep Tissue Injuries (DTI) (2 device related) and 1 unstageable pressure injuries (0 device related) • Incidents continue to have the incorrect level of harm reported; the Tissue Viability Team inform the incident investigators for this to be addressed. • Category 1 pressure ulcers are not routinely recorded onto DATIX
Actions:	<ul style="list-style-type: none"> • The Tissue Viability Team review all hospital acquired category 2 and above skin damage to support clinical areas to minimise wound deterioration • The team continues to support the digital team implementation of Purpose T with an emphasis on staff awareness of individualising the skin integrity plan of care • Nerve centre photography continues to be implemented to support categorisation of pressure damage and clinical support to ward staff
Mitigations:	<ul style="list-style-type: none"> • Implementation of improvement programme to see a reduction in patients developing hospital acquired pressure ulcers against strategic ambition 'harm free care' in the Quality Strategy 2022/2025.

2.4 Inpatient falls causing harm

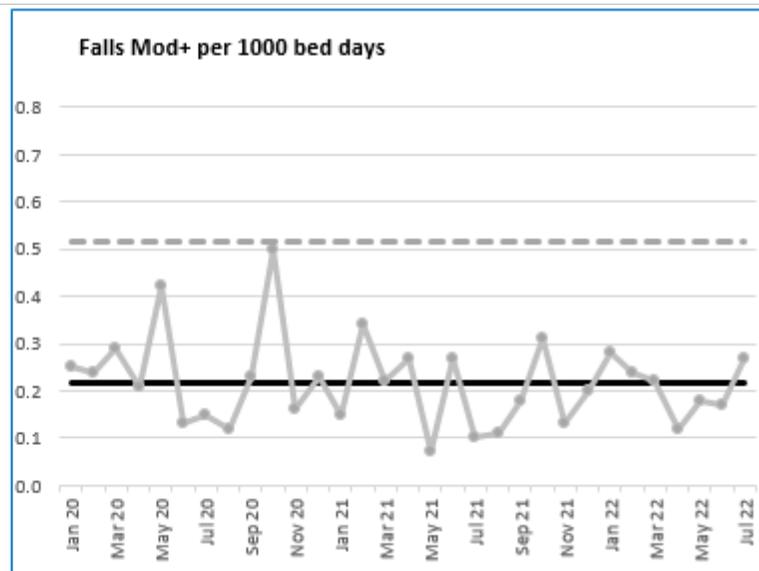
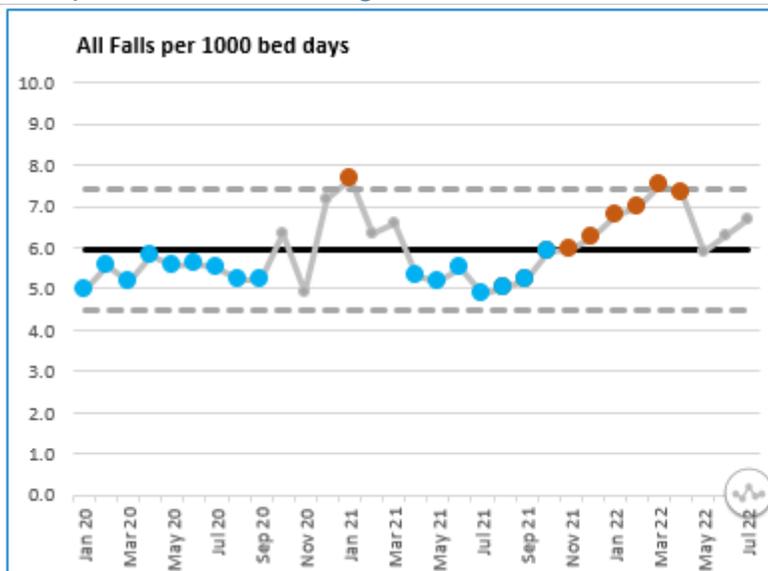
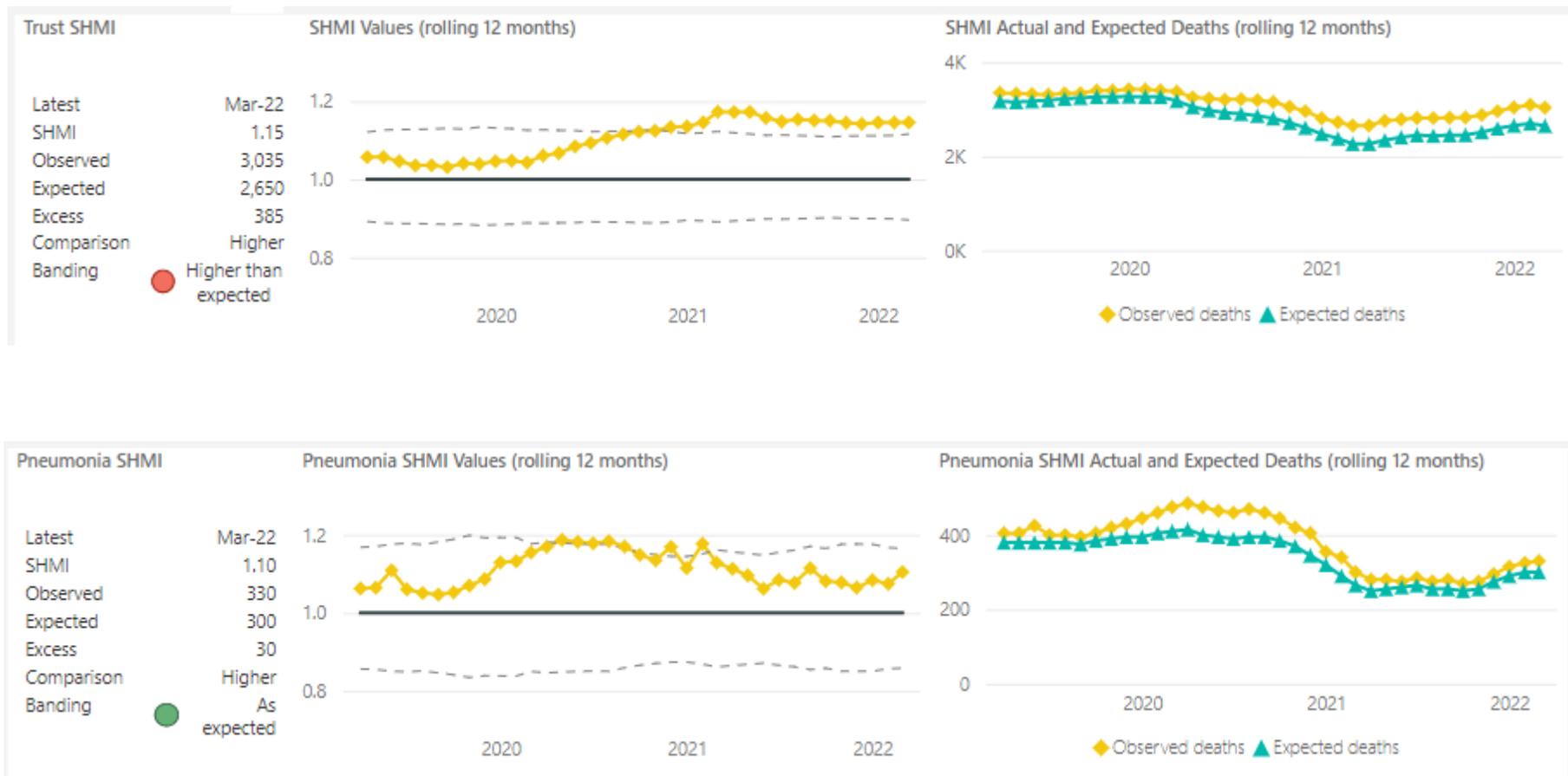


Chart Says:	<ul style="list-style-type: none"> There were 7.1 inpatient falls per 1000 bed days recorded in August 2022 (n=312). 0.20 (per 1000 bed days) inpatient falls resulted in moderate, severe or catastrophic harm to the patient. The number of falls being reported is in line with control limits
Issues:	<ul style="list-style-type: none"> The Trust is reporting a high number of inpatient falls however the number of falls resulting in harm remains low within control limits. The Chest Medicine wards reported the highest number of inpatient falls resulting in harm The numbers of falls resulting in harm to the patients is low The majority of falls reported are un-witnessed
Actions:	<ul style="list-style-type: none"> To work with the digital team to develop an electronic falls bundle on NerveCentre Development of Falls Champions network to share lessons learned, best practice and quality improvement initiatives
Mitigations:	<ul style="list-style-type: none"> The Trust Multi-Disciplinary Falls Committee continues to meet bi-monthly Implementation of improvement programme to see a reduction in patients coming to harm from falls against strategic ambition 'harm free care' in the Quality Strategy 2022/2025.

3. Performance Review – Effective

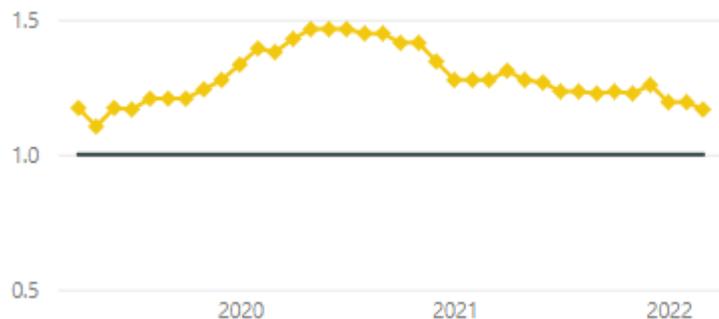
3.1 Mortality; HSMR and SHMI



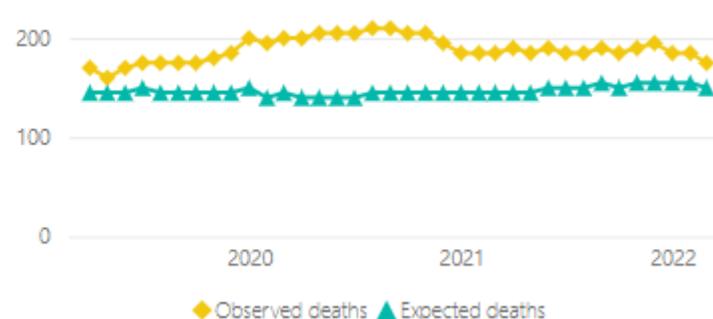
Stroke SHMI

Latest SHMI	Mar-22	1.17
Observed		175
Expected		150
Excess		25
Comparison Banding		Lower

Stroke SHMI Values (rolling 12 months)



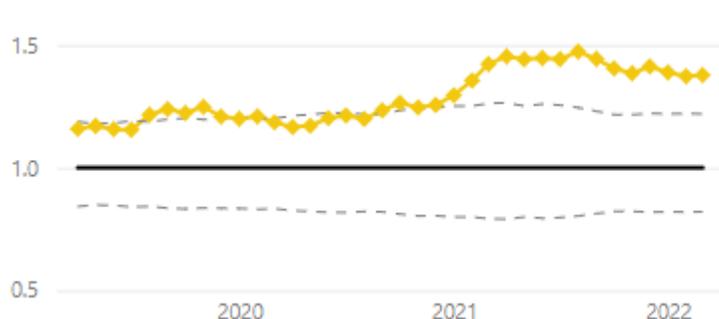
Stroke SHMI Actual and Expected Deaths (rolling 12 months)



Septicaemia SHMI

Latest SHMI	Mar-22	1.38
Observed		205
Expected		145
Excess		60
Comparison Banding		Higher
		Higher than expected

Septicaemia SHMI Values (rolling 12 months)



Septicaemia SHMI Actual and Expected Deaths (rolling 12 months)

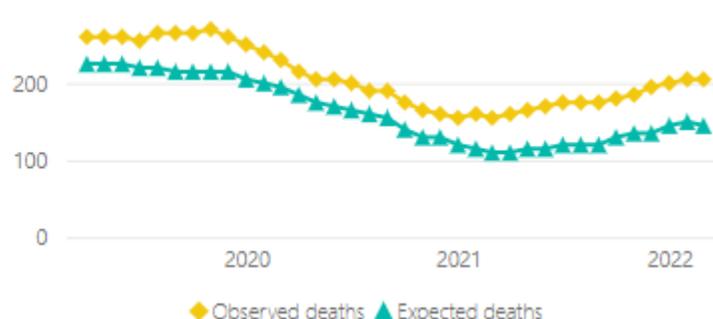


Chart Says:	<p>The SHMI continues to remain above the England average of 100.0. This continues to be highlighted as a cause for concern and is being used to inform internal improvement work, in particular Pneumonia, Stroke and Sepsis.</p> <p>Pneumonia remains slightly higher than expected; however, the chart is demonstrating ongoing improvements since 2021.</p> <p>Sepsis remains higher than expected.</p> <p>Stroke also remains higher than expected; however, the chart is demonstrating some improvements since 2021</p>
Issues:	<p>The Trust continues to be reported as an outlier in the CQC Insight Report for HSMR and SHMI. Both these indicators are under investigation to understand the reasons.</p>
Actions:	<p>The Mortality Task and Finish Group Led by the Chief Medical Officer continues to undertake in-depth analysis and improvement work on the high risk areas highlighted in the HSMR and SHMI data. A range of mortality indicators are monitored by the Mortality Dashboard Current areas of focus are Septicaemia, Pneumonia and Stroke.</p> <p>An MDT team from HUTH visited Liverpool NHS Trust in September 2022 to continue with our learning on how they improved their SHMI and in particular Sepsis deaths. The outcome from this visit will further inform the improvement work the task and finish group is working on. A post visit meeting is scheduled for Monday 12 September 2022 to agree next steps and further actions.</p>
Mitigations:	<p>The group continues to meet twice-weekly to deliver the Mortality Improvement Plan following the internal HSMR review, which was also supported by external scrutiny by Dr Foster to address the Trust's Mortality Outlier status. This group also reviews the HSMR and SHMI data in more detail to undertake improvement work in the key areas. This is being informed and supported by the development of an in-house Mortality dashboard and the completion of SJRs as well as other improvement actions as agreed by the group.</p>

Complaints – excluding EMHG

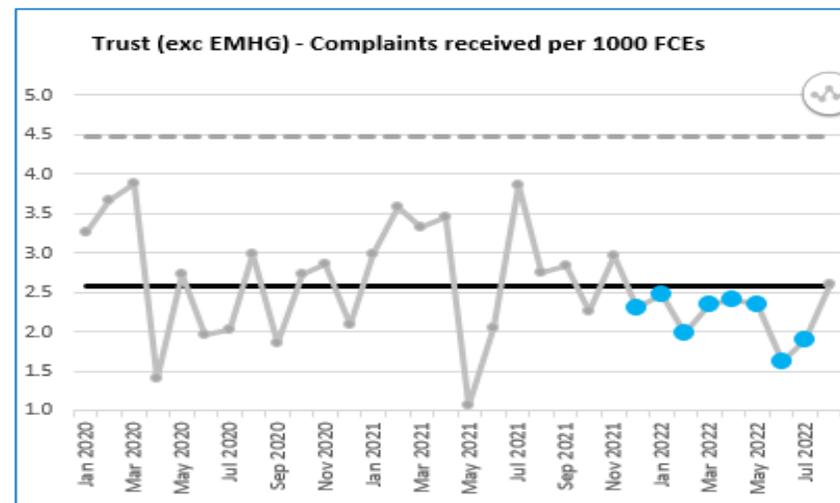
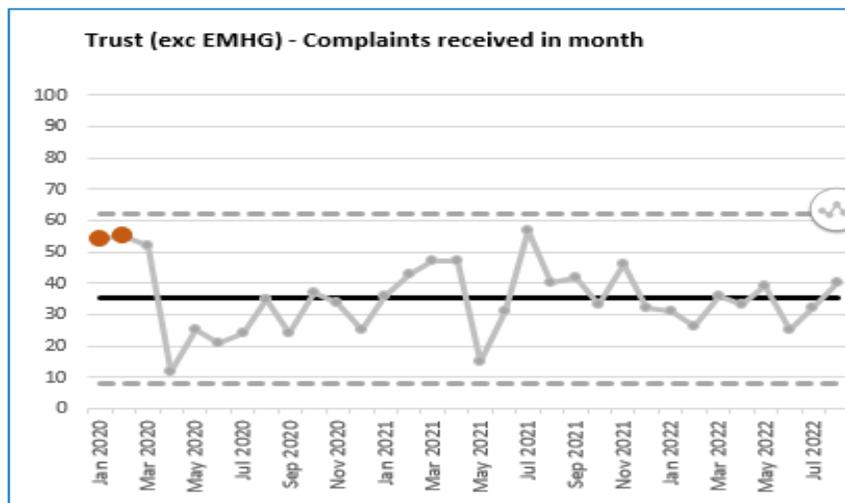


Chart Says:	<ul style="list-style-type: none"> • There were 34 complaints received (excluding those against the ED) in August 2022, this equates to 2.6 complaints per 1000 Finished Consultant Episodes (FCEs). • The graphs for the total numbers received per month show common cause variation with no cause for concern. • The graph against the FSEs shows that there has been improvement with fewer complaints received over a 8 month period
Issues:	<ul style="list-style-type: none"> • In the month of August the HG with the highest number of complaints (15) was MHG; main theme care & comfort (5) and discharge (4) • Treatment concerns accounted for the highest number of complaints received across the Trust (19) with un-satisfaction with treatment plans the common theme
Actions:	<ul style="list-style-type: none"> • Development of a public and patient engagement strategy • Learning from experience and themes arising from complaints • Work in partnership with the patients and the public to develop and improve services • To see a reduction in formal complaints particularly across the Trust top categories e.g. staff attitude and communication
Mitigations:	<ul style="list-style-type: none"> • Introduction of the Role of Patient Safety Partners & Patient Safety Champions • Learning from 'lived experience' across a number of different platforms including the Patient Councils
Learning:	<ul style="list-style-type: none"> • We know many patients a lack of stimulation leading to a sense of boredom. Therefore, Patient Experience are working with the Health Groups to explore ways to enhance the experience of inpatients with the development of activity volunteers, introduction of magazine / book trolley visits to wards. Working with local academies to introduce Hand Massages / art and craft activities. Exploring the use of volunteers to help keep communication lines between patients and their families open by use of phone / iPad video calls

Complaints – EMHG

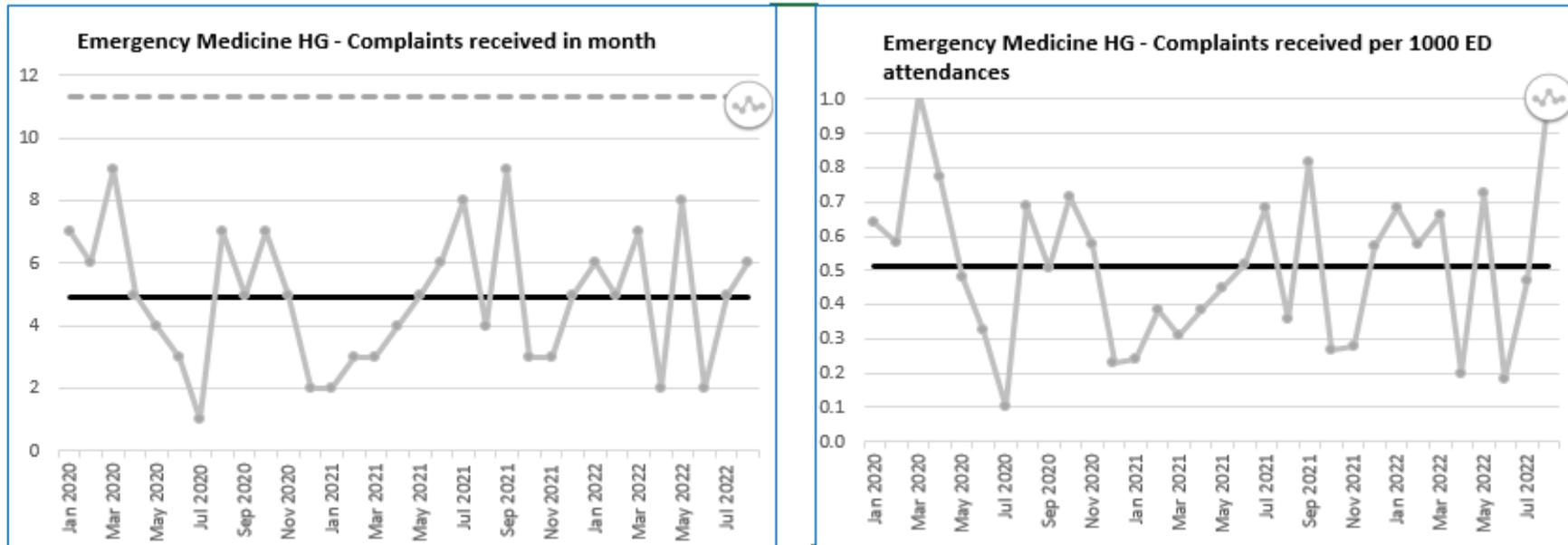


Chart Says:	<ul style="list-style-type: none"> • There were 6 complaints received in the Emergency Medicine Health Group (ED) in August 2022, this equates to 1 complaint per 1000 ED attendances • The graphs for the total numbers received per month show common cause variation with no cause for concern.
Issues:	<ul style="list-style-type: none"> • The 6 complaints received were in relation to treatment (4) delays (1) and communication (1) • The ED is seeing an increasing number of patients visiting the department with 4hr performance targets challenged • The average time a patient spends in the department has risen by more than 50% compared to the same month in the previous year
Actions:	<ul style="list-style-type: none"> • Development of a public and patient engagement strategy • Learning from experience and themes arising from complaints • The work in partnership with the patients and public to develop and improve services • To see a reduction in formal complaints particularly across the Trust top categories e.g. staff attitude and communication
Mitigations:	<ul style="list-style-type: none"> • Introduction of the Role of Patient Safety Partners & Patient Safety Champions • Learning from 'lived experience' across a number of different platforms including the Patient Councils
Learning:	<ul style="list-style-type: none"> • We know some patients with long stays in ED report little food is offered / available. We have increased the use of volunteers to support giving drinks/food to patients within the department

Complaints – Closed

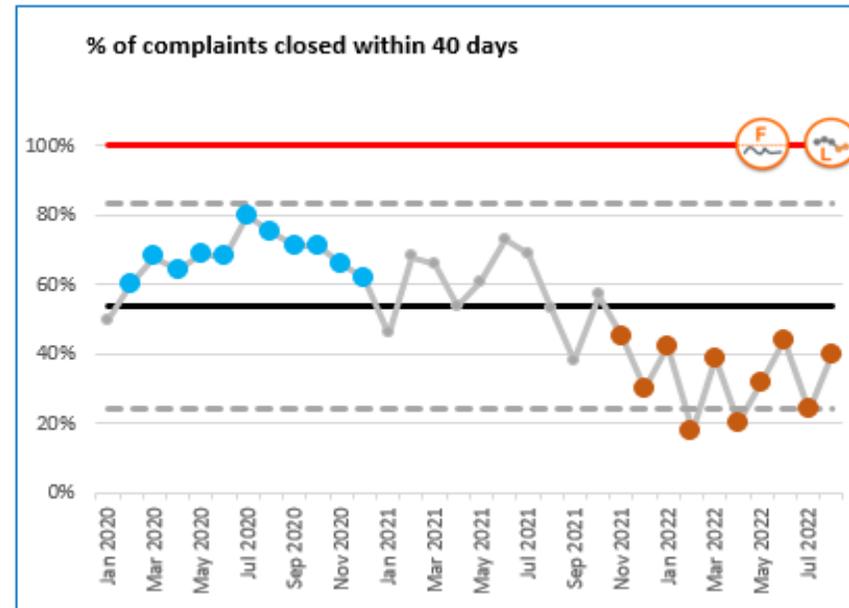
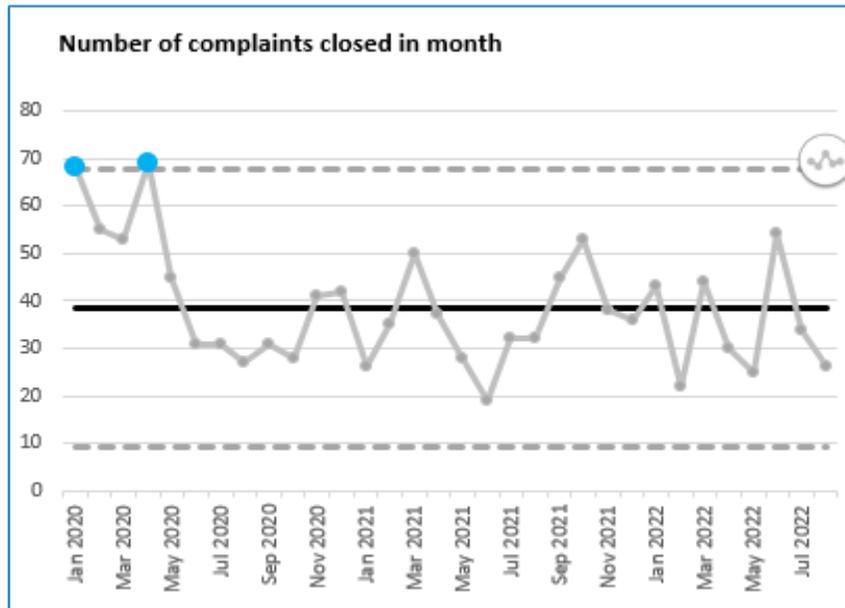


Chart Says:	<ul style="list-style-type: none"> • 26 Complaints were closed in the month of August with 40% closed within the HUTH recommended 40 day response deadline • 3 Complaints were upheld and 9 partly upheld. 14 complaints were not upheld • The timescales to close within 40 days have breached the mean for 10 months
Issues:	<ul style="list-style-type: none"> • There are a total of 107 complaints that are currently breaching the deadline and have been open for investigation for more than 40 days • The complaint response workload is not always distributed across all investigatory managers who investigate within their own Health Groups • The Health Group with the highest number of complaints investigations overdue is Surgery Health Group with 47 open (reduction of 9 from previous month)
Actions:	<ul style="list-style-type: none"> • To increase the monthly closure rate per month to eliminate the backlog of open complaints investigations • Monthly meetings between the Head of Patient Experience and Engagement with Health Group representative to review open complaints • Escalation of variations to the Health Group Triumvirates and PESC
Mitigations:	<ul style="list-style-type: none"> • SHG challenged with nurse director on leave – replacement ND commences early September 2022

5. Continuous Quality Improvement

Quality, Service Improvement and Redesign

Within the last reporting period there been two QSIR programmes launched. The first being a one day QSIR Fundamentals programme which celebrated attendance from 20 colleagues ranging from a variety of roles within the Trust. The second programme was day one of our five day QSIR Practitioner Programme. The first QSIR Practitioner cohort delivered following the Trust gaining QSIR College accreditation which saw fifteen colleagues begin the QSIR Practitioner journey. Amongst the fifteen delegates was members from NHS England who chose HUTH as their preferred QSIR Academy to undertake the programme.



GREATIX

The GREATIX learning from excellence recognition award was launched in August 2022 to help promote, celebrate and learn from all the excellent work happening throughout the Trust. Since the launch 88 colleagues have been nominated for a GREATIX award.



“The Cath Lab Team designed a co-ordinator role to assist the cardiology wards to ensure the patient care

was optimised and reduced cancellations from medical reasons/ incorrect preparation. They also designed a training package including simulation to increase the knowledge base of the nursing teams on the cardiology wards.

Another aspect of patient care that was optimised was the transfer of patients from the district general hospitals that had been waiting for more than the three days to ensure that patients from all locations were treated in a more timely manner. This increased better collaboration of service provision and the team are now extending this to not only cover treat and return for NSTEMI - but also the patients waiting for TAVI procedures.”





ThinkTank

The Trust launched its ThinkTank platform in August 2022 ready for Improvement Month launching in September. The ThinkTank platform which was pioneered by the Trusts Communications team allows staff to submit ideas for improvement and develop their improvement projects with the support of Trust Improvement teams.

Within two weeks of launching; the ThinkTank platform received over one hundred staff suggestions. The suggestions are reviewed by the ThinkTank board comprised of panel experts from each improvement team, communications team, finance and digital services before being assigned to a submission lead to support the development of the idea.

“I want to improve patient experience and reduce 'did not waits' and attempts at absconsion for patients who have attended the Emergency Department after an episode of self-harm or overdose. In order to do this I want to plan a service that puts the patients' priorities at the centre of our approach. I would like to run a project according to Experience Based Design techniques. In order to do this, I would need assistance and support from someone who has either ran an EBD project or has the knowledge and skills to help set this up.”

“Could we start virtual meetings at 5 past the hour as an organisation? Often there are not even seconds between the next meetings.”

Agenda Item	Meeting	Quality Committee and Trust Board	Meeting Date	
Title	Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme			
Lead Director	Joanne Ledger Chief Nurse			
Author	Jayne Gregory Clinical Governance Midwife Helen Yates Neonatal Consultant Lorraine Cooper Head of Midwifery			
Report previously considered by (date)	Quality Committee August 2022			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	Y
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Committee is requested to:</p> <ul style="list-style-type: none"> • Receive the report findings • Decide if any further information and/or assurance are required.

**Hull University Teaching Hospital NHS Trust
FAMILY AND WOMENS HEALTH GROUP
WOMEN SERVICES DIVISION**

**Avoiding Term Admissions into Neonatal Units (ATAIN):
Learning from Term Admissions Quarter 1 2022**

Background

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. This report will update progress from Hull University Teaching Hospital Trust in regards Safety action 3 : *Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme* . Furthermore this report will focus on an action plan to address local themes from Avoiding Term Admissions into Neonatal unit reviews, this will be agreed with the Maternity and Neonatal safety champions and Board level champion.

The Aim of the ATAIN program is to reduce the avoidable causes of harm that can lead to infants born at term (at or over 37 weeks' gestation) being admitted to the Neonatal Unit. Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the ATAIN work to date. The case reviews of unanticipated term admissions to the NNU to determine whether there were modifiable factors, which could be addressed, as part of an action plan the ATAIN program at hull University Teaching hospital has been continuing throughout the recent covid 19 pandemic.

The National target for term admissions into a NNU per 1000 birth is < 5 % with the previous target aimed to reduce the number of term admissions into a NNU per total admissions by 20% by 2020. At Hull University Teaching Hospital NHS Trust the aim to reduce the number of term admissions into the neonatal unit to meet the stretch trajectory.

In Quarter 1 the auditors for this report have focused on the primary reason for admission with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed, in order to develop the action plan.

In addition year 4 of CNST, Trusts are required to report on the number of babies admitted to the NNU that would have met current Transitional Care (TC) admission criteria, but were admitted to the NNU due to capacity or staffing issues. In addition the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on. Finally reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

Hull University Teaching Hospitals Current position

As demonstrate by table 1 they has been a decrease in the number of Term admissions to NUU since 2016. **Table 1** highlights the number admissions to the NNU during the commencement of the ATAIN programme.

Table 2 shows the current position for the year 2021 in Quarter 1 (01/04/21- 30/06/21) 3.1 % and quarter 2 (01/07/2021- 30/09/21) 3.0 %.Quarter 4 01/01/22-01/03/22

Table 3 highlights the number of admissions in Quarter 1 of 2022

Table 1

Year	In born term admissions	% of total NNU admissions	% of Term admissions to NNU
2016	191	39.6%	4.1%
2017	186	37.7%	3.9%
2018	154	35.2%	3.3%
2019	175	35.5%	3.1%
2020	159	33.3%	3.2%
2021	187	39.9%	2.6%

Table 2 2021/2022

Duration	In born admissions	% of total NNU	% of term admissions
Quarter 1 2021	1250	33.4%	3.1%
Quarter 2 2021	1450	35.6%	3.0%
Quarter 3 2021	1282	45.2%	2.6%
Quarter 4 2022	1223	34.7%	2.6%

Table 3 2022/2023

Duration	In born admissions	% of total NNU	% of term admissions
Quarter 1 2022	1182	26.6%	2.6%

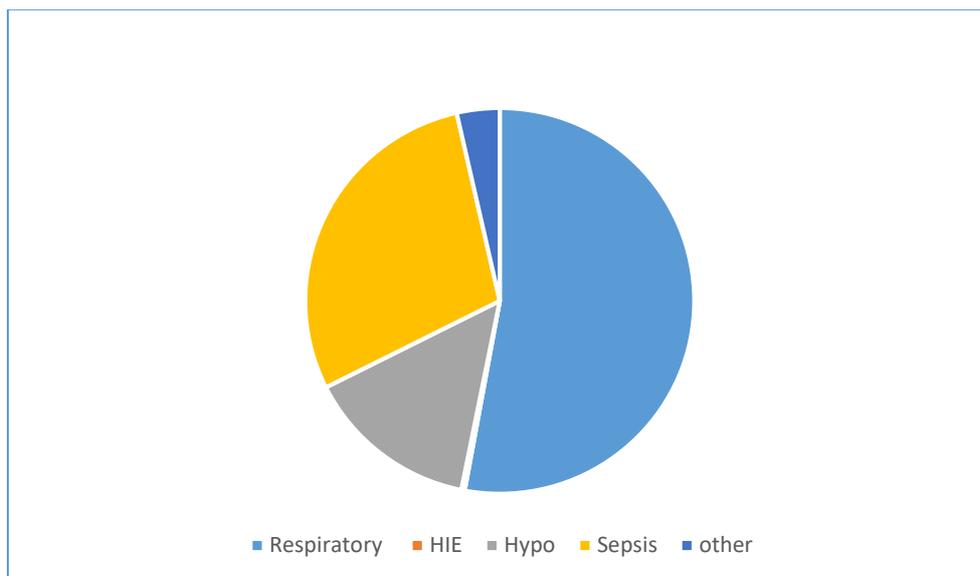
All unexpected term admissions to NICU are reported through the DATIX system and investigated through the weekly Maternity Case Review multi-disciplinary meeting. The CNST approved template ATAIN proforma is completed for data collection purposes. The themes, trends and learning points are shared amongst all clinical staff from both Maternity and Neonatal services. In addition an online training package is available on the Trust HEY 24/7 educational platform which is required learning for all midwives which covers these learning points. This report considers all term admissions to the NICU in previous reports the length of stay has currently only been considered if over 4 hours.

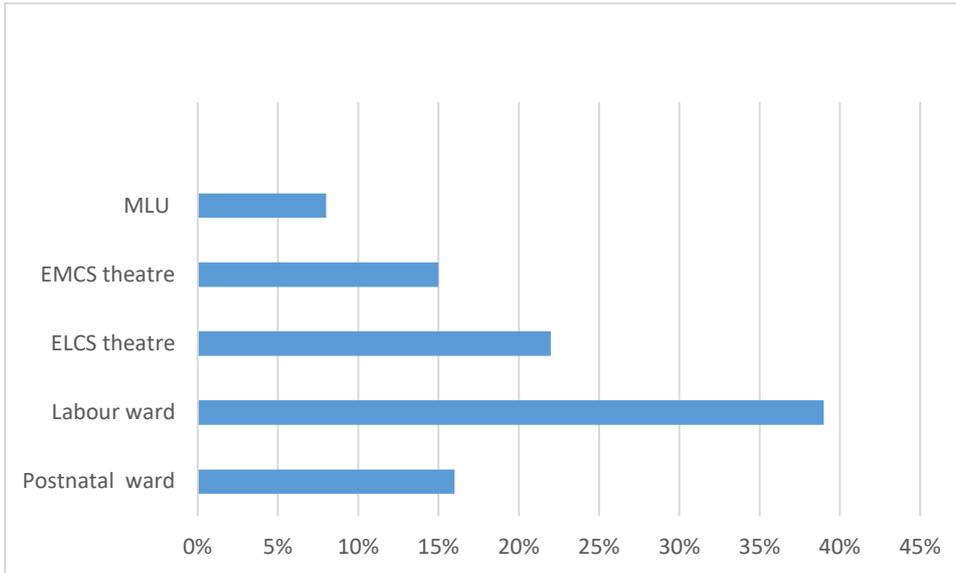
A high-level review was completed of the primary reasons for all admissions, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. Firstly the focus was on gestation as demonstrated below 47.7% of the cohort of babies are 40- 40+7weeks gestation. A deep dive was then completed to identify the primary reasons for admission from this cohort of babies as recommended in the technical guidance for CNST year 4. The review then looked focused on area of admission.

6 admission from neighbouring trusts were identified

Gestation

In quarter 1, 44 cases of Unexpected Term Admissions to NICU have been reviewed through Maternity case review and the themes identified are presented below. The average gestation at admission to NICU was 38 - 38+ 6 weeks. The primary reason for admission at gestation 38 weeks 38+6 to NICU was for respiratory support, requiring CPAP.





Admission Location

- Babies were most commonly admitted to NICU from the labour ward and theatre. Within the action plan the Neonatal team have identified through this review that that this cohort of babies are admitted to NNU for a short period and are soon returned back to the mothers. The Neonatal team will be trialling a new quality improvement initiative 2022, which involves using the lifestyle platform at the bedside on labour ward which in turn should reduce the number of babies admitted to NICU on CPAP.

Preventable admission – Perinatal management

- It has been identified that changes in the perinatal management may have prevented admission to NICU. Most common mode of delivery for admission to NNU was Elective Caesarean Sections not in labour. As babies born by this mode can struggle with adaptation and in view of National recommendation a baby should be placed skin to skin at least until after the first feed and for as long as the mother wishes. This is currently not standard practice in this mode of delivery within a theatre situation therefore this has been added as a quality improvement within the action plan. This work is ongoing and training video is in the process of being completed and will be added to the maternity and obstetrics workspace.

Birth Weight

- The most common birth weight range at admission to NICU was 3.0 – 4.4kg.

Length of NICU stay

- The length of stay on NICU was most commonly between 1 -3 days.

Category of care

- The most common category of care at admission to NICU was Intensive Care Level 3.

Suitability for transitional care

The number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU is 11 and the number of babies that were admitted to, remained on NNU because of their need for nasogastric tube feeding is 0. It has been identified the capacity on the transitional care is the reason in all 11 cases.

The themes as identified above were reviewed and the following action plan agreed through multidisciplinary discussion

Action	Lead	Status
Respiratory management platform to be trialled for respiratory support (CPAP) at the bed side on labour ward	Helen Yates Neonatal consultant	February 2022
To embed practice of skin to skin at EMCS/ELCS Training video to be completed by the infant feeding co-ordinators	Pippa Toogood and Anna Lee Hughes	August 2022

Compliance with the above action plan will be monitored regularly through the weekly Maternity Case Review meeting. A copy of this report will be shared through the Obstetric Governance meeting and, the Family, and Women's Health Group Governance meeting. It will also be shared with the Executive Maternity Safety Champion and the Neonatal Safety Champion. An update of progress on this action plan will be reported via the Health Group Governance process

Jayne Gregory - Clinical Governance Midwife
Helen Yates - Neonatal Consultant (ATAIN program lead)
July 2022

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

Agenda Item	Meeting	Trust Board Meeting	Meeting Date	
Title	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving Babies’ Lives care bundle version two? Element 2 – Process Indicators 4 and 7			
Lead Director	Joanne Ledger Interim Chief Nurse			
Author	Lorraine Cooper Head of Midwifery			
Report previously considered by (date)	Quality Committee (August 2022)			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	Y
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Trust Board is requested to:</p> <ul style="list-style-type: none"> Receive the report and decide if any further information and/or assurance are required.

**MATERNITY SERVICES
FAMILY AND WOMEN'S HEALTH GROUP**

**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 -
Safety Action 6 – Can you demonstrate compliance with all five elements of the Saving
Babies' Lives care bundle version two? Element 2 – Process Indicators 4 and 7**

1. Purpose

The purpose of this report is to provide assurance to the Trust Board that the organisation, to the standard required by the Clinical Negligence Scheme for Trusts (CNST), is compliant with Safety Action 6: Element 2: Process Indicators 4 and 7.

2. Introduction

Saving Babies' Lives care bundle version 2 (SBLCBv2) is a care bundle for reducing perinatal mortality across England published in April 2019. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice. Element 2 covers the risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, including:

- Publication of small for gestational age/fetal growth restriction detection rates and percentage of babies born <3rd centile and >37+6 weeks gestation
- An on-going case-note audit of <3rd centile babies not detected antenatal (at least 20 cases per year) to identify areas for future improvement and monitoring of babies born >39+6 and 10th centile to provide an indication of detection rates and management of small for gestational age babies

For the purposes of this report, this links to CNST Safety Action 6, Element 2:

Process Indicator 4 – a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation.

Process Indicator 7 – a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected & evidence of quality improvement initiative to address any identified problems

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will receive a share of any un-allocated funds. In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (MIS@resolution.nhs.uk), Trust submissions will be subject to a range of external verification points.

3. Requirements for Safety Action 6, Element 2 – Process Indicator 4 – a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation

Quarter 1: April, May, and June 2022:

Number of babies born at HUTH = 1182

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

Number of babies born at HUTH < 3rd centile & >37+6 = **24**

Percentage = 2.03 %

4. Requirements for Safety Action 6, Element 2 – Process Indicator 7

A quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected & evidence of quality improvement initiatives to address any identified problems

Through the Perinatal Institute Growth Assessment Protocol (GAP) Score system and the Trust's Datix system, maternity cases within these criteria are reviewed as missed cases with a low birth centile and/or missed fetal growth restriction.

For Quarter 1 (April, May, June 2022), there were 7 missed cases and of these, it was highlighted that:

- 1 case involved possible incorrect fundal height measurements by midwifery or obstetric practitioners
- 3 cases were not referred for ultrasound growth scans when risk factors for growth restriction were identified
- 2 cases involved possible growth ultrasound deviations or that fell within the variance allowed by the ultrasound parameters

Emails were sent to the relevant practitioners to inform them that they had missed GAP scan referrals. Details of ultrasound growth deviations close to the time of birth were sent to the obstetric sonographers for discussion at their multi-disciplinary meeting(s). It remains encouraging that the number of apparent incorrect fundal height measurements has remained low in this quarter, and it is felt that face to face fundal height assessment/training has been able to identify any issues with individual practitioners.

At the time of writing, a new detailed GAP score report is awaited from the Perinatal Institute, and then a GAP newsletter will be produced for all relevant maternity staff in August 2022.

5. Summary

- i) For Safety Action 6, Element 2 – Process Indicator 4 – a quarterly audit of the percentage of babies born <3rd centile >37+6 gestation has been undertaken
- ii) For Safety Action 6, Element 2 – Process Indicator 7 - a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation has been undertaken

6. Recommendations

The Trust Board is requested to:

- Receive the above report
- Receive assurance by the team that the relevant audits and review requested by CNST have been undertaken.
- Decide if any further information is required

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

Agenda Item	Meeting	Trust Board Meeting	Meeting Date	13/09/2022
Title	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4			
Lead Director	Joanne Ledger Interim Chief Nurse			
Author	Lorraine Cooper Head of Midwifery			
Report previously considered by (date)	Quality Committee			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
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Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Trust Board is requested to:</p> <ul style="list-style-type: none"> Receive the report and decide if any further information and/or assurance are required.

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

**CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)
MATERNITY INCENTIVE SCHEME – YEAR 4
September 2022**

1. PURPOSE OF THE REPORT

The purpose of this report is to provide information following a review of the impact of Covid-19, and readiness to apply for a 10% reduction in the Clinical Negligence Scheme for Trusts (CNST) Maternity premium in 2021/22.

This report presents the following:

- Background
- Covid-19 impact on reporting
- Review of the year four CNST safety actions

2. BACKGROUND

As part of its insurance against clinical negligence claims and litigation, the Trust pays an annual insurance premium under the Clinical Negligence Scheme for Trusts (CNST), administered by NHS Resolution. The Maternity CNST rebate in 2019 was £470k with a further £21k allocation from Trusts who were not compliant with all ten-safety actions.

3. COVID-19 IMPACT ON REPORTING –

The 10 maternity safety actions are, as follows:

1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?
2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
3. Can you demonstrate that you have transitional care (TC) services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? (ATAIN)
4. Can you demonstrate an effective system of clinical workforce planning to the required standard?
5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?
6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2 (SBLCBv2)?
7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
8. Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?
9. Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
10. Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification (NHSEN) scheme

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

Pause in reporting procedure regarding the maternity incentive scheme

In recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements relating to demonstrating achievement of the maternity incentive scheme (MIS) 10 safety actions are paused with immediate effect for a minimum of 3 months.

This will be kept under review. Trusts are asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples of continuing to apply the principles include: undertaking midwifery workforce reviews, ensuring that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continue, as well as using available on line training resources.

Trusts are asked to continue to report to MBRRACE-UK and report eligible cases to the Health Safety Investigation Branch (HSIB). In addition, every reasonable effort should be made to make the Maternity Services Data Set submissions to NHS Digital.

In the current challenging circumstances, in descending order of priority for reporting to MBRRACE-UK as follows:

- Notify all perinatal and maternal deaths;
- Complete the surveillance information for COVID-19 related perinatal deaths where either the mother and or baby is infected with SARS-CoV-2;
- Continue to complete the perinatal surveillance information for all other deaths, whilst there is capacity to do so;
- Continue to complete reviews using the Perinatal Mortality Review Tool, whilst there is capacity to do so.

The reporting period for MIS year 4 will also be kept under review and may potentially be extended by the MIS Collaborative Advisory Group (CAG) who will reconvene in February 2022. Trusts will be provided with a timetable and revised technical guidance in due course and those will also be shared via your submitted MIS nominated contacts and posted on NHS Resolution's website

The reporting period has been extended although we are awaiting confirmation of the reporting and submission periods. In response to the current situation, the 10% uplift to the Clinical Negligence Scheme for Trusts (CNST) for the maternity incentive scheme has not been collected for the year 2020/2021.

The scheme was reviewed and relaunch from 6 May 2022. The scheme's submission deadline has been extended from June 2022 to 5 January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended.

Safety Action	Compliance	Board Request
1	Perinatal Mortality Review Tool Compliant	<p>All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.</p> <p>A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust</p>

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		<p>At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.</p> <p>For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby’s death will take place, and that the parents’ perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion</p> <p>Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.</p>
2	<p>MSDS Partial Compliance</p>	<ol style="list-style-type: none"> 1. By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2). 6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)

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		<p>7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in 19 the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:</p> <p>Midwifery Continuity of carer (MCoC)</p> <ul style="list-style-type: none"> i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. <p>Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information)</p>
3	<p align="center">TRANSITIONAL CARE Partial Compliance</p>	<ul style="list-style-type: none"> a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 week’s gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family

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		<p>integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.</p> <p>f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet.</p> <p>In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues.</p> <p>The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been 27 cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.</p> <p>g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.</p> <p>h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.</p>
4	<p style="text-align: center;">Medical Staffing Non Compliance</p>	<p>a) Obstetric medical workforce</p> <p>1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/</p> <p>2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.</p> <p>b) Anaesthetic medical workforce</p> <p>A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)</p> <p>c) Neonatal medical workforce</p> <p>The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress</p>

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		<p>against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.</p> <p>d) Neonatal nursing workforce 37 The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.</p> <p>If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.</p>
5	<p align="center">Midwifery Staffing Partial Compliance</p>	<p>a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.</p>
6	<p align="center">SBLV2 Compliant</p>	<p>1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network. 3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.</p>
7	<p align="center">Maternity Voices Partnership Compliant</p>	<p>Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?</p>

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8	Mandatory Training Partial Compliance	<p>a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years</p> <p>b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four</p> <p>c) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four</p> <p>d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four</p>
9	Safety Champions Partial Compliance	<p>a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.</p> <p>b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-about; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.</p> <p>c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.</p> <p>d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)</p>
10	NHS Resolution Partial Compliance	<p>1. A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022</p> <p>2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022</p> <p>C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:</p>

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		4. 1. The family have received information on the role of HSIB and NHS Resolution's EN scheme; and 5. 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
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7. SUMMARY

In summary, following a review of the current position the service is declaring full compliance with three standard, partial compliance with seven of the standards. A quarterly update will be provided, and the final evidence to be signed off by the Chief Executive will be submitted once the submission dates have been agreed with NHSR.

Attached APPENDIX 1 is a comparison of the year 3 & 4 standards and identified challenges to achieving year 4 safety standards.

8. RECOMMENDATIONS

The Trust Board is requested to:

- Agree that the review of the position at this current time demonstrates full compliance with one standard, partial compliance with seven of the standards, and a non-compliance with two standards.
- Decide if any further information and/or assurance is required.

Lorraine Cooper
Head of Midwifery
September 2022

Joanne ledger
Executive Chief Nurse

APPENDIX 1

Clinical Negligence Schemes for Trust Year Three and Four Comparison

Background

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions.

Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

Rationale

The purpose of this paper is to identify to the Trust Board and Executive team the main comparisons and potential resource required between year three and year four of the CNST scheme. On review of year four CNST scheme, there are significant changes to the following identified safety actions:

Safety Action 1 - Perinatal Mortality Review Tool

- Notification to MBRRACE-UK, changed from 7 working days to 2 working days
- Surveillance form must be completed, changed from within 4 months of the death to within 1 month of the death.
- Timeframe for review using PMRT changed to will have been started within two months of each death.
- PMRT cannot be completed until the HSIB report is complete
- Draft report timeframe changed to within four months of each death and the report published within six months of each death.
- Quarterly reports discussed with Trust Maternity Safety Champions, now includes Board Level Safety Champions.

Safety Action 2 - MSDS data

There are significant detailed targets and dates that are listed for Year 4 for MSDS data ensuring that Maternity Information System procured or fully funded. Data quality criteria for at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs), data submission by January 2022.

Safety Action 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units Programme?

- Pathways of care into transitional care reintroduce with a focus on minimising separation of mothers and babies.
- Reintroduce with audit period changed from every other month to quarterly. Audit to also be shared with LMNS, Commissioners and ICS at quality surveillance meeting each quarter.

Safety action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

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- The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: “Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology” <https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/>. (By January 2022 and monitored monthly from then).
- Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts’ positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.
- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.
- The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year three of MIS as well include new relevant actions to address deficiencies.

Safety action 6

Can you demonstrate compliance with all five elements of the Saving Babies’ Lives care bundle version two?

- There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks’ gestation.
- They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).
- Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.
- They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks’ gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems.

Safety action 8

Can you evidence that a local training plan is in place to ensure that all six-core modules of the Core Competency Framework will be included in your unit-training programme over the next 3 years, starting from the launch of MIS year 4?

- A training plan should be in place to cover all six-core modules of the Core Competency Framework. The training plan will span a 3-year time period and will include;
 - Saving Babies Lives Care Bundle
 - Fetal surveillance in labour
 - Maternity emergencies and multi-professional training.
 - Personalised care
 - Care during labour and the immediate postnatal period
 - Neonatal life support
- A multi-professional ‘in house’ training day should be reinstated as face-to-face training no later than the 30th September 2021 (in line with Public Health England COVID-19 guidance).
 - Fetal monitoring and surveillance (in the antenatal and intrapartum period)
 - Maternity emergencies training scenarios,
- Neonatal life support
- Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:

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- Risk assessment
- Intermittent auscultation
- Electronic fetal monitoring
- System level issues e.g. human factors, classification, escalation and situational awareness
- Use of local case histories
- Using their local CTG machines

Safety action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the 'implementing-a-revised-perinatal-quality-surveillance-model.pdf'(england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.
- Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the perinatal quality surveillance model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.
- Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.

Conclusion

There are significant detailed targets and dates that are listed for Year 4 MSDS data ensuring that Maternity Information System procured or fully funded. Data quality criteria for at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs), data submission by January 2022. HUTH will be transferring over to an LMS system wide maternity IT system, which may affect data capture and submission.

The service has identified that Safety Action 4 will require investment in consultant obstetricians to meet the recommendation in the RCOG workforce document by January 2022.

The neonatal Nurse staffing is an ongoing priority for Safety Action 4 to ensure the service meets the service specifications for nursing standards.

Safety Action 8 will require the release of midwifery, neonatal, anaesthetic, ODPs and medical staff for mandatory training compliance against Ockenden standards.

Safety Action 9 will require a robust plan in line with national guidance to delivery wholesale continuity of carer and sufficient midwifery workforce.

Recommendations

The Executives are asked:

1. Review the paper to meet the year 4 safety actions
2. Decide if any further information and/or assurance are required.

**Lorraine Cooper
Head of Midwifery**

**Hull University Teaching Hospitals NHS Trust
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Agenda Item	Meeting	Trust Board Meeting	Meeting Date	
Title	Maternity Transformation A plan to illustrate the ambition of the organisation to ensure that Continuity of Carer is the default Model of care offered to all eligible women by 2024.			
Lead Director	Joanne Ledger Interim Chief Nurse			
Author	Lorraine Cooper, Head of Midwifery Claire Spear, Better Births Implementation Lead Midwife			
Report previously considered by (date)	Quality Committee (August 2022)			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	Y
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Trust Board is requested to:</p> <ul style="list-style-type: none"> Receive the report and decide if any further information and/or assurance are required.

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**HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
TRUST BOARD**

Purpose of the Report

The purpose of this report is to provide The Trust Board with a concise co-produced plan for the implementation of continuity of carer (MCoC) teams in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels as outlined in the 2021/22 priorities and operational planning guidance. It will provide a detailed timetable of the building blocks we will put in place to best achieve this target by 2024. Consideration will be given to how we will achieve this whilst also taking into account the need for maternity staff to be supported to recover from the challenges faced during the COVID-19 pandemic.

Executive Summary – Key Points

There is strong evidence, along with many national drivers, to support the implementation of Continuity of Carer in maternity services as a service model and choice for women. In addition, NHS England and NHS Improvement are committed to working with regions, systems, providers and partners to implement the actions from both the initial and final Ockenden reports published in December 2020 and March 2022.

Transformation objectives remain committed to women receiving continuity of carer as set out in the NHS Long Term Plan. Some potential barriers need tackling at the outset. These include; engaging the midwifery workforce, putting adequate staffing in place, ensuring that the model is based on a team approach with a named obstetrician linked to each team and ensuring training and equipment needs are considered.

Maternity services have been asked to demonstrate a plan, approved by Trust Board by July 2022 that will;

- Put in place the building blocks to ensure that continuity of carer is the default model of care offered to all women by 2024.
- This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.
- Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds, most deprived areas are placed by on a continuity of carer pathway by 2024.
- Develop an enhanced model of continuity of carer, which provides for extra midwifery time for women from the most deprived areas for implementation from April 2024.

Recommendation

The Trust Board is requested to review the Maternity Services plan to deliver MCoC in conjunction with NHS England 2021/22 priorities and operational planning guidance, implementation guidance. The service request financial investment from the Trust Board to support a phased implementation plan that aims to maintain quality and safety. The detail of the midwifery workforce requirement to deliver MCoC is being progressed by the Head of Midwifery.

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Trust Board and Quality Committee**

Introduction – Background

Better Births - Improving outcomes of maternity services in England' was published in 2016 and has a simple vision: for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. Also for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries.

Continuity of carer is associated with improved health outcomes for both mothers and babies. Women are 19% less likely to lose their baby before 24 weeks, 24% less likely to have a premature baby, 15% less likely to have regional analgesia and 16% less likely to have an episiotomy (Sandall et al 2016). Continuity of carer is known to significantly improve outcomes for women from Black, Asian minority ethnic groups and those living in areas of deprivation (Homer et al 2017)

Continuity of carer is defined as a model of care in which each woman is cared for by a team of no more than 8 midwives. It involves being allocated to a named midwife with whom the woman can develop an on-going relationship of trust. The midwife who cares for her will provide at least 70% of appointments in the antenatal and postnatal periods. The woman will be cared for by a midwife she knows during the intrapartum period and birth, if not attended by her named midwife.

Current position HUTH

In response to the Ockenden Report specific action on Midwifery Continuity of Carer (MCoC) that:

'All Trusts must review and suspend if necessary, the existing provision and further roll out of MCoC unless they can demonstrate staffing meets safe minimum requirements on all shifts.'

A review of midwifery staffing levels was undertaken to ensure that the service could continue to provide a safe and sustainable workforce. An impact assessment was presented to the Trust Board in April 2022, which demonstrated the need to suspend the 4 operational MCoC teams from 6th June 2022 until midwives currently in the recruited process can become established in their positions. This decision was not taken lightly, but was necessary for us to continue to provide high quality, safe maternity care.

Implementation Plan

There are multiple steps that have been identified and considered by the service to be undertaken before the relaunch of MCoC and work towards full implementation of MCoC.

	PLAN FOR IMPLEMENTATION OF MCoC
Communication/Engagement	<ul style="list-style-type: none">• Staff meeting held April 2022 with presentation re plans for service suspension, letters sent to all staff affected and co-produced communication for women sent via letter and social media May 2022.• Plan engagement events across site with staff, service user representatives, stakeholders, LMS and MVP to ensure the plan for transformation is co-produced when in a position to look at relaunch of teams.

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	<ul style="list-style-type: none"> • Planned hospital-based staff engagement sessions for reimplementation – LMS Midwife and Regional Lead to visit and engage with staff re role of LMS and Continuity of carer • Consideration to be given to current restrictions and plan video/webinar information events for staff and service users • Trust website to offer a dedicated site to include FAQ, information and resources • Communication with senior leaders – Attend monthly senior team meeting • Trust Communication Team – Trust Website and Social Media • Use of LMS and MVP websites to highlight planned events and progress • Co-produce a monthly staff newsletter with staff, service user representatives
Consult with HR	<ul style="list-style-type: none"> • Review the process of whole-scale change • Options appraisal required for changes in remuneration (on call/standby) meeting planned 11/7/22. • Develop a formal agreement for travel time/expenses • Plan to offer 1:1 staff meetings to identify health issues/working restrictions that may affect ability to work within the MCoC teams. • Include Trade Union representation to offer transparency – TBA
Workforce	<ul style="list-style-type: none"> • Agreed workforce planning tool undertaken - 13.6.2022 • Birthrate Plus recommendations to be worked through and Development of Business Case to support workforce requirements. • Explore the role of the MSW, produce an LMS agreed SOP – LMS work on going. Applied for enhanced MCoC funding for MSW roles. • 5 x International nurses recruited to undertake scrub role, commenced in post and currently undertaking a programme of training. • Recruitment & retention Midwife commenced in post. • Review Escalation Policy and look to develop and agree a workforce inclusive policy • Review Home Birth provision • Ockenden Report stated Band 5 to remain for 1 year in hospital setting-under National review
Collaborative working	<ul style="list-style-type: none"> • Meeting with MVP Chairs • Involvement of Trade Union TBA • Regular communication with LMS Midwife and other trust implementation leads including wider regional/national network • Work with the Clinical lead to ensure Lead Consultant obstetricians are involved with newly formed teams from the planning stage.
Staff Training	<ul style="list-style-type: none"> • Bespoke training sessions. New starter day is provided • Development of a further training day including community skills/home birth/roster and time management skills – community Matron/continuity lead midwife

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	<ul style="list-style-type: none"> • Development of home birth skills workshop – Working Group • Training Needs Analysis (TNA) to be undertaken July 2022 as per essential actions of Ockenden Report to ensure training needs of the future workforce are addressed. • Induction and Preceptorship of newly qualified staff
Guidance & Patient Leaflets	<ul style="list-style-type: none"> • SOP suspended 6th June 2022. MVP to support the reintroduction of the SOP for new teams to ensure the document is co-produced. • Guideline to be reviewed and approved to support MCoC • MCoC team information leaflets – On going
Implementation of Teams	<ul style="list-style-type: none"> • Assess current caseloads and prioritise new teams in areas of high deprivation, ensuring Black, Asian and minority ethnic communities are placed onto the pathway • Identify numbers of women booked not eligible to be included on a CoC pathway – Information request submitted • Review on-going impact on current community services (on call for home births) • Ensure each team has a linked obstetrician when launched, and a plan for quarterly team meetings. • Ensure each new team has 7 WTE midwives • Explore possibility of seconding Labour Ward Band 7s to new teams for a fixed period of time to help aid understanding and appreciation of the model, improving preparedness of Delivery Suite coordinators and staff to service changes. • Develop a plan & Business Case to look at a phased approach of reimplementation and the teams required to achieve wholesale change and the National Ambition by 2024.
Pandemic Recovery	<ul style="list-style-type: none"> • On-going Pandemic recovery - The removal of restrictions on women's access to support in line with local risk assessments – IPC • On-going support for staff that have been adversely affected by the challenges during Covid. • Unplanned delays due to Omicron variant and resurgence of positive infection amongst staff has left staffing numbers across maternity depleted. Recruitment of newly qualified midwives to support staffing deficit commenced and on-going.
Equipment	<ul style="list-style-type: none"> • Equipment already purchased with Maternity Transformation funding remains available for the initial 4 teams when relaunched. • Equipment costs for more teams to be considered and funding applied for. • Identify Community Hubs and consider cost and availability
IT Services	<ul style="list-style-type: none"> • Provision of Mobile phones • Provision of laptops • LMS wide IT system upgrade currently on-going
Community Hubs	<ul style="list-style-type: none"> • Scope availability/cost of office and clinical community space

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	<ul style="list-style-type: none"> In process of submitting a business case for a pilot hub at Goole Hospital site, allowing cross boundary working with NLAG, between Bluebell Team and Goole & Isle Midwives – at development stage
LMS and Trust Assurance	<ul style="list-style-type: none"> LMS funding provided to keep MCoC Lead Midwife in post until September 2022 to continue reporting, supporting staff through suspension and planning for future relaunch. On-going support of the LMS and Regional & National Transformation Teams Submission of Monthly Board Reports Submission of Monthly statistic and planned trajectory spread sheets to the LMS
CNST Year 4 requirements - Safety Action 9 Point C *Suspended*	<ul style="list-style-type: none"> Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by 2024, prioritising those most likely to experience poor outcomes.'

Financial Considerations/Options

- A share of £135,000 has also been made available for the 3 Trusts to look at an LMS wide approach to providing enhanced care for women with vulnerabilities or from Black, Asian and ethnic minority backgrounds.
- Application submitted for enhanced funding to support relaunch of 4 teams in areas of deprivation and for people from Black, Asian and vulnerable minority ethnic groups, in region of £185,000.

HUTH recently completed a workforce planning tool with the national MCoC lead, below are the midwifery resources that would be required for the phased relaunch of 4 teams in 2 waves, full implementation would require **199.29 WTE** using the national workforce planning tool and Birthrate plus data 2021.

Table demonstrating (workforce, number of teams and dates for delivering full MCoC):

Waves	Date of rollout	Number of MCoC teams	Number of WTE Midwives required	Number of women in MCoC	Number of women in traditional midwifery model
Wave 1	June 2023	2	185.12WTE	560	4674 = 5234
Wave 2	August 2023	4	187.52WTE	1176	4058 = 5234
Wave 3	March 2024	8	192.64WTE	2352	2882 = 5234
Wave 4	September 2024	12	193WTE	3528	1706 = 5234
Wave 5	March 2025	18	199.29	5439	

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Options Appraisal

1. Do nothing and continue with a traditional model of midwifery
2. To implement a full phased programme of work, which will eventually allow wholesale change across the service and ensure HUTH achieve the 2024 National Ambition this will require a midwifery budget of 199.29WTE midwives.
3. Phased approach – Wave 1, the relaunch of 2 Continuity Teams in June 2023, which will require the midwifery budget to be set at 185.12WTE midwives, followed by a further 2 teams in August 2023 with a budget of 187.52WTE midwives.

Preferred Option

The preferred option is option three and if supported by the Executive Team the next step of implementation would be to relaunch 2 new geographically based MCoC teams in June 2023. These 2 teams will be based in areas of the city that will prioritise those most likely to experience poorer outcomes, including women from Black, Asian and minority ethnic communities, those for whom English is not a first language and also those from the most deprived tenth postcode areas.

- By concentrating the relaunch of continuity in the HU91, HU1,2 & 3 areas, each month approximately 30% of women booked onto the continuity pathway would live in the most deprived tenth postcode areas of the city
- More than 75% of Black, Asian and ethnic minority women on the Trust caseload will live in areas now covered by Continuity of Carer teams, helping to address and reduce health inequalities.
- 17 midwives and 2 MSWs will staff these 2 teams and benefit from a more flexible work life balance, increased autonomy and enhanced job satisfaction.
- A Band 7 Midwifery Manager will support two teams.
- If successful in our bid for enhanced funding, a sum of approximately £86,000 will be available to help these teams tackle health inequalities in some of the poorest communities in the city.

Summary

In summary, The Trust Board are kindly requested to review and consider the co-produced plan of Maternity Services in relation to Continuity of Carer in conjunction with The NHS priorities and operational planning guidance for 2021/2022. The maternity service is seeking support from the Trust Board to facilitate implementation of a phased programme of work, which will eventually allow wholesale change across the service and ensures HUTH is on the right pathway to achieve the 2024 National Ambition.

Lorraine Cooper
Head of Midwifery
July 2022.

Claire Spear
Better Births Implementation Lead Midwife

Agenda Item		Meeting	Trust Board	Meeting Date	13/09/2022
Title	Hull University Teaching Hospital NHS Trust - Ockenden Feedback, update on progress to date.				
Lead Director	Beverley Geary Chief Nurse				
Author	Lorraine Cooper Head of Midwifery				
Report previously considered by (date)					

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	Y
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The Committee is requested to:

- Receive the report findings and identified quality improvements for HUTH
- Decide if any further information and/or assurance are required.

MATERNITY SERVICES

Update and progress against Ockenden 7 Immediate and Essential Actions

Executive Summary

1. This paper provides the committee with an overview of the position of this Trust in relation to the recommendations from the 7 Immediate and Essential Actions (IEA) from the Ockenden report published in December 2020, and the 15IEA from the final report.
2. The first requirement was for an initial declaration by the Chief Executive Officer against 12 specific urgent clinical priorities to be submitted to NHSI by December 2020, which was completed.
3. The second requirement is for the Trust to implement the full set of seven Ockenden Immediate and Essential Actions (IEA) and for the Trust Board to have oversight on the progression against the 7IEA.
4. An initial gap analysis has been completed when the actions were first published against the maternity services provided by Hull University teaching Hospital NHS Trust. The analysis of the information was in collaboration with the internal quality improvement team.
5. The organisation submitted its evidence via the Futures Platform on the 30 June 2021 and the Trust received RAG rating feedback on the 29 November 2021.
6. The organisation is compliant or partially compliant with the majority of the interim Ockenden 7IEA and has set up a fortnightly working group, developed terms of reference, developed an Ockenden Charter and associated action plan. This project will support the Health Group to deliver the 7 immediate and essential actions detailed below from the Ockenden report, providing a formal centrally located progress tracker and by providing structure and regular meetings to update on progress to-date.
7. The ongoing project will seek to use change management and quality improvement methods to identify and address key issues with relevant processes and systems, including the use of the Quality Service Improvement Redesign (QSIR).
8. The assurance assessment tool has been reviewed at the Quality Committee, it has also been through the Local Maternity System (LMS) and shared with regional teams.
9. In order to support Board discussion there was a requirement for Trust to complete and take to the Board an assurance assessment tool. As part of that maternity assurance and assessment tool a review of compliance has been completed against the following as an overarching review of maternity service provision.
10. The Final Ockenden report was published and received on the 30 March 2022 with 15IEA for organisations with maternity services to implement.
11. An external assurance visit was undertaken on the 6 June 2022 by Tracey Cooper (Regional Chief Midwife) on behalf of NHSE/NHSI.

Conclusion

Maternity services have undertaken a thorough review of the Interim and Final Ockenden report and key recommendations to ensure safety in maternity services. The Trust is compliant or partially compliant with the majority of the 7IEA, a formal report was received by the Chief Executive and Chief Nurse on Friday the 26 August 2022 following the external assurance visit.

Please see **Appendix 1** for Assurance Visit RAG rating.

In conclusion all 7IEA were 'met' or 'partially' met with none of the 7IEA criteria following into the 'not met' criteria.

Recommendations

The Trust Board is asked to consider whether the assurance mechanism within the Trust are effective and, with the local maternity system (LMS) they are assured that poor care and avoidable deaths with no visibility or learning cannot happen in this organisation.

1. Purpose of the Report

- 1.1. The purpose of this report is to provide assurance to the Trust Board that the maternity service has received and reviewed Ockenden feedback following the external assurance visit on the 6 June 2022.

2. Background

- 2.1. The Ockenden report was written following a review at The Shrewsbury and Telford Hospital NHS Trust following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at that Trust.
- 2.2. The first terms of reference for the review were written in 2017 for a review comprising of 23 families. Since the review commenced more families contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. The terms of reference were amended in November 2019 to encompass over a thousand families.
- 2.3. Due to the size of the review the second and final independent report is due in 2022. Having performed the first 250 clinical reviews the review team identified emerging themes. Recommendations were issued for all acute Trusts offering maternity care and the wider maternity community across England to be addressed as soon as possible

3. Interim Ockenden Report (7 Immediate and Essential Actions)

- 3.1. The interim Ockenden report was published on the 10 December 2020. The report identified a number of important themes which must be shared across all maternity services as a matter of urgency. Therefore, with the full support of the Department of Health and Social Care and NHS England and Improvement the sharing of emerging findings formed Local Actions for Learning and made early recommendations which were seen as Immediate and Essential Actions.
- 3.2. There were seven immediate and essential actions (IEAs) within the Ockenden report comprising 12 specific urgent clinical priorities. An initial gap analysis has been undertaken with the input of the Trust maternity safety champion, Local Maternity System and the executive leads.
- 3.3. In fulfilment of requirements a declaration against the immediate actions was submitted as required on the 21st December 2020.
- 3.4. One year on organisations are being asked to review and discuss local findings at Trust Board Level before the end of March 2022. Local reviews should incorporate progress against the 7IEAs and workforce plans outlined in the Ockenden report and the plan to ensure they are working towards full compliance.

4. Final Ockenden Report (15- Immediate and Essential Actions)

- 4.1. The final Ockenden report was published on the 30 March 2022, identifying 15IEA for organisations to implement:
 - Workforce Planning and sustainability
 - Safe Staffing
 - Escalation and Accountability
 - Clinical Governance – Leadership
 - Clinical Governance – Incident Investigation
 - Learning from Maternal Deaths
 - MDT Training
 - Complex Antenatal Care
 - Preterm Birth
 - Labour and Birth
 - Obstetric Anaesthesia
 - Postnatal Care
 - Bereavement Care
 - Neonatal Care
 - Supporting Families

5. Assurance Visit 6 June 2022 – Next Steps

- 5.1. Feedback was received following the Assurance and Support Visit Hull University Teaching Hospitals NHS Trust on 6th June 2022. The purpose of the visit was to assess compliance with the 7 immediate and essential actions from the first Ockenden report published December 2020. The visit was supported by LMS teams, CCG teams and the MVP and was intended to be supportive.

- 5.2. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were in place and becoming embedded in practice. The team reviewed both your self-assessment and the evidence shared on the day.
- 5.3. The team were very grateful to all the individuals who gave up their time to speak to us on the day, an open and honest culture was clearly evident and commitment to high quality compassionate maternity care was positive to see.
- 5.4. The findings we particularly noted an open and transparent workforce with an obvious desire to share, learn and improve. There was open relationships and good clinical engagement and clear evidence of collaborative working with the LMNS. The team noted the impact of the new pastoral role was extremely positive.

6. Recommendations

- 6.1. Explore solutions for supporting the MVP to attend Safety Champion meetings and Triumvirate meetings.
- 6.2. Consider dedicated obstetric governance lead with sufficient PAs to undertake the role effectively.
- 6.3. Consider involvement of MVPs in the serious incident and complaints reviews.
- 6.4. Involve the MVP in reviewing of the website and other service user resources to ensure coproduction.
- 6.5. Consider innovative engagement by NED and safety champions with staff to ensure safety issues are reported and escalated to board.
- 6.6. Utilise LMNS pathways for external review of incidents to comply with perinatal surveillance model.
- 6.7. Consider how audit is achieved to gain assurance of all aspects of Ockenden IEA's.
- 6.8. Consider investment in an end-to-end maternity information system to improve data quality, audit and therefore assurance as well as improving women's experiences.
- 6.9. Consider investment in the maternity leadership to meet the ask of the RCM leadership manifesto including a DoM, deputy HoM and consultant midwife.

Appendix 1

Trust: Hull University Teaching Hospitals NHS Trust

Site: Hull Royal Infirmary

Date: 6th June 2022

Visiting Team:

Dr Tracey Cooper – Regional Chief Midwife, Claire Keegan – Regional Deputy Chief Midwife, Dr Sarah Winfield – Regional Lead Obstetrician, Debi Gibson – Regional Senior Midwife, Sarah Wall – Regional Service User Representative, Wendy Barker – Deputy Chief Nurse HNY NHSE, Michela Littlewood – MVP chair, Becky Case – LMNS Programme Lead, Sallie Ward – LMNS Lead Midwife,

Colour key for areas	
Meeting	
Virtual	

IEA Qu	KLOE	Visiting Team Met with	Evidence submitted prior to visit	Triangulation at visit	Self-assessment December 2021 Met Partially Met Not Met	Compliance at visit Met Partially Met Not Met	Comments and observations
Safety Action 1 Enhanced safety							
Q1							
Q1	Are maternity dashboards a formal item on LMNS agendas at least every 3 months?		LMNS Agenda		Partially Met	Met	Yes
	Are you able to meet as a triumvirate monthly and minute meetings?	Triumvirate	Board minutes	Met to discuss		Met	Meetings not currently minuted. The trust should consider moving forward how they capture this with clear reference to actions taken.
	Is there evidence of actions taken, and where is this shared?						Ockenden action plan is discussed at local governance level and shared at trust board.
	In relation to the Ockenden action plan, where and how often is this tabled for discussion and what are your concerns?						Key concerns reported are workforce, developing positive culture, achieving year 4 MIS and achieving the national ambition for CoC.
	What other concerns are raised on your Ockenden action plan?						

Q2	How is triangulation of incidents/complaints and claims achieved?	Triumvirate	Governance papers	Met to discuss		Partially Met	Triangulation of incidents and complaints was well narrated however claims were not clearly integrated into this. Ideas were shared as to how this could be achieved. There was a good variety of ways that information was shared with all staff groups, however there was no clear evidence of testing of learning and assurance that any changes were embedded, ideas were shared as to how this could be achieved. Staff described a variety of processes through which feedback was received. Some staff felt supported but didn't always feel concerns were acted on. Staff described feeling mostly comfortable about raising issues, but responses to the issues were mixed.
	Is there external clinical specialist opinion from outside the Trust (but from within the region), mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death?		Minutes of PMRT discussions/ review	Met to discuss	Partially Met	Partially Met	The trust acknowledge that this is proving challenging for the them currently. They should continue to work with the LMNS process to ensure this becomes embedded within there governance structures.
Q3	Are all maternity SI reports (and a summary of the key issues) sent to the Trust Board and the LMNS quarterly?	Triumvirate	Trust Board minutes LMNS Board minutes	Met to discuss	Met	Met	Process clearly articulated and board papers seen
Q4	Are all PMRT cases reviewed to the required standard?	Triumvirate	Ratified SOP/Guideline Audit timetable and actions Audit with 95% compliance	Met to discuss	Partially Met	Met	The last three audits were received and show compliance with this element. The trust should consider how they can improve the presentation of this by perhaps utilising a table to represent data rather than narrative.
Q5	Are you submitting data to the Maternity Services Dataset to the required standard?	Triumvirate	Confirmation of compliance Action plan if improvements needed	Met to discuss	Met	Met	Yes

Q6	Have all HSIB cases been reported?	Triumvirate	Audit timetable Audit demonstrating 100% compliance	Met to discuss	Met	Met	Centralised data base, evidence shared.
Q7	Has the Perinatal Clinical Quality Surveillance Model been implemented June 2021?	Triumvirate	Ratified Trust SOP/Guideline Trust Governance structure	Met to discuss	Partially Met	Met	Continue to ensure that this element is well embedded with ICB and their governance frameworks
			Ratified LMNS SOP/Guideline Minutes agreed ICS sign off				
Q8	Are all maternity SIs shared with Trust boards at least quarterly and the LMNS?	Triumvirate	Ratified Trust SOP/Guideline of how SI's are shared monthly with Trust Board and LMNS Board Agenda to include SI's as an item Minutes to include, summary, learning and actions		Partially Met	Met	Process clearly articulated and board papers seen
Q9	What other concerns are raised on your Ockenden action plan?	Triumvirate	Action Plan				See Q1
Safety Action 2 Listening to women & families							
Q10							

Q 11	Is there an allocated Non-Executive at Board level who works collaboratively with the maternity safety champions?	NED		JD and date appointed Activities Attendance at meetings	Partially Met	Met	Staff reported that they would appreciate any efforts the trust may consider in raising the visibility of the NED.
				Recorded output of meetings presented to Board and evidence of action from the interactions			
				Interactions with staff, services users and MVP			Staff were aware that there is a maternity NED. The organisation should consider how the profile of the NED can be raised in maternity post pandemic. This would strengthen the relationships with MVP and staff and support the ward to board reporting.
Q 12	Is the PMRT tool used to review perinatal deaths to the standard required including women and families involvement?	Triumvirate	Ratified SOP/Guideline Audit timetable and actions Audit with 95% compliance		Partially Met	Met	See Q4
Q 13	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		Meeting with Triumvirate and MVP Chair	Met	Met	Explore solutions to enable MVPs to attend Safety Champion meetings and Triumvirate meetings Consider how user feedback is obtained and evidence of being acted upon demonstrated (Whose Shoes and 15 Steps to Safety) Consider involvement of MVPs in the serious incident and complaints reviews 'Ask the Midwife' social media tool is working really well in terms of listening to women & families and feeding out information

				How is user feedback obtained?			See above
				Examples of co-production			The trust shared an excellent example around development of their surrogacy guideline. The involvement of those with lived experience in the development of this guideline was exemplary. The trust should consider how they replicate this with all other guidelines.
Q 14	Do the Trust safety champions (MW /Obstetrician/Neonatal) meet bimonthly with Board level safety champions and escalate concerns, issues and blockers to improvement work	Safety Champions		Review talk through ratified SOP/Guideline/TOR	Partially Met	Met	Safety champions meet and the minutes and action log were shared. Staff update flyers are also shared. The NED and CN are engaged in maternity issues and a good working relationship was evident.
			Minutes of meetings Action Log				
			Evidence of action and improvement from the meetings				
Q 15	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		How is user feedback obtained?	Met	Met	See Q13
				Examples of co-production			
Q 16	Does the non-executive director support the Board level safety Champion who works collaboratively with the maternity safety champions to bring challenge and ensure all voices are heard?	NED Safety Champions		JD and date appointed	Met	Met	See Q11
				Activities			Attend safety champions meetings, trust board, walkarounds and engagement sessions Evidence of NED & chief nurse at safety champion meetings
				Attendance at meetings			There have been 'walkabouts' and engagement events. Continuation of these to become business as usual would be beneficial to staff, women, service users and the organisation so that these voices are heard directly at board level.
				Interactions with staff, services users and MVP			
				Evidence of check and challenge as a result			
Safety Action 3 Staff training and working together							

Q 17	What MDT training does the maternity service provide?	Triumvirate PDM	Agenda LMNS Board Minutes LMNS Board	Meet PDM: View TNA How is training decided? Ask staff: How effective is the training?	Partially Met	Met	TNA was under review at the time of the visit and was not seen. Trajectory for training compliance in place. There is limited time allocated for midwifery training and the trust should consider how they support improvement in this area. Training compliance is discussed at local governance and trust board. Feedback from staff at the visit was that training was valued. The back to basics training in reference to fetal wellbeing was particularly reported as being positively received.
Q 18	Have you implemented a day and night Consultant led MDT ward round on the LW?	Staff		Ask staff what time the MDT ward round is and who attends? Review ward round sign in sheet	Partially Met	Met	Twice daily ward rounds established and audits in progress.
	Do you have a dedicated obstetric governance lead? Do they have protected PA's?			What difference have you seen in outcomes since the introduction e.g. incident reduction, women's experience Look at Job plans and discuss with General Manager/Consultant clinical director/governance consultant who has oversight		Met	Governance lead in place. It was discussed that the service and organisation should consider how they themselves triangulate the effectiveness of having a dedicated obstetric governance lead and the impact this has on quality and safety.

Q 19	Is all external funding allocated for training ring fenced and confirmation from the Finance Director?	Triumvirate	Ratified SOP/Guideline Invoices Budget spending plans Confirmation from FD Spend reports to LMNS		Partially Met	Met	Evidence seen
Q 20	Have 90% of each maternity unit staff group attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	PDM		Report of attendance records Trajectory Audit demonstrating 90% of each staff group attendance	Partially Met	Met	See Q17
Q 21	Is MDT schedule for training in place?	Triumvirate	Agenda LMNS Board Minutes LMNS Board		Partially Met	Met	See Q17
		PDM Staff		View TNA How is training decided? Ask staff: How effective is the training?			
Q 22	See question 18						
Q 23	See question 19						
Safety Action 4 Managing complex pregnancy							
Q 24	Is there an agreement for the criteria for cases referred to the tertiary level Maternal Medicine Centre?	Consultant Fetal Medicine Lead / AN screening coordinator		Discuss referral pathway	Partially Met	Met	Pre-existing pathways are now being formalised working with LMS and wider network to develop audit once service fully implemented. Audit processes need initiating and strengthening with clear feedback mechanisms into governance processes

							Continued engagement with the LMS will establish clear pathways in this area.
				Review audit programme Review audit results of compliance and action plans	Partially Met	Partially Met	Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Q 25	Do women with complex pregnancies have a named Consultant lead?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	Partially Met	Partially Met	Referral pathway clearly articulated, Audit evidence and therefore assurance of women with complex pregnancy having a named consultant was not clear Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Q 26	Do women with complex pregnancies receive early intervention?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	Partially Met	Partially Met	See Q25
Q 27	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Leads for SBLCBv2		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	Partially Met	Met	Pathways in place and audits in progress.

Q 28	Do all women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	Not Met	Partially Met	Referral pathway clearly articulated, Audit evidence and therefore assurance of women with complex pregnancy having a named consultant was not clear Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Q 29	Do you have agreed maternal medicine specialist centre?	Consultant Fetal Medicine Lead/AN screening coordinator		Discuss referral pathway Review audit programme Review audit results of compliance and action plans	Not Met	Met	Plans are in progress within the LMS to fully implement the maternal medicine service. Further work with the LMNS to identify and define how they will work within this pathway is required to give an oversight or how assurance will be gained.
Safety Action 5 Risk assessment throughout pregnancy							
Q 30	Does the AN RA include the ongoing review of place of birth?	Triumvirate		Discuss pathway for out of guidance births Review ratified SOP/Guideline	Partially Met	Partially Met	Pathways are in place Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.

Q 31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Triumvirate		Discuss pathway for out of guidance births	Partially Met	Partially Met	See Q30
				Review ratified SOP/Guideline			
				Audit timetable			
				Audit results and action plan			
Q 32	Are you compliant with all 5 elements of SBLCBv2?	Leads for SBLCBv2		Ratified SOP/Guidelines for all 5 elements	Partially Met	Met	See Q27
				Audit results for all 5 elements (local and regional audit)			
				Review of impact on perinatal mortality Deep dive results			
Q 33	Is a RA review and discussion of place of birth recorded at every contact with a Personalised Care Support Plan	Triumvirate		Discuss pathway for PCSP Review ratified SOP/Guideline Audit timetable Audit results and action plan	Partially Met	Partially Met	Personalised care plans in place but not audited. Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.
Safety Action 6 Monitoring fetal wellbeing							
Q 34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated	Lead Midwife and Lead Obstetrician		Rotas/duties	Not Met	Met	Leads in place. RM JD seen but no obstetric JD seen. LMNS support with obtaining a suitable JD would help with this element.

	expertise to focus on and champion best practice in fetal wellbeing.			Examples of roles Incident case reviews			Good variety of training in this element shared. The service clearly identified that triangulation of SI's is utilised to develop training in this area.
Q 35	Do the leads demonstrate sufficient seniority and expertise?	Lead Midwife and Lead Obstetrician	Job Description for both roles and confirmation that roles are in post		Partially Met	Met	See Q34
Q 36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Leads for SBLCBv2		SOP's Audits for each element Guidelines with evidence for each pathway	Partially Met	Met	See Q27
Q 37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	PDM		Training compliance	Partially Met	Met	See Q17
Q 38	Element 4 we are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	Lead Midwife and Lead Obstetrician		Lead midwife and obstetrician in place to lead best practice, learning and support Training sessions Reviews		Met	See Q34 The trust should consider the impact of these roles and how this is demonstrated.
Safety Action 7 Informed Consent							

Q 39	Do you have accessible information to enable informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery?	Triumvirate		Demonstration of the information service users can access for mode of birth in all formats Review CS information MVP review of information	Met	Partially Met	Website reviewed on day of visit, easy to navigate and can be translated into different languages. No leaflet seen relating to caesarean section for maternal choice. The service should consider inviting the MVP to review the website and its content and coproduce materials which will fulfil this criteria.
Q 40	Do you have accessible information to enable accurate evidence based information including all care AN, Intrapartum & PN?	Triumvirate		Demonstration of the information service users can access for evidence based information in all formats	Met	Met	See Q39
				Review information including all care AN, Intrapartum & PN			
				MVP review of information			
Q 41	Can women participate equally in all decision-making processes and make informed choices about their care?	Triumvirate		Ratified SOP for decision making process and informed choice Review of last CQC maternity survey and action plan Audit timetable	Partially Met	Partially Met	Professional discussion explored the services understanding of informed choice and sharing of all evidence with women to enable them to make truly informed choices. It was clear that assurance around this element was given from a professional perspective rather than a lived experience perspective. The service were keen to consider and develop methods of gaining feedback around this element that reflected the lived experience perspective.

				Audit results and action plan			<p>Consider how user feedback is obtained and evidence of being acted upon demonstrated (Whose Shoes and 15 Steps to Safety)</p> <p>Consider involvement of MVPs in the serious incident and complaints reviews</p> <p>Consideration should be given to all elements within the Ockenden 7 IEA's being continually audited until embedding and sustainability is evidenced and trust board has assurance of this.</p>
Q 42	Are women's choices respected following informed discussion and decision made?	Triumvirate		Ratified SOP for decision making process and informed choice and how choices are respected Audit timetable Audit results and action plan	Partially Met	Partially Met	It was clear from discussion that this service is forward thinking in supporting women's choices and use language within guidance which is considered and respectful. Audit of this needs to be strengthened so that the service can continue with this philosophy.
Q 43	What is the mechanism for service user feedback, and how this is obtained through MVP to coproduce maternity services?	Triumvirate MVP		How is user feedback obtained? Examples of co-production	Met	Partially Met	See detail in Q13
Q 44	Are pathways of care clearly described in written information in formats consistent with NHS policy and posted on the trust website.	Triumvirate		Demonstration of the information service users can access for evidence based information in all formats MVP review of information If gaps identified action plan	Partially Met	Partially Met	<p>See Q39</p> <p>Further co-production needed for the Trust website</p> <p>Ensure evaluation by the service users themselves</p>
Workforce Planning/Guidelines							

Q 45	Is the clinical workforce planning to the required standard?	Triumvirate	Review BR+ report how current and accurate is it? Trust Board minutes to fund Six monthly reviews LMNS/ICS workforce plans				No evidence seen
Q 46	Is the midwifery workforce planning to the required standard?	Triumvirate	Review BR+ report how current and accurate is it? Trust Board minutes to fund				Birthrate plus has been completed, recent changes to workforce noted (removal of midwife scrub) as well as leadership developments. It would be helpful if the trust could demonstrate how they plan to meet the ask with the RCM leadership manifesto by sharing their action plan in respect to this.
	Can you describe the pathway for transitional care and how do you audit this?	Triumvirate		Transitional Care Guidelines and Pathways staffing model for transitional care evidence of incident reporting and management of incidents that cross maternity and neonatal care audits of infant outcomes on the transitional care pathways			Pathways in place

Q 47	Is the HOM/DOM responsible/accountable to an executive director?	Triumvirate	Review the JD to ensure accountability is to an executive director Ask how this translates in practice				HoM accountable to divisional clinical director.
Q 48	Is the maternity leadership in line with the RCM Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders	Triumvirate	Review the gap analysis				HoM in post. The trust should consider further development and investment to the midwifery leadership team.
			If gaps identified action plan to address				
Q 49	Where non-evidenced based guidelines are utilised, is there a robust assessment process before implementation and ensures that the decision is clinically justified.	Triumvirate	Review ratified SOP Identify if national guidance not followed Evidence of risk assessments if national guidance not followed How many guidelines are out of date				The service has a robust process around guidelines being up to date. Where national guidance is not followed a risk assessment is undertaken and this is escalated through governance meetings and risk log

Agenda Item	Meeting	Trust Board Meeting	Meeting Date	
Title	Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4 Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool			
Lead Director	Joanne Ledger Interim Chief Nurse			
Author	Sue Cooper Bereavement Midwife/Lorraine Cooper Head of Midwifery			
Report previously considered by (date)	Quality Committee (August 2022)			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	Y
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Trust Board is requested to:</p> <ul style="list-style-type: none"> Receive the report and decide if any further information and/or assurance are required.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

MATERNITY SERVICES FAMILY AND WOMEN'S HEALTH GROUP

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 4

Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool

1. Purpose of the Report

The purpose of this report is to provide assurance to the Trust Board that a multidisciplinary team is completing the national Perinatal Mortality Review Tool (PMRT) to the standard required by the Clinical Negligence Scheme for Trusts (CNST) Year 4.

2. Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths.

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme, to support the delivery of safer maternity care. Trusts involved in the maternity incentive scheme will contribute an additional 10% of the CNST maternity premium creating the CNST maternity incentive fund. The scheme incentivises 10 safety actions, Trusts demonstrating they have achieved all ten of the safety actions will recover their contribution and will receive a share of any unallocated funds. The scheme was relaunched in May 2022 and will include eligible cases between the 6th May and 5th December 2022. In order to be eligible for payment under the scheme, Trusts must demonstrate that they have been compliant with action one and submit their completed declaration form to NHS Resolution by 12 noon on Thursday 5th January 2023. Trust submissions will be subject to a range of external verification points including cross checking with MBRRACE-UK data (safety action 1 point a,b,c).

3. Requirements for Safety Action 1; are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard. **Appendix 1 and 2**

A)

- i. Perinatal deaths eligible to be notified to MBRRACE-UK from 6th June 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month. When surveillance is required to be assigned to another Trust cases are exempt from being completed in a month.
- ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6th May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust

B) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6th May will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

C) For at least 95% of all deaths of babies who died in your Trust from 6th May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents, should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors, which may have a bearing on a future pregnancy. In the absence of a bereavement lead, ensure that someone takes responsibility for maintaining contact and for taking actions as required.

D) Quarterly reports will have been submitted to the Trust Board from 6th May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

4. Perinatal Mortality Review Tool (PMRT)

The aim of the PMRT programme is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales.

The PMRT has been designed with the following principles:

- A comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth
- Reviews conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
- Review by a multidisciplinary group at a meeting where time is set aside for doing the work;
- Parental input into the process from the beginning.
- An action plan should be generated from each review, implemented and monitored;
- The review should result in a written report, which should be shared with families in a sensitive and timely manner.
- Reporting to the Trust/Health Board executive should occur regularly and result in organisational learning and service improvements.
- Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results, and thereby ensure national learning.

5. Summary

The below summaries the quarter April to June 2022 which includes the reporting period from 6th May pertinent to the relaunch of the CNST year 4 incentive scheme.

- i. The Trust was **100%** compliant with the standard in Q1. All eligible perinatal deaths were notified to MBRRACE-UK within 7 working days. Excluding cases, which required assigning to another Trust, the surveillance was completed within one month.
- ii. In Q1 there have been 4 stillbirths, 5 neonatal deaths and 2 late losses suitable for review. In **100%** of all deaths of babies, a PMRT review has been started within two months of each death in the Trust during the reporting period.

b) In Q1, 11 cases in the Trust are suitable for review using the PMRT. In this period 4 cases have been completed and the report written and published from Q4 within time frames, 1 case remains outstanding demonstrating **80%** compliance in Q4. In Q1, 3 cases are complete and the report is

being written. 8 cases have been commenced and are under review. All case reviews completed are within the CNST standard time frame. **100%** of the cases completed, were within 4 months.

c) In **100%** of all deaths of babies who were born and died in the Trust Q1 reporting period, the parents have been told that a review of their baby's death will take place, and the parents' perspectives and any concerns they have about their care and that of their baby has been sought. The bereavement midwife maintains contact with the parents through the PMRT review.

d) Quarterly reports are submitted as per standard and discussed with the Trust safety champion

6. Recommendations

The Trust Board is requested to:

- Receive (the report outlining the details of the deaths reviewed and the action plans.
- Receive assurance by the team that the PMRT has been used to review eligible perinatal deaths and that all the required standards have been achieved.
- Decide if any further information and/or assurance are required

Sue Cooper Bereavement Midwife

Lorraine Cooper Head of Midwifery July 2022

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

APPENDIX 1 Quarter 1 PMRT Update

Hull University Teaching Hospitals NHS Trust Perinatal Mortality Review Tool Review update Q1									
Outstanding and completed Neonatal cases Q1									
	MBRRACE ID	Stillbirth/ Neonatal Death	Date of death	PMRT commenced	Target for completion	PMRT Completed	Grading	Report date complete	Actions / Good practice
1	79668	NND 28 weeks	26/01/2022	25/02/2022	26/05/2022		C		Requires neonatal review to complete - maternity element complete escalated as an SI
2	79978	NND 25 weeks	14/02/2022	28/02/2022	14/06/2022	13/05/2022	A/A/A	13/05/2022	Complete no issues with care
3	81119	NND 24 weeks	15/04/2022	04/05/2022	15/08/2022				Under review- Delivered in Scunthorpe Ex utero transfer
4	81213	NND 39 weeks	20/04/2022	26/05/2022	20/08/2022				Under review- Baby died in Martin House Hospice
5	81534	NND 25 weeks	09/05/2022	26/05/2022	09/09/2022				Under review- In utero transfer from Bamsley
6	81975	NND 25 weeks	10/06/2022	12/07/2022	10/10/2022				Under review- Delivered in Scunthorpe Ex utero transfer
7	81982	NND 23 weeks	12/06/2022	29/06/2022	12/10/2022				Under review
	MBRRACE ID	Stillbirth/ Neonatal Death	Date of death	PMRT commenced	Target for completion	PMRT Completed	Grading		Actions / Good practice
Outstanding and completed Maternity Q1									
1	79329	37+5 week stillbirth	07/01/2022	17/01/2022	07/05/2022	25/03/2022	B/A	29/04/2022	Complete and report published. Action - ensure QR code includes information on reduced fetal movements
2	79996	Twin SB and LB 34 weeks	15/02/2022	28/02/2022	15/06/2022	04/05/2022	B/A	01/06/2022	Complete and report published - Actions- 1.documentation by vulnerabilities midwife 2. feedback re observations in labour. 3. Screening for gestational diabetes
3	80160	37 week stillbirth	25/02/2022	28/02/2022	26/06/2022	29/04/2022	C/B	09/06/2022	Complete and reported published - SI in progress
4	80937	30 week stillbirth	04/04/2022	08/04/2022	04/08/2022	26/06/2022	C/B		Completed -writing report. Escalated for consideration of an SI. Actions identified in relation to language barriers to effective care
5	81125	25 week stillbirth	16/04/2022	20/04/2022	16/08/2022	26/06/2022	A/B		Completed- writing report. Actions in relation to effective communication following a loss to community midwives and to parents on the results of investigations
6	81126	34 week stillbirth	15/04/2022	20/04/2022	15/08/2022	26/06/2022	B/A		Completed- writing report. Actions in relation to documentation of risk and providing written information on fetal movements in pregnancy.
7	81543	28 week stillbirth	10/05/2022	16/05/2022	10/09/2022				Under review
8	81761	22 week late loss	22/05/2022	09/06/2022	22/09/2022				Under review
9	82125	22 week late loss	19/06/2022	22/06/2022	19/10/2022				Under review

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

**APPENDIX 2
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
PMRT ACTION MATERNITYTRACKER JUNE 2022**

MBRRACE ID	ACTIONS	Lead	Due date	RAG
77778	Set a trust standard with frequency of 'fresh eyes' on an antenatal CTG and classifying latent phase CTGs	SN	26/01/22	Amber
	Liaise with USS regarding DNA process and take to governance meeting	WMc	10/01/21	Amber
77800	Create a pre-term guidance counselling checklist	KS	25/02/22	Amber
78076	Obstetric team tutorial and learning package in relation to documenting care planning and advice given to women in preterm birth	KS	01/04/22	Amber
79153	Look at options for families with regard to bereavement information, when English is not the first language	SC	30/08/22	Green
80937	Reminder to staff to obtain a HVS prior to IOL following a loss of unknown cause in the monthly PMRT newsletter	SC	30/08/22	No colour
	Reminder to staff re completion of the partogram section in the bereavement care plan documentation in the PMRT and Labour Ward newsletter	SC	30/08/22	No colour
	Explore bereavement resources for women whose have limited understanding of English	SC	30/08/22	Green
81125	Reminder to staff to investigate why women fail to attend a AN appointment following an inpatient episode in the community meetings/ newsletter	AH	30/08/22	Green
81126	Reminder to staff to document risk assessment correctly on the handheld records in the community meetings/newsletter	AH	30/08/22	Green
	Reminder to staff to ensure women receive written information with regard to fetal movements in pregnancy in the PMRT newsletter and community meetings/newsletter.	SC AH	30/08/22	No colour
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

RAG rating

Red – off track and overdue
Amber- off track but recoverable
Green – complete
No colour – not yet commenced

Agenda Item		Meeting	Trust Board Meeting	Meeting Date	
Title	Perinatal Quality Surveillance Tool				
Lead Director	Joanne Ledger Interim Chief Nurse				
Author	Julia Chambers Lead Midwife Lorraine Cooper Head of Midwifery				
Report previously considered by (date)	Quality Committee (August 2022)				

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	Y	Commercial Confidentiality		Safe	Y	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	Y	Valued, Skilled and Sufficient Staff	Y
Assurance		Staff Confidentiality		Caring	Y	High Quality Care	Y
Information Only		Other Exceptional Circumstance		Responsive	Y	Great Clinical Services	Y
				Well-led	Y	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Trust Board is requested to:</p> <ul style="list-style-type: none"> Receive the report and decide if any further information and/or assurance are required.

PERINATAL QUALITY SURVEILLANCE TOOL

April, May, June

1.0 INTRODUCTION

The following document provides a monthly update on key measurements, as detailed in the NHSI/E report on the revised requirements for perinatal quality surveillance tool.

2.0 CQC MATERNITY RATINGS

	Safe	Effective	Caring	Responsive	Well Led	Overall
Maternity	Good	Good	Good	Good	Good	Good

In June 2018, the CQC undertook a full inspection of both the Castle Hill Hospital & Hull Royal Infirmary sites and achieved an overall rating of 'Requires Improvement'. Within this inspection, Maternity Services received an award of 'Good' against the five domains – safe, effective, caring, responsive and well led.

In March 2020, the CQC returned to repeat their inspection however due to the COVID-19 pandemic this inspection was suspended to relieve pressure on the healthcare systems. Maternity Services had not been inspected by this point, and therefore the rating of 'Good' remains in place. With an overall trust rating of 'Requires Improvement'.

3.0 REVIEW OF PERINATAL DEATHS

The following provides numbers of perinatal deaths using the real time data-monitoring tool.

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
2	3	0	6	2	1						

In April to June 2022 we reported:

██████	NND 24 weeks	15/04/2022
██████	NND 39 weeks	20/04/2022
██████	NND 25 weeks	09/05/2022
██████	30 week stillbirth	04/04/2022
██████	25 week stillbirth	16/04/2022
██████	34 week stillbirth	15/04/2022
██████	28 week stillbirth	10/05/2022
██████	22 week late loss	22/05/2022
██████	22 week late loss	19/06/2022

PMRT meeting update June 2022 (Meeting in May cancelled):

MBRRACE ID	Stillbirth/ Neonatal Death	Grading	Report date complete	Actions / Good practice
██████	NND	B/B/A	18/06/2022	Complete - report pre published
██████	NND 26 weeks	B/C/B	01/06/2022	Joint review with Lincoln - Care graded C in Lincoln
██████	NND 28 weeks			NND Jessops - delivered HUTH, booked in Doncaster

██████	NND 28 weeks	C		Requires neonatal review to complete - maternity element complete escalated as an SI
██████	NND 25 weeks	A/A/A	13/05/2022	Complete no issues with care
██████	NND 24 weeks			Delivered in Scunthorpe Ex utero transfer
██████	NND 39 weeks			Baby died in Martin House Hospice
██████	NND 25 weeks			In utero transfer from Barnsley
MBRRACE ID	Stillbirth/ Neonatal Death	Grading		Actions / Good practice
██████	37+5 week stillbirth	B/A	29/04/2022	Complete and report published. Action - ensure QR code includes information on reduced fetal movements
██████	Twin SB and LB 34 weeks	B/A	01/06/2022	Complete and report published - Actions- 1.documentation by vulnerabilities midwife 2. feedback re observations in labour. 3. Screening for gestational diabetes
██████	37 week stillbirth	C/B	09/06/2022	Complete and reported published - SI in-progress
██████	30 week stillbirth			To complete
██████	25 week stillbirth			To complete
██████	34 week stillbirth			To complete
██████	28 week stillbirth			To commence
██████	22 week late loss			To commence
██████	22 week late loss			To commence

4.0 HSIB REFERRALS

The following provides numbers of HSIB referrals made:

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
0	0	0	2	0	2						

There were two cases referred to HSIB in April but both were triaged and rejected.
Two cases have been referred in June:

MI-009862 Historical case, - not referred at time of event – internal SI undertaken at time, triaged and accepted by HSIB

MI – 009922 – triaged and rejected

5.0 INCIDENTS

The following provides the number of incidents reported:

Severity	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
Moderate	0	0	1	2	2	1						
Major	0	0	0	0	0	0						
Catastrophic	0	0	0	0	0	0						

W255512 Unexpected Admission to NICU, transfer to LGI for surgery

W256363 Mum fell asleep with baby, fell to the floor from bed, sustained cephalhaematoma

W259149 14 litre PPH, hysterectomy, ICU admission
W257668 10 litre PPH, hysterectomy, ICU admission
W259612 Breech LSCS, difficult delivery, baby sustained arm fracture

Themes & Actions

Although there were two massive postpartum haemorrhage and hysterectomy in May – there are no recurrent themes to these two events. There has been a MDT meeting to discuss any learning points from these cases. The clinical lead has prepared a presentation of all three cases and a quality improvement was to have a specific hysterectomy trolley and created a video explaining were it is to all staff. This action has been completed by the clinical lead.

Serious Incident declared:

April - SUI/2022/8072

May - SUI/2022/8686

June - SUI/2022/12568 referred to HSIB historical case

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022
0	0	2	1	1	1						

6.0 TRAINING COMPLIANCE

The on-going COVID-19 pandemic is having a detrimental impact on the delivery of mandatory training due o high sickness levels across the service. Training compliance is monitored regularly through the CNST scheme, but providing direct clinical care remains the priority.

Obstetric Emergencies (PROMPT)

ACTUAL PERFORMANCE TO DATE

Area	No of Staff	PROMPT - REMINDER (10 MTHS)	Expired - Review (1 yr)	In date	% Perf	Shortfall	No.Staff Req'd to achieve 90%
Obstetric Cons, Ass Spec	15	11	10				
	15	11	10	12	80%	2	14
Obstetric Registrar	12	6	5				
Obstetric SHO	13	4	4				
	25	10	9	14	56%	9	23
Anaesthetic Consultant	7	8	6				
	7	8	6	5	71%	1	6
Anaesthetists*	16	18	16				
	16	18	16	11	69%	3	14
Labour & Del. MW	39	17	13	30			
Community	42	19	15	29			
Specialist Senior Midwives	19	8	7	17			
Maple & Rowan Ward Core Midwives	30	13	7	23			
MLU Midwives	42	13	8	31			
Bank Midwives	4	2	2	6			
ANC - W&C Midwives	36	15	14	33			
	212	87	66	169	80%	22	191

Labour & Del. MW Assist	8	6	4	7			
Community MW Assistants	4	4	3	3			
Maple & Rowan Ward Midwifery Assistant	29	17	13	20			
MLU MW Assistant	14	6	3	8			
Bank Midwife Assistant	2	2	2	1			
ANC - W&C Midwives Assistant	7	6	6	10			
	64	41	31	49	77%	9	58
ODA-Ps	28	28	26	23			
Gynae Theatre Nurses	15	15	15	11			
	43	43	41	34	79%	5	39
							330
Total No. Staff	382		179	294	74%		

CTG Training

Staff have to complete K2 competency assessments in Fetal Physiology, Intrapartum CTG & Intrapartum Intermittent Auscultation with a pass mark of >85%. Compliance is as below for completion of the competency assessment.

A number of staff have fallen outside of their 1-year repeat requirement. All out-of-date staff have been emailed with a reminder to complete by the end of September 2021. The Manager will escalate anyone remaining non-compliant for performance management.

ACTUAL PERFORMANCE TO DATE				
Area	No of Staff	In date	% Perf	
Obstetric Cons, Ass Spec	14			
	14	10	71%	
Obstetric Registrar	11	9	82%	
Obstetric SHO	12	6	50%	
	23	15	65%	
Labour & Del. MW	41	35	85%	
MLU Midwives	40	35	87%	
Community	36	28	77%	
Specialist Snr Midwives	16	12	75%	
Maple & Rowan Midwives	28	15	53%	
Bank Midwives	6	2	33%	
ANC Midwives	37	29	78%	
	204	156	76%	

Neonatal Resuscitation

It is a mandatory requirement for all Midwifery staff to complete the Newborn Life Support (NLS) Course at least once and to undertake a neonatal resuscitation update annually (delivered by an NLS trained instructor).

ACTUAL PERFORMANCE TO DATE

Area	No of Staff	DAY 1 - REMINDER (10 MTHS)	Expired - Review (1 yr)	In date	% Perf	No.Staff Req'd to achieve 90%
Neonatal Consultant	10	7	7	4		
	10	7	7	4	40%	9
Neonatal Registrar ANNP	12	3	3	9		
Neonatal SHO	5	1	1	4		
	17	4	4	13	76%	15
Specialist Snr NICU Nurses	8	4	4	4		
NICU Nurses	94	29	29	65		
NICU Bank Nurses	0	0	0	0		
	102	33	33	69	68%	92
Labour & Del. MW	38	20	13	25		
MLU Midwives	35	16	16	24		
Community	44	17	10	34		
Specialist Snr Midwives	24	14	10	14		
Maple & Rowan Midwives	25	17	12	13		
Bank Midwives	6	3	2	4		
ANC Midwives	39	16	7	32		
	211	103	70	146	69%	190

7.0 MINIMUM SAFE STAFFING LEVELS

Birthrate Plus Report 2021

HUTH in line with national guidance has undertaken a Birthrate plus assessment using three months case mix data for the months of April to June 2021. The Birthrate plus Workforce Planning system provides Hull University Teaching Hospitals NHS Trust Board and Committee with a detailed breakdown of the number of midwives required for each area of service in both hospital and community. It also provides each service with its own individual ratios of hospital births per whole time equivalent midwife and the number of cases and home births per wte community midwife.

This allows each service to apply its own allowances for holiday, sickness and study leave and for time spent in travel by community staff. A 21.6% uplift was applied to cover annual, sickness and study leave has been included in the staffing calculations, and 12.5% travel allowance.

The report identified the percentage of women in Categories IV and V has increased from the 2018 data, and most noticeably in Category V (High category). The Delivery Suite casemix has 74.3% in the 2 highest categories whereas in 2018, it was 66.5% of which 35.8% was in IV and 30.7% in V, an increase of 7.8%. The higher the casemix, the more clinical staffing is required to ensure women receive 1 to 1 care in labour and delivery as a minimum but also to provide additional support as necessary.

	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
2021 DS % Casemix	7.9	14.3	3.5	35.4	38.9
	25.7%			74.3%	
2018 DS % Casemix	33.5%			66.5%	

2021 Generic % Casemix	11.8	21.3	3.0	30.5	33.4
(Includes Birth Centre)	36.1%			63.9%	
2018 Generic % Casemix	42.0%			58.0%	

Casemix Table 1

The 2021 Birthrate Plus Report identified Annual Activity based on the FY 2020/2021 total births has fallen to 4814 total birth rate, however women have been identified as having more complex health needs falling into category IV and V and thus requiring an increase in midwifery hours.

Following the report and review of midwifery staffing a piece of work has been undertaken to recruit 18WTE newly qualified midwives who will commence in September following successful completion of their Midwifery training.

Following the publication of the final Ockenden Report and the subsequent 15 Immediate and Essential Actions the decision was made to pause the four Continuity of Carer teams. This was following a review of the staffing levels in Maternity Services. On review of the midwifery roster from June 2022 there were over 2000hrs of midwifery staffing uncovered.

The pausing of Continuity of Carer will be reviewed in January 2023.

Birth Rate Plus Red Flags

Maple Ward – 0 red flags were reported from April to June 2022

Rowan Ward – 0 red flags were reported from April to June 2022

Fatima Allen Birth Centre – 0 red flags were reported from April to June 2022

Labour ward – 5 red flags reported from April – June 2022:

- 5 of these were missed / delayed care

8.0 SERVICE USER VOICE FEEDBACK

Information from the 'Ask a Midwife' service at HUTH for June 2022.

Hull University Teaching Hospitals NHS Trust	Northern Lincolnshire and Goole NHS Foundation Trust	York and Scarborough Teaching Hospitals NHS Foundation Trust
559 questions this month	134 questions this month	164 questions this month
540 questions last month	196 questions last month	173 questions last month
73 new users this month	30 new users this month	50 new users this month
31 referrals to GP, midwife or other agencies	9 referrals to GP, midwife or other agencies	6 referrals to GP, midwife or other agencies
5.5 % referral rate	6.7 % referral rate	3.6% referral rate
Most asked question was about: antenatal symptoms and visiting and we've sent 31 MATB1 certificates in the post	Most asked question was about: antenatal symptoms and mental health	Most asked question was about: antenatal symptoms and baby care (not feeding related)

Thanks so much for providing this service by the way, it's so helpful	That's great. Thanks so much. I find things much easier to deal with if I know exactly what's going to happen...plus it sounds less scary haha thank you again 😊	Not a question but just want to say this service is fantastic and so easy to access. My baby is now 12 weeks and I have spoken to you a few times now.	Thank you very much for your kind and reassuring words.	So just, thank you 😊
Thank you to your team on here for always answering my questions, you were amazing throughout my pregnancy	Thankyou for answering my questions you've been really helpful 😊	Okay thank you so much, you are amazing!	Awww thank you you have definitely helped ease my mind and guilt. Thank you so much. Have a lovely day xx	Sending lots of love and thanks for all your help
Thank you so much you've been so kind xx	Thank you for the reassurance. I am feeling okay again	That's great thank you for getting back to me with this information x	Ahh I see, thank you! I'll check that out. Thanks again, have a great afternoon 😊	Yeah deffo feel reassurance I have to thank you so much this facebook page is a huge help, and also have relaxed over the weekend knowing I don't feel unwell or have any symptoms xx

Dadpad App
 “The Essential Guide for New Dads...because babies don't come with a set of instructions.”

The app covers topics such as:

- Feeding, holding, changing and cleaning your baby
- Surviving without sleep and coping with crying
- Getting to know your baby
- Home safety and first aid
- Looking after yourself and supporting your partner



The app is available to all dads and dads-to-be within the Hull, East Riding, North Lincolnshire, North East Lincolnshire region, York and North Yorkshire region.

The app can be downloaded from the App Store and Google Play. Once the app is downloaded it will ask for your location and direct you to your localised version of DadPad.

To find out more visit the DadPad website. <https://thedadpad.co.uk/>

9.0 STAFF FEEDBACK

A Senior Midwife's Assurance Handbook was undertaken. Part of this assurance handbook will explore staff experience in relation to culture, communication, support, incidents and learning lessons.

Action Plan:

Required Actions / Improvements				
Improvement required	Action	Time Frame	Accountable Person	Completed
Transport Incubator check reminder	Training issues identified with specific staff. Training to be provided	End of July	Julia Chambers / Labour Ward Practitioners	

10.0 EXTERNAL CONCERNS OR QUERIES

There is one pending coroner's case regarding a forceps birth; a date has not yet been set for the hearing.

11.0 CORONERS

The Trust was issued with no Coroners Regulation 28 in relation to maternity:

Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2021	Oct 2022	Nov 2022	Dec 2022
0	0	0	0	0	0						

12.0 CNST

The section of the report provides details on the Trust's progress against compliance with the 10 CNST Standards.

The new Maternity Incentive Scheme – Year Four Safety Actions have been released. There have been some significant changes to some of the requirements, which the necessary people are looking at.

A letter was received on 23rd December 2021 from NHS Resolution highlighting the decision to pause the reporting procedure for the maternity incentive scheme for a minimum of 3 months.

The scheme was reviewed and relaunch from 6 May 2022. The scheme's submission deadline has been extended from June 2022 to 5 January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended.

Below are our current compliance ratings for each of the 10 standards

Safety Action	Compliance	Board Request
1	Perinatal Mortality Review Tool Compliant	<p>All perinatal deaths eligible to be notified to MBRRACEUK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.</p> <p>A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust</p> <p>At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.</p> <p>For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion</p> <p>Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action</p>

		plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
2	<p style="text-align: center;">MSDS Partial Compliance</p>	<p>1. By October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.</p> <p>2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.</p> <p>3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.</p> <p>4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.</p> <p>5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2).</p> <p>6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)</p> <p>7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in 19 the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:</p> <p>Midwifery Continuity of carer (MCoC)</p> <ul style="list-style-type: none"> i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. <p>Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the</p>

		<p>complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information)</p>
3	<p>TRANSITIONAL CARE Partial Compliance</p>	<p>a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.</p> <p>b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.</p> <p>c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.</p> <p>d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 week's gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.</p> <p>e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.</p> <p>f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been 27 cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.</p> <p>g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.</p> <p>h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.</p>

4	<p style="text-align: center;">Medical Staffing Non Compliance</p>	<p>a) Obstetric medical workforce</p> <p>1. The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report/</p> <p>2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts’ positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMNS.</p> <p>b) Anaesthetic medical workforce</p> <p>A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)</p> <p>c) Neonatal medical workforce</p> <p>The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.</p> <p>d) Neonatal nursing workforce</p> <p>37 The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.</p> <p>If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.</p>
5	<p style="text-align: center;">Midwifery Staffing Partial Compliance</p>	<p>a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.</p> <p>b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.</p> <p>c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service</p> <p>d) All women in active labour receive one-to-one midwifery care</p>

		e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
6	SBLV2 Compliant	<p>1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.</p> <p>2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.</p> <p>3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.</p> <p>The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.</p>
7	Maternity Voices Partnership Compliant	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
8	Mandatory Training Partial Compliance	<p>a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years</p> <p>b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include maternity emergencies starting from the launch of MIS year four</p> <p>c) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multiprofessional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four</p> <p>d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four</p>
9	Safety Champions Partial Compliance	<p>a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.</p> <p>b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-about; minimum staffing in</p>

		<p>maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.</p> <p>c) Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcomes.</p> <p>d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)</p>
10	<p>NHS Resolution Partial Compliance</p>	<p>1. A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022</p> <p>2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022</p> <p>C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:</p> <p>4. 1. The family have received information on the role of HSIB and NHS Resolution's EN scheme; and 5. 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.</p>



Perinatal Quality, Safety and Assurance Group (PQSAG) Highlight Report – April to June 2022

LMS	Humber and North Yorkshire	Programme Lead	Becky Case		
Trust	Hull Teaching Hospitals	Completed by/date	12/07/2022		
No of Serious incidents	K2 & PROMPT Compliance	ATAIN Rates	HISIB reported events	No of complaints/PALS - themes	
2 hysterectomy 1 breech delivery		2.8%	4 (2 rejected) (1 active) 1 no consent	8 behaviours and attitude 2 patients did not feel listened to	
Top 5 Perinatal DATIX Themes (combined obstetrics and neonatology)		Top 5 PMRT Themes (combined obstetrics and neonatology)		Top 5 HSIB Themes (combined obstetrics and neonatology)	
1/ PPH		1/ Ensure all women receive written information in regards to RFM via OR code /leaflet		1/ The Trust to ensure that an interpreter is available to women for whom English is not their first language. Understanding should not be assumed.	
2/ Unexpected admission to NICU		2/ At AN apt if unable to locate FH refer to ADU		2/The Trust to ensure that guidelines are developed collaboratively, align together and reflect national guidance.	
3/ Organisational issues		3/ Unexplained loss requires a HVS inc early neonatal death		3/The Trust to support staff to pull the emergency buzzer when a bradycardia occurs.	
4/ Postnatal readmission		4/ Ensure all women are offered all PN investigations following unexplained pregnancy loss		4/	
5/		5/		5/	

BAPM 7 KPIs – Local data received via ODN re % of women receiving the interventions: <i>Please check your unit's data received via ODN.</i>			
	April22	May22	June22
Early breast milk			
Thermoregulation			
DCC			
Intrapartum antibiotics			
Correct place of			

Perinatal - Key Themes from Incident Reviews	Perinatal - Key Safety Interventions Implemented
1/ Hysterectomy case	1/ Placenta accrete trolley identified to all staff members and a daily checklist for this trolley to be implemented 2/ A MOH can be activated without a cross match in place reviewed to ensure the policy was correct
2/Unexpected admission to NICU	3 learning points identified Increase in baseline more than 10% significant change. If unable to interpretate CTG oxytocin should not be commenced. Expedite delivery if signs of decompensation.
3/	
4/	4/
5/	5/

Hull University Teaching Hospitals NHS Trust Trust Board and Quality Committee

Appendix 2 – HUTH Maternity Dashboard

Maternity Dashboard	Threshold	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Activity													
Number of Births per month		387	411										
Number of Bookings per month		420	400										
Direct Access before 12+6													
Booking over 13 weeks within 2 weeks	95.0%	90%	90.0%										
Caesarian Section	26.2%	27.8%	35.7%										
Elective Caesarean Section	11.1%	14.4%	15.1%										
Emergency Caesarean Section	15.4%	13.4%	20.6%										
Instrumental Birth	13.1%	8.4%	4.0%										
Normal Birth	61.0%	63.0%	60.0%										
Home Birth		1.0%	1.0%										
MLU Births		13.6%	11.3%										
Induction of Labour		32.0%	34.0%										
Epidural		29%	33.0%										
Workforce													
Weekly hours of Consultant cover on LW	98	95	95	95	95	95	95	95	95	95	95	95	95
Midwife/Birth Ratio	1:32	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30
Provision of 1:1 Care in Labour	100.0%	130.0%	130.0%										
Supernumary status of Labour Ward Coordinator	100.0%	100.0%	100.0%										
Maternal Morbidity													
Eclampsia		0	0										
ICU/HDU Admissions in Obstetrics		0	1										
Blood Transfusion (>4 units)		3	4										
Post-Partum Hysterectomies		0	1										
Neo-Natal Morbidity													
Number of cases of meconium aspiration		0	0										
Number of cases of hypoxic encephalopathy (grades 2 & 3)		0	0	1									
Referrals to NHR		0	0										
Total Stillbirths		0	1										
Stillbirths at Term (after 37 weeks)		0	1										
Risk Management													
Failed Instrumental Delivery	< 1%	1.2%	0.5%										
Maternal Death	0	0	0										
Massive PPH > 2 litres	10	13	11										
Shoulder Dystocia	6	0	0										
3rd/4th degree Tear	20	3	3										
Complaints													
Number of Complaints		4	5										

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total	Average per month
TOTAL BIRTHS 2022/23	387	411												
TOTAL BIRTHS 2021/22	428	395	397	391	430	449	435	458	388	389	398	444	5002	416
TOTAL BIRTHS 2020/21	405	394	454	438	409	437	426	401	380	393	353	379	2963	423
TOTAL BIRTHS 2019/20	391	465	414	455	469	405	423	390	444	420	364	414	5054	421
TOTAL BIRTHS 2018/19	422	439	458	445	432	480	442	429	419	420	367	404	5157	430
TOTAL BIRTHS 2017/18	434	433	458	414	462	474	467	484	448	407	370	434	5285	440
TOTAL BIRTHS 2016/17	432	461	453	520	481	463	459	454	467	444	420	451	5505	459
TOTAL BIRTHS 2015/16	419	466	483	492	501	486	488	468	459	464	450	448	5624	472
TOTAL BIRTHS 2014/15	461	486	485	468	438	529	485	492	457	458	432	462	5653	478

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total	
Stillbirths 2022/23	0	1												
Stillbirths 2021/22	0	2	2	0	1	1	2	1	1	1	1	1	13	
Stillbirths 2020/21	1	2	2	1	1	1	0	0	0	1	2	2	14	
Stillbirths 2019/20	1	4	2	1	2	0	1	2	2	1	2	2	20	
Stillbirths 2018/19	0	0	2	0	3	2	2	4	1	2	0	0	16	
Stillbirths 2017/18	1	1	1	3	1	1	0	0	0	3	3	3	17	
Stillbirths 2016/17	2	6	4	3	1	1	2	3	1	0	1	3	27	

Appendix 3 – Abbreviations

- ATAIN – Avoiding Term Admissions to Neonatal Unit

**Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee**

- BBA – Born Before Arrival to Hospital
- CTG – Cardiotocograph
- HSIB – Health Safety Investigation Branch
- IUD – Intra Uterine Death
- LSCS – Lower Segment Caesarean Section
- NND - Neonatal Death
- PMRT – Perinatal Mortality Review Tool
- PPH – Postpartum Haemorrhage
- PSROM – Prolonged Spontaneous Rupture of Membranes
- PROMPT – Practical Obstetric Multi-Professional Training
- SB – Stillbirth

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

SAFEGUARDING ADULTS

ANNUAL REPORT

2021 - 2022



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ANNUAL REPORT FOR SAFEGUARDING ADULTS – 2021/22

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for Safeguarding Adults. The report will identify Safeguarding Adults activity within the Trust over 2021/22, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2022/23.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities to safeguard adults at risk of harm, abuse and neglect that access its services and premises. The challenges facing vulnerable adults remain significant in this health economy and, in particular, the increase in people that have complex needs, such as Mental Health, Dementia and Learning Disabilities.

The Trust continues to meet its regulatory and contract obligations in relation to Safeguarding Adults and is a proactive member of both Hull and East Riding Local Authority Safeguarding Adult Partnership Boards.

In terms of highlights during 2021/22:

- The Trust submitted their Section 11 joint annual assurance survey's for both East Riding and Hull Safeguarding Boards, which were well received and provided good assurance for both Adult and Children's Safeguarding Services
- Positive feedback from NHS Hull and East Riding Clinical Commissioning Groups about the governance and progression of Safeguarding Adults agenda items.
- The Learning Disabilities Liaison Nurse postholder commenced on secondment in May 2021 and the post was substantiated in April 2022. The post holder is progressing well, providing support to patients, families and staff. A senior management team meeting has been established with the Assistant Chief Nurse (ACN), Named Nurse SG Adults, Operational manager for LD nurse and LD matron (Humber Teaching Foundation Trust, HTFT) which meets monthly to monitor activity reports and progress on role objectives. It has been recognised that the activity for this postholder has increased significantly over her tenure and raised the need for further support for patients, families and staff for East Riding patients. The current post is commissioned by Hull CCG.
- HTFT are supporting to provide a secondment for maternity cover of the LD nurse postholder.
- The Dementia Matron post has been reassigned to Corporate Nursing under the management of the ACN / Safeguarding Lead due to reorganisation in the Medicine Health Group and review of portfolios. The post holder commenced on secondment, May 2021, then the post was substantiated in February 2022. The postholder works closely with the Safeguarding Team and Enhanced Care Team (ECT) Matron.
- The review of Mental Health Legislation Service Level Agreement with Humber Teaching Foundation Trust, improving the provision of Mental Health training, governance and data sharing.

- The training compliance of over 85% for Safeguarding Adults predominantly but no lower than 84%, Mental Capacity, and Deprivation of Liberty Safeguards 82% and above and 80% compliance for Prevent Health Wrap.
- Positive feedback from Hull and East Riding Safeguarding Adult Board Managers and Independent Chairs regarding the Trust arrangements for Safeguarding Adults.
- Established and positive partnership working with a range of external agencies to improve the care and treatment of patients with vulnerabilities including those under legal detention. This has continued despite the restrictions of Covid safety measures.
- Routine / Selective Enquiry has continued to be rolled out across the organisation with 1221 staff now completing the mandatory Level 2 Domestic Abuse Training.
- The Trust continues to work towards full implementation of the Hull Strategic Domestic Minimum Standards. A domestic abuse task and finish group has been developed to support the implementation and development of these standards and has also reviewed and identified issues related to victims of DA in the newly published Domestic Abuse Act 2022.
- The Trust continues to have access to the Independent Domestic Abuse Advocate (IDVA) as an in-reach service provided by the Hull Community Safety Partnership. The IDVA service has been reinstated within the Trust site in August 2021, two days each week.
- Continued to support the Learning Disabilities Mortality Review (LeDeR) programme. Changes in the delivery of LeDeR reviews by the National Team has meant that staff trained within the wider Trust will no longer be called upon to undertake a full review. However, the safeguarding team have continued to be supportive by undertaking Structured Judgement Reviews (SJR's), information gathering for external reviewers and being valued members of the regional operational and strategic groups. Lessons learnt from reviews, both for improvement and positive findings are posted on the Trust LD Pattie page and shared with Trust Safeguarding leads.
- Reviewed and amended the Terms of Reference for the LD and Autism Operational Group; a sub-group of the Mental Health and LD/Autism Steering Group. This multiagency, multiprofessional group has identified learning from Safeguarding Adult Reviews, LeDeR reviews and SJR's and have been working to support the development of a regional 'passport' and 'red bag' for LD patients. The group also has reviewed flagging for patients and supported the review of the outcomes from the 3rd NHSI/NHSE Benchmarking submission.
- Continue to review how to improve feedback to referrers on the quality of the safeguarding referrals raised.
- Embedding of feedback and recording of submitted concerns made by clinical staff.
- Developed a more robust recording process in the safeguarding team to reflect the calls for support and advice from clinical staff. This identified the rise in domestic abuse calls from staff about patient victims that did not always result in a formal concern being raised.
- Following triage of safeguarding adult concerns submitted by clinical staff, the safeguarding adult's team continues to ensure a more accurate categorisation of the abuse categories are being reported to the trust via the safeguarding steering group.
- Led on multiagency strategic meetings for complex needs patients.
- Continue to raise awareness of MAPPA patients and the need for robust risk assessment plans for individuals who pose a risk to public.
- Implementing a process for identifying patients who are detained by the judicial system and the requirement to undertake robust risk assessments to ensure patient, public and staff safety.

- The Safeguarding Fundamental Standards were reviewed with the questions being amended to reflect and higher standard of understanding of both adult and child safeguarding procedures and safety mechanisms from all clinical areas where these audits are undertaken. Covid restrictions have reduced and audits have commenced to fully test out these changes in all areas but in the areas that have been audited, there has been positive results that can give some reasonable assurance to the trust board that staff have a good understanding of their safeguarding obligations.
- Updates and compliance with Safeguarding Policies and Procedures in line with review dates and changes required.
- Two members of the safeguarding team have undertaken training in Forensic Aspects of Adult Safeguarding. This initiative to offer the same oversight of non-accidental injuries in vulnerable adults as in children was developed by the Assistant Chief Nurse and the Named Doctor for Safeguarding Adults in the East Riding CCG. The concept has been championed and supported by the NHSI/E North safeguarding England team with regional training delivered in January and February 2021. The Humber pilot initiative has commenced, which will only include the Humberside health providers.
- Work continues with the Lorenzo development team to provide an integrated reporting system for safeguarding adults concern and MCA/DoLS forms.
- Supported the mental health liaison service to secure access to Lorenzo to enable more timely and accurate recording of assessments and care plans for patients with mental health issues in the trust.
- Initiated an audit for trust compliance with mental health section 5.2 responsibilities.
- Identifying staff training needs for mental health act decision making and supporting opportunities for this training in the HUTH workplace, improved monitoring, reporting and legal compliance with all mental health detentions.
- The representative from Humberside Police reported back to the Trust that the work between the Safeguarding Adults Named Nurse, the Emergency Department and the care provider for the Hull police custody suite for immediate electronic discharge information, had been reported at the North of England Chief of Police forum, and had been held up as an exemplar in transfer of care arrangements. Other forces have been instructed to implement a similar procedure for their custody suites.

There have been a number of challenges during 2021/22 for safeguarding but overall, the Trust is in a strong position for 2022/23. The team understands the areas which require focus and strengthening and these are fully sighted on moving forward. There have been many positive aspects to comment on over the past year and in particular; good partnership working with the local authority Safeguarding Adult boards, internal governance of safeguarding, staff knowledge and training, and experienced and credible leaders in the safeguarding team. The Safeguarding Adult team has a substantial post to a Named Nurse Safeguarding Adults nurse to be in line with national profiles for Safeguarding Adults. The team also has a full time Enhanced Care Team Matron / MCA Lead and a full time Safeguarding Specialist Nurse post.

In the last annual report for 2020/21 a summary of work was planned as detailed below. The table below details the statement along with a brief update for each of the statements:

Statement	Update
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Statement	Update
<p>Establish a Domestic Abuse Working Group and affect change in line with local, regional and national priorities, producing regular reports on activity and outcomes from referrals and supporting staff to support victims of domestic abuse across the Trust.</p>	<p>Completed</p>
<p>Continue roll out plan for Routine/Selective enquiry in identified areas of the Trust, including staff training</p>	<p>This work was started as per the project plan, namely in general OPD's at CHH and HRI, ERCH OPD, Surgical OPD (Plastics), Paediatrics, Medical Day Unit, Fracture Clinic and Oncology Day Unit. There have been areas targeted for training due to incidences or staff requests following domestic abuse queries. These areas include Cardiac Physiology and Cedar Ward. The planned roll out has been stalled due to HUTH pandemic responses. It is planned to resume the systematic roll out across the Trust from April 2021.</p>
<p>Ensure the introduction and implementation of Intercollegiate Level 3 safeguarding adults training across professional groups in the trust is embedded within the organisation in line with the Training Needs Analysis.</p>	<p>A plan for the implementation of Level 3 training has been submitted to and agreed at the Trust Safeguarding Committee. The pandemic has delayed the introduction of the programme and it was launched in August 2021 and is on track for compliance of 85% by end of March 2023.</p>
<p>Review the current 'Think Family' model of training to ensure staff are receiving all required information related to the levels one and two (for children and adults) to enable competent application in the clinical workplace</p>	<p>This has been reviewed by the safeguarding adults and child teams and in collaboration with the education and development team.</p>
<p>Produce an action plan for the introduction and implementation of Intercollegiate Level 3 safeguarding adults training across identified professional groups in the trust.</p>	<p>An action plan has been agreed and is systematically being implemented. This is a three-year plan with phase one ongoing. Mandatory MCA training has been reviewed and a summative assessment added.</p>
<p>Aim to reach 85% within two years (2022/23) of introduction of the training package for level three safeguarding adults training to comply with commissioning arrangements</p>	<p>Phase One of level three safeguarding adults training is ongoing. Phase two is in development to incorporate MCA, domestic abuse and a third safeguarding adults' related subject available on the trust e learning platform.</p>
<p>Review of the Prevent Health Wrap Training Plan and in line with the changing national requirements and guidance.</p>	<p>Completed by the education and development team. Further work will continue in 2022/23 with regards to training needs analysis and</p>

Statement	Update
<p>Enhanced care team key actions:</p> <p>To have full recruitment by December 2021. Appoint to 1-year seconded band 6 post. Improve quantitative and qualitative data collection to inform service development. Repeat audits of ECT documentation and continue to improve in light of findings. Review the reduction in security use and expenditure. Support the Digital Team in rolling out ECT Nerve Centre assessment tool.</p>	<p>cleansing.</p> <p>ECT continued to be affected by recruitment and retention issues but by December 2021 had recruited to 12.12 WTE December 2021. In February 2022, 5 WTE were deployed to support the social care wards.in /discussion with the Chief and Assistant Chief Nurse.</p> <p>Recruitment was paused in April 2022 to review the ECT service model.</p> <p>Security use and expenditure continues on a downward trend, in particular the decreasing length of time security is use for patients.</p> <p>Planned 6 month ECT audits of service provision, assessment of process and staff experience has been delivered.</p> <p>The ECT digital assessment tool is live at CHH and is ready for use within HRI once it is launched at the site</p> <p>Recruitment to the band 6, one year secondment was agreed.</p>
<p>Continue to review the Learning Disabilities and Autism NHSI/NHSE national standards to enable compliance with actions identified from the 2018, 2019 and 2020 benchmarking exercises, where possible and to produce justifications where compliance is not achievable.</p>	<p>Action plan updated and monitored during 2020/21 and reported to the safeguarding and mental health committees for comment.</p>
<p>To undertake the fourth LD and Autism benchmarking audit when it is available in 2021.</p>	<p>The fourth audit was opened on line by NHSE/I in November 2021 with a deadline for January 2022. This deadline was extended by the national team to March 2021 and was submitted as per instruction.</p>
<p>To support the new LD Liaison Nurse in the role.</p>	<p>The LD Liaison Nurse postholder commenced in May 2021 and is progressing well, providing support to patients, families and staff.</p>
<p>To work with the Hull CCG to review the LD Liaison Role and identify any changes that will enhance the service.</p>	<p>It has been recognised that the activity for the LD liaison nurse has increased significantly over her tenure and raised the need for further</p>

Statement	Update
	support for patients, families and staff for East Riding patients. Assistant Chief Nurse has raised this issue with both Hull and East Riding CCGs and is continuing discussions with regards to workforce planning and resilience.
Resume the active involvement of reviewers in the LeDeR process and continue to support the local and regional multiagency teams in this programme.	Changes in the delivery of LeDeR reviews by the National Team has meant that staff trained within the wider Trust will no longer be called upon to undertake a full review. The safeguarding team continue to be supportive by undertaking SJR's, information gathering for external reviewers and being valued members of the regional operational and strategic groups.
To review the training needs analysis (TNA) and action plan for LD and Autism training in preparation for mandatory training status to be implemented by the national team.	A TNA was completed with the safeguarding team and the education and development team and submitted to the safeguarding committee for approval. There has been no mandate from NHSE/I for the content of this training up to the publication of this report. There has been a lack of support available within the education and development team due to a current vacancy which has been recruited to and commences in August 2022. A clinical nurse educator for learning disability and dementia educator has commenced post in February 2022 and a further review of the TNA is needed in line with national guidance.
To enable the Mental Health Liaison Team and AMHPS (Approved Mental Health Professionals) to have access to the Trust's Lorenzo electronic medical records system.	The staff cohort (Registered) in Humber were identified for requiring full access to HUTH's system and training was offered and accepted to allow that access though not all identified staff have completed this mandatory training. The issue with finance of the licence for this access between both trusts has been resolved. An issue relating to unregistered staff requiring access has been escalated to the Caldicott Guardians. The Learning Disabilities Liaison Nurse continues to have full access to the Trust's Lorenzo system.
Maintain the Mental Health and LD Committee and deliver on the agreed programme as described in the work plan.	The MH and LD committee/steering group continued to make progress on the actions outlined in the work plan.
The safeguarding team to work with the	The safeguarding team have worked with the

Statement	Update
Lorenzo team to develop electronic recording of safeguarding and MCA records and referral system.	Lorenzo development team to move this work forward. The team report that the work is ongoing but it is not on their priority list for urgent attention by the Lorenzo project team.
Develop a survey for capturing internal feedback about the Trusts Safeguarding Service.	This work was started early in the 2019/20 time period; however, it has not been circulated to staff due to the pandemic.
Review the revised Fundamental Care for Safeguarding Adults and Children audit tool to ensure successful implementation and improved knowledge base for staff.	Revision completed and agreed at the safeguarding committee. Following the pandemic, a recovery plan to undertake audits in all areas has now commenced.
Develop an audit tool to review the quality of concerns received from staff and undertake at least one meaningful audit. Results to be shared with safeguarding committee members and actions agreed dependent on the results, and disseminated within the health groups for implementation.	This has not been achieved in this annual report timeframe due to pressures from the pandemic. This is an action identified for 2022/23.
Review the capacity and structure of the Safeguarding Adults Team.	Discussions taken place with Chief Nurse and ACN regarding structure of the team. The action is ongoing into 2022/23 via the MH and LD delivery framework and the safeguarding delivery plan.
Work with the Chief Nurse Information Officer and the IT team to review and advice on the development of the electronic assessment tool for nursing.	Work undertaken to review and advise on the electronic assessment tool developed for nursing, including safeguarding and learning disabilities.
Resume partnership working with the Humber Modern Slavery Partnership following its pause due to Covid-19 and report progress, including the development of the multiagency information sharing agreement, into the Safeguarding Committee.	Partnership working with the Humber Modern Slavery Partnership was resumed in 2022 with trust representation by the Named Midwife Safeguarding Children and Safeguarding Adults Specialist Nurse. A multiagency information sharing agreement has been developed and approved via the Safeguarding and Governance Committees.
Implementation of a Learning, Audit and Assurance Group, (sub group to the Safeguarding Committee) to identify learning from case reviews or other investigations, ensure implementation in the health group clinical areas and monitor outcomes.	Due to operational pressures, the group has not been set up as an independent group. However, the safeguarding steering group does monitor actions required from high level reviews such as safeguarding concerns.
Scope and develop a business case for Mental Health Practitioner to enhance the	This action has not been achieved this year, however this is included within the MH and LD,

Statement	Update
safeguarding team and support patients who have mental health needs.	Autism strategy and delivery framework.

3. BACKGROUND

The Care Act* came into force in 2015 and replaces all previous guidance such as 'No Secrets 2001'**.

What is the Care Act?

Adult safeguarding is the process of protecting adults with care and support needs from abuse or neglect (hereafter referred to as "adults"). It is an important part of what many public services do, but the key responsibility is with local authorities in partnership with the police and the NHS. The Care Act 2014 puts adult safeguarding on a legal footing and from April 2015 each local authority must:

- make enquiries, or ensure others do so, if it believes an adult is subject to, or at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom
- set up a Safeguarding Adults Board (SAB) with core membership from the local authority, the Police and the NHS (specifically the local Clinical Commissioning Group/s) and the power to include other relevant bodies
- arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them
- cooperate with each of its relevant partners in order to protect adults experiencing or at risk of abuse or neglect.

The Care Act 2014, Department of Health, 2014

It also updates the scope of adult safeguarding:

- Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) –
 - a) has needs for care and support (whether or not the authority is meeting any of those needs),
 - b) is experiencing, or is at risk of, abuse or neglect, and
 - c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In effect, this means that regardless of whether they are providing any services, councils must follow up any concerns about either actual or suspected adult abuse. Safeguarding Adult Boards have been strengthened and have more powers than the current arrangements set up by "No Secrets**"

but they also have to be more transparent and subject to greater scrutiny. All organisations who are involved in adult safeguarding need to reflect the statutory guidance, good practice guidance and ancillary products that have been developed when devising their training and implementation plans for staff. Policies and procedures should be based on the processes laid out in the statutory guidance.

Key messages of the Care Act 2014

The statutory guidance enshrines the six principles of safeguarding:

- 1) **empowerment** - presumption of person led decisions and informed consent
- 2) **prevention** - it is better to take action before harm occurs
- 3) **proportionality** - proportionate and least intrusive response appropriate to the risk presented
- 4) **protection** - support and representation for those in greatest need
- 5) **partnerships** - local solutions through services working with their communities
- 6) **accountability** - accountability and transparency in delivering safeguarding.

It signalled a major change in practice - a move away from the process-led, tick box culture to a person-centred social work approach which achieves the outcomes that people want. Practitioners must take a flexible approach and work with the adult all the way through the enquiry and beyond where necessary. Practice must focus on what the adult wants, which accounts for the possibility that individuals can change their mind on what outcomes they want through the course of the intervention.

The NHS is a key component of safeguarding and the local Clinical Commissioning Groups (CCGs) are one of the three statutory core partners of the Safeguarding Adults Partnership Boards.

The CCG is in the best position to ensure that NHS providers meet their responsibilities through its commissioning arrangements with them. However, Safeguarding Adult Boards are free to invite additional partners to sit on the Board. For example, many SABs also have local NHS Provider Trusts on their Boards. Many Boards have also found it extremely helpful to have a representative GP on their Board who can communicate directly with their colleagues to emphasise the importance of their role in protecting adults at risk of abuse and neglect.

There have been a number of high-profile hospital scandals that have highlighted the need for vigilance and action among staff and managers. The NHS has particular duties for patients less able to protect themselves from harm, neglect or abuse. All commissioners and contractors have a responsibility to ensure that service specifications, invitations to tender, service contracts and service level agreements promote dignity in care and adhere to local multi-agency safeguarding policies and procedures. Commissioners must also assure themselves that care providers know about and adhere to relevant CQC Standards. Contract monitoring must have a clear focus on safeguarding and robustly follow up any shortfalls in standards or other concerns about patient safety.

NHS managers, commissioners and regulators will want assurance that when abuse or neglect occurs, responses are in line with local multi-agency safeguarding procedures, national frameworks for Clinical Governance and investigating patient safety incidents. Therefore, these services must

produce clear guidance to managers and staff that sets out the processes for initiating action and who is responsible for any decision making. To prevent cases falling through the net, the NHS and the local authority should have an agreement on what constitutes a 'serious incident' and what is a safeguarding concern and appropriate responses to both.

With regards to Safeguarding Adults, the Hull University Teaching Hospitals NHS Trust works in close partnership with local health providers such as City Health Care Partnership, Humber Teaching NHS Foundation Trust and the Hull and East Riding Clinical Commissioning Groups as well as the Police, Local Authorities, the Probation and the Prison Service.

The Trust is a member of the two local Safeguarding Adults Partnership Boards in Hull and in East Riding. During 20120/21, attendance of the Trust representatives at both was excellent via electronic meeting platforms. The East Riding SA Board completed a review of the sub groups supporting the board and reduced the number from four to three. This change is expected to be reviewed by the Board on a regular basis. This has released approximately 18 hours a year for the safeguarding adults team.

The CQC did not visit the Trust in this annual report timeframe. However, on the identification of staffs understanding of the implementation and application of the Mental Capacity Act and Deprivation of Liberty Safeguards, an external audit was commissioned by the Chief Nurse to identify any areas of concern across the organisation. The results provided assurance to the Board that although there were some areas in the understanding and application within the general workforce that require further training to improve knowledge, the level of understanding gave good assurance. The performance of the safeguarding adult's team gave no areas of concern.

The Trust is required to submit quarterly reports on Safeguarding to the NHS Hull CCG as part of the locally set Key Performance Indicators. These are presented to the Contract Monitoring Board and then discussed at the Quality Delivery Group which is a sub group of the Contract Monitoring Board and whose membership consists of local and specialist commissioners with Trust representatives. The Chief Nurse attends this meeting and has received positive feedback regarding the progression of safeguarding during 20120/21. No contractual concerns have been raised and commissioners continue to praise the trust for their information and governance of safeguarding adults which is deemed to be of a very high standard and is shared with other partners as a positive benchmark. The Assistant Chief Nurse meets quarterly with the CCG Designated Safeguarding Professionals to discuss key performance indicators and exception issues.

4. LOCAL CONTEXT

Hull University Teaching Hospitals NHS Trust (HUTH) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs in excess of 9000 staff and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The local care system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

Hull is a geographically compact city of approximately 270,000 people. It was identified as the third most deprived local authority in England in 2017 (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average) The top five causes of death; CHD, dementia, lung cancer, COPD and stroke, account for 45 per cent of all deaths in Hull. Additionally, with the exception of dementia, these same diseases are the top causes of people dying under the age of 75. This is commonly considered a measure of premature death.

In December 2019 the claimant count (those claiming benefits due to unemployment) for Hull was 6.6% among men and 4.2% among women; this compares with 3.3% and 2.4% for men and women across England. 30,140 people of working age (17.6%) in Hull were claiming benefits in November 2016, compared with 6.7% across England.

In Hull 30% of children and 25% of older people are living in poverty. (Hull Director of Public Health Annual Report 2020)

The East Riding of Yorkshire is predominantly a rural area populated by approximately 342,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull.

Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are Eastern European, South Asian, Black, mixed race, Chinese or other origin.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long-term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations.

From a Safeguarding Adult perspective, the local landscape and population is an increasing challenge and in particular, with rates of abuse, neglect and harm which are closely linked with deprived areas. The increase in the ethnic minority population is also a challenge for Safeguarding Adults due to the cultural traits and behaviour which meet the thresholds for safeguarding in both children and adults. Examples of this would be Female Genital Mutilation, Domestic Abuse and Prevent. Financial abuse has seen a significant increase in its reporting in this area and this has resulted in the Safeguarding Adult Board in Hull working with financial institutions to raise awareness and help prevent this type of abuse. The increase in people who self-neglect and who are hoarders is also a concern locally and numerous services use a significant amount of resources working with these individuals. Fire risks attached to these individuals is significant and the Humberside Fire and Rescue work proactively with individuals and the housing associations to try to minimise the risk. The increase in the population requiring mental health services is also a concern locally. The Trust works closely with Humber Teaching NHS Foundation Trust regarding mental health and is a member of the Mental Health Crisis Care Concordat, the Mental Health and

Dementia Strategic Steering Group (East Riding) and the recently established Suicide Prevention Group (Humber, Coast and Vale).

Resource limitations in all public sectors are proving challenging for all agencies to meet the increasing safeguarding agenda although these continue to be met with good partnership working and relationships between agencies. Increase in referrals, advocacy requirements, deprivation of liberty applications are just some of the local challenges that the Safeguarding Adult Partnership are facing and in individual organisations. The importance of good working relationships and communication between agencies is key protecting adults at risk from abuse.

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

The Executive Trust Lead for Safeguarding Adults and Children in 2021/2022 was the Chief Nurse, Mrs Beverley Geary.

The Trust's Lead for Safeguarding Adults and Children is Assistant Chief Nurse, Miss Kate Rudston. The Safeguarding Adults team comprises:

- ❖ Mrs Christine Davidson B8a (0.8 WTE), (0.4 WTE January – March 2021) - Named Nurse for Safeguarding Adults
- ❖ Mrs Jayne Wilson B7 (1.0 WTE) – Safeguarding Specialist Nurse (April 2021 – February 2022). B7 (0.4 WTE) Safeguarding Adults Specialist Nurse, B8a secondment (0.6 WTE) Named Nurse for Safeguarding Adults.
- ❖ Ms Rachel Hoggarth (1.0 WTE) B8a - Enhanced Care Team Matron and Lead for the Mental Capacity Act

Further roles that support or work within the team are:

- ❖ Natalie Wood B7 (1.0 WTE) – Learning Disability Liaison Nurse – Post commissioned by Hull CCG, hosted by Humber Teaching FT.
- ❖ Independent Domestic Abuse Advisor (IDVA) – (16 hours per week – in reach) Post holder seconded into the Trust from the Hull Safety Partnership via Hull DAP (Domestic Abuse Partnership). Outreach support maintained during the covid pandemic and an in-reach service recommenced August 2021.

The Assistant Chief Nurse manages the strategic and operational function and governance of Safeguarding in the Trust including; Mental Capacity, Restraint, Deprivation of Liberty Safeguards, Consent, Prevent, Mental Health, Learning Disabilities and managing safeguarding allegations against staff. To ensure resilience in the team for safeguarding allegations against staff, Mrs Davidson has also undergone the training to become a Designated Officer.

This structure is supported by the Executive Chief Nurse, the Executive Board and Health Group Directors.

The Assistant Chief Nurse has open access to the Executive Directors and the Chief Executive Officer on matters pertaining to safeguarding and meets with the Executive Chief Nurse regularly to discuss safeguarding issues.

The Non-Executive Director champion for Safeguarding, Learning Disabilities and Mental Health is Mrs Tracey Christmas, who has significant experience in the role of Non-Executive Director and is also a strong advocate for all matters pertaining to safeguarding. This working arrangement continues and is working well. Safeguarding continues to be embedded in all aspects of governance in the Trust and work continues with patient experience, risk and governance to ensure that information is triangulated and acted upon with regards to protecting vulnerable children, young people and adults at risk.

Learning Disabilities is also covered under the portfolio of Safeguarding and the Trust hosts a Learning Disabilities Liaison Nurse, Mrs Natalie Wood, who is employed by Humber Teaching NHS Foundation Trust, but funded by Hull CCG. The Learning Disabilities Nurse is co-located within HUTH Safeguarding Adults Team. She also regularly meets with the Trust Named Nurse Safeguarding Adults, who acts as the post holder's manager on a day-to-day basis. There are regular meetings with HUTH leads, LD Nurse and CTLD Lead for the LD Liaison Nurse post from Humber Trust, to identify areas for development.

The LD post holder has begun to work extremely closely with the Trust MCA operational lead matron to ensure complex clinical issues for patients with LD are dealt with swiftly and appropriately. This has resulted in two patients with very complex clinical and social needs been supported to go through the Court of Protection process, with positive outcomes in both scenarios.

The Trust Safeguarding Committee reports to the Operational Quality Committee and this changed to the Patient Experience Sub Committee in February 2022. The Safeguarding Committee met five times out of possible six during 2021/22.

The Safeguarding Adult's team is a small team which manages a series of items such as Mental Health, Deprivation of Liberty, Making Safeguarding Personal, Safeguarding Adult Reviews and Domestic Abuse. The requirements with Multi Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conference (MARAC) are also significant as partnership working with the Police, Prisons and Probation has continued to increase and improve over the past year. Regular meetings continued to take place with the personnel from the police and probation service and this had led to a real improvement in the transfer of care of this population, improving communication and learning lessons from when pathways have not gone as well as expected. The representative from Humberside Police reported to the Trust that the work between the safeguarding team, the Emergency Department and the care provider for the Hull police custody suite for immediate electronic discharge information, had been reiterated at the north of England Chief of Police forum, and had been held up as an exemplar in transfer of care arrangements. Other forces have been instructed to implement a similar procedure for their custody suites.

The Safeguarding team also facilitates and chairs meetings with the Learning Disability liaison teams from the community and the Trust LD Liaison Nurse, CCG representatives and LD leads from the acute trust health groups.

The Compliance team within the Trust Governance department provides the administration and governance processes for Safeguarding Adults and this support has been invaluable in the excellent improvements that Safeguarding Adults has made. Kelly Northcote-Orr and Jamie Bell in the main, along with Leah Coneyworth, Compliance Team Manager, have continued to the improvements in the governance of Safeguarding Adults and work closely with the team, ensuring

the information is cleansed regularly and that the operational processes are compliant. The Assistant Chief Nurse, Named Nurse Adult Safeguarding, Enhanced Care Team Matron/Mental Capacity Act lead and Safeguarding Adults Specialist Nurse meet regularly with the Compliance team to ensure systems are up to date and innovative ideas are progressed.

All data received and sent from the Trust with regards to Safeguarding Adults is captured by the Compliance Team and intelligence gathered to provide not only an internal view but also a local picture. This information can help inform areas of concern not just within the Trust with regards to high levels of safeguarding reporting but also externally. For example, if a local care provider is causing a high level of referrals to be placed by Trust staff then this is not only detected quickly but also sent to the relevant Designated Professional for Safeguarding Adults in the Clinical Commissioning Group.

5.1 INTERNAL GOVERNANCE

The Trust has an overarching Safeguarding Adults Policy that sets out the standards and requirements when dealing with safeguarding issues or concerns (CP277), which was reviewed and updated in 2021. The Trust has Mental Capacity Act, Deprivation of Liberty Safeguards, Consent and Physical Restraint Policy (CP354). There are a number of other Safeguarding related policies and procedures to underpin the core areas of the portfolio.

The Trust continues to roll out training to clinical staff for domestic abuse routine enquiry to all women over the age of 16 years attending the hospital for treatment. This enquiry will be recorded on the new electronic initial assessment record via Nerve Centre which has been rolled out at CHH with a plan to implement at HRI in April 2022.

Safeguarding Policies are supported by procedures, protocols and guidelines. All of the documents are underpinned by the Safeguarding Adult Board Policies and Procedures as well as Department of Health guidance. All are available on the Trust Intranet Safeguarding Adult Site.

All Safeguarding Adult's activity is recorded in a monthly report and presented to the Safeguarding Steering Group (formally the Safeguarding Committee).

All Safeguarding Adult's Investigation Reports and Reviews are reviewed, quality checked and approved by the Assistant Chief Nurse before they leave the organisation.

The Safeguarding Adult's team review all complaints that may have a safeguarding element within them. An opinion is offered on the complaint with regards to Safeguarding and this is sent to the lead patient experience officer.

All Serious Incidents when they are declared are sent to the Assistant Chief Nurse for review and opinion on Safeguarding. The development of a Serious Incident and Safeguarding Checklist was reviewed by the Assistant Chief Nurse and the SI panel in 2021/22 to assist the panel with their review of the investigation and final review. This process will provide further assurance to the commissioners and regulators with regards to the Trust seeing safeguarding as part of the core business and at the heart of patient safety and care.

The Trust has contributed to six Domestic Homicide Reviews which were commissioned or completed and submitted to the Home Office in 2021/22 by the Hull Community Safety Partnership and the East Riding Community Safety Partnership. The initial review on the cases reflects the learning from Routine Enquiry training undertaken by Trust staff. Patients were asked the question about domestic abuse but it has been recorded in more than one case that the patient declined ongoing support.

It is clear that the incidence of domestic abuse continues to be a local and national concern and the trust safeguarding team are dealing with an increase in reportable concerns as well as concerns that the victim does not want progressing. Sadly, it is expected that there will be an increase in requests for the safeguarding teams in the trust to support Domestic Homicide Reviews for Hull and the East Riding in 2022/23.

The Trust continues to be supported by the Independent Domestic Abuse Advocates (IDVA), who have a presence on the HRI site twice a week. They have been increasingly asked by the Safeguarding Team to support patients and staff who have disclosed they are the victims of domestic abuse. The introduction of weekly walk arounds by the Safeguarding Practitioner and IDVA within the Maternity, Neonatal and Gynaecology services has been extremely well received by patients and staff. They have been on hand to support many victims of domestic abuse within our organisation, either at the time of the visit or on later follow up appointments.

5.2 EXTERNAL GOVERNANCE

During 2021/22, the Trust was represented on the Hull and East Riding Safeguarding Adults Partnership Boards by the Assistant Chief Nurse. In addition, the Trust is represented on the Safeguarding Adult Boards sub committees by the Safeguarding Adult Named Nurse and Specialist Nurse.

The overarching purpose of a Safeguarding Adult's Board is to help and safeguard adults with care and support needs. It does this by:

- Assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance.
- Assuring itself that safeguarding practice is person-centered and outcome-focused.
- Working collaboratively to prevent abuse and neglect where possible.
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

Safeguarding Adult Boards have three core duties. They must:

- Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute.
- Publish an annual report detailing how effective their work has been.
- Commission safeguarding adult's reviews (SARs) for any cases which meet the criteria for these.

The Hull and East Riding Safeguarding Adult's Boards are structured differently.

The East Riding Safeguarding Adult's Board incorporates a wide range of members and is supported by sub groups; Training, Audit and Assurance and Safeguarding Adult Review Group. The East Riding Safeguarding Adult Board reviewed the groups supporting underpinning the governance processes and disbanded the Business Improvement Group, preferring instead to perform that scrutiny at the Board meeting itself. The Board requests an annual self-assessment to be completed by partners and this is followed up by a challenge panel event. This was still undertaken in 2021/22, and the Board Chair and Manager were extremely satisfied with the Trusts arrangements and governance of Safeguarding Adults.

The Hull Safeguarding Adult's Board consists of an Executive Board consisting of the three statutory partners stated in the Care Act 2014; the Police, the Clinical Commissioning Group and the Local Authority. In addition to the core partners, the Independent Chair, the Board Manager, and the Chair of the Strategic Delivery Group are also members. The Board is supported by a Strategic Delivery Group which consists of the wider partnership. The Assistant Chief Nurse chairs the Strategic Delivery Group and this is referenced and commended in the Hull Safeguarding Adults Board Annual Report 2021/22.

Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework- NHS England – August 2019

Health providers are required to demonstrate that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Adult and Children's Board, and in regular monitoring meetings with their commissioners.

Health providers must ensure staff are appropriately trained in safeguarding adults, children, Prevent, domestic abuse, the Mental Capacity Act and Deprivation of Liberty Safeguards at a level commensurate with their role. The intercollegiate document by NHS England was published in 2018 and set out the specific requirements for Safeguarding Adults.

Health providers are required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of children and adults at risk of harm and abuse in every service that they deliver. Providers must demonstrate safeguarding is embedded at every level in their organisation with effective governance processes evident. Providers must assure themselves, the regulators, and their commissioners that safeguarding arrangements are robust and are working. These arrangements include:

- Identification of a named nurse, named doctor and named midwife (if the organisation provides maternity services) for safeguarding children. Identification of a named nurse and named doctor for looked after children/ children in care. Identification of a named lead for adult safeguarding and an MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff. In the case of ambulance trusts, this could be a named professional from any relevant health professional background.
- Safe recruitment practices and arrangements for dealing with allegations against staff.
- Provision of an Executive Lead for safeguarding children, adults at risk and PREVENT.
- An annual report for safeguarding children to be submitted to the trust board.

- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the Intercollegiate Document for Safeguarding Children, Intercollegiate Documents for Looked after Children and the Intercollegiate Document for Safeguarding Adults.
- Safeguarding must be included in induction programmes.
- Providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals).
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.
- Developing and promoting a learning culture to ensure continuous improvement.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance such as the Mental Capacity Act 2005.

The Trust is compliant with the above arrangements and all of these elements are included in the local commissioning contract/key performance indicators to which the Trust reports quarterly to NHS Hull Clinical Commissioning Group.

Named professionals have a key role in promoting good professional practice within their organisation, supporting the local safeguarding system and processes, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding lead, Designated Professionals and the Safeguarding Boards.

All providers are required to have a Mental Capacity Act Lead who is responsible for providing support and advice to clinicians in individual cases and supervision for staff in areas where these issues may be particularly prevalent and/or complex. They should also have a role in highlighting the extent to which their own organisation is compliant with the MCA through undertaking audit, reporting to the governance structures and providing training. The named lead(s) will work closely with the Clinical Commissioning Group adult safeguarding lead.

Due to the reallocation of work and capacity during the pandemic, there was no audit of Mental Capacity and Associated Documentation. However, the Fundamental Standards audits carried out on wards in the trust did contain MCA questions, which enabled the team to get assurances of staff understanding of this process. These results are monitored by the safeguarding team and the health group nursing managers. The fundamental audit results in 2020/21 for Safeguarding that were undertaken prior to the pausing of the process due to Covid 19 measures, were mostly in the 95% and over attainments. This gave some assurance to demonstrate that staff generally understand safeguarding, their responsibilities and who to contact for advice and support.

The Trust Safeguarding Adults Team have all attended external higher level training in Mental Capacity, Consent, Best Interest and Deprivation of Liberty and provide advice and expertise to colleagues as and when requested or sought. Where legal advice is required for complex cases or court of protection applications then this is referred to the Trust solicitors.

The Trust is compliant with the requirements of named leads for Safeguarding Adults, Mental Capacity Act and Managing Safeguarding Allegations against Staff. The Assistant Chief Nurse undertakes this role and is also the Prevent Lead for the organisation.

Care Quality Commission

All providers of health services are required to be registered with the Care Quality Commission. In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported.

The fundamental standard on safeguarding states that children and adults using regulated services must be protected from abuse and improper treatment. Providers should establish and operate systems and processes effectively to ensure this protection and to investigate allegations of abuse as soon as they become aware of them.

In addition, the standard states that care or treatment must not:

- i. discriminate on the grounds of any of the protected characteristics of the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation)
- ii. include acts intended to control or restrain an adult or child that are not necessary to prevent, or not a proportionate response to, a risk of harm to them or another person if the adult or child was not subject to control or restraint
- iii. be degrading to the adult or child
- iv. significantly disregard the needs of the adult or child for care or treatment.

The standard goes on to state that no adult or child must be deprived of their liberty for the purposes of receiving care or treatment without lawful authority. Under the Mental Capacity Act 2005, the Care Quality Commission is responsible for monitoring how hospitals and care homes operate the Deprivation of Liberty Safeguards.

There are two Key Lines of Enquiry (KLOE) questions relating to safeguarding that the CQC inspect for NHS hospitals. These are:

- KLOE S3: Are there reliable systems, processes and practices in place to keep people safe and to safeguard them from abuse and neglect?
 - Prompt – are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements?

And:

- KLOE E6: Is people's consent to care and treatment always sought in line with legislation and guidance?
 - Prompt – Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004?
 - Prompt – Do staff understand the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty?

The Trust was last inspected in February 2020 by the Care Quality Commission. No issues were raised with regards to Safeguarding Adults or to the care of patients with Learning Disabilities in the reports received by the Trust.

5.3 ROLES & RESPONSIBILITIES

The Safeguarding Adults Team provides specialist advice, support and supervision pertaining to the safeguarding of adults at risk or suffering from harm, abuse or neglect to all Trust staff and volunteers.

A dedicated Safeguarding Adults Telephone is in operation Monday to Friday 8.30am to 4.30pm (excluding bank holidays). Outside of these hours, the Site Matron team provide advice and support.

Safeguarding Adult concerns are all submitted electronically. The Safeguarding team have been unable to progress, with the Lorenzo system team to build a replica concern form that will sit inside the patient's electronic records. This would allow easy access to ward staff to review feedback from the trust safeguarding team and the local authority investigations. Although this work is seen by the safeguarding team as a positive and long overdue governance tool, due to the capacity of the Lorenzo team they do not believe the form will be ready for use in the near future.

The Safeguarding Adults team's responsibilities are as follows:

- 1) Provide specialist advice on safeguarding adult's issues, mental capacity, consent, Prevent, mental health, best interests, Deprivation of Liberty Safeguards, human trafficking, domestic abuse and learning disabilities.
- 2) Support and supervision to staff in relation to incidents that have occurred or are disclosed as part of safeguarding adult's reviews/referrals.
- 3) Bespoke training to staff and ensure the safeguarding adults training is updated as required and in line with any lessons learnt locally or nationally.
- 4) Compliance with regulatory and contract standards in relation to Safeguarding Adults.
- 5) Compliance with Safeguarding Adult Boards policies and procedures including information sharing and good partnership working across agencies.
- 6) Undertake Safeguarding Adult Investigations (section 42 under the Care Act) and reviews and advise on Serious Incidents, ensuring actions from learning lessons are implemented and embedded.
- 7) Review and triage all safeguarding adult referrals and Deprivation of Liberty applications.
- 8) Review, support and triage all Independent Mental Capacity Advocate (IMCA) requests.
- 9) Reporting on all activity and items for escalation to the Trust Safeguarding Committee.
- 10) Support and advice on detainment of patients under the Mental Health Act or Mental Capacity Act.
- 11) Develop and undertake audits as required.
- 12) Provide leadership and visibility on Safeguarding Adults.
- 13) Advise on potential areas of concern to the Trust Executive Directors.

Training attended by the Safeguarding Adults team in 2021/22 continues to be limited due to the lack of opportunities during and following the lifting of restrictions due to the pandemic. However,

the team continued to keep up to date with the latest research and or information around Domestic Abuse and how this affects the whole family, Modern Day Slavery and Human Trafficking, Liberty Protection Safeguards, County Lines, and Grooming and Sexual Exploitation of adults with LD.

Case Studies

Patient A:

Background

Ben (pseudonym) has learning disabilities and associated sensory processing difficulties. He finds changes to his routine very distressing and any admission to hospital needs to be carefully managed. Ben has developed cataracts in both of his eyes and his eyesight has deteriorated significantly which has been recognised that this is impacting on Ben's everyday activities. Concerns raised include that Ben may react following surgery with self-harm behaviours to the affected areas following surgery.

What happened

A best interest meeting was arranged to decide in Ben's best interests whether to proceed with elective eye surgery. The Best interest meeting arranged involved the safeguarding adult's team, MCA Lead, community learning disabilities team, learning disabilities liaison nurse, consultant, GP, CCG, social worker, senior matron, Shared Lives carers and family. The outcome of the meeting was escalated to Trust solicitors and appropriate steps to taken to present to the Court of Protection due to the level of restrictive practices required.

The best interests meeting ensured that all areas of preadmission, admission, procedure, recovery, post-operative care and post discharge care were discussed and all actions required.

Following the best interests meeting, all parties were in agreement for removal of cataract surgery to one eye and due to restrictive practices being required to be considered, an application to the Court of Protection application was made.

Learning

- Multi agency working and care planning essential.
- Supporting patient's families in making difficult decisions.

Patient B:

Background

Katy (pseudonym) booked for pregnancy care with the maternity services with her fifth pregnancy. Katy's first language was not English and she had a history of mental health illness and complex social factors resulting in child protection with her children not being in her care. Katy suffered psychosis in her pregnancy and was detained within a mental health placement under a Mental Health section 3.

What happened

During Katy's pregnancy she was admitted to an inpatient Mental Health Unit under the Mental Health Act and was reported as having fluctuating mental capacity and being uncommunicative/mute. Katy was also assessed as lacking mental capacity for specific decisions required relating to maternity care and decisions were made using the best interest's process.

Following a multidisciplinary meeting including Consultant Obstetrician, Consultant Psychiatrist, Specialist Midwife, a reasonable adjustment made to undertake a joint mental capacity assessment around labour and birth in the community. Katy was assessed as lacking capacity for decision making around labour and birth at that time, with all relevant information around mental health, mental capacity and outcome of the best interest decision made being uploaded within the patient records. Katy was admitted from inpatient Mental Health Unit to labour and delivery via ambulance, and then delivered a live infant.

On review of Katy's intrapartum care following admission in labour the following was identified: Intrapartum hand-written record documented 'Mental Health Problems' but there was no evidence to acknowledge that Katy was detained under a mental health section or any implications this could have for Katy's care and admission to hospital. Katy was assumed to have mental capacity for her decision making although there were clear indications in the documentation that Katy may lack capacity to make her own decisions. There was no evidence of the supporting information being utilized in Katy's electronic patient record which confirmed she was assessed as lacking mental capacity around labour and birth 2-3 days prior to admission in labour. No interpreter was utilised on assessment when initial plan was made as Katy was viewed as 'not engaging'. 'Consent not declined' documented. References to Katy nodding in agreement. (No interpreter and no verbal communication), but also documented as being very distressed and not talking. Post-operatively, documentation states Katy wasn't responding, remaining disengaged and silent. The consent form used prior to Katy being taken to theatre for a potential CS was not appropriate as this was not signed by Katy and was not suitable for adults who lack mental capacity.

Learning

- Application of the mental capacity act (MCA) on admission in labour would have identified if Katy continued to lack mental capacity for the decisions required during her intrapartum care and the best interest (BI) process would have considered any past beliefs, values, wishes and feelings. Also, the BI process would include the view of others such as carers, relatives, friends or advocates, as well as to consider actions which are the least restrictive.
- In accordance with MCA, the appropriate consent form should be used for a person who lacks mental capacity for the decision required (time and decision specific). The development of a clear plan in relation to any admission whilst under a mental health section would have supported both Katy and staff.
- On any admission, for women who are detained under the Mental Health Act, consideration of any legal implications must be sought from Trust Safeguarding Adults Team or the Humber Mental Health Legislation Team/Mental health service out of hours, unless there is a clear plan already agreed. Relevant documentation to admit a patient on a mental health section may need to be completed, dependant on whether authorised leave has been granted from the detaining authority.
- Other considerations include, detention under a mental health section only applies when related to the person's mental health. Detention for treatment for physical health needs (unless directed, such as in eating disorders) is not applicable and for women who lack mental capacity, a Deprivation of Liberty may need to be considered.

Patient C

Background

Ellen (pseudonym) attended a Gynaecology outpatient appointment. Ellen's first language was not English and interpretation was required to ensure appropriate assessment and provision of care. Prior to the appointment, concerns had been raised in a pre-assessment appointment around potential domestic abuse. This concern was raised with the Trust safeguarding adults team and the Trust's Independent Domestic Abuse Advocate (IDVA) attended to support Ellen at her outpatient appointment planned, with Ellen's prior consent. Ellen has no children.

What happened

During Ellen's outpatient appointment, a face-to-face interpreter attended as arranged but this person was known to Ellen. To support Ellen and maintain confidentiality, a telephone interpreter was arranged and the face-to-face interpreter was not used. During the outpatient appointment, Ellen disclosed significant domestic abuse and was wanting to flee the relationship. With support from both the clinical staff and the trust IDVA, emergency accommodation was sought for Ellen and she was taken to a place of safety from HUTH with a plan for follow up by the domestic abuse services.

Learning

- HUTH clinical staff escalated concerns in relation to domestic abuse appropriately to seek advice and support on how to best to safeguard Ellen.
- Clinical staff and the Trust IDVA recognised the risks of using an interpreter known to Ellen and an alternative interpretation service was utilised.
- Ellen received specialist advice and support from the Trust IDVA and was secured a place of safety following her disclosure and wish to flee a domestic abusive relationship.
- Making safeguarding personal was undertaken with Ellen's views, wishes and consent being ensured.
- Effective partnership working ensured a safe discharge for Ellen to a place of safety with a plan for follow up support.

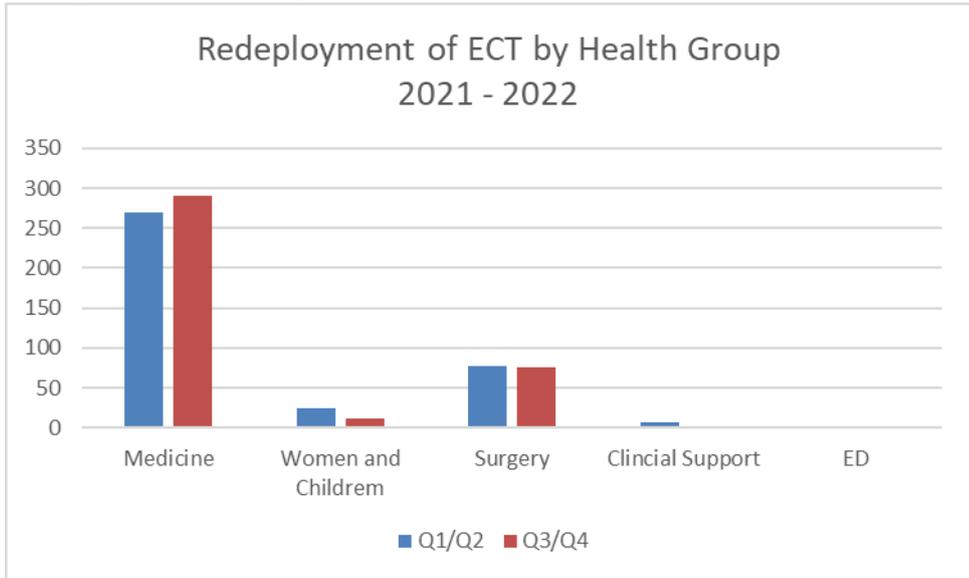
These cases demonstrate that with early intervention with the key professionals involved, positive outcomes are more likely to be achieved.

Staff should never delay contact with the members of the safeguarding team who will support staff through the complex and delicate processes involved in applying the Care Act, Mental Capacity Act, Equality Act and Mental Health Act.

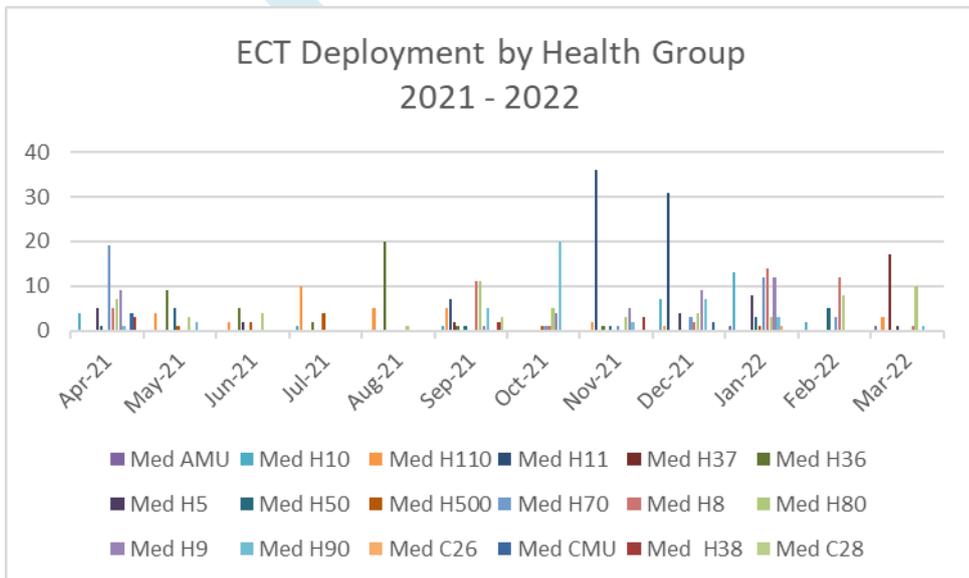
Enhanced Care Team (ECT)

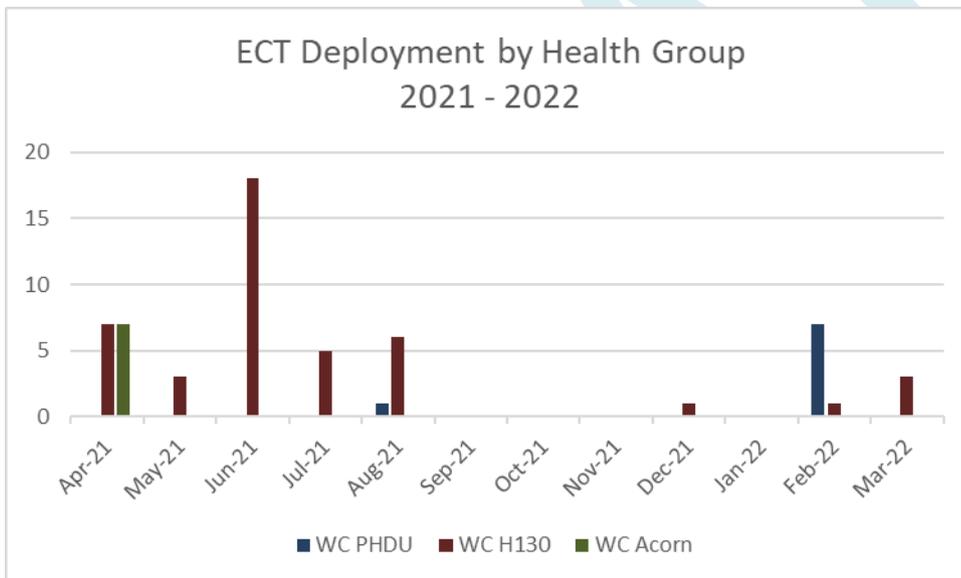
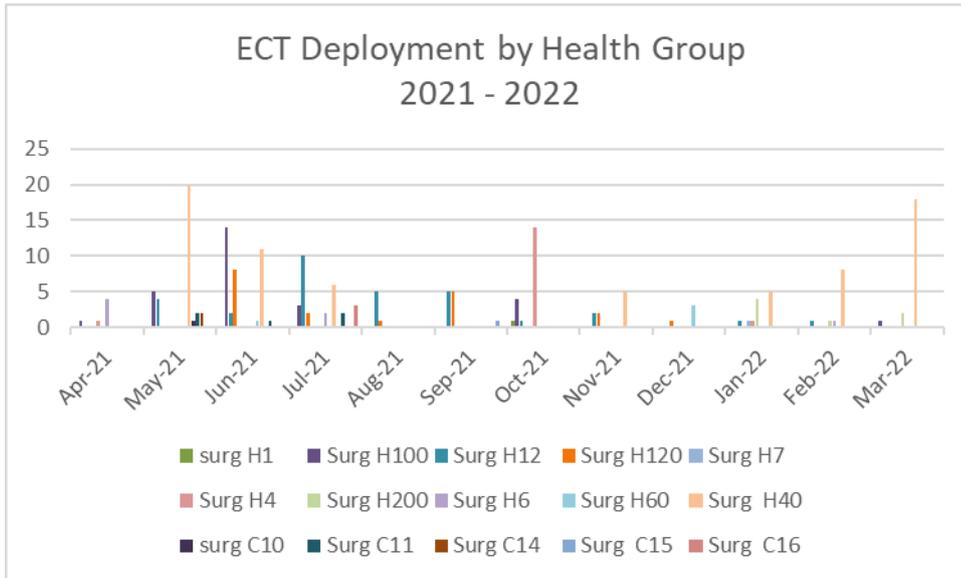
The ECT, provides supervision, support and nursing care to patients identified as Level 4 and 5 who pose a potential or actual risk to themselves and who have been identified as requiring an enhanced level of care and supervision (Security are allocated to Level 5 patients who are at risk to others).

The Health group with the highest use of level 4 support is medicine accessing over 75% of the deployments over the year.

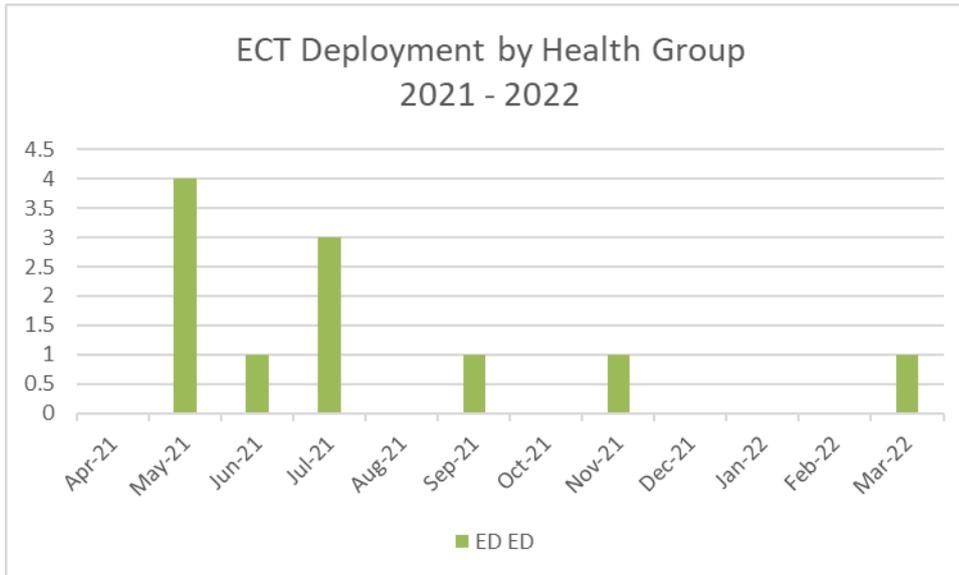


The ECT Matron monitors requests for Level 4 and 5 1:1's, in collaboration with the HUTH Security Team. Data demonstrates that demand often outstrips supply for both level 4 and 5 supervision. Between 30% and 50% of all level 4 requests were unfilled and approximately 25% of level 5 requests remained unfilled. This has a had direct impact on overall staffing within HUTH, requiring redeployment from other areas and the use of Bank HCA's to fulfil the shortfalls.





The ECT Matron continues to collect and monitor data from a number of sources to provide a robust review of ECT usage, budget management and impact on clinical areas. The tables show the redeployment of ECT to each of the Health Groups. Although use is across all clinical areas, significant use has been H4 and H40 for surgery, H70, H9, H90 and H11 for Medicine. This reflects the clinical need of patients in the areas, presenting with Dementia, Brain Injury and altered states of consciousness.



The work of the ECT Matron has led to associated activity to support the needs of complex patients in HUTH. Examples of which are involvement in the Dementia Programme Board, working with the Learning Disability Teams and supporting Serious Incident information requests.

Mental Capacity Act

Work has been ongoing to support and guide staff to ensure patients assessed as lacking capacity are safeguarded. The MCA Lead triages and manages all Deprivations of Liberty safeguards applications to the Local Authorities.

A specific MCA was conducted at the elective PEG insertion during 2021/22 and results submitted to the Safeguarding Committee.

Forensic Service Pilot for Adults at Risk of Harm – Non-Accidental Injury

The Trust has been identified as a partner in the first pilot for an Adult Forensic Service. The pilot project is commissioned by NHSI/E and is being led by the Named Doctor for Adult Safeguarding at the East Riding CCG. The Assistant Chief Nurse worked with the Named Doctor for Adult Safeguarding in ER CCG pre pandemic to facilitate a regional workshop to explore this area and has supported this piece of work since to offer to the Trust to be a pilot trust.

Members of the Safeguarding Adults Team and Tissue Viability Team have undergone training from the Faculty of Forensic Medicine and have supported the development of a project plan for the pilot.

The aim of the pilot is to provide a timely, professional and knowledgeable process to identify, investigate and document any cases of potential non accidental injury in an adult at risk of harm. This will be a mirror of the processes of the children's' safeguarding responsibilities.

The project has gained approval for the project outline and funding to commence the work, from NHSI/E.

To take this forward there will need to be further training and development for a core team of staff and training for key areas to enable them to identify NAI in adults.

5.3.1 Mental Health and Learning Disabilities

A Mental Health, Learning Disabilities and Autism Committee was established in 2020 and continued to meet bi-monthly during 2021/22. The group is made up of staff from all health groups, training and development, patient experience, allied health, dementia team, mental health liaison team, learning disabilities, governance, human resources, information services and the safeguarding teams. The group reported to the Trust Safeguarding Committee in 2021/22. The governance arrangements have changed in 2022 and this steering group now reports directly to the Trust Patient Experience Sub Committee to ensure the issues in this portfolio are at the fore front of discussion.

The committee progressed the MH, LD and Autism agenda during 2021/22 albeit at a significantly slower pace than originally planned. Key priorities included:

- Development of a MH and LD Strategy, with supporting Delivery Framework
- NHSE/NHSI LD and Autism Standards
- Review and progress of NCEPOD Treat Me Well (Mental Health Strategy) for adults and children
- Right Care Right Person (Humber Police Strategy for Mental Health)
- Mental Health Act Detainments
- Suicide Prevention (Humber Coast and Vale)
- Working arrangements with Humber Teaching FT
- Key working arrangements – Dementia, CAMHS, Emergency Department
- Lorenzo reporting arrangements for Mental Health staff
- Mental Health Concordat
- Training and Development
- Mental Health staff support for Safeguarding team
- Homelessness

The group recognises that national priorities for Mental Health, LD and Autism are coming to the fore, especially as a consequence of the pandemic, so the trust will have to be able to meet those challenges as and when they emerge, and this will be led through this group.

The Trust undertook the annual revision of the Service Level Agreement with Humber Legislation Department for Mental Health Support. This provides improved governance and structure to activity, training support and advice. Communication between adult mental health service leads in Humber Teaching NHS Foundation Trust and Hull University Teaching Hospitals NHS Trust has been strengthened. The information related to Mental Health detainments has improved 2021/22 due to regular communications with the safeguarding team, Humber and the trust risk management team. This has resulted in a better understanding on the number of MH detainments within the Trust over identified periods of time. The Named Nurse has been working with Humber Teaching NHS Foundation Trust and the Chief Nurse Information Officer to improve the access for the mental health team to the trusts electronic health records. This has been partially successful with the issues around Information Governance being positively resolved. The licencing of the systems issue has

been resolved but the training for staff from Humber to access the system still appears to be problematic. Work will continue to resolve this issue to enable safe care for patients and compliance with national reporting requests for the trust in 2022/23.

NHSE & NHSI – Learning Disability Improvement Standards

The improvement standards commenced in 2018 and are to reflect the strategic objectives and priorities described in national policies and programmes, in particular those arising from Transforming Care for people with learning disabilities – Next Steps and the Learning Disabilities Mortality Review (LeDeR) programme. Compliance with these standards requires NHS Trusts to assure themselves that they have the necessary structures, processes, workforce and skills to deliver the outcomes that people with learning disabilities, their families and carers, expect and deserve. It also demonstrates a commitment to sustainable quality improvement in developing services and pathways for people with learning disabilities. The standards review aims to collect data from a number of perspectives to understand the overall quality of care across Learning Disability services.

The Trust has consistently been compliant with the vast majority of the benchmarking questions on the year on year audit. There are issues with some strategic and information compliance, particularly around user involvement in service design and identification of patients on Trust waiting lists. There is also lack of information to report to the national team on the number of staff working in the Trust with learning disabilities or autism.

The Mental Health, Learning Disabilities and Autism Strategy will identify these key points as actions, and the Delivery Framework will detail how the Trust will work towards full compliance over the next one to five years.

The Trust has failed to elicit responses for the NHSI/E audit from patients, users or carers since the collections began. It is expected the LD Liaison Nurse postholder will ensure that this will be rectified for the 22/23 census.

Progress will be reported to the organisation through the Mental Health, LD and Autism Steering Group.

Learning Disabilities Mortality Review programme (LeDeR)

The LeDeR programme was commissioned by NHS England in 2015 to support local areas in England to review the deaths of people with a learning disability to:

- Identify common themes and learning points and
- Provide support to local areas in their development of action plans to take forward the lessons learned

There are two specific ways that healthcare professionals may be involved in the LeDeR Programme:

- I. One is with regard to notifying the death of any of their patients with a learning disability.

- II. The other is to input into a review into the circumstances leading to the death, of those aged 4 years and over. This may involve sharing information about a patient who has died or participating in a multi-agency review where knowledge and perspectives in primary care will be of significant importance.

The LeDeR programme is part of a suite of programmes previously known as confidential enquiries. It has approval from the Secretary of State under section 251 of the NHS Act 2006 to process patient identifiable information without the patient's consent.

Service condition 26 of the NHS Standard Contract requires any provider of services to the NHS to participate in the projects within the National Clinical Audit and Patient Outcomes Programme relevant to the Services.

The LeDeR programme strives to ensure that reviews of deaths lead to learning which will result in improved health and social care services for people with learning disabilities. It is not an investigation nor is it aimed at holding any individual or organisation to account. If individuals and organisations are to be able to learn lessons from the past it is important that the reviews are trusted and safe experiences that encourage honesty, transparency and the sharing of information in order to obtain maximum benefit from them.

The Humber LeDeR Steering Group have developed learning briefings with good practice and areas for improvement presented from reviews. These briefings are shared across the patch and are available on the Trust Learning Disabilities web site for staff to access.

Deaths of patients with a Learning Disability that occur within the Trust

All deaths are monitored via the Trust Medical Examiners. Any deceased patients who have had a diagnosed Learning Disability and or Autism are identified for a mortality review. This is a significant improvement on the previous system and enables more timely and accurate information is ready for the reviewer. The mortality manager and the safeguarding team regularly met during 2021/22 to ensure LD patients were being identified following their deaths and supported structured judgement reviews being undertaken by the team for those LD patients.

The Trust is represented by the Assistant Chief Nurse and Named Nurse for Safeguarding Adults at the Hull and East Riding LeDeR Strategic Steering Group and its sub group, where quality assurance reviews are undertaken on all local reports as well as discussing themes and trends that are emerging.

The operational application of LeDeR is managed by the Named Nurse for Safeguarding Adults who provides quarterly update papers to the Trust Safeguarding Committee. The process for reviewers has been changed at a national level and the Trust is no longer required to undertake full reviews. However, during 2021/22 the safeguarding team have been asked to provide case histories on many patients who have died either in the Trust or who have had relatively recent episodes of care with us, for external reviewers. This has been very onerous at times on the capacity of the team. The learning from the reviews are shared with local partners through agreed leads from the Trust, CCGs and other agency leads.

6. SAFEGUARDING ADULTS TRAINING 2020/21

Training and education of staff for Safeguarding Adults, Mental Capacity and Deprivation of Liberty continues to be a high priority for the Trust.

Safeguarding Adults, training is updated regularly and in line with any changes in national guidance or legislation. The training is aligned to the key principles of the local Safeguarding Adult Boards Policies and Procedures.

Safeguarding adults training compliance is shown in the table below:

Compliance (as of 10 th April 2022)	% Compliance Target 85%
Safeguarding Adults Level 1	89.7%
Safeguarding Adults Level 2	85.2%
Mental Capacity Act	84.2%
Deprivation of Liberty Safeguards	82.5%

The Trust is compliant with mandatory training for all staff and has consistently maintained a position of over 80% for Safeguarding adults, Mental Capacity Act and Deprivation of Liberty Safeguards in 2020/21. A new target of 85% compliance was commissioned to commence on 1st April 2021 and the Trust has achieved this in most areas despite the operational pressures that COVID has presented. Training compliance is reviewed and monitored at each Safeguarding Steering Group Meeting and any exceptions escalated to the Patient Experience Sub Committee.

Prevent training was 82.1% and compliant for 2021/22 as over 80%. The education and development and safeguarding teams are working to cleanse the data in 2022 to consider movement of staff and the affects Covid-19 will have on the delivery to this target of 85% for 2022/23.

As well as mandated safeguarding training, bespoke training has been delivered to clinical areas that have identified a need. These areas include have been supported by the Adult Safeguarding team, in particular, H10, H11, H4, C16, H6. Subjects have included Safeguarding Adults, Deprivation of Liberty Standards, restraint, supporting patients with complex needs and the Mental Capacity Act.

ALLEGATIONS AGAINST STAFF

The Trust is under a legal obligation, within the Children's Act, for managing cases where allegations are made about Trust staff that indicate that children, young people or adults at risk are believed to have suffered, or are likely to suffer, significant harm.

The Trust's policy relating to concerns raised against staff CP391 Allegations against Staff was reviewed, amended and republished in November 2021. An addition of an algorithm for the identification, reporting and management of staff who fit the criteria for referral to the Local Allegations Designated Officer at the Hull or East Riding Local Authorities, or who have been referred to the Trust from those officials, has been included for clarity of responsibilities for managers.

The Safeguarding Adult Team has, for the last three years, supported this obligation with identified Senior Designated Officers. The Assistant Chief Nurse and the Named Nurse for Adults have undertaken bespoke training to undertake these roles.

Over the last year the number of referrals have significantly increased and this has prompted the training of two more professionals to undertake this advisory and highly sensitive confidential role.

The ACN will be recruiting and arranging further training to staff from the senior nursing and Allied Health Professional body in 2022/23. The expectation will mean there will be at least eight staff able to take and manage referrals for medical, professional and non-clinical persons via this process. LADO activity will be presented in Safeguarding Adults Annual Report for 2022/23.

7. SAFEGUARDING ADULTS ACTIVITY 2020/21

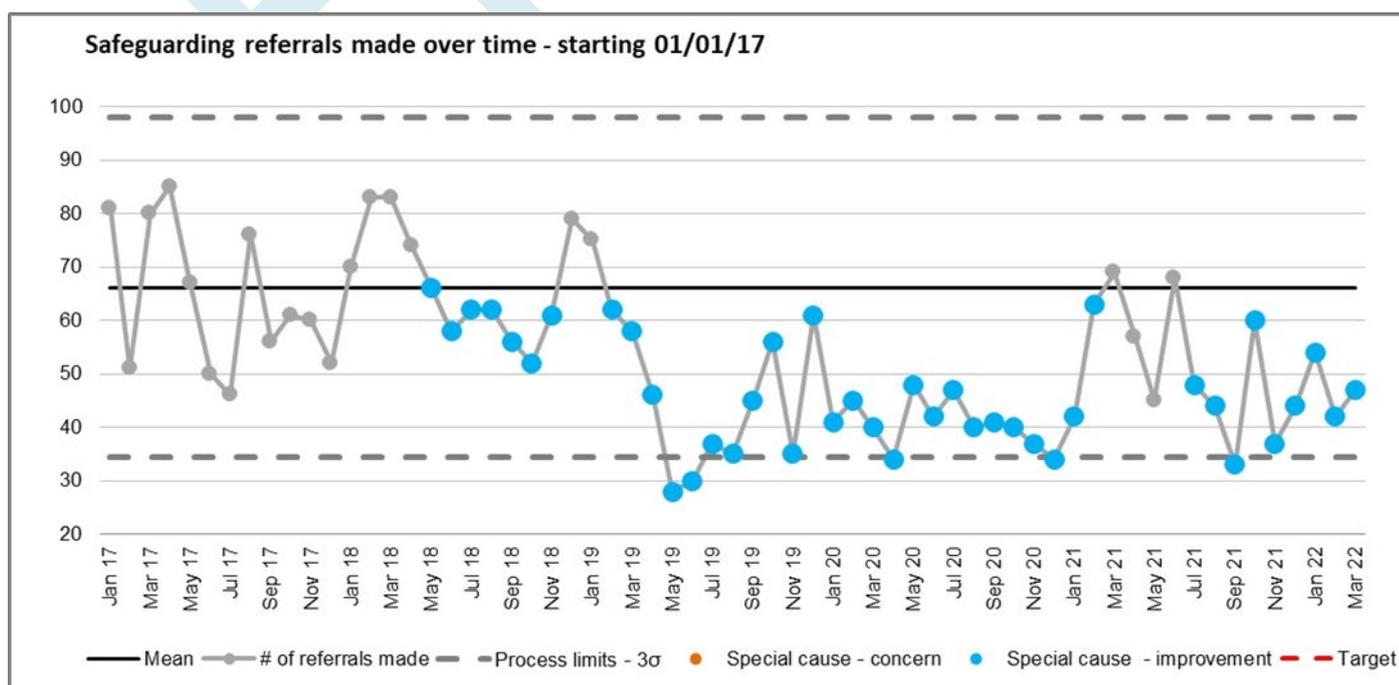
7.1 INTRODUCTION

This section of the annual report 2021/22 provides an update on activity relating to safeguarding and vulnerable adults to provide assurances that processes are implemented and embedded in practice. All data is captured by the Trust’s Compliance Team and the databases are cleansed regularly with regular meetings with the Safeguarding Adults Team. This is to ensure that all referrals are followed up as required and outstanding actions addressed in a timely manner.

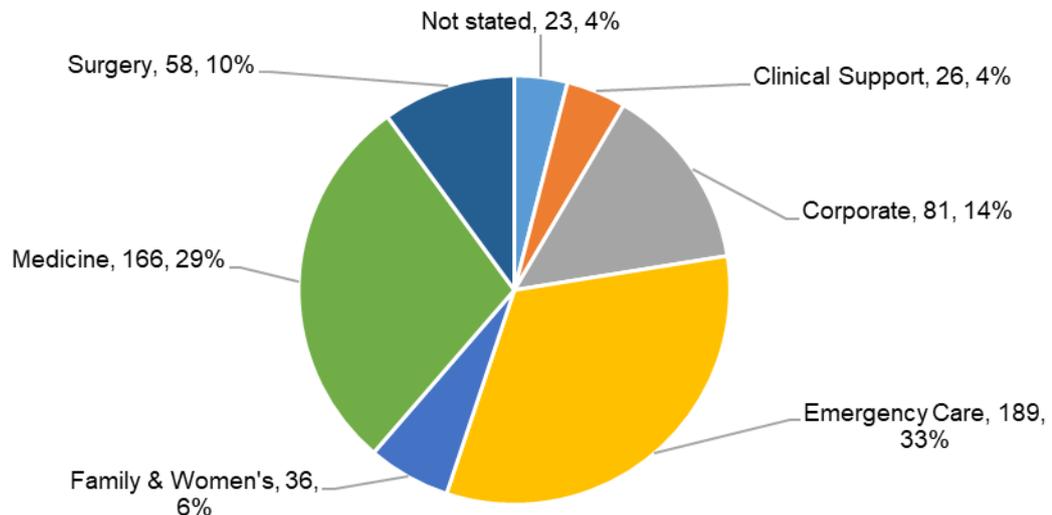
7.2 SUMMARY OF SAFEGUARDING ADULT REFERRALS MADE

7.2.1 Total reported

During 21/22, there were **592** adult safeguarding concerns made. This is a **10%** increase in the number of concerns made from the same reporting period in 20/21 (**538**). The graph below demonstrates the number of concerns made over time from January 2017 up to March 2022:



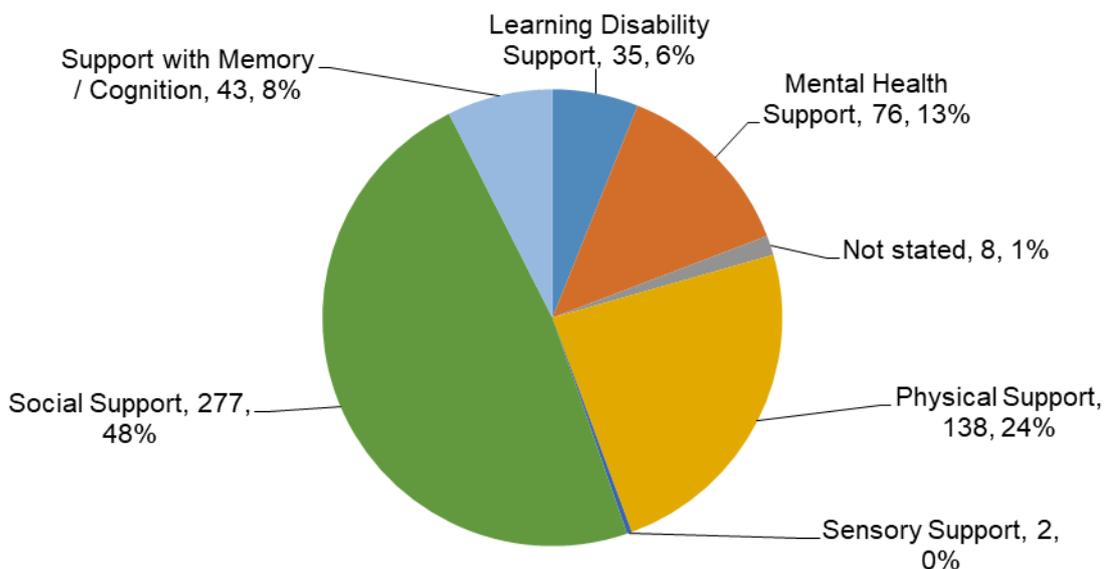
The below graph demonstrates the number of adult safeguarding concerns made by each of the Health Groups during 21/22:



For the year 2021/22, Emergency Services reported the highest number of adult safeguarding concerns accounting for **33% (189)** of the concerns. There was a decrease of **15%** in comparison to **48%** of the reports recorded from Emergency Medicine in the year 20/21.

7.2.3 Concerns Made by Client Group

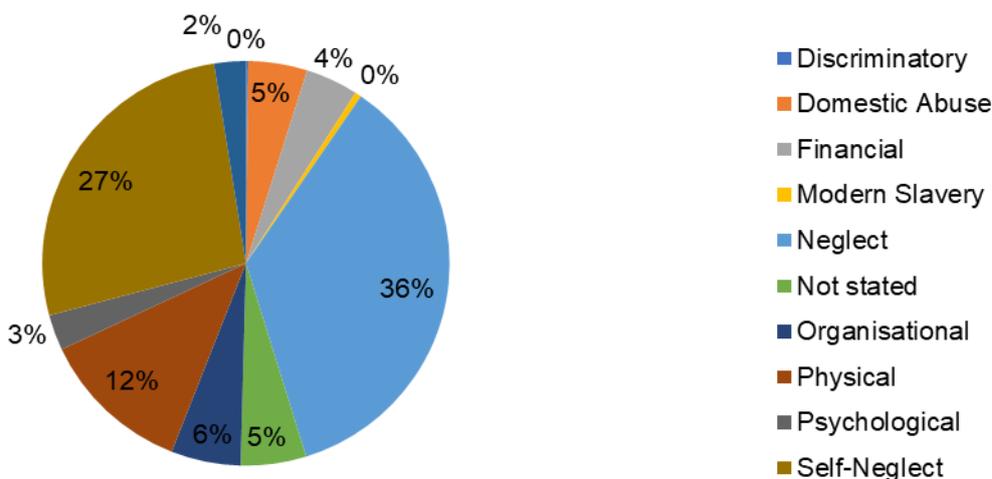
The below graph demonstrates the number of adult safeguarding concerns made during 21/22 by Client Group:



Adult safeguarding concerns around social support was the highest reported client group accounting for **47% (280)** of the **592** concerns reported during 21/22 with slight increase of **4%** from 20/21 (**269**) report on social support.

7.2.4 Concerns Made by Abuse Type

The below graph demonstrates the number of adult safeguarding concerns made during 21/22 by Abuse Type¹:



Adult safeguarding concerns around neglect was the highest reported type of abuse accounting for **34% (202)** of the **592** concerns reported during 21/22 with a slight decrease of **1.5%** from 20/21 (**205**).

7.2.5 Concerns Made – Themes and Trends

On a monthly basis, the Compliance Team review all concerns made and identify the reason why the concern had been made to help identify any themes and trends. Whilst this may not always be apparent and can be subjective, it has provided useful information.

The table below shows the themes and numbers of all concerns made 21/22 and whether there has been an increase/decrease from the previous year:

Topic	20/21	21/22	Up / Down from previous year
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¹ **NB:** The abuse types are selected by the referrer and will not necessarily correspond with the ‘topic’ which is selected by the Compliance Team from a broader range of choices.

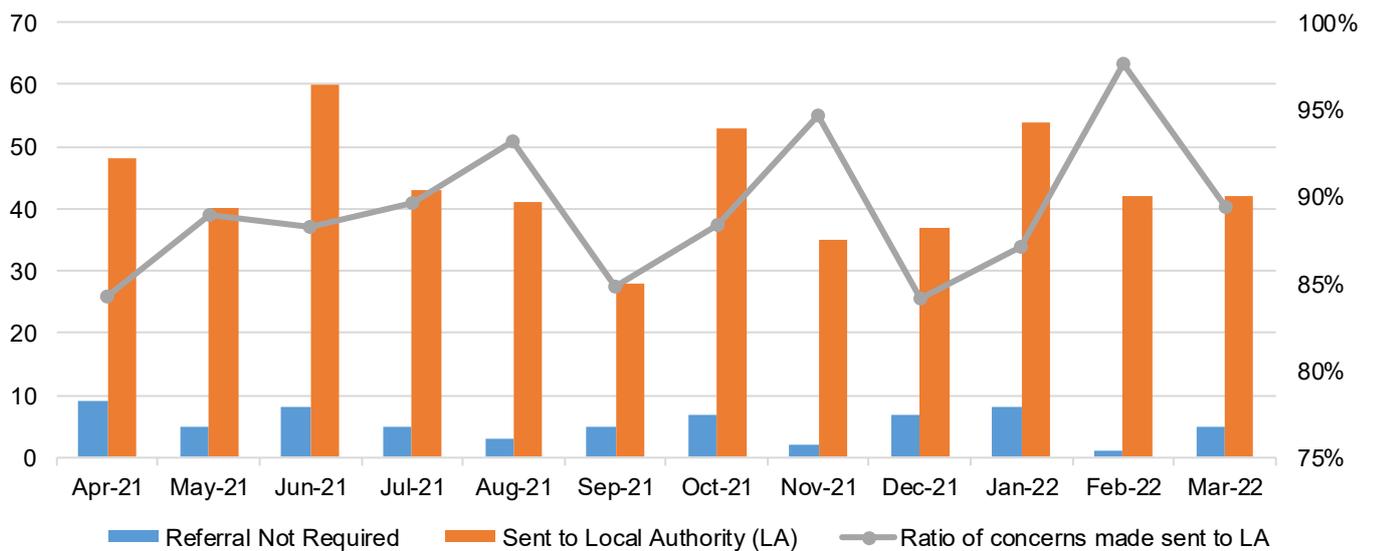
Topic	20/21	21/22	Up / Down from previous year
Accidental overdose	3	1	↓
Alcohol / substance misuse	1	3	↑
Attempted suicide / intentional overdose / self-harm	12	9	↓
Child referral	2		↓
Deliberate Neglect - care home / carer	3	3	↔
Deliberate Neglect - family / partner		3	↑
Domestic Violence / Abuse	47	63	↑
Failure to follow care plans / escalate	2	3	↑
Failure to follow care plans / escalate - medication	2	1	↓
FGM	1		↓
Financial/Self-Neglect/Organisational	1		↓
Financial abuse - carer	1	3	↑
Financial abuse - family	10	15	↑
Financial abuse - friend / neighbour	7	7	↔
Financial abuse - partner	2	2	↔
Financial abuse - unknown	1	4	↑
Financial, physical and neglect	1		↓
General neglect / lack of personal cares	27	17	↓
General neglect / lack of personal cares / Increase in care / support at home / self-neglect	9	31	↑
General neglect / lack of personal cares / Pressure Damage / Deep Tissue Injury - Care Home Acquired	2		↓
General neglect / lack of personal cares / psychology	1		↓
General Neglect / Lack of Personal Cares	1		↓
Homeless	3	5	↑
Hospital - Failure to follow care plans / escalate or treatment delay	1	1	↔
Hospital - medication error	1		↓
Hospital - Other		3	↑
Hospital - Patient Absconded	1		↓
Hospital - physical abuse from Staff Member	1		↓
Hospital acquired pressure damage/ deep tissue injury	8	2	↓
Hospital Fall	3	3	↔
Hospital SI	4	24	↑
Human Trafficking / Modern Slavery Concern	6	3	↓
Increase in care / support at	1		↓

Topic	20/21	21/22	Up / Down from previous year
home / self-neglect			
Increase in care / support at home / self-neglect	155	16	↓
Mental Health / Vulnerable person	29	28	↓
Mental Health/Vulnerable Person	1		↓
Missed appointments	1	1	↔
Neglect	17	66	↑
Neglect / missed diagnosis	1	1	↔
Neglect / organisational	12	50	↑
Neglect / substance misuse	1		↓
Not enough information	3	5	↑
Other	7	25	↑
Patient Absconded	1	3	↑
Physical - unknown	1	7	↑
Physical abuse / assault - family	18	11	↓
Physical abuse / assault - friend / neighbour	2	2	↔
Physical abuse / assault - Health Professional / Nursing home	11	9	↓
Physical abuse / assault - other resident		1	↑
Physical abuse / assault - stranger/unknown	1	5	↑
Physical abuse / domestic abuse	1		↓
Pressure Damage / Deep Tissue Injury	28	26	↓
Pressure Damage / Deep Tissue Injury - Care Home Acquired	27	20	↓
Pressure Damage/ DTI/ Care home acquired	1		↓
Pressure Ulcer/Neglect	1		↓
Psychological / emotional abuse - carer / professional	1	1	↔
Psychological / emotional abuse - family	8	6	↓
Psychological / emotional abuse - other		3	↑
Self-neglect	9	87	↑
Sexual	3	2	↓
Sexual / physical abuse	3	4	↑
Sexual abuse / assault - family	2		↓
Sexual abuse / assault - friend		2	↑
Sexual abuse / assault - stranger/unknown	1		↓
Sexual abuse / assault - stranger/unknown/professional	3	1	↓
Unaccompanied for appointment / admission inc. no	1		↓

Topic	20/21	21/22	Up / Down from previous year
history/information			
Unexplained bruising / marks	2	2	↔
Unwitnessed fall / multiple falls	7		↓
Un-witnessed fall / multiple falls	13		↓
Un-witnessed fall / multiple falls (Hospital)	1		↓
(Blank)		2	↑
	538	592	↑

7.2.6 Total Sent to the Local Authority 20/21

The below graph demonstrates the number of adult safeguarding concerns made by Hull University Teaching Hospitals (HUTH) each month and the number of concerns made that had been sent to the Local Authority (LA):

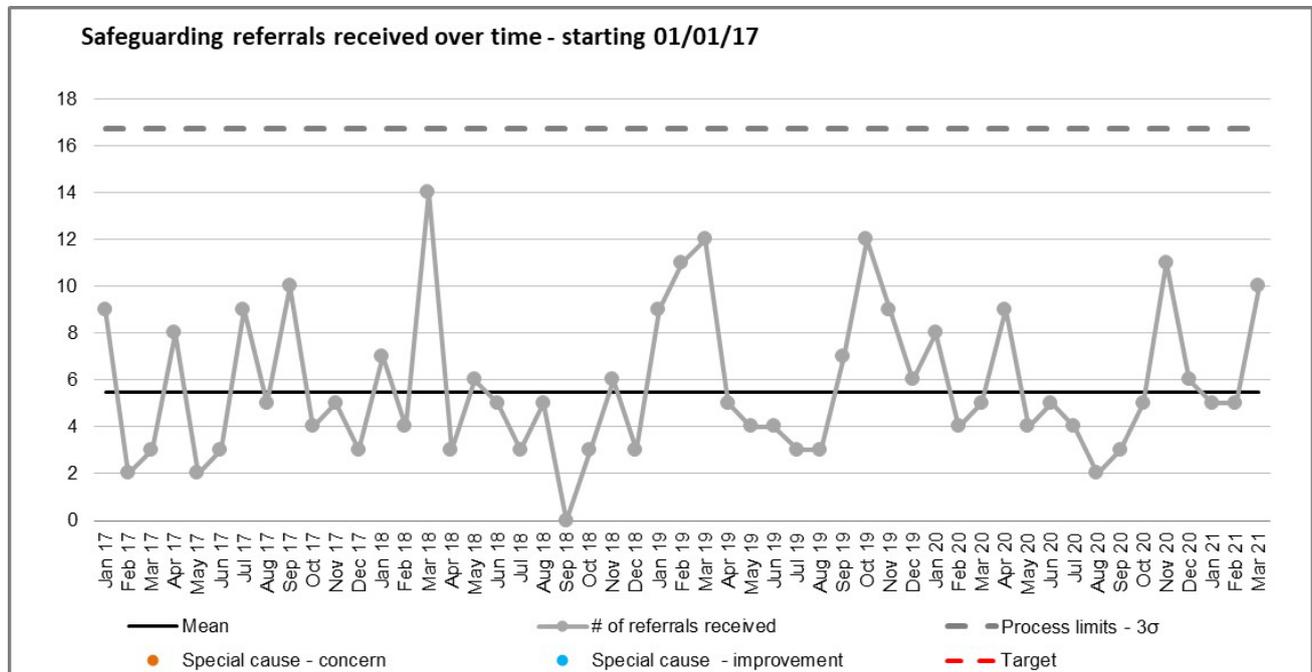


Of the **592** adult safeguarding concerns made during 21/22, **89% (524)** were sent to the local authority. The Compliance Team continues to send bi-monthly requests for updates against open concerns to all Local Authorities as a minimum. Following changes to the process for managing open adult safeguarding concerns, those concerns that have been open for over a year are now closed and the local authority advised accordingly.

7.3 SUMMARY OF SAFEGUARDING ADULT REFERRALS RECEIVED

7.3.1 Total reported

There have been **84** formal concerns made to the Safeguarding Adults Team during 21/22. This is a significant increase of **22%** from the same reporting period in 20/21 (**69**). The below graph demonstrates the number of concerns made over time.

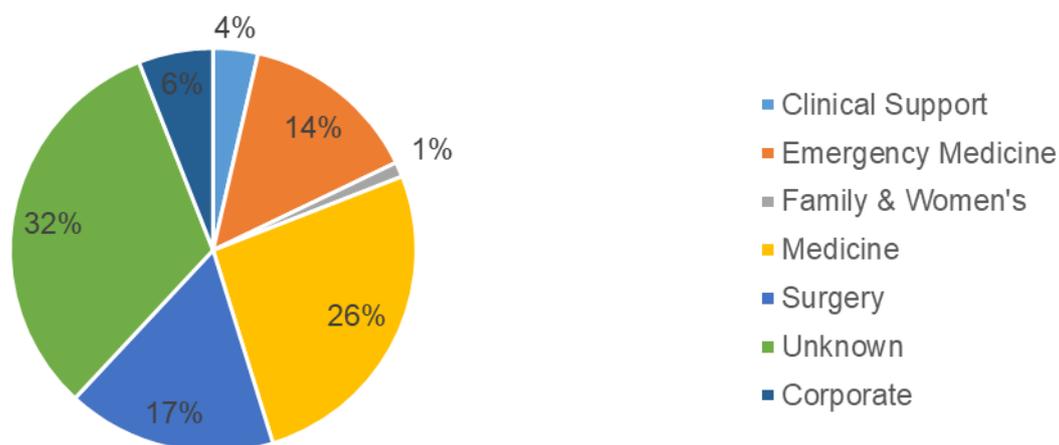


The below table shows of the concerns received and the ratio that required investigation over the last five financial years:

	17/18	18/19	19/20	20/21	21/22
Total Received	74	66	70	69	84
Total met criteria for investigation	38	51	53	51	53
Ratio requiring investigation	51%	77%	77%	74%	63%

7.3.2 Concerns Received against Health Group

The below graph is a breakdown of the concerns received against each of the health groups during 21/22:



Medicine Health Group received the highest number of adult safeguarding concerns accounting for **35% (24)** of the **69** adult safeguarding concerns received during 20/21 with a significant increase of **60%** from 19/20 (**15**).

7.3.3 Referrals Received – Themes and Trends

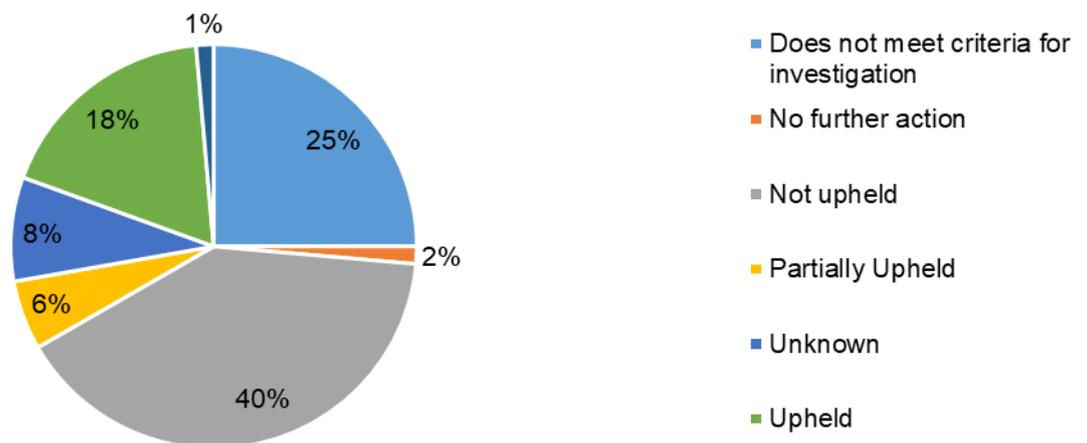
The table below shows the themes and numbers of all concerns received in 20/21 and whether there has been an increase/decrease from the previous year:

Topic	20/21	Up/ Down from previous year	21/22	Up/ Down from previous year
Attempted suicide / intentional overdose / self-harm	1	↑		↓
Care within hospital including neglect	6	↓		↓
Care within hospital including neglect	8	↑	30	↑
Communication / Information		↓	3	↑
Concerns relating to discharge	8	↑	15	↑
Discrimination / lack of treatment	2	↑		↓
Fall	4	↑		↓
General neglect / lack of personal cares	8	↑	6	↓
Hospital - Failure to follow care plans / escalate	3	↑	2	↓
Hospital - medication error	1	↓	5	↑
Hospital - treatment delay	4	↑	7	↑
Hospital acquired pressure damage	2	↑	1	↓
Hospital acquired pressure damage / deep tissue injury	6	↑	2	↓
Hospital acquired pressure damage or deterioration in existing pressure damage		↓	2	↑
Not enough information	11	↑		↓

Topic	20/21	Up/ Down from previous year	21/22	Up/ Down from previous year
Not for Investigation	1	↓	4	↑
Physical abuse / assault	1	↓	2	↑
Self-neglect / organisational	2	↑	1	↓
Unexplained bruising / marks	1	↑	1	↑
Unknown		↔	3	↑
Total	69	↓	84	↑

7.3.4 Outcome of Closed Investigations

There were **72** concerns closed during 21/22. The following graph demonstrates the outcome of the investigations, including how many were upheld²:

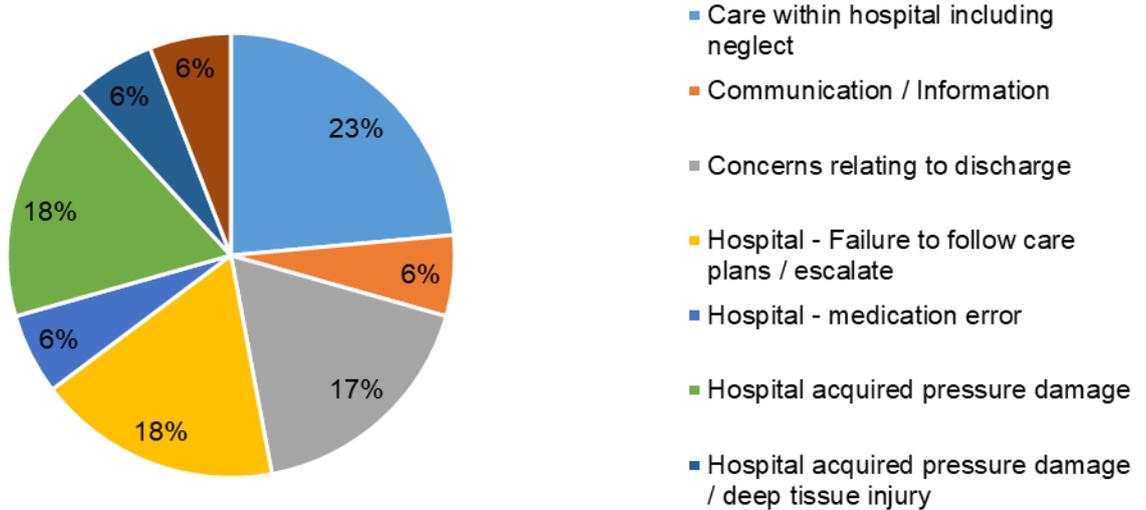


Of the **72** closed concerns received during 21/22, **24% (17)** of the investigations undertaken showed the concerns received as upheld or partially upheld.

7.3.5 Themes and Trends – Completed Investigations

Of the **17** completed investigations that were upheld and partially upheld, **36% (4)** involved hospital acquired pressure ulcers. Common themes around communication and documentation were recognised following investigation. The below table shows the themes of the closed investigations that were either upheld or partially upheld:

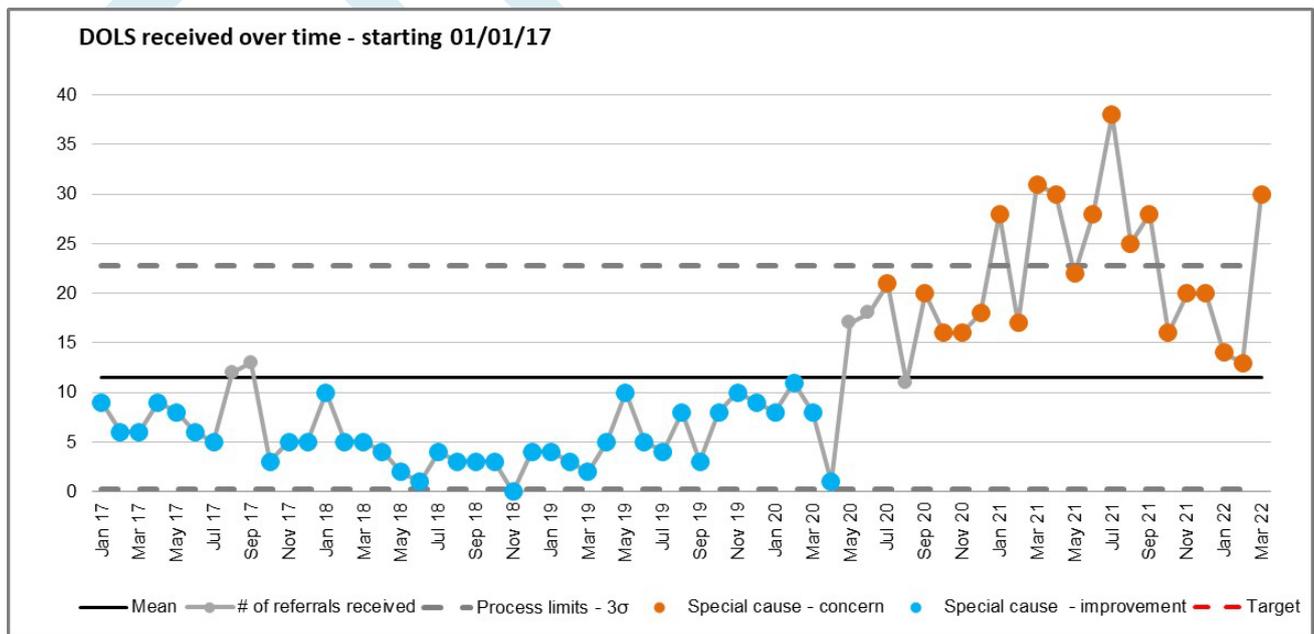
² **NB:** The number of concerns that were upheld for previous years may increase from each report as there are a number of concerns that are in the process of investigation.



The timescale for investigations to be undertaken is 28 working days, this is to allow staff sufficient time to investigate and complete investigation reports (this is an internal timescale). During 21/22, the average number of days for completing investigations for those concerns closed in 21/22 was **60** working days. This is an increase of **22%** from 20/21 (**49**) in average number of working days for completing an investigation.

7.4 DEPRIVATION OF LIBERTY (DOLS) APPLICATIONS

There have been **284** DOLS applications received by the Compliance Team for review and/or action during 21/22. This is a significant increase of **33%** from the same reporting period in 20/21 (**214**). The below graph demonstrates the number of DOLS made over time:



Of the **284** DOLS received during 21/22, **72% (204)** were approved for submission to the relevant local authority. Of the **284** DOLS received during 20/21, **28% (80)** did not require an application to

the local authority. A reason for not sending an application to the local authority or cancellation of the DOLS request includes:

- Insufficient information and/or forms are incomplete
- The request did not meet the criteria
- The patient has been discharged or regained capacity
- The patient had died before the application was approved

7.5 INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) CONCERNS

There were **35** IMCA applications made during 21/22, this is an increase of **105%** from 20/21 (**17**). All **35** applications were processed as per the agreed process by the Compliance Team however engagement with the Local Authority and the Advocacy services remains an area for improvement.

7.6 MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS ALERTS

There were **13** alerts received during 21/22, this is an increase of **30%** from the same reporting period in 20/21 (**10**). The alerts were logged and escalated to the Named Nurse for Safeguarding Adults for action and dissemination.

7.7 INFORMATION REQUESTS

There were **69** formal information requests made during 20/21, this is an increase of **97%** from 19/20 (**35**). All information requests were dealt with and responded to.

7.8 HUMAN TRAFFICKING CONCERNS

There were **6** concerns reported in 21/22 relating to possible human trafficking / modern slavery incidents, this is an increase of **100%** from the same reporting period in 20/21 (**3**). All **6** concerns were investigated and none were deemed to be human trafficking / modern slavery concerns.

7.9 DOMESTIC ABUSE AND DOMESTIC HOMICIDE REVIEWS

There were **96** concerns reported relating to Domestic Abuse (DA) during 21/22, this is an increase of **16%** from 20/21 (**83**).

The below table details the number of safeguarding concerns submitted where the following criteria – ***'Is there a concern about Domestic Abuse'*** had been selected as yes:

	Q1 21/22			Q3 21/22			Q4 21/22			Q4 21/22		
	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Total received	20	9	9	6	4	9	10	5	8	8	3	-
Sent to the LA	16	8	7	5	3	9	8	5	7	8	3	-
Not sent to the LA	4	1	2	1	1	-	2	-	1	-	-	-
Concerns sent to the IDVA	7	3	1	3	1	3	5	4	4	1	1	-

	Q1 21/22			Q3 21/22			Q4 21/22			Q4 21/22		
	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Consent: Yes	15	5	4	5	1	5	6	3	5	6	2	-
Consent: No	4	4	4	1	2	4	3	2	3	2	1	-
Consent: Not stated	1	-	1	-	1	-	1	-	-	-	-	-

7.10 DATIX INCIDENTS

As per Trust policy, all safeguarding concerns made should have a corresponding incident reported on Datix and all safeguarding incidents reported on Datix should have a corresponding safeguarding concern made. The Compliance Team monitor both of these aspects and report on them within the monthly escalation reports.

7.10.1 Concerns Made Without a Corresponding Datix Incident

In 21/22, there were **27** concerns made without a corresponding Datix incident recorded accounting for **5%** of the safeguarding concerns submitted.

7.10.2 Datix Incidents Recorded Without a Corresponding Safeguarding Concern

In 21/22, there were **76** incidents reported without a corresponding safeguarding concern. In order to mitigate these numbers of incidents reported without a safeguarding referral, the Compliance Team have implemented a number of actions on a monthly basis to inform and remind staff of the requirement to complete the online concern form in addition to recording the incident on Datix. An email is sent to all Matrons with details of those incidents which require review and action as well the inclusion of this list on the Health Group Governance Briefing Reports and the Safeguarding Adults Escalation and Information report.

8.0 SAFEGUARDING ADULT REVIEWS

The Trust has participated in several Safeguarding Adult Reviews during 2021/22 for both Hull and East Riding Safeguarding Adult Boards.

Not all of the investigations are published; this is the decision of the Safeguarding Adult Board. The learning from these cases is fed back to the Trust Safeguarding Steering Group.

9.0 KEY ACHIEVEMENTS IN 2021/22

A list of key operational and strategic achievements is stated as follows:

- A satisfactory review of Safeguarding Adults by NHSE/I regional safeguarding lead – no compliance issues raised during the inspection undertaken in early 2020 or areas of concern.
- Positive feedback from NHS Hull and East Riding Clinical Commissioning Groups about the governance and progression of Safeguarding Adults agenda items.
- Seconded appointment for vacant post - Learning Disability Liaison Nurse.

- The Dementia Nurse post has been reassigned as a corporate role under the management of the Assistant Chief Nurse / Safeguarding Lead. A secondment has been filled for this post due to a reorganisation in the medicine health group.
- ECT Digital assessment embedded in practice within Castle Hill site.
- The implementation of the revised Mental Health Legislation Service Level Agreement improving the provision of MH training and data sharing.
- The consistent training compliance of over 85% for Safeguarding Adults, Mental Capacity, and Deprivation of Liberty Safeguards and 80% compliance for Prevent Health Wrap.
- Positive feedback from Hull and East Riding Safeguarding Adult Board Managers and Chairs regarding the Trust arrangements for Safeguarding Adults.
- Established and positive partnership working with a range of external agencies to improve the care and treatment of patients with vulnerabilities including those under detention.
- The ratification of a Trust Domestic Abuse Policy for Patients and Visitors. This includes a plan to introduce Routine / Selective Enquiry across the organisation over the next three years with a revised start date of 2021/22 due to reduced capacity of the trust services from Covid-19 plans.
- The Trust signed up at executive level for implementation of the Hull Strategic Domestic Abuse Minimum Standards. The trust is working with all statutory and local partners to ensure accordance with these standards and is in the process of developing a trust wide domestic abuse working group to support the implementation and development of these standards and national guidance.
- The Trust continues to have access to the Independent Domestic Abuse Advisor (IDVA) for part of the year as an in-reach service provided by the Hull Community Safety Partnership. However, since wave one of the pandemic, the practitioner has not been able to physically attend the trust therefore the safeguarding team have had access to the Hull Domestic Abuse Partnership practitioners remotely when needed. This did affect the opportunities for patients to have direct access to the IDVA but the safeguarding team for the trust ensured victims were supported in other ways if they consented to that support.
- Supported the Learning Disabilities Mortality Review (LeDeR) programme with staff from the Trust undertaking reviews at the request of Hull and East Riding CCG Local Area Contact. The trust continued to support the programme with reviewers until the second wave of Covid. At that point, the trust had to suspend all offers of support to these in-depth reviews due to clinical commitments of the staff. The trust safeguarding team did support external reviewers in providing access to information, including medical records (within the GDPR arrangements), Structured Judgement Reviews and other LeDeR related information. Prior to the suspension of reviews, the trust completed five full reviews for the Hull and East Riding programme.
- Continue to review, revise and enhance the processes and governance of the LeDeR programme with partner agencies and commissioners.
- Progression of the work in the Task and Finish Group to implement the Learning Disabilities and Autism national standards that have been identified for action. This work has also been affected by the capacity of staff during the pandemic
- A third-year return for the NHSE/I LD and Autism Benchmarking Improvement Standards annual review.
- Continue to review how to improve feedback to referrers on the quality of the safeguarding referrals raised.

- Embedding of feedback and recording of submitted concerns made by clinical staff. Developed a more robust recording process in the safeguarding team to reflect the calls for support and advice from clinical staff. This identified the rise in domestic abuse calls from staff about patient victims that did not always result in a formal concern being raised.
- Following triage of safeguarding adult concerns submitted by clinical staff by the safeguarding adult's team, a more accurate categorisation of the abuse categories is being reported to the trust via the safeguarding committee.
- Led on multiagency strategic meetings for complex needs patients.
- Continue to raise awareness of MAPPA patients and the need for robust risk assessment plans for individuals who pose a risk to public.
- Implementing a process for identifying patients who are detained by the judicial system and the requirement to undertake robust risk assessments to ensure patient, public and staff safety.
- The Safeguarding Fundamental Standards were reviewed with the questions being amended to reflect and higher standard of understanding of both adult and child safeguarding procedures and safety mechanisms from all clinical areas where these audits are undertaken. Due to Covid restrictions it has not been possible to fully test out these changes in all areas but in the areas that have been audited, there has been positive results that can give some reasonable assurance to the trust board that staff have a good understanding of their safeguarding obligations.
- Updates and compliance with Policies and Procedures in line with review dates and changes required.
- Two members of the safeguarding team have undertaken training in Forensic Aspects of Adult Safeguarding. This initiative to offer the same oversight of non-accidental injuries in vulnerable adults as in children was developed by the Assistant Chief Nurse and the Named Doctor for Safeguarding Adults in the East Riding CCG. The concept has been championed and supported by the NHSI/E North Safeguarding England team with regional training delivered in January and February 2021. There is to be a pilot of this initiative which will only include the Humberside health providers.
- Worked with the Lorenzo development team to provide an integrated reporting system for safeguarding adults concern and MCA/DoLS forms.
- Supported the mental health liaison service to secure access to Lorenzo to enable more timely and accurate recording of assessments and care plans for patients with mental health issues in the trust.
- Initiated an audit for trust compliance with mental health section 5.2 responsibilities. Identifying staff training needs for mental health act decision making and supporting opportunities for this training in the HUTH workplace, improved monitoring, reporting and legal compliance with all mental health detentions.
- The representative from Humberside Police reported back to the Trust that the work between the Safeguarding Adults Named Nurse, the Emergency Department and the care provider for the Hull police custody suite for immediate electronic discharge information, had been reported at the north of England Chief of Police forum, and had been held up as an exemplar in transfer of care arrangements. Other forces have been instructed to implement a similar procedure for their custody suites.
- In February 2022, the Safeguarding Adults Team and the Named Nurse for Safeguarding Adults in particular, was nominated for a Moment of Magic. The team were thanked for all their support and advice.

10. KEY ACTIONS FOR 2022/23

The Trust has identified a number of actions required to strengthen the Safeguarding Adult's service. Actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Adult's Board activities and from the lessons learned from Case Reviews

A summary of work planned in 2022//23 is as follows:

Domestic Abuse	<ul style="list-style-type: none"> • Continue roll out plan for Routine/Selective enquiry in identified areas of the Trust, including staff training. • To gain White Ribbon UK Accreditation to support ending men's violence against women. • To seek Domestic Abuse Champions to champion the subject of domestic abuse within the Trust, as part of the Hull and East Riding Domestic Abuse Partnership Boards strategic plan, of which HUTH is a key partner.
Training and Development	<ul style="list-style-type: none"> • Ensure the continuation of implementation of Intercollegiate Level 3 safeguarding adults training, phases two and three, and across professional groups in the trust is embedded within the organisation in line with the Training Needs Analysis. • Aim to reach 85% within two years (2021/23) of introduction of the training package for level 3 safeguarding adults training to comply with commissioning arrangements • Review of the Prevent Health Wrap Training Plan and in line with the changing national requirements and guidance.
Enhanced Care Team	<ul style="list-style-type: none"> • To review service model in light of audits, service requirements and business intelligence. • Review 1 year seconded band 6 post with a view to permanency. • Improve quantitative and qualitative data collection to inform service development. • Audit delivery of new model. Repeat audits of ECT documentation and continue to improve in light of findings. • Support the Digital Team in rolling out ECT Nerve Centre assessment tool in HRI.
Learning Disabilities	<ul style="list-style-type: none"> • Include the Learning Disabilities and Autism NHSI/NHSE national standards results into the Mental Health and Learning Disability (Trust) Strategy, to enable compliance with actions identified from the 2018, 2019, 2020 and 2021 benchmarking exercises, where possible and to produce justifications where compliance is not achievable • To undertake the fifth LD and Autism benchmarking audit when it is available in 2022 • To continue to host and support the LD Liaison Nurse in the role. • Provide detailed activity profiles for patient interventions (LD and Autism) to identify pressure points and any increases in the needs of the service for this patient group. • To review the model of the LD Liaison Nurse with East Riding and Hull Commissioners (as detailed within the MH and LD strategy), to enable

	<p>patients and families in need of are identified and supported whilst in the Trust.</p> <ul style="list-style-type: none"> • Maintain the Mental Health and LD Steering Group and deliver on the agreed programme as described in the Mental Health, LD and Autism Strategy 2022-2027. • To continue to support the LeDeR process and continue to support the local and regional multiagency teams in this programme. • To ensure the Learned Lessons from local and national LeDeR reviews are regularly shared, discussed and actioned with HUTH staff. • To review the training needs analysis and action plan for LD and Autism training in preparation for mandatory training status to be implemented by the national team.
Mental Health	<ul style="list-style-type: none"> • To enable the Mental Health Liaison Team and AMHPS (Approved Mental Health Professionals) to have full access to the trusts Lorenzo electronic medical records system. • Scope and develop a business case for Mental Health Practitioner to enhance the safeguarding team and support patients who have mental health needs. • Identify 'Champions' for MH from the Medical teams in key health groups to support patients and staff with complex issues. • To launch the MH, LD and Autism Strategy in the Trust and finalise the delivery framework/action plan.
Electronic Solutions	<ul style="list-style-type: none"> • The safeguarding team to work with the Lorenzo team to progress the development of electronic recording of safeguarding and MCA records and referral system • Work with the Chief Nurse Information Officer and the IT team to review and advise on the development of the electronic nursing IT tool, and safeguarding / LD /MH electronic care plans. • Develop a survey for capturing internal feedback about the Trusts Safeguarding Service • Develop an audit tool to review the quality of concerns received from staff and undertake at least one meaningful audit. Results to be shared with safeguarding committee members and actions agreed dependent on the results, and disseminated within the health groups for implementation.
Mental Capacity Act	<ul style="list-style-type: none"> • Develop and implement a tool for monthly auditing of Deprivation of Liberty applications, to review quality and compliance to the code of practice • MCA lead to establish a HUTH Liberty Protection Safeguards working group to support the transition from DoLs to LPS • MCA lead to establish a Restrictive Practice Working group to work towards CQC compliance with Restraint Reduction Network (RRN) standards • The MCA lead to design and implement an audit to evaluate the use of the Act in emergency and elective admissions

Other	<ul style="list-style-type: none"> • Resume partnership working with the Humber Modern Slavery Partnership following its pause due to Covid-19 and report progress, including the development of the multiagency information sharing agreement, into the Safeguarding Committee. • Review the results of the revised Fundamental Care for Safeguarding Adults and Children audit tool to ensure successful implementation and improved knowledge base for staff. • Review the capacity and structure of the Safeguarding Adults Team. • Monitor and update the Safeguarding Adults and Children's' Operational Delivery Plan, and report to the Trust Board twice a year via the Quality Committee. • LADO/SDO – to recruit and train 5 senior trust staff to undertake the role of SDO, to support managers and staff through this process, liaising with external agencies as part of the process. • Review and update policies as required
Forensic Project for Adults at Risk of Harm	<ul style="list-style-type: none"> • To support, contribute and participate in the Pilot Process of Forensic Examination of Adults at Risk of Harm who present with suspected non-accidental injuries • Identify a cohort of appropriately trained staff who will undergo specific training and development to enable them to provide a service at the level required for this NHSE/I project

Special thanks and recognition to Mrs Christine Davidson, who retired in July 2022 after working 47 years in Hull NHS Trust. Her work and leadership for the Safeguarding Adults agenda internally and externally has been significant and has enabled the Trust to achieve so many positive improvements in Safeguarding Adults over the past eight years.

11 REPORT END

Report Author: Kate Rudston, Assistant Chief Nurse and Trust Safeguarding Lead

- Christine Davidson, Named Nurse Safeguarding Adults,
- Rachel Hoggarth ECT Matron and MCA lead
- Jayne Wilson, Safeguarding Specialist Nurse/Acting Named Nurse Safeguarding Adults
- Kelly Northcott-Orr, Compliance Officer
- Ben Greenwood, Education and Development.

With thanks to report contributors:

Date: July 2022

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

**SAFEGUARDING CHILDREN &
YOUNG PEOPLE**

ANNUAL REPORT

2021 – 2022

FEMINIA

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FINAL

1. PURPOSE

The purpose of this Annual Report is to inform Trust Board Members of the progress with regard to its responsibilities for Safeguarding Children and Young People. The report will identify Safeguarding Children and Young People activity within the Trust over 2021/2022, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2022/2023.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities (section 11 Children Act 2004) to safeguard the best interests of children and young people that access its services and premises.

Safeguarding children referrals by Trust staff are made to a range of Local Authority Children's Services in the locality of the child's home address. Safeguarding referrals for children to both Hull and East Riding Local Authority Children's Services in 2021/2022 continue to decline and remain much lower than previous years. In comparison, unborn referrals have shown a steady increase to levels above the average for the organisation. It is difficult to accurately account for this variation but factors that appear to have influenced activity include the development of improved pathways for communication with Children's Social Care and targeted audit activity related to thresholds and referral quality.

In addition, the Assistant Chief Nurse has been instrumental in leading discussions with the maternity leadership team in regards to the context of safeguarding children/unborn at risk and safeguarding supervision systems and processes. These meetings have been crucial to improve the links between services and understanding of the need to have robust systems for reporting safeguarding activity across maternity services.

The positive impact of these changes can be evidenced by the increase in early help referrals utilising the thresholds of need assessment and the decrease in number of inappropriate contacts, which do not progress to assessment by a social worker.

The effects of the COVID-19 Pandemic have affected everyone, for many these effects will be long lasting with exacerbation of risk and vulnerability for children in our communities. This year has seen a sharp increase in reports of Domestic Violence and Abuse within the home setting, cases of neglect and physical harm and complex mental health conditions which have required prolonged hospital admissions. In addition, the ongoing effects of the pandemic have had a direct impact on the delivery of most core NHS services including safeguarding activity. Staff shortages due to the requirement for isolation had a direct impact on service provision, delivery and attendance of safeguarding training, supervision and overall safeguarding activity within the Trust.

Although the Safeguarding Children Team / Child Sexual Assault Service business continuity plan was not activated there were concerns regarding the risk to service delivery of reduced staffing, both Medical and Nursing. This report will provide details of the measures that were taken to reduce safeguarding risk and ensure that individual staff members and the Trust were able to fulfill their responsibilities under Section 11 of the Children Act 2004.

Service provision for Child Protection Medicals/CSAAS continued as normal following Health and Justice Guidelines in relations to the use of PPE.

SAFEGUARDING CHILDREN AND YOUNG PEOPLE

2021/2022 has been a challenging year for Safeguarding Children activity across all organisations. There were expectations that the COVID restrictions that impacted on children and service delivery in 2019/2020 would have been lifted with a return to near normal pathways and processes. This was not the case as infection rates remained high and restrictions needed to stay in place.

Both Maternity and Paediatric services faced unprecedented levels of staff absence and sickness, in addition to difficulties filling vacant posts. From a safeguarding children perspective this led to some necessary changes in process, as prioritisation was required to ensure children's/unborn immediate health and safety needs were met. Unfortunately, there was a negative impact on attendance at safeguarding meetings including case conferences, core group meetings and strategy discussions.

Processes were put in place within the organisation to reduce risk including ensuring completion of a report where attendance was not possible, utilising staff who were home based to undertake the meeting via Microsoft teams software and close liaison with the Local Authority and Safeguarding Partnerships regarding the difficulties being faced within the organisation and the plans which were in place. This remains an active risk on the Family and Women's Health Group risk register.

Additional challenges facing staff in the organisation during this time were related to the changes in communication pathways as safeguarding partners were partial office and home based. The identified risk related to difficulties for staff with both information gathering and sharing. The Safeguarding Children Team continued to provide a high level of visible support to help identify concerns and provide support at an early stage. This included daily morning telephone contact with paediatric departments and maternity services and regular planned ward rounds which provided an opportunity to undertake adhoc supervision and review all safeguarding cases. In addition, the team was able to utilise secure emails to ensure there was appropriate sharing of safeguarding information, risks and concerns. These processes ensured that staff were supported with information sharing and decision-making in order to minimise risk.

On a positive note, the practice of attending remote safeguarding meetings has now become standard practice with all practitioners having good access to IT equipment. This has meant that staff who previously may not have been able to attend meetings could do so flexibly either at work or at home. This has opened up attendance at safeguarding meetings to a wider range of professionals thus improving communication pathways and information sharing. These changes have helped to ensure throughout this period that the organisation was able to evidence and meet its Statutory Section 11 responsibilities.

The expansion of the use of Trust Information systems provided robust systems for analysing data and identification of potential risk. This including setting up Business Intelligence (BI) reports for children who were inpatients on adult wards and those children who had remained inpatients for over 90 days. This information has been utilised by the Safeguarding Children Team to provide safeguarding support to staff where safeguarding children processes are not at the forefront of their practice.

Both East Riding and Hull Children's Social Care continued to be subject to improvement activity following Ofsted inspections. The improvement plans included the requirement for improved information sharing processes and involvement of health with decision-making. The Assistant Chief Nurse (Trust Safeguarding Lead) and Named Nurse, Safeguarding Children have worked closely with the Local Authority's on both a Strategic and Operational

level to support and develop processes and pathways which have ensured there are improved avenues for communication/information sharing and escalation.

The Trust's Named Professionals and the Safeguarding Team continue to strengthen the safeguarding children arrangements in the Trust working with the Safeguarding Adult Team to ensure a holistic approach to safeguarding across all ages groups including adults at risk.

The Trust continues to meet its statutory obligations in terms of having the required Named Nurse, Interim Named Doctor and Named Midwife in post. Governance structures for the Local Safeguarding Children Partnerships for Hull (HSCP) and the East Riding (ERSCP) have become well established with HUTH Safeguarding leads and Named Professionals being highly visible and forming an integral component of the partnerships. As an organisation, HUTH is prominent and has a voice within the new structure. This has included regular attendance at strategic partnership forums.

The Child Sexual Assault Assessment Service (CSAAS) has undergone some significant changes. This has included staff changes as the long standing Child Protection Administrator retired and new staff came into post. Pathways and processes were reviewed in response to a reduction in the number of requests for Child Protection Medicals. This was the first decrease of numbers seen in the service in a five-year period. The review identified that there was a lack of understanding in the wider safeguarding partnership of the purpose of a Child Protection Medical and the benefits for the child and family. There was a focus on the forensic requirements, which is only part of the services that are provided by the team at the Anlaby Suite.

Extensive work has been undertaken to promote the service in order to increase the number of children who are referred and able to access the specialist team. This includes the development of a multi-agency CSAAS/CP Medical Review Group, chaired by the Named Nurse. An operational group including representatives from across the Humberside region to support the review and update of the referral pathway and processes and benchmarking exercises with both local and National CSAAS services.

This has led to the development of RAG rated action plans with short and long-term goals. 2022/2023 will see a communication strategy in place, which includes new and improved patient leaflets and improved web content including a promotional film of the Anlaby Suite. Stakeholder engagement and training have increased, as this is key to ensuring the success of the service.

Following on from last year's annual report progress against the key actions for 2021/2022 are:

2.1 KEY ACHIEVEMENTS AND OUTCOMES:

- In order to strengthen the communication between the Local Authorities and the Trust we have improved our links with external safeguarding partners. Trust safeguarding leads and named professionals are members of key strategic forums within the new partnership structure providing an opportunity for effective two-way communication. The links which have been established are now fully embedded with HUTH having a high level of credibility and visibility.
- To progress the recruitment to the Named Doctor for Safeguarding Children. Despite the restriction of COVID the post of Locum Consultant Paediatrician has become well established in practice. The job description and plan have been completed and it is anticipated that this will be advertised during the next financial year.
- We have continued to review safeguarding arrangements for children who are admitted to adult wards/departments in order to strengthen pathways and processes for sharing

information and searching support. This has included establishing systems including a BI report to identify children who are admitted to adult wards. Both the Children and Adult safeguarding teams provide contact and support either by telephone or face to face if this is required.

- We have continued to support the roll out programme of Domestic Abuse training. A DA subgroup has been established within the organisation with representatives from all health groups. This has provided a conduit to promote and drive training and improve the sharing of DA information across the organisation.
A mapping exercise forms part of the safeguarding team's activity with regular review of progress and action planning.
Domestic Abuse (DA) training for staff relevant to their role - E-Learning DA and Routine Enquiry modules is being delivered as part of a roll out programme across the organisation.
- We have reviewed the Safeguarding referral process within the Trust. This has required close partnership with the Hdigital and Change Management Team to develop a plan for implementation of the electronic safeguarding referral portal within the organisation. Processes have been reviewed with the Local Authority and Designated Nurses. Agreement was reached with a long-term plan for integration with the electronic referral portal. A briefing paper has been presented to the strategic EHASH board
- There has been an ongoing review for the Child Sexual Assault Assessment Service (CSAAS). This has included Humberside wide Director level communication related to service improvements and established senior level multi-agency CSAAS review meetings. There has been a drive to strengthen operating procedures and accountability around forensic medicals in order to ensure future service provision. This remains a key focus for 2022/23
- Continue to develop the governance, pathways and quality assurance process for the Child Sexual Assault Assessment Service (CSAAS) – Significant work has been undertaken within the service and with partners. This been presented to the Trust safeguarding committee and at NHSI contract meeting with positive feedback form the changes.
- Continue work in strengthening multi-agency links for the CSAAS and Child Abuse Medical Service -The Named Nurse chairs a multi-agency CSAAS review group, which includes members of the senior leadership teams from the Police, LA and Health. Strong links are in place across all services with a rolling training programme to support increased knowledge and understanding of the service.
- Support the implementation of the ICON programme in Maternity services – ICON is now established within maternity services
- Safeguarding children policies and procedures are up to date.
- HUTH was at the forefront in the partnership discussions related to Section 85/86 (children accommodated by health authorities and local education for more than 12 weeks). This included a review of local processes and creation of a new Policy CP430 for children resident in hospital for over 90 days – Development of a BI report, Trust Policy and Partnership procedure to identify and appropriately refer children.
- Creation and submission of a monthly quality report for Children and Adult Safeguarding activity which is presented to the Trust Quality Committee as part of the Quality Report.
- Joint submission of weekly data to the Chief Executive and Chief Nurse regarding Children and Adults who have mental health concerns and there is delayed discharge once medically fit.
- Review of processes with the Enhanced Care Matron related to restrictive practices in the care of children and young people. This includes development of a new policy (CP431) a training needs analysis and training plan for the Paediatric and Safeguarding Children team.

- The delivery of Suicide awareness training. This was funded by Hull City Council and delivered by MIND and Papyrus and has been delivered to staff across the organisation who come into and contact with children and young people.
- Safeguarding support provided by the Named Midwife to aid the successful implementation and delivery of the ICON programme (coping with crying babies) within the Trust.

KEY ACTIONS CONTINUING INTO 2022/23

- Safeguarding Supervision arrangements have been strengthened in line with the Trust Safeguarding Supervision Policy (CP341) to ensure that all Trust staff who have a safeguarding concern can access planned and/or ad-hoc safeguarding supervision. Staffing issues has led to a reduced capacity for safeguarding supervision within Paediatric and Maternity services. This will continue to be a key action for 2022-23 as this needs to be fully embedded in practice.
- Review and expand the use of a CSE /CCE risk assessment tool within the organisation to identify risk. The Named Nurse attends the Intra and extra familial risk groups and the Rape and Serious Offences Service Improvement group (RASSO). Although work has been delayed within the organisation to introduce a risk assessment tool to maternity services this has provided an opportunity to review the tools available nationally with a plan to pilot other CSE/CCE tools during 2022-23.
- To continue to raise awareness and assessment/identification of children that access Trust services and who may be at risk of Child Sexual Exploitation (CSE) and extend this to those children at risk of Child Criminal Exploitation (CCE) 'County Lines'. Additional training and updates are being provided through 'hot topics' training sessions.
- To implement use of a risk assessment tool for FGM in Maternity services. A change manager is working closely with the Named Midwife and maternity services to integrate the risk assessment tool to the Electronic Patient Record (EPR). This will continue to be reviewed and updated in 2022/23 as the BadgerNet maternity record is implemented in practice.
- Continue to work to strengthen the communication process between Child and Adolescent Mental Health services (CAMHS) and the Trust to ensure that, where a young person with a mental health care plan is receiving care within the Trust, there is a clear plan of care documented within the records to ensure their safety while they remain in the care of Trust services.

3. BACKGROUND

Working Together to Safeguard Children 2018¹ sets out the statutory framework and the legislation relevant to safeguarding and promoting the welfare of children for all organisations and agencies who have functions relating to children. While the Children Act 1989² places a duty on local authorities to take the lead role and meet this requirement in relation to children in need in their area, safeguarding children and young people and protecting them from harm is everyone's responsibility. The Children Act 1989 was amended in 2004 and sets out the statutory responsibility for key agencies under Section 11.

Section 11 of Children Act 2004³ places duties on a range of organisations and individuals to ensure their functions and any services they contract out to others are discharged having regard to the need to safeguard and promote the welfare of children. NHS organisations are subject to Section 11 as health professionals are felt to be in a 'strong position to identify

¹ HM Government. Working together to safeguard children - A guide to inter-agency working to safeguard and promote the welfare of children, July 2018.

² The Children Act 1989 – Government Legislation, Parliament of the United Kingdom

³ The Children Act 2004 – Government Legislation, Parliament of the United Kingdom

welfare concerns' and have 'a critical role to play in safeguarding and promoting the welfare of children' (Working Together 2018).

Hull University Teaching Hospitals Trust (HUTH) is an NHS organisation that provides acute and specialist health care to children. It works in close partnership with local health providers such as City Health Care Partnership, Humber Teaching NHS Foundation Trust and the Hull and East Riding Clinical Commissioning Groups. The Trust Safeguarding Children's services also works closely with Children's Social Care and the Police.

The responsibility for this joined up working rests with the three safeguarding partners, Local Authority, Police and the Clinical Commissioning Group, who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in the local area and to monitor and ensure the effectiveness of those arrangements.

The strategy of HUTH, in line with Hull (HSCP) and East Riding (ERSCP) Local Safeguarding Children Partnerships (LSCP) and partner agencies is to ensure Trust staff are provided with the skills, support and reporting mechanisms in order to fulfil their section 11 responsibilities. This would include appropriately recognising safeguarding concerns, escalating, reporting and sharing information with other agencies in a timely manner.

Safeguarding leads from HUTH including the Assistant Chief Nurse, Named Nurse and Midwife and Named Doctor are active members of several multi-agency Operational and Strategic groups across the region that feed into the Safeguarding Partnerships. This guarantees that the voice of the organisation and health is heard and there is a co-ordinated and collaborative approach to safeguarding children activity. All of which will ensure the Trust is in a strong position to deliver effective arrangements for safeguarding

The Trust has remained compliant with the requirements for the statutory Named Professional Posts. The Named Doctor role has continued to be covered by Dr Chris Wood (the local area Designated Doctor). A locum consultant paediatrician with specialist interest in safeguarding, Dr Lesley Clarkson, is FME trained and also works within the Anlaby Suite as part of her work plan. The formal recruitment processes for the Named Doctor has been delayed due to the impact of COVID and staffing issues. The Job description and work plan have been written and it is expected that this will go out to recruitment in the near future. Patricia Darley is the Named Nurse for Safeguarding Children and manages the team. Paula Peacock continues to provide Strategic and Operational guidance and support in the role of Named Midwife.

The Safeguarding Children's service remains under the leadership and management of the Assistant Chief Nurse/Safeguarding Lead, Kate Rudston. The Trust Executive Chief Nurse and Director Lead for Safeguarding during this period was Beverley Geary.

The Trust Safeguarding Children's Service continues to work with Hull and East Riding of Yorkshire partners to meet the challenges of the wider safeguarding agenda by contributing to Learning Lessons Reviews (LLR's), Safeguarding Practice Reviews (SPR's) Care Quality Commission (CQC) and Ofsted Inspections.

HUTH contribute to all local Child Death Reviews (CDR), Child Safeguarding Practice Reviews (SPR) and Lessons Learned where they have had contact with a child and/or their family. Recommendations and actions from these reviews are monitored through the Trust Safeguarding Committee.

The Child Sexual Assault Assessment Service (CSAAS) has seen a period of reduced activity during this financial year. This is the first decline seen in the past five years where

there has been year on year increases in activity. In order to address this downturn there has been a multi-agency review of the referral pathway into the service. This has led to a rewrite of the pathway, establishment of a CSAAS Review Group chaired by the Named Nurse, creation of an Operational task and finish group and a Training Needs Analysis and updated training plan for safeguarding partners.

During the reporting period 2021/2022 there have been no reported concerns or complaints about the safeguarding children's service or the Anlaby suite with regards to Section 47 Child Protection Medicals from local partners, service users or external agencies. The NHS Hull Clinical Commissioning Group remains satisfied with the provision and standards of the Safeguarding Children's service and compliance with safeguarding children training. No contract notices have been received regarding the Safeguarding Children's service.

The term "children" within the *Working Together to Safeguarding Children* (2018) document, and the Children's Act of 1989 and 2004 respectively, define that "a child is anyone who has not yet reached their 18th birthday". Therefore, the term 'children' means 'children and young people', throughout this report.

4. LOCAL CONTEXT

Hull University Teaching Hospitals NHS Trust (HUTH) is a large acute Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs over 10,000 staff (headcount) and delivers its services on two main sites; Castle Hill Hospital and Hull Royal Infirmary. Outpatient services are also delivered from across locations across the local health economy area. The Trust provides a full range of urgent and planned general hospital specialities, routine and specialist diagnostic services and other clinical support services. These secondary care services are provided to a catchment population of approximately 600,000 in the Hull and East Riding of Yorkshire area.

The local care system served by the Trust centres on the City of Kingston Upon Hull, its suburbs and the surrounding East Riding of Yorkshire, a rural area containing a number of market towns.

Hull is a geographically compact city of approximately 260,000 people, approximately 52,000 of which are children aged 0-15 years. It was identified as the 4th most deprived local authority in England in 2020-21 with 45% of residents living in the top 10% deprived areas nationally. (Index of Multiple Deprivation, Department of Communities and Local Government). The health of people in Hull is generally worse than the England average, with life expectancy for both men and women being lower than the England average.

The East Riding of Yorkshire is predominantly a rural area populated by approximately 349,000 people. The geography of the East Riding makes it difficult for some people to access services. Life expectancy for men is higher than the England average. A larger proportion of the East Riding population is over 65 years of age compared to Hull. Whilst the ethnicity of the two populations is predominantly white, Hull has a higher percentage of residents who are Asian, Black and Mixed race. The top non-UK nationalities are Polish, other Eastern European, Middle East and China.

Although the two local authority areas are very different in their patient populations, health profiles, geographical landscape and distribution, common themes have emerged in respect addressing health inequalities, prevention and management of long-term conditions. The higher incidence of deprivation in Hull and the ageing and increasing population of the East Riding requires the Trust to tailor its services to meet the needs of these two very different patient populations. Additional factors which can impact of safeguarding children activity

include high rates of unemployment and economic inactivity; 27% of the population with high levels of child poverty (32% of children living in households with relative low income)

From a safeguarding children perspective, the local landscape and population is an increasing challenge and in particular, with rates of abuse, neglect and harm which are closely linked with deprived areas. The increase in the ethnic minority population is also a challenge for safeguarding children due to the cultural traits and behaviour which meet the thresholds for safeguarding in both children and adults. Examples of this would be Female Genital Mutilation, Domestic Abuse and Prevent (the Governments agenda on anti-terrorism and preventing vulnerable people from being radicalised).

5. MANAGEMENT AND ORGANISATIONAL ARRANGEMENTS

5.1 THE ANLABY SUITE

The Anlaby Suite is located on the Hull Royal Infirmary site close to the Women and Children's Hospital, urgent care services, and support services. It is a purpose-built unit that provides dedicated facilities for the provision for undertaking Section 47 Child Protection medical examinations (S47 Medicals).

The Anlaby Suite is furnished with fixtures and fittings intended to meet the required forensic standards for a Sexual Assault Referral Centre (SARC), as well as maintaining a child friendly environment. The Anlaby Suite is also used by the Police 24/7 as an Achieving Best Evidence (ABE) interview facility for children, young people and vulnerable individuals who require DVD interviews following an allegation/disclosure of harm and or a criminal act.

Access to the service is by referral from the police or Children's Social Care as part of a S47 investigation when there is suspicion of, or actual harm, abuse or neglect that has occurred to the child or young person and they require a medical examination. There is an agreement with both Hull and East Riding Local Safeguarding Children Partnerships that the Anlaby Suite and the Trust practitioners provide this service locally. The service is provided Monday to Friday (excluding bank holidays) 8.30am to 4.30pm. Outside of these hours, there is an agreement that the Police and Children's Social Care request a S47 Medical via the General Paediatric Consultant although this is only in circumstances when it cannot wait and is deemed in the best interest of the child or young person and in cases of injury in non-mobile babies.

The service is commissioned by NHS England and NHS Improvement to provide a Child Sexual Assault Assessment Service (CSAAS) for the Humberside Police and Local Authority Area for children under the age of 16 years and for 16 to 17 year olds with vulnerabilities (see section 5.4)

The Safeguarding Children's Team support the administrative function of the Section 47 medicals. The governance around Section 47 Child Protection Medical processes has continued to improve during 2021/2022 with quarterly reporting of key performance activity into an auditable database. This provides information to regulators/contract commissioners as requested and as part of the contract arrangements with NHSI England.

The Anlaby Suite continues to be the base for the Trust's Safeguarding Children's Team including the Named Nurse for Safeguarding Children, Named Midwife and Interim Named Doctor for Safeguarding Children and Locum paediatrician.

5.2 SAFEGUARDING TEAM STRUCTURE

The Working Together to Safeguard Children 2018 document states that all providers of NHS funded health services including NHS Trusts, NHS Foundation Trusts and public, voluntary sector, independent sector and social enterprises should identify a Named Doctor and a Named Nurse and a Named Midwife if the organisation provides maternity services for safeguarding.

Named practitioners have a key role in promoting good professional practice within their organisation and agency, providing advice and expertise for fellow practitioners, and ensuring safeguarding training is in place. They should work closely with their organisations/agency's safeguarding lead on the executive board, designated health professionals for the health economy and other statutory safeguarding partners. The requirements for statutory and lead roles are also referenced in the *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2019*.

The Trust for 2021/2022 has remained compliant with the requirements for the statutory Named Professional Posts and the following structure has been in place during this period.

- Named Doctor for Safeguarding Children
- Named Nurse for Safeguarding Children
- Named Midwife
- CSAAS Lead Nurse/Safeguarding Supervision Coordinator
- Safeguarding Educator/Practitioner (0.96 WTE)
- Safeguarding Children Practitioners x 2 (1.33 WTE)
- Administrator for S47 Child Protection Medicals
- Management Assistant

5.3 ROLES & RESPONSIBILITIES

The Safeguarding Children's Team provides specialist advice, support and supervision to HUTH staff pertaining to the safeguarding of children and young people. Additional child protection support and advice is available via the on-call consultant paediatrician and the site matrons so there is 24 hours, 7 days a week cover.

The Named Doctor works closely with the Assistant Chief Nurse, Named Nurse and Named Midwife to support the wider safeguarding agenda and ensure that Trust staff feel supported and empowered to act on their safeguarding concerns. To support the wider 'Think Family' approach the Named Nurse and Named Midwife have established and maintained robust communication processes with the Trust Adult's safeguarding team for activity and cases that involve children and adults with vulnerabilities.

The Safeguarding Children's Team and Named Leads continue to be responsible for the delivery of the following key duties:

1. Medical examinations under Section 47 Children Act 1989 in partnership with the Local Authorities Children's Social Care (CSC) services and the Police.
2. Advice and support (safeguarding supervision) to staff members in relation to safeguarding children and young people matters presenting within the Trust.
3. Providing safeguarding Children Training to Trust staff and to contribute to the training resources across the local health partnership and to pre-registration nursing and midwifery training.
4. Administration of safeguarding children activities within the Anlaby Suite.

5. Compliance with regulatory standards in relation to Safeguarding Children and Young People.
6. Compliance with LSCP's policies and procedures including information sharing and good partnership working across agencies.
7. Compliance or working towards compliance of Commissioner contracts as per annum.
8. Participation in Safeguarding Practice Reviews and Serious Incident investigations, ensuring the actions from learning lessons are implemented and embedded.
9. Review of all Safeguarding Children's referrals and incidents involving children and young people occurring in the Trust.
10. Providing a monthly quality report detailing Safeguarding Children and Child Protection activity.
11. Identification of themes, reporting on activity and items for escalation to the Trust Safeguarding Committee.
12. Providing leadership on the Safeguarding Children and Young People's agenda.
13. Advising the Trust's Safeguarding Lead and Chief Nurse on any impending or likely changes that will impact on the Safeguarding Children and Young People agenda and activity.
14. Escalation both within the organisation and external to with safeguarding partners any concerns and risks to children and the organisation.

The Trust is required to have a Senior Designated Officer (SDO), who manages allegations against staff for safeguarding children concerns. This role is held by the Assistant Chief Nurse/Safeguarding Lead who has implemented a number of changes to improve the governance of the role. The Trust's Policy has been revised to reflect this and includes both adults and children. In the absence of the Assistant Chief Nurse/Safeguarding Lead the SDO role is covered by a team of senior leaders who have completed the managing allegations workshop. This team receive regular support and supervision from the SDO.

The role of the SDO is to ensure that safeguarding allegations that are raised against Trust staff are managed according to the LSCPs policies and procedures.

5.4 CHILD SEXUAL ASSAULT ASSESSMENT SERVICE (CSAAS)

The CSAAS service has continued to be co-commissioned by NHS England and Yorkshire & Humber Police and Crime Commissioners during 2021/2022. The service delivers a high quality and cost effective Child Sexual Assault Assessment Services for children and young people aged 0 to 16 years old, and 16-18 years old (up to their 19th birthday) if the young person has additional needs are deemed clinically appropriate. This is provided for both Acute (up to 7 days of the alleged incident) Recent (7-30 days since the alleged incident) and Non-Recent (after 30 days since the alleged incident) cases for the Humberside Police area i.e. East Yorkshire, Hull, North Lincolnshire and North-East Lincolnshire. The CSSAS covers core hours 8.30 am to 4.30pm Monday to Friday, with the weekend and bank holiday cover provided by Sheffield Children's Hospital and Mountain Health Care in Leeds.

The aim of the service is to conduct a comprehensive Child / Young Person Child Protection Medical Assessment when the child / young person sexual assault is alleged, has been disclosed or is suspected. The service provides medical and forensic assessments for child sexual abuse at the request of the local Children's Social Care department and Humberside Police, offering holistic medical and nursing support. This includes full medical assessment, sexual health assessment, screening and treatment where necessary, emergency contraception, and post exposure prophylaxis for HIV. In addition the assessment also supports identification of those at risk of self-harm or Child Sexual Exploitation. Information and evidence is gathered to assist joint investigation by Children's Social Care service and

Police, which may result in criminal action being taken. In addition, referrals may be taken from General Practitioners for the investigation of genital warts or specialist advice, where there are no immediate safeguarding concerns.

Professionals completing the medical assessments for child sexual abuse are trained specifically to undertake the role of Forensic Medical Examiner (FME). The doctors are supported by registered nurses, with paediatric experience and/or paediatric qualification. A Locum Paediatric Consultant has been employed since 2019 to undertake duties within the CSAAS service, this consultant has completed FMERSA training and undertakes forensic medical examinations. This has increased capacity and flexibility within the service providing options of a female or male examiner.

The service links with local Sexual Health Services, Conifer House (CHCP) for children in Hull and East Riding and Virgin Health for the North East Lincolnshire, referrals are made to local Children and Adolescents Mental Health Service (CAMHS) services were indicated. In addition, there are referrals to Children's Independent Sexual Violence Advisers (ISVAs) to provide on-going support for child victims as necessary. Contacts have been forged with voluntary sector support, such as ReFresh, substance misuse support and Cornerhouse, Child Sexual Exploitation support.

Quarterly data performance reports i.e. SARC-IPS and Management Information (MI) are submitted to NHS England using the NHS England's reporting template. Contacts meetings and the data provides assurance regarding service provision, activity and the effective delivery of the service. These meetings are attended by the Assistant Chief Nurse, Trust Senior Contracts Manager, the Named Doctor, the Named Nurse for Safeguarding Children, CSAAS Lead Nurse and Child Protection Administrator.

The CSAAS has continued to develop in the following areas:

- CSAAS service promotion through networking and the delivery of a service specific training package to key stakeholders of the service across the Humberside area including the North and South Bank.
- Strengthening operating procedures and accountability around forensic medicals.
- Improving patient experience and collection of feedback of the service - Viewpoint
- Improving public knowledge of the CSAAS service via a web page.
- Delivery of service specific training/briefing as requested.
- Implementation of a multi-agency senior leadership team group to review and update the referral pathway and processes.
- Regular attendance at the RASSO (Rape and Serious Sexual Offences) service Improvement Group.
- Update to the referral pathway for CP medical. This includes improved guidance for primary care and details regarding when and how to seek specialist advice.
- Improved information sharing regarding CP Medical data. This has been split into the four regions and include the categories of harm, requests and attendance from the specialist team at the Anlaby suite for involvement in strategy discussions
- Regular multi-agency dip sample analysis related to strategy discussion where there is sexual harm identified.
- Creation of a Proforma for Information sharing related to ABE interviews for children at the Anlaby Suite.

5.5 INTERNAL GOVERNANCE

The Trust has an overarching Safeguarding Children Policy that sets out the standards and requirements when dealing with safeguarding issues or concerns (CP278). The Policy is supported by procedures, protocols and guidelines. All of the documents are underpinned by the LSCPs Policies and Procedures. All are available on the Trust's intranet for Safeguarding Children.

The overall accountability for Safeguarding in the Trust is the Chief Executive. The delegated Executive Director responsible for Safeguarding is the Chief Nurse with the Assistant Chief Nurse undertaking the role as Safeguarding Lead. The Named Nurse reports directly to the Safeguarding Lead, but also has a direct professional line to the Chief Nurse.

Safeguarding activity is monitored within HUTH through the Safeguarding Steering Group, which meets bi-monthly. The Safeguarding Children report is presented bi-monthly detailing activity and items for discussion and consideration. The Safeguarding Steering Group report to the Trust's Patient Experience Sub Committee (previously the Operational Quality Committee) and escalates issues by exception when required.

A monthly quality report is produced to provide an update on the key themes and trends for safeguarding children activity this is presented at the Trust Quality Committee as part of the Quality Report.

The Assistant Chief Nurse and the Named Nurse reviews all reported incidents (DATIX) within the Trust related to children to ensure there are no missed safeguarding concerns and the risk rating for each incident is appropriate. This also provides an opportunity to identify any training needs. Serious Incidents (SI's) may be declared internally to the Trust or externally by the designated safeguarding professionals. All SI's relating to children in 2021/2022 were shared with the Safeguarding Lead for a safeguarding overview. If a SI has a child or midwifery element then the SI is sent to the Named Nurse/Midwife to determine if there are any safeguarding issues that require oversight and review.

All Safeguarding Practice Review's (SPR's) and SI reports are reviewed, quality checked and signed off by the Assistant Chief Nurse or a Senior Manager/Director before leaving the organisation.

5.6 EXTERNAL GOVERNANCE

HUTH is one of the key stakeholders who form part of the Partners and relevant Agencies Meeting (PRAM) and the EHASH strategic group. These are attended by the Assistant Chief Nurse and/or Named Nurse.

In addition, HUTH is represented on LSCP's sub committees by the Named professionals and staff working within the Safeguarding Children Team. The LSCPs monitor the Trust safeguarding performance through:

Section 11 Self-Assessment Audit of Safeguarding Children arrangement is completed on a minimum of three yearly basis but usually annually as requested by the local LSCPs. The Section 11 audit was submitted to East Riding Safeguarding Children's Partnership in July 2021 and Hull Safeguarding Children Partnership March 2022.

**Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.*

The Trust is also monitored and/or inspected by the following agencies with regards to Safeguarding Children arrangements:

- Ofsted – Ofsted is responsible for inspecting the Local Authorities and their Partner Agencies in relation to their Safeguarding Children and Looked after Children arrangements. During this period the Named Nurse for Safeguarding Children participated in a peer review session with Hull City Council CSC.
- NHS England and the Care Quality Commission (CQC) – CQC monitor and review the Safeguarding Children Standards of the Trust. The Child Sexual Assault Assessment Service (CSAAS) was last Inspected January 2020.
- NHS Hull Commissioners – As part of the Quality Contract with the Trust Commissioners, the Trust has a number of key performance indicators for Safeguarding Children and Adults. The Trust delivered the majority of the performance for 2020/21 with agreed indicators carried forward to 2021/2022. There is no financial target attached to the key performance indicators. The Chief Nurse attends the Quality Delivery Group meetings with the Commissioners and receives any questions regarding safeguarding from the Contract Monitoring Board to which the quarterly reports have previously been submitted. Due to some changes in this meeting the safeguarding reports were not requested and due to this the Assistant Chief Nurse established quarterly meetings with the Hull and East Riding Designated Safeguarding Professionals to review any outstanding concerns, new matters and partnership issues with regards to Safeguarding.

5.7 SERVICE USER AND STAKEHOLDER FEEDBACK/INVOLVEMENT

The Anlaby Suite staff actively promotes feedback from all service users and Stakeholders i.e. children, parents/carers, police and local authority staff, who access the service. During the period of 2021/2022 the feedback was strongly positive across all service users and stakeholders. Engagement in this process can be limited by the sensitivity of the case, however all feedback is used to develop improved communication pathways and service improvement specifically service user experience.

The team have been working with the information team to create a communication strategy for the service. A scoping exercise has taken place to review the current provision of information that is available to service users and professionals. The communication strategy will be driven in 2022/23 to include updated leaflets, media and feedback processes.

As part of the CSAAS contract a quarterly feedback report is submitted to NHS England and monitored through the quarterly contract meetings.

6. TRAINING AND DEVELOPMENT

6.1 SAFEGUARDING CHILDREN TRAINING

Training and education of staff for Safeguarding Children continues to be a high priority for the Trust.

The key performance indicator for training compliance was reviewed prior to the pandemic with an increased requirement to meet compliance from 80-85%. The impact of COVID has continued to effect compliance as there is minimal face-to-face training, high sickness levels and absence due to COVID infections that has delayed completion of training.

On a positive note, due to the drive and commitment of the Safeguarding Children Educator training figures at all levels show remarkable compliance. Comparable services have reported significant concerns regarding levels of compliance in other Acute Trusts. It is a credit to staff in the trust that they have engaged with safeguarding training at a time of staff shortages. This is a reflection of their understanding of the importance of having a good safeguarding knowledge to ensure they provide care that is safe for children and families.

The CCG have remained updated throughout his period regarding compliance with safeguarding training

Table 1: Compliance Rates as at 31 March 2022

Intercollegiate Level of Training	Current Compliance (%) Target 80%
Level 1 (Basic)	88.9%
Level 2 (Intermediate)	83.8%
Level 3 (Advanced, multi-agency)	85.1%
Level 4/5	75.0%
Threshold	77.0%

Compliance with Threshold training has also been delayed due to COVID-19 restrictions. The 3-year plan to achieve over 80% compliance has been extended the end of the 2022/23 period.

The compliance with Safeguarding Children Training is monitored closely by the Training and Education department, the Named Nurse for Safeguarding Children and the Assistant Chief Nurse. Training data is submitted bi-monthly to the Trust Safeguarding Steering Group so that any areas of concern are reviewed and actions agreed if required.

6.2 SAFEGUARDING SUPERVISION TRAINING

There has been a hybrid model of Safeguarding supervision in 2021/2022. Small group and 1:1 sessions have been delivered face to face with on line training offered where required. Staff shortages and high level of absence due to sickness and COVID infections has impacted significantly on compliance with supervision, particularly in Maternity Services. Work has been undertaken with health groups to review processes for offering, delivering and recording safeguarding supervision in practice.

This information will be utilised to update the safeguarding supervision policy and create more innovative ways of delivering and recording supervision. Safeguarding supervision arrangements within the organisation will be reviewed and will remain a key priority for 2022/23.

7. MANAGING INDIVIDUAL CASES/ ACTIVITY

7.1 CHILD PROTECTION INFORMATION SYSTEM - CP-IS

The CP-IS is a national system that connects Children's Social Care (CSC) IT systems with those used by the NHS. CP-IS gives health professionals the ability to see if there is a 'Child Care Alert' on a child's Summary Care Record (SCR) and whether a child is subject to a child protection plan (CPP), a pre- birth CPP or is a Child Looked After (CLA) regardless of which local authority the child resides in. In turn, local authorities can see where, when and

how often a child in their care has made an unscheduled visit to the NHS through emergency departments, minor injury units and other unscheduled paediatric and maternity settings.

CP-IS is being utilised effectively in the Trusts unplanned care/emergency department providing frontline practitioners with additional safeguarding information to support their decision-making around children safeguarding. Use of CP-IS has been extended to both unscheduled Paediatric and maternity settings and has become embedded in the routine review of alerts/safeguarding communication in records and in accessing this information via the SCR.

The Safeguarding Children Team access a daily Business Intelligence (BI) report. This gives details of all children who attend ED over the previous 24 hours. The report highlights children with safeguarding alerts, CP-IS alerts, repeated attendance and any safeguarding concerns highlighted by staff in the ED at the time of attendance. A Standard Operating Procedure (SOP) is in place that supports the team to identify those Red Flag cases which need to be shared with other safeguarding partners.

Paediatric safeguarding audits take place quarterly to review safeguarding processes and documentation across a range of departments who come into contact with children.

This provides assurance that safeguarding policies and procedures are being utilised and will identify areas of safeguarding practice, which are good or need improvement. The findings of the audit are presented at the trust safeguarding committee.

CP-IS activity is audited within the safeguarding partnership to ensure systems are working effectively and all cases are recorded and shared. Any omissions are reported through the Quality and Assurance sub group.

7.2 REFERRALS TO SOCIAL CARE

Practitioners from the Trust safeguarding team continue to participate in Local Authority (LA) led multi-agency safeguarding audits and support the LA work to improve the quality of referrals and outcomes. As a result, the number of referrals made by the Trust has decreased as the quality of referrals has improved.

The Safeguarding Children team reviews all referrals which help monitor the quality of referrals and ensure that the Trust policies for safeguarding children and women with vulnerabilities are adhered too. Work is on-going to support the LA to improve communication and feedback to the referrers, and the outcome of their referrals.

On 28/10/2020, the single integrated front door portal for referrals went live for Hull City Council social services. All local health providers including HUTH had raised concerns via the CCG regarding the change, risks and difficulties with integration to local health processes and systems.

Agreement was reached across the partnership that health providers could delay use of the safeguarding referral portal so that individual agencies could review their current processes to safely integrate any necessary changes in a planned structured way. These changes are being supported by the Designated Nurse for Safeguarding Children

To support integration HUTH implemented the new Multi-Agency Referral Form (MARF) into the current Trust safeguarding children referral pathway in January 2021. This replicates the information which is within the referral portal and is transcribed to liquid logic (social care electronic record system) by the Local Authority Team.

The Named Nurse and a small working group from HUTH, including an allocated change manager and Hdigital team, continue to work closely with the Local Authority and CCG to review practice/processes in preparation for implementation of the integrated front door portal to the organisation.

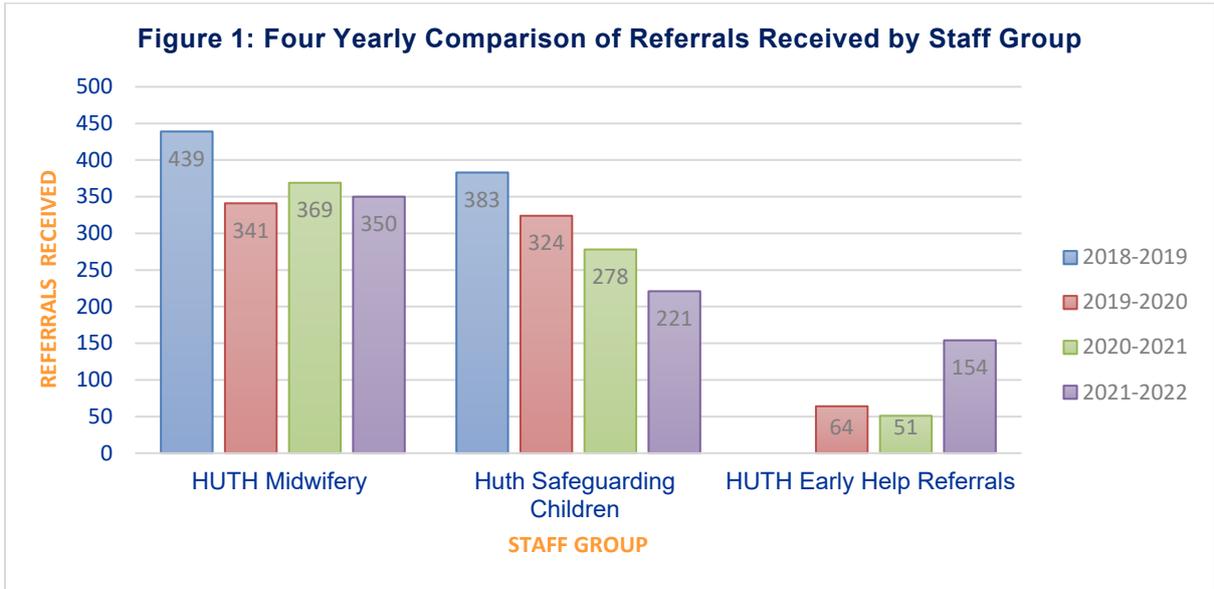
All safeguarding children/unborn documentation including referrals are uploaded directly to the child's/mothers (for unborn) EPR where it can be easily viewed by staff who are community and hospital based and have access to the electronic patient record.

Table 2: Number of Referrals Made to Children's Social Care

Referral Type	2018-2019	2019-2020	2020-2021	2021-2022
Midwifery	439	341	369	350
Safeguarding Children	383	324	278	221
Early Help Referrals	-	64	51	154
Total number of Referrals Made	822	729	698	725

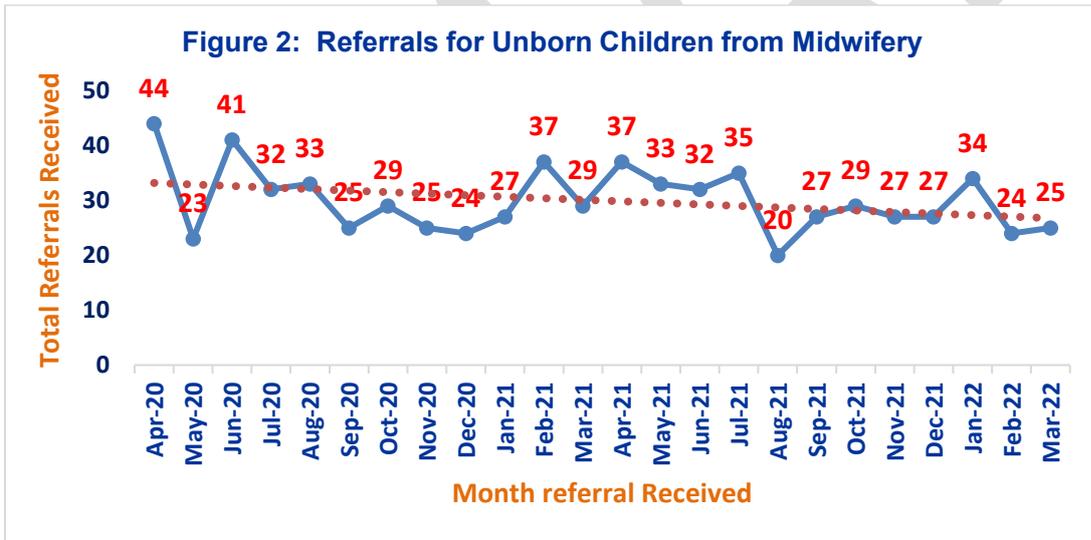
As Table 2 and Figure 1 (see below) show, there has been an upturn in the total number of referrals received this year. In particular, there has been a significant increase in the number of Early Help referrals submitted in 2021-2022 compared to both 2020-21 and 2019-2020.

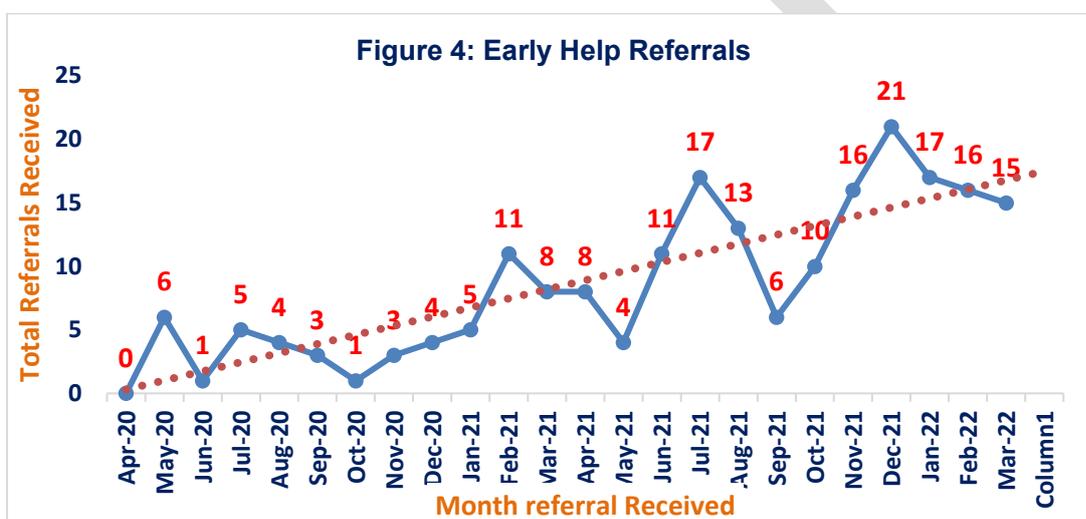
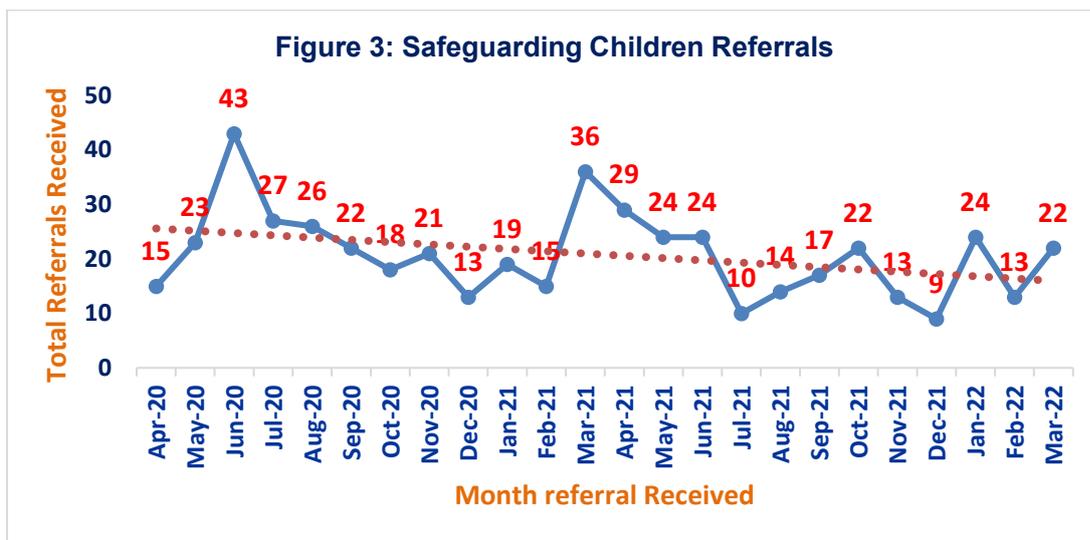
Early help referrals are predominantly made by midwifery services for families who require additional single agency support e.g. housing, parenting courses, financial advice/support. Facilitated by the provision of threshold training, this increase in the number of referrals received suggests that this process is now firmly embedded in practice with staff appropriately identifying the level of support required.



Figures 2 to 4 below provides from April 2020 onwards a monthly comparison of referrals received for midwifery, Safeguarding Children and Early Help respectively.

Referrals 01/04/2021-31/03/2022 by referral source





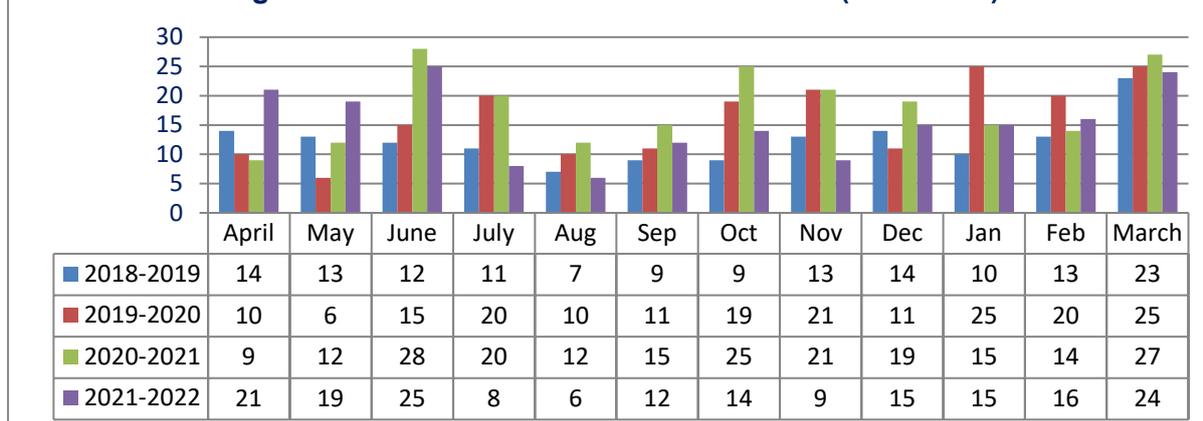
7.3 CHILD PROTECTION MEDICALS

The following table illustrates the number of S47 Child Protection Medicals carried out during office hours within the Anlaby Suite over the last 4 years. In total, there were 184 medical examinations carried out 2021-2022.

Table 3: Number of Child Protection Medicals with Reason for Attendance

Type of Examination	2018-2019	2019-2020	2020-2021	2021-2022
Sexual Abuse	74	98	87	65
Physical Abuse	45	49	77	72
Neglect	3	25	33	19
Other	7	0	2	0
Follow-Up/Outpatient	19	21	24	28
Total	148	193	217	184

Figure 5: Medical Examinations Carried out (2018-2022)



The S47 Medicals are undertaken by a Paediatric Consultant, with additional specialist training in undertaking Forensic Medicals. Reports are submitted to the lead agencies to support the S47 investigation. These are used to inform the evidence for court and care proceedings and/or criminal charges against the perpetrator/s.

7.4 CHILD DEATHS

Child Death review (CDR) processes were made mandatory for Local Safeguarding Boards (LSCBs) in England in 2008 for all child deaths up to the age of 18 years. The overall purpose was to understand why children die and to put in place interventions to protect other children and prevent future deaths.

In 2018 the department of health and social care published new and revised statutory and operational guidelines related to Child Death Reviews (CDR). The aim of the guidance is to provide organisations involved in the process of child deaths standardisation when responding to, investigating and reviewing child death. The new guidance requires CDR partners to gather information from every agency that has had contact with the child, during their life and after death, including health services, children social care, police and education services.

In response to the new guidance, the Designated Doctor for Child Death, Named professionals, Safeguarding Lead and Divisional manager for Women and Children's services have been working closely with the CCG and other safeguarding partners to review and implement these changes. Although there has been some delay in implementation of the standards as a Trust, we are in a favourable position in terms of the progress we have made as a comparison to other similar organisations. Developments in this financial year include:

- Agreement that the Child Death Process will move to the Corporate Nursing under the leadership of the Assistant Chief Nurse and the management of the Named Nurse for Safeguarding Children.
- Transfer of Child Death Coordinator for Hull to HUTH on an honorary contract.
- Proposal paper completed for Hull CCG – Review of workforce structure with request for funding for new Specialist Child Death Nurse/Key Worker post.
- Job description/person specification and banding agreed and agreed at job evaluation panel.

The Named Nurse and the Named Doctor act as the central point within the Trust for the notification and subsequent sharing of information with other agencies in regard to child deaths. Access to a Designated Doctor for Child Deaths is a requirement for every LSCP as

part of the Child Death Review process. Dr Mary Barraclough, Consultant Paediatrician at HUTH carries out this role.

The Child Death Overview Panel (CDOP) collates information in relation to the number of child deaths locally and their categorisation as either expected or unexpected. HUTH provides reports which feed into the CDR process. The CDOPs provide annual reports, to which HUTH receive.

8. SAFEGUARDING SUPERVISION

At the core of the Nursing and Midwifery Council Code (2018) is the expectation that nurses and midwives will practise effectively, preserve safety and promote professionalism and trust. Safeguarding supervision is central to safe nursing and midwifery practice and therefore supports all nurses and midwives to meet their professional standards to promote safe and effective practice in their place of work. Nurses and Midwives need and are expected to receive affective regular safeguarding supervision.

This requirement is embedded through training and trust policies, including the CP278 safeguarding children and CP341 Safeguarding Supervision which lay out the requirement for supervision and identify pathways and processes for the organisation

During 2021/22, the COVID pandemic continued to impact on the delivery of planned group Safeguarding Supervision within both maternity and paediatric services. Staff absence, sickness and the need to cover essential services led to safeguarding supervision being cancelled and the number of trained and updated safeguarding supervisors on the register declining. In addition, there has been issues in maintaining the impetus of planned group safeguarding supervision (8.2) within community midwifery services. This has been escalated. Joint efforts continue to progress this, supported by the Named Midwife, Safeguarding Supervision Coordinator and maternity service managers.

Adhoc supervision, regular ward rounds and ease of access to the Safeguarding Children Team provided some mitigation and assurance that staff could access safeguarding supervision if this was needed this on a case by case basis.

The need to review and refresh the model of delivery of safeguarding supervision across the organisation is paramount and will be another key focus for 2022/23

The Safeguarding Children Team deliver planned, individual, group and face-to-face supervision sessions to the following groups:

- Paediatric ward nursing teams
- Paediatric ward new starters
- Paediatric band 6 and 7 nurse managers
- ED nurses
- ED ECP's
- ED new starters
- NICU Nursing team
- NICU Outreach team
- Paediatric Out Patient department
- Midwifery new starters
- Maternity Leadership Team
- Paediatric Senior matron

8.1 CASELOAD HOLDER SUPERVISION

Caseload holder supervision is for staff who work with a caseload of patients, with paediatric involvement. This planned quarterly supervision is either delivered on a 1:1 or as a group, in accordance with the type of caseload held. Shared caseloads require planned group supervision; individual caseloads require 1:1 supervision.

Planned quarterly caseload holder safeguarding supervision is well established in specialist paediatric areas, working with an individual or shared caseload, with excellent engagement from staff and positive feedback received from supervisees. Community midwifery services are also caseload holders.

8.2 MATERNITY

The Named Midwife has continued to work closely with maternity services to support the development of the maternity safeguarding database. This is one of the actions of the maternity safeguarding meetings, which has been taking place quarterly during 2021/22. Further review and analysis of the data for safeguarding supervision within maternity services is required to support development of an achievable safeguarding supervision plan.

8.3 SAFEGUARDING SUPERVISION TRAINING

Face to face, training for safeguarding supervisors has been affected by the pandemic going from face to face to online. Online training via 'the big blue button' continued to be offered throughout 2021, however due to sickness and short staffing this needed to be postponed. Monthly refresher sessions for supervisor have continued to be delivered. The training offer provided by the Safeguarding Children Team/ Education lead has been reviewed with a plan to restart training in the next financial year.

8.4 PLANNED GROUP SUPERVISION – NONE CASELOAD HOLDERS

Planned group safeguarding supervision is for all staff in clinical areas with high paediatric traffic. Planned group safeguarding supervision is delivered on paediatric study days. At times there have been operational difficulties for the wards in maintaining the study days, which has affected the uptake of planned group safeguarding supervision. Unfortunately, the Covid-19 pandemic has impacted upon the delivery of the supervision, due to the need to cancel face-to-face training.

Planned group supervision for the Paediatric wards has not yet recommenced due to staffing pressures. PHDU have successfully commenced safeguarding supervision sessions via Microsoft teams, which have been well attended. NICU have also returned to face-to-face supervision in smaller groups. The commitment remains consistent with only two sessions cancelled in this period due to staffing issues.

The Paediatric band 6 and 7 ward managers, 13th floor and Acorn ward have maintained their commitment to receiving bi-annual face-to-face safeguarding supervision. Despite the lack of organised group supervision across the Paediatrics areas (excluding NICU) the nurses continue to receive planned and unplanned safeguarding supervision via the Safeguarding Children Team's ward round and daily telephone contact.

Staff working on the paediatric wards continue to have their safeguarding supervision requirement incorporated into the annual appraisal. There has also been an increase in the delivery of unplanned safeguarding children supervision to nurses on adult wards and departments who have children aged 16-17 years old.

Planned group supervision for non-case load holders is specifically appropriate to hospital-based midwives who do not hold a caseload. A safeguarding supervision/teaching session is delivered to all Midwifery staff on midwives mandatory study day each year.

8.5 AD HOC SUPERVISION

Ad-hoc safeguarding supervision is available to all staff across the Trust regardless of work area. The safeguarding children team provide this service during office hours. Ad-hoc safeguarding supervision is also available with any of the trained safeguarding supervisors, working in the clinical areas across the Trust. In addition a practitioner from the Safeguarding Children Team visits the paediatric and maternity wards daily to give staff access to daily ad-hoc supervision.

9. SAFEGUARDING CHILDREN

The Safeguarding Children team review a daily Business Intelligence (BI) report which provides the details of those children admitted via ED where there are red flags for safeguarding identified. This would include the activation of a CP-IS alert, Children with local safeguarding alerts and those where staff in the ED have stated there is a safeguarding concern on the Electronic Patient Record. The Safeguarding child practitioner will review the ED attendance to assess what action was taken during the admission and assess if any additional support or actions are required. Contact would be made with appropriate professionals such as school nurse if required. The BI report is also utilised to provide anonymised statistics to both Hull and East Riding Local Authorities such as regarding self-harm.

There are good links between the senior leadership team in Paediatrics, the Safeguarding Children Team and staff working in areas who come into contact with children. The Senior Matron for paediatrics has planned 1:1 meetings with both the Assistant Chief Nurse and Safeguarding supervision with the Named Nurse Safeguarding Children. These provide an opportunity to review practice, have case discussions and plan care which ensures risks are minimised for the children, staff and the organisation.

In addition, all paediatric documentation has been reviewed and is audited quarterly to ensure that it provides a comprehensive, chronological record of any safeguarding concerns, restrictions and risk assessments

During the reporting period, the Safeguarding Children Team have responded to the changing needs of the staff and organisation in the delivery of the service.

This has included:

The Safeguarding Children Team phone the children's wards daily to discuss any existing or new safeguarding concerns that have presented on the wards. The team discuss safeguarding management plans, support with liaising with partner agencies and offer both practical and restorative supervision.

The team contacts any adult ward that has had a child aged under 18 admitted to ensure that the child is receiving the appropriate parental/carer support for the duration of their admission and to support the adult nursing or midwifery team who may not be familiar with safeguarding children issues and processes. If required the team will also visit the ward to offer additional face to face support and supervision.

The Safeguarding Children Team carry out a routine paediatric ward rounds three days a week which covers the whole paediatric unit, NICU, Acorn ward, ward 130, PHDU, POPD, PAU and ED. This provides the nursing and medical staff with an opportunity to discuss historical or current safeguarding cases. The team offers immediate safeguarding supervision to the staff at this point or if not convenient, will offer a day and time which will allow the member of staff time and space to discuss and reflect.

The Safeguarding Children Team and Named Midwife have continued to offer quarterly planned face-to-face supervision to the Specialist Nursing Teams, Community Midwife Managers and Vulnerabilities Midwife who all hold complex caseloads, often with differing levels of safeguarding concerns. In addition monthly group supervision is available to the maternity leadership team.

Support to complete Court statements and attend legal proceedings. There has been a noticeable increase in requests from the Local Authority Legal Teams for court statements pertaining to care proceedings for children and babies who have had contact with HUTH. Often safeguarding for this group of babies and children have been identified during pregnancy or as a result of a paediatric ED or ward admission, (safeguarding supervision will be offered or requested in these events).

When the Midwife or Nurse are called to provide a statement, it is often a very stressful event for that professional. The Safeguarding Children Team support staff through this process and will provide safeguarding supervision and an opportunity for reflective practice. The Safeguarding Children Team will also support HUTH staff if they are required to attend court.

In addition, the Named Midwife has also continued to visit the maternity service areas a minimum of three times each week. This supportive approach has resulted in a raised awareness of Thresholds of Need (HSCP 2018) and has contributed to an improvement in the quality of referrals from Women and Children's Services and Paediatric ED.

9.1 EHASH (Early Help and Safeguarding Hub)

Both Hull and East Riding Local Authorities operate a 'Front door' team approach to the initial assessment for all safeguarding children and early help contacts. For Hull this is the Early Help and Safeguarding Hub (EHASH) and East Riding the Safeguarding and Partnership Hub (SAPH). The Assistant Chief Nurse attends the Hull Strategic EHASH management meeting and the Named Nurse attends the Hull EHASH Operational Management Group meeting to support improved communication and feedback in relation to safeguarding contacts and referrals. Both Hull and East Riding Local Authorities are undergoing improvement plans following Ofsted inspections. The Trust Safeguarding Leads/Named professionals have been supporting the work undertaken as part of the improvement plan. This includes; Multi-agency audit activity and training, task and finish groups related to the pre-vulnerability pathway, strategy discussions and the referral portal.

In order to address and escalate concerns at an early stage health representatives from organisations including the Named Nurse at HUTH meet monthly with the senior leadership team from children's social care in Hull and East Riding. These meetings provide an opportunity to constructively challenge practice, undertake specific complex case discussion and commend good practice.

9.2 MENTAL HEALTH

The number of cases of children presenting with complex mental health concerns has increased significantly during 2021/22. It is uncertain if this increase is a direct impact of the COVID pandemic and associated effect on the child and family. Weekly mental health concerns reports provides an update to the executive team regarding those children and adults who are in patients who are subject to a section of the mental health act. The report provides additional details of any delay in discharge when the person is medically fit.

This data has identified the rising numbers of cases where children are being admitted to the hospital setting for 'a place of safety' and where children cannot be discharged as there is no appropriate mental health placement available.

In many cases, there are no identified safeguarding concerns. In these situations the safeguarding team continue to provide support to the ward as cases are often complex and require multi-agency escalation in order to support an appropriate placement for the child. In addition, in a number of these cases the children remain in hospital for a prolonged period which activates section 85 of the Children Act 2004. At this point a safeguarding referral would be required to assess the needs of the child and family. This data is gathered and presented to the trust safeguarding committee for consideration.

Concerns related to children who are admitted as a place of safety, prolonged stay when medically fit for discharge and children requiring restrictive practices for safety are reported through the Datix system. A process is in place for Joint review of the cases with the paediatric and safeguarding team

The Assistant Chief Nurse and Senior Management Team continue to work with multi-agency partners to review processes and formulate an appropriate action plan to address some of the concerns raised. This will be a focus for on-going communication in 2022/23.

9.3 CHILD EXPLOITATION (including County Lines and Missing Children)

Child Sexual Exploitation (CSE) remains a priority area of work across both Hull and East Riding of Yorkshire Safeguarding partnerships. This work has extended to include Child Criminal Exploitation (CCE). The Trust Safeguarding Children's Team continue to contribute and support this work representing the Trust at the CSE/CCE Strategic and operational meetings.

Work to review and expand the use of the CSE risk assessment tool has been delayed but will remain a priority for 2022/23.

10. MIDWIFERY

10.1 FEMALE GENITAL MUTILATION (FGM)

On average the Trust receives two to three newly identified cases of FGM at the Trust each month. This figure has remained static during 2021/22. In contrast the total number of FGM cases reported through the National Dataset from the Trust has increased. These differences are caused as women move into the area and then remain for future pregnancies. The dataset is completed at each new episode of care within the Trust hence the total number of cases rising if families of childbearing age move into area and continue to live here.

Midwives have shown that they are confident in asking questions as part of the antenatal booking related to history and risk factors for FGM. Staff are following the FGM Policy and

this is evidenced in the completion of good quality referrals where the family have been given the opposing statement and the National Dataset updated.

The Named Midwife has reviewed the process for risk assessment related to FGM. Evidence has been obtained, through discussion with other Trusts, regarding the widespread use of the *FGM Risk Assessment Tool in practice*. (DOH, 2016).⁴

Introducing the DOH risk assessment tool into existing assessment process had been delayed due to the COVID Pandemic. A change manager was allocated in early 2022 to work with the Named Midwife to review the process maps and implement the risk assessment tool to the EPR. This will remain a focus for the next year to help ensure there is a robust, consistent approach to identify risk for the unborn or any other children.

FGM-IS is a National Information System that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who have a family history of Female Genital Mutilation (FGM). FGM-IS supports safeguarding because:

- Family history is known to be relevant when considering potential risk to a girl of undergoing FGM
- A record will be created when a family history has been identified using the FGM-IS
- When a professional sees the FGM-IS indicator, they know a family history of FGM has been identified and they can treat the child accordingly.

FGM-IS is fully implemented in the Trust with the Named Midwife adding family history of FGM alerts to the Summary Care Records of all female babies born who were born during 2021-2022

10.2 DOMESTIC ABUSE

As mentioned earlier in the report Domestic Abuse forms one of the highest reasons for safeguarding children referrals. It therefore remains a high priority and focus with all safeguarding activity.

The Trust continues to rise to the challenge of ensuring that the workforce is knowledgeable to identify the signs of DA and be confident to ask appropriate questions if this is felt to be safe.

To support this the Trust now has a Domestic Abuse Sub group which has members from all health groups. In addition, an Independent Domestic Violence Advisor (IDVA) provides in reach services within the organisation two days a week.

Communication pathways are well established between agencies and the children's and adults safeguarding teams. The Trust receives information from the Multi-Agency Risk Assessment Conference (MARAC) Domestic Abuse Partnership (DAP) and Humberside Police for all pregnant women involved in a Domestic Abuse incident. This information is shared with Midwifery practitioners who are providing direct care for the woman and her family. This information sharing has helped to ensure that women receive an enhanced level of care and midwives are more involved with the multi-agency partners who are supporting the woman and her family.

⁴ Department of Health (2016) Female Genital Mutilation Risk and Safeguarding; Guidance for Professionals

The Safeguarding Adults Named Nurse continues to lead the development of a Domestic Abuse Strategy for the Trust, supported by the Safeguarding Children's Named Nurse. The Trust has a Domestic Abuse policy for staff and patients who access our service.

Domestic Abuse and Routine Enquiry e-learning training is now part of the mandatory uptake by all nursing, midwifery and allied professional staff groups training. This is being delivered as part of a three-year roll out program across the trust with excellent uptake during 2021/22.

10.3 CARING FOR VULNERABLE WOMEN

The Trust's Vulnerability Risk Assessment Toolkit for pregnant women (Supporting women with complex health needs guideline 451) is an invaluable resource used by all midwives to assist in the assessment and identification of those women and families who require additional support and service delivery. The assessment helps the professional to ensure that the woman is placed on the correct pathway and receives the appropriate support and intervention based on their individual circumstances.

The pre-birth pathway has been developed and designed in partnership, in order to develop consistent pre-birth assessment practice, which identifies potential vulnerability early in pregnancy and provides a clear pathway through appropriate support services.

The Named Midwife has worked closely with multi-agency partners in Hull to update the unborn procedures and guidance which includes the pre-birth pathway. This has been updated on Hull safeguarding partnership website and Tri.X system. Multi agency training is planned for summer 2022 to promote the pathway.

The Named Midwife is an active participant in a weekly meeting of safeguarding professionals to review those women who have been referred to Children's Social Care and have been identified as requiring support as part of the pre vulnerability pathway. This multi-agency forum has been effective in ensuring there is appropriate information sharing and has supported the identification of risk and review of Thresholds.

The Named Midwife represents the Safeguarding Children's Team at internal operational meetings in maternity services and represents the Trust at external partnership meeting contributing to the wider discussion about safeguarding issues. Regular monthly meetings have been established with the Maternity Leadership Team.

The ongoing effects of the COVID pandemic has continued to have a direct impact on maternity services ability to meet their section 11 responsibilities. This includes difficulty with capacity to attend multi-agency meetings and low-level compliance with safeguarding supervision. Maternity and safeguarding leads have developed good relationships and regular meetings provide an opportunity to identify what is working well in practice and areas, which require additional support to ensure safeguarding responsibilities are met. This will continue to be a focus for 2022-2023.

The Named Midwife actively contributes to service improvement across the organisation and partnership. In line with local and national Safeguarding Practice Review recommendations the Named Midwife is currently working alongside the Designated Nurses Safeguarding Children across the Local maternity system (LMS) to consider how health partners can work together to improve the engagement and assessment of fathers of unborn. This work is known as the 'SIRS' Project (Sharing Information regarding Safeguarding) and will progress throughout 2022/23

10.4 MODERN DAY SLAVERY

The Named Midwife and Adult Safeguarding Specialist Practitioner are members of the Humber Modern Slavery Partnership and attend regular multi agency meetings. Updates and relevant key actions are fed into the Trust Safeguarding committee and cascaded as appropriate the Trust intranet and safeguarding supervision.

11. SERIOUS INCIDENTS/SERIOUS CASE REVIEWS

11.1 SERIOUS INCIDENTS

Serious Incidents where a child has been or neglected or the child has died or been seriously harmed are included in the safeguarding children monthly reports to the Safeguarding Steering Group. Cases can be reported as an SI by the Trust or reported on STEISS by a Designated Nurse for Safeguarding Children.

In 2021/22 there have been no reported SI cases.

11.2 SAFEGUARDING PRACTICE REVIEWS / LESSONS LEARNED REVIEWS

The Trust has participated in two Safeguarding Practice (SPR's) in the 2021/2022 reporting period (minimal trust involvement in these cases) one Lessons Learned Reviews (LLR) and two Line of Sight reviews across Hull and East Riding. HUTH contributes to the process in relation to its contacts with the child and their family. The level of involvement in the review process varies on a case by case basis ranging from a scoping exercise to the completion of an agency report with recommendations and actions for HUTH. Updates on the progress of these reviews are reported monthly into the Safeguarding Committee

All Safeguarding Practice Review's (SPR's) and SI reports are reviewed, quality checked and signed off by the Assistant Chief Nurse or Chief Nurse before leaving the organisation.

The Named Nurse and Named Midwife, supported by the Assistant Chief Nurse/ Safeguarding Lead, take lead responsibility for recommendations, actions from SPR's and LLR's and support the implementation of changes in practice. This includes participation in the learning from Individual Case Group (LICG) in Hull and the Learning and Improvement Group (LIG) in the East Riding. Progress against Serious Case Review recommendations are reviewed and monitored by the LSCP's. There are no outstanding actions for the organisation

12. KEY ACTIONS FOR 2022-2023

The Trust has identified a number of actions required to strengthen the Safeguarding Children's arrangements in the Trust and continue on from 2021/22. The actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Children's Partnership activities and from Lesson's Learned Reviews and Serious Care Reviews.

A summary of work planned for 2022/23 is as follows:

- Restructure of the Safeguarding Children Team and leadership of the CSAAS to meet the needs of the expanding service

- Work with the information team to develop a Communication strategy /mission statement to include branding. The aim is to provide improved access and knowledge of the service to families, children and professionals.
- Establish and embed a CSAAS Operational Group to aid improved information and data sharing, communication pathways and increase access and knowledge of the service.
- Ongoing review for the Child Sexual Assault Assessment Service (CSAAS) to drive and strengthen operating procedures and accountability around forensic medicals in order to ensure future service provision.
- Continue to develop processes for Safeguarding Children Team involvement with all CSAAS strategy discussions. Provide training and updates to partner agencies regarding these changes in practice.
- Work with NHSE and Humberside Police to review and develop an exception plan for children aged 16/17 year who require CSAAS.
- The safeguarding children team and CSAAS service are expanding and require improved facilities to meet the on-going needs of the service. This includes a dedicated forensic suite and changing room. This needs to be discussed and reviewed at both Trust level and with commissioners of the service.
- Review and refresh Safeguarding Supervision arrangements within Paediatric and Maternity services. Reflect any changes within the safeguarding supervision policy and promote with training and updates.
- Review and expand the use of a CSE /CCE risk assessment tool within the organisation to identify risk. This will raise awareness of the assessment/identification of children that access Trust services and who may be at risk of Child Sexual Exploitation (CSE) and extend this those children at risk of Child Criminal Exploitation (CCE) 'County Lines'.
- To implement use of a risk assessment tool for FGM in Maternity services. Prompt via training updates and supervision.
- Review and consider how we can better work with children and families to improve processes and systems for obtaining the voice of the child/family.
- Work with Safeguarding Partnership's to develop guidance for; injuries to pre mobile babies, multi-agency guidance regarding section 85 and escalation and resolution guidance.
- Work with the CCG/ICS to establish the role of Specialist Nurse/Key worker for Child Death within the organisation. Support the development of guidance, policies and SOP's related to the Child Death Review Process.
- Work with the Change Management team and local authority to review and establish improved links between the trust electronic patient record and the EHASH safeguarding referral portal.
- Continue to support with the roll out programme of DA training, i.e. e-learning Routine Enquiry and DA.
- The Named Midwife will offer support and safeguarding advice to help progress the 'SIRs' project within maternity services and review how this can be delivered trust wide.

REPORT END

Report Authors:

Patricia Darley, Named Nurse for Safeguarding Children

Kate Rudston, Assistant Chief Nurse

Date: July 2022

**Report to the Board in Public
Quality Committee
August 2022**

Item: Digital Safety Brief	Level of assurance gained: Reasonable
<p>The committee received a presentation on the digital safety brief. The Trust have rolled out Nerve Centre, which went live at Castle Hill last year and HRI site this year. A live demonstration was provided and the digital safety brief has been developed pulling together all the different nursing documents, as many columns as the systems allow are pre-populated and the remaining columns are updated manually. It provides the ward with an oversight and highlights high-risk patients and medications required. It will also capture patients with cognitive issues and will be launched in September 2022.</p> <p>This will be able to be displayed on the wards white boards and can be updated live to support the safety huddles which will aim to become more MDT focused than nursing only. Teams will be looking at ward round times to use this tool to direct the ward rounds and one again later to look at accomplishments and flow.</p> <p>Insights were introduced during Covid July 2020 when audits and fundamental standards were stopped but checks were still needed. The aim is that it will triangulate with fundamental standards and my assure audits and get a full understanding of performance on wards. BI report will produced once fully developed; and information will be shared at ward level, health group and Trust level.</p>	
Item: Learning from Deaths	Level of assurance gained: Reasonable
<p>The report provided an overview of the actions taken for outlier status and statistical report on the number of deaths within the Trust in 2021/22.</p> <ul style="list-style-type: none"> • During 2021/22, there was a total of 2621 patients who died within the hospital. Of these 2621 deaths, 106 patients were admitted to the Trust electively, with the remaining 2312 patients attending the Trust as an emergency admission and includes those who arrived already deceased. • This is a reduction of 8% from 2020/21 and is within normal mortality limits. • The Trust is identified as having a higher than expected SHMI, with the overall SHMI of 1.15 which is slightly higher. The number of actual deaths remains to be slightly higher than the number of expected deaths. The way we present our data and coding needs to be improved. • The Trust is focussing efforts on understanding the current outlier status in regards to SHMI and HSMR. • There are quality improvement initiatives set around Sepsis, Pneumonia (Deteriorating Patient) and Acute Cerebrovascular disease (Stroke) • Key learning is shared throughout the year and is presented at mortality and morbidity meeting. • Structured Judgement reviews are undertaken and we achieve 100% for every stroke death. 	
Item: Tissue Viability Presentation	Level of assurance gained: Reasonable
<p>The committee received a presentation on pressure-acquired ulcers and provided an overview on the fundamental standards the teams actions.</p> <ul style="list-style-type: none"> • There are 30-50 pressure ulcers confirmed every month, with a 100 reported before validation. • Glide sheets still need to be embedded in practice • ASSKING framework to be embedded in practice • All category two pressure ulcers are visited and validated to ensure they do not progress. • Task & Finish group established • Mattress audit performed, large proportion have been replaced after being substandard. • National increase seen for pressure ulcers, Trust is not an outlier • Looking to roll out best practice from areas getting it right. 	
Item: Quality Indicator Report	Level of assurance gained: Reasonable
<p>The committee were assured that the Trust is on trajectory to meet the SI target by October.</p> <p>Two never events have been declared, a meeting was held with the area last week and actions will shared at Septembers meeting.</p> <p>September will be focusing on safety and the Patient Safety Conference will on Friday 16th September.</p>	

Item: Antimicrobial Resistance Presentation	Level of assurance gained: Reasonable
<p>The committee received a presentation on Antimicrobial Resistance.</p> <ul style="list-style-type: none"> • There is a national focus and two CQUINs this related to antimicrobial resistance this financial year. • The World Health Organisation consider Antimicrobial Resistance to be a global threat and there is limited development from pharmaceuticals in this area. • Study published in January 2022, 19.m people died globally in 2019 due to infections that were resistant to antimicrobials. • 1/3 of our inpatients are on antimicrobials at anytime • Antimicrobial Stewardship links to improved patient safety, high quality prescribing and improves patient outcomes as well as complimenting IPC and sepsis management. • Target for 22/23 is to reduce broad spectrum agents by 4.5%, currently HUTH is not on trajectory to meet the target. • Full guideline review and update process by AMS team for all major patient groups • Summary guidelines now readily available as posters in clinical areas • Micro-guide app for HUTH guidance launched Aug 2022 >400 downloads • AMS task and finish group and support from quality team & Noemi K for speciality specific QIP projects • Staff encouraged to pledge to be an Antibiotic Guardian. 	
Item: Patient Experience Update	Level of assurance gained: Reasonable
<p>The committee received the patient experience and engagement quarterly update.</p> <ul style="list-style-type: none"> • There were 334 concerns raised with the PALs Team (excluding those against the ED) in July 2022 with ED receiving 29 • The highest number of concerns raised was in regards to delays and waiting times (135) particularly within the outpatients service for follow up and the next highest were concerns regarding communication and telephone enquiries not being responded to. • There were 37 complaints received main theme treatment and discharge. Treatment concerns accounted for the highest number of complaints received across the Trust (13) with un-satisfaction with treatment plans the common theme. Five complaints received in ED were in relation to treatment and communication. • 34 complaints were closed in July, Five Complaints were upheld and 18 partly upheld. 11 complaints were not upheld. • There are 103 complaints that are currently breaching the deadline and have been open for investigation for more than 40 days. • The committee received an update on Patient Surveys. • Interpreters contracts are being reviewed as an ICS as partner organisations contracts are expiring, looking to move to a single contract if feasible. • Volunteers continue to provide a valuable contribution to the organisation with 1,439 hours worked in July. 47 new volunteers were recruited in July. • Monthly response rate for July below HUTH 25% target for Family and Friends Test, with some departments still to engage. • Patient Engagement continues to strengthen. 	
Item: Clinical Negligence Scheme For Trusts (CNST) / Maternity Report's	Level of assurance gained: Reasonable
<p>Head of Midwifery updated the community on five separate reports in relation to maternity, which would be submitted to Trust Board next month.</p> <ul style="list-style-type: none"> • Saving Babies' Lives care bundle version 2. In quarter one, 1182 babies were born at HUTH, 24 at< 3rd centile & >37+6 = 2.03% • A quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks gestation to identify themes that can contribute to fetal growth restriction not being detected. There were 7 missed cases which were raised with the practitioners for discussion at MDTs. • Perinatal Mortality Review Tool, the Trust achieved 100% in all areas except one case remains outstanding for the case review which related to 80% compliance. • Two cases were reported to HSIB in April but both reviewed and rejected. Two cases have been referred in June, a table top exercise has been completed, learning identified but no common theme. • Paper is being produced for the implementation of Continuity of Care identifying next steps, staffing remains the highest challenge. • Avoiding term admissions to neonatal, we have low figures locally at 2.6% 	
Item: Patient Safety and Clinical Effectiveness	N/A
<p>The committee noted the escalated report.</p>	

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		Meeting	Trust Board	Meeting Date	13.9.22
Title	Our People				
Lead Director	Simon Nearney - Director of Workforce and Organisational Development				
Author	Simon Nearney - Director of Workforce and Organisational Development				
Report previously considered by (date)	This report has not been received at any other meeting.				

Purpose of the Report		Reason for submission to the Trust Board private session	Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval		Commercial Confidentiality	Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality	Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance	✓	Staff Confidentiality	Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance	Responsive	✓	Great Clinical Services	✓
			Well-led	✓	Partnerships and Integrated Services	✓
					Research and Innovation	✓
					Financial Sustainability	✓

Key Recommendations to be considered:

The Trust Board is requested to note the content of the report and provide any feedback.

Hull University Teaching Hospitals NHS Trust

Trust Board

13th September, 2022

Our People

1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues.

2. Background

At the previous Board meeting in July, 2022 the Trust had 56 Covid-19 inpatients. As at 1st September, 2022 the Trust have 36 Covid-19 inpatients. The pandemic still poses a real threat to the Trust and staff absence remains higher than normal. Covid-19 staff absences did increase early summer but have continued to reduce since July. The Trust's key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 181 patients which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure.

3. Key Issues

Staff Absence

The total staff sickness absence for the financial year 2020-21 was 3.91%. The total absence including sickness and Covid-19 for 2021-22 was 6.71%. The Trust attendance target for attendance is 96.1% (sickness not to be greater than 3.9%).

The Trust currently has 38 staff absent due to Covid-19 which is 0.36% of the workforce. Total sickness and Covid-19 absence is currently 5.04%. This is a reduction from 5.6% as at the last Board meeting in July.

With effect from 7th July Covid-19 absences will be treated the same as other sickness absence meaning all NHS staff off with Covid-19 after this date will have this absence recorded as sickness and it will contribute toward an individual's sick pay entitlement. NHS Employers issued this national change to guidance late June.

4. Staff Testing

Symptomatic Testing (PCR)

The guidance for NHS staff to self-isolate and be tested has significantly changed. Staff can now continue to attend work if they have symptoms, but return a negative (Lateral Flow Device LFD) result. If the LFD is positive then the staff member will isolate and not attend work until a negative result is shown. The only exception to this is for C33, C33 and H50 where we have extremely vulnerable patients. There is no requirement for staff to have a PCR test and therefore PCR results will no longer be reported.

5. Employee Service Centre (ESC)

Shared Payroll Services (NLAG & HUTH)

In a market where it is becoming increasingly difficult to recruit experienced payroll professionals with the appropriate knowledge and experience of processing a complex NHS payroll the HUTH payroll management team are now working in partnership with colleagues in NLAG to manage and deliver a shared payroll service across both Trusts.

This partnership working, led via the HUTH management team, will aid the development and retention of key payroll staff through shared learning opportunities ensuring the payroll functions within both Trusts remain financially viable and robust enough to deliver key payroll functions within a multi-professional NHS environment. Whilst the challenges of delivering an effective payroll across two Trusts with different culture, processes and procedures should not be underestimated the longer term aim is grow a payroll workforce to support the creation of a "NHS

Payroll Centre of Excellence” offering payroll advice and/or services to other NHS trusts within the regional.

Temporary Increase in Mileage Rates

The Trust in partnership with staff side colleagues increased all its mileage rates by 9p per mile. The increase, which is a temporary measure to help with fuel costs commenced on 1st August 2022 and will be reviewed every 3 months.

Agenda For Change (Average Holiday Pay Payments)

Over the last number of years there has been significant developments in case law related to which payments should be included in the calculation of pay during annual leave. Over the summer all Agenda for Change staff moved to an average holiday pay payment method which, subject to meeting nationally agreed eligibility criteria, ensures overtime/additional hours, unsocial hours and on call payments are taken into account for pay during annual leave. The project required significant partnership working with staff side colleagues and the updating of systems and processes across a number of key services including ESR, Payroll and E-Roster.

Workforce BI Reports

The Workforce Planning and Insight Team have worked closely with colleagues within Information Services to develop a suite of workforce business intelligence reports. These reports enable managers across the Trust to access workforce reports on absence, turnover, appraisals, training, vacancies and staffing levels when they wish to access the information instead of receiving monthly reports the month after. The Workforce BI reports have been rolled out to over 400 managers within the Trust.

6. Staff Vacancies

The Trusts overall vacancy position as at 31st July 2022 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1345.9	1289.1	63.3	0.0	0.0%
Add Prof Scientific and Technical	368.8	323.5	0.0	45.3	12.3%
Administrative and Clerical Staff	1636.9	1620.5	12.8	3.6	0.2%
Allied Health Professionals	510.5	461.6	6.7	42.2	8.3%
Estates and Ancillary	609.5	525.3	2.0	82.1	13.5%
Healthcare Scientists	190.2	155.8	0.0	34.4	18.1%
Medical & Dental - Consultant	508.8	460.9	14.9	33.0	6.5%
Medical & Dental - SAS	71.4	51.1	0.2	20.0	28.0%
Medical & Dental – Trainee Grades	672.0	651.0	22.8	0.0	0.0%
Nursing and Midwifery Registered	2475.7	2330.6	41.6	103.5	4.2%
Trust Total	8389.6	7869.3	164.4	356.0	4.2%

Overall the Trust vacancy position is 4.2%. The Consultant vacancy rate has reduced to 6.5%. The vacancy rate for Registered Nursing and Midwifery is currently 4.2% across the organisation.

The Trust has offered 146 adult nurse students a post and 20 paediatric nurse students predominantly from the University of Hull to commence in September / October, 2022. In addition we have employed 340 international nurses and are recruiting a further 60 this year. From November onwards whilst the our newly qualified staff will be completing their preceptorship the Trust will have no registered nurse vacancies and will actually be over-established to assist the Trust with the additional wards open because of the NCTR patients and winter pressures.

As detailed in previous reports the Trust offers a range of apprenticeship programmes across clinical and non-clinical services including our Registered Nursing Associate (RNA) programme, our Registered Nursing Degree (RND) programme and our Health Care Support Worker (HCSW) programme.

7. Vaccination programme.

Our Head of Occupational Health and Chief Nurse Information Officer operationally jointly manage the staff seasonal flu and Covid-19 vaccination programme.

Covid-19 vaccine is still available for new starters to the Trust and anyone who has not completed a course or had a first booster dose.

Planning has started for the 2022/23 staff vaccination programme which will include seasonal flu vaccine for all staff and a second Covid-19 booster for frontline staff. Vaccination hubs will be set up in the Lecture Theatre at CHH and Ward 20 at HRI and roving teams of vaccinators and peer vaccinators in some area will also offer vaccination. The Occupational Health nurses will offer opportunistic flu vaccines to staff attending the department for other reasons.

In response to the increase in Monkeypox cases the Occupational Health Department has developed plans and vaccinated a limited number of clinical and domestic staff on Ward 7, CHH due to the worldwide shortage of smallpox vaccine national.

The department was successful in passing the annual SEQOHS accreditation assessment in July.

8. Communications and engagement

The executive manager briefing sessions have commenced with four held to date. Almost 300 managers have attended the sessions, which set out the Trust's strategy for the next three years and our commitment to 'putting people first'.

Staff-led improvement is regarded as a key element in the NHS overall score for engagement. In response to staff feedback requesting more support for improvement ideas the HUTH Improvement Month started on 1st September. The HUTH ThinkTank (a database for recording and storing improvement ideas) went live the preceding week and has received 100 suggestions from staff. A ThinkTank board, made up from improvement, finance, communications, digital and clinical professionals is triaging the ideas to understand how feasible they are and what level of support, if any, staff need to help them deliver on their suggested projects.

Following the field work in April/May/June the Barrett cultural values survey results have been received. These set out the desired culture of our trust as perceived by our workforce. The results will help us to reinforce our existing values and re-evaluate our staff charter based on the feedback staff have provided to us. A piece of work is underway to interrogate the data fully before engaging with our staff to feedback the findings and strengthen our commitment to the staff charter.

The Golden Hearts Awards will be held on 30th September 2022 for the first time since 2019. This ceremony will recognise the 2020 winners and runners up who missed out on the opportunity to celebrate due to the pandemic. The 2023 Golden Hearts Awards will be launched on the same day, inviting staff to submit their nominations.

9. Staff Support

We are now beginning to embed a more sustainable structure for Staff Support Psychology, which includes a full time clinical psychologist in ICU. We also have a General Staff Support Clinical Psychology 3 days a week in post. We are currently advertising for the remainder of the post so that we have a whole time equivalent in place to support our staff. We also have an HEE funded post for 1 year to support an Assistant Psychologist to develop training and support programmes for our staff ensuring we have an effective, safe and trauma informed programme available for all staff to access.

Occupational Health Services remain the main route for staff to access support and help for a wide range of mental and physical challenges at work. The staff support service continues to work alongside our Occupational Health Service and offers an email and telephone hotline service. The Trust is promoting and advertising the [Humber, Coast and Vale Resilience Hub](#) widely for staff to access support. The Trust continues to support staff via Focus Counselling, Occupational Health Team and the Pastoral and Spiritual Care Team for general mental wellbeing support. Coaching services are now being accessed via the coaching referral form available on Pattie.

The 24/7 staff support hotline continues to be available and is run by the Pastoral and Spiritual Care team. The OD team continue to monitor and signpost staff through the [hyp-tr.staff.support@nhs.net](mailto:tr.staff.support@nhs.net) email address.

10. Learning and Organisational Development Great Leaders Programmes

Our Great Leaders Be Remarkable programme starts its 11th Cohort in September with a wide range of leaders accessing this programme including Consultants, Senior Nurses/AHP alongside key non-clinical roles. This programme has now been updated to include the Trusts QSIR fundamentals programme building upon the current programme which focusses our leaders to explore and role model a compassionate leadership approach. The programme is split into 3 modules:

1. Getting to know yourself as a leader
2. Mindset and skills for Compassionate Leadership
3. Making a difference (aka walking the walk) – 90 Day Leadership Challenge incorporating solution focused thinking and QSIR Fundamentals.

Great Leaders 90 Day Challenge

Building on the success of the 90 Day Leadership Challenge Module within Be Remarkable, we are now making this module available as a standalone programme. Alumni of Be Remarkable fed back that the deadline helps them focus on delivery and they would value it being available more widely for their staff. This programme is in collaboration with the Trust's Improvement Team and enables staff with ideas or projects to come as individuals and groups. They receive training and support on being solution focused alongside change management. They also get a full day of QSIR fundamentals training before moving into action. The programme begins in September and is already filling up fast.

Surgical Skills Centre

The Surgical Skills Suture Centre have successfully, been awarded Grassroots in Surgery funding for their Surgical Skills To Inspire Careers – Hull (SSTICH). This is a course for schools designed to expose a young person to surgery and the allied careers – operation department practitioner, surgical care practitioner, scrub nurse – to learn more about the professions through talks by professionals and potential entry routes. They also have the opportunity to have a go at basic surgical skills such as suturing and knot tying. The session was trialled with St Marys, which received excellent feedback from both tutors and pupils alike in April 2022 and it will now be offered to interested schools late 2022 to July 2023.

This project is very close to the heart for Dr Francesca Leone (Clinical Research Fellow, Cardiothoracic Surgery) and she has worked alongside Professor Mahmoud Loubani, Director of Surgical Skills and the team to make this project become a reality. Dr Leone states, "As a young woman myself from a benefits family and a previous young carer, I wish to use my position to encourage more young people from backgrounds like mine into surgery and its allied professions".

11. Equality, Diversity & Inclusion (EDI) Initiative

Equality, Diversity & Inclusion (EDI) Initiatives

On the 30th July Pride in Hull took place in Queens Gardens, Hull. During the morning the Trust took its place in the NHS section of the parade around Queens Gardens and during the afternoon joined other local NHS organisations in a marquee to showcase the support the NHS can provide to the LGBTQ+ community.

The EDI team are currently working with LBGBTQ+ staff network to establish equality objectives for 2022/23 that would equate to the objectives set under the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES).

The Trust are one of only a small number of NHS Trusts accepted on a Rainbow Badge assessment programme. The Rainbow Badge initiative, developed at the Evelina Children's hospital in London, is a way for staff to demonstrate that the Trust is an open, non-judgemental and inclusive place for people that identify as LGBTQ+. If patients see a member of staff wearing a rainbow badge, it identifies the member of staff as someone the patient can talk to about who they are, how they feel and that the member of staff will do their best to get support for the patient if they need it. The initiative aims to make a positive difference by promoting a message of inclusion. Many young LGBTQ+ people say that they do not have an adult they can turn to or confide in. It stems from the belief that people who work in healthcare can play a key role in making things better.

During August 2022 the Enabled Staff Network, rebranded itself as the Disabled Staff Network and reclaimed the word disability as something to be open about. The Disabled Staff Network have also launched a Bridging the Gap initiative to support the Trust in creating an environment of disability confidence, at the same time as recognising that there may be staff, who are not yet comfortable with the idea of their disability or condition being 'visible' at work. The initiative is supported by webinars - one offers an insight into the lived experiences of staff with a disability and the importance of having a psychologically safe working environment for all staff and how it can enable colleagues with a disability to feel safe enough to share their disability status, and the benefits this can bring to their working lives. The second webinar focuses on the role of the line manager in embedding psychological safety and encouraging disclosure to ensure staff with a disability can bring their authentic selves to the work place.

12. Recommendations

The Trust Board is requested to note the content of the report and provide any feedback.

Officer to contact:

Simon Nearney

Director of Workforce and OD

Hull University Teaching Hospitals NHS Trust

Agenda Item	Meeting	Workforce Education and Culture Committee	Meeting Date	8.8.22
Title	Workforce Race Equality Standard (WRES) - Trust Submission 2021/22			
Lead Director	Simon Nearney, Director of Workforce and OD			
Author	Mano Jamieson, Equality Diversity and Inclusion Manager			
Report previously considered by (date)	Chair of the BAME staff leadership network			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	✓	Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	✓
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The Workforce Education and Culture Committee is asked to note the content of this report and its appendices and, subject to any amendments, endorse the WRES return and action plan for submission to the Trust Board for approval.

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES) Trust Submission 2021/22

1 Purpose

The purpose of this paper is to present the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2021/22 and proposed Action Plan for 2022/23. The 2021/22 WRES is based on data as at 31 March 2022.

2 Background

The NHS Workforce Race Equality Standard (WRES) was commissioned in 2015 and is overseen by the NHS Equality and Diversity Council and NHS England. The main purpose of the WRES is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators;
- To produce action plans to close the gaps in workplace experience between White and Black, Asian and Minority Ethnic (BAME) staff; and
- To improve BAME representation at the Board level of the organisation.

By using the WRES, NHS England expects that all NHS organisations will, year on year, improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of the CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

Equality, diversity and inclusion is one of the key strategic workforce themes within the Trust's People Strategy 2019 to 2024, which states:

"we will continue to develop an organisational culture that encourages every member of staff, whatever their role or background to succeed. A Trust where our staff work hard to make a difference for patients, where staff access opportunities to learn, develop and grow and work in a positive environment free from discrimination."

This report should be read in the context that as at 31 March 2022, the Trust employed 9,138 staff, of which:

- 7,433 (81.34%) identify as White;
- 1,558 (17.05%) identify as BAME; and
- 147 (1.61%) did not declare their ethnicity.

It should be noted that approximately 1,300 bank staff are excluded from this number for the first time this year as a separate Bank WRES (BWRES) will be published later in the year.

3 WRES Submission 2021/22

The Trust is required to submit and publish a number of returns. These include:

- Raw Technical Data: Contains validated raw technical data from the Trust's Electronic Staff Record (ESR) for staff in post at 31 March 2022. The data is used by NHS England to benchmark the Trust against other NHS organisations. The WRES Implementation Team have continued to exclude indicators 5 to 8 (which are taken from the staff survey results) from the raw technical data. The deadline to submit this data to NHS England and NHS Improvement is 31 August 2022.

- Report (Appendix 1): Supplementing the Data Template, this provides an overview and 2 year comparison of the organisation's WRES data. To enable a full comparison to be made against the nine WRES indicators; indicators 5 to 8 have been included in this report. The report must be published on the Trust's website by 27 September 2022.
- WRES Action Plan 2022/23 (Appendix 2): Based on the outcomes from the raw technical data, the Action Plan is intended to address any disparities in the experiences of BAME staff compared to White staff. The Action Plan must be published on the Trust's website by 27 September 2022.

4 Achievements throughout 2021/22

There have been a number of achievements in the past year, which are detailed below:

4.1 Re-Appointment to EDI Role

To embed the Trust's commitment to equality, diversity and inclusion, funding has been secured to appoint a dedicated equality, diversity and inclusion manager for the Trust, who will continue to cover all the protected characteristics but will have a focus on delivering the Trust's Zero Tolerance to Racism framework. The Trust's Senior OD Facilitator also continues to support the equality, diversity and inclusion agenda, particularly linked to issues which underpin the WRES.

4.2 Zero Tolerance to Racism

In collaboration with the BAME Leadership Network a Zero Tolerance to Racism task and finish group was established to explore ways in which the Trust could adopt an Anti-Racism stance that would improve the lived experience of BAME staff in the Trust.

The main objective of the group is to develop a methodology to enable the Trust to establish a Zero Tolerance to Racism process with a proposed launch date of August 2022.

4.3 Recruitment

The Trust has developed a proposal to introduce a Diversity in Recruitment scheme, whereby BAME employees are being trained to be able to sit on recruitment panels for the promotion into Band 6 nursing roles. It was identified that the first promotion to a management role is the most difficult progression for BAME nursing staff.

4.4 Our Voices Project

The 'Our Voices' project has now concluded, the project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the national Staff Survey / feedback forums.

Amongst the successes of the project was the delivery of a cookbook including recipes from a variety of members of staff from ethnic minority backgrounds, featuring recipes from each individual's cultural background.

"We come together from around the globe. We come to Hull and the East Riding. We come together united in care. We come to serve."

"The cookbook is a celebration of our staff and the diversity we bring to our community. It is also a celebration of you. People make a place."

4.5 BAME Representation on Hearing Panels

This initiative has been introduced to try to normalise BAME representation on formal employee relations panels. When a case involving a BAME colleague is referred to panel, HR colleagues first seek BAME representation for the panel from a list of trained colleagues. When the list does not have capacity, contact is made to the Chair of the BAME Network to recommend a colleague who may be able to support the panel who will be trained accordingly.

5 Overview of Key Findings from the 2021/22 Data

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 130 (from 1428 to 1558) which is a positive, this is especially significant considering Bank staff have been removed from the raw data. As previously, further work to provide career progression opportunities to BAME colleagues needs to continue (in line with the national WRES Model Employer goals).
- BAME staff continue to be less likely to enter into the formal disciplinary process compared to White staff.
- BAME staff are marginally less likely to access non-mandatory training and CPD compared to White staff, as previously highlighted as a need this data collection methodology has now been improved but still more work is required to facilitate individuals inputting of training onto HEY247.

Further improvements need to be made across the following indicators:

- The percentage of BAME staff being appointed from shortlisting increased in the last 12 months, which is the same for White staff. This indicates that the Trust have been shortlisting more candidates. The relative likelihood of White staff being appointed from shortlisting compared to BAME staff has improved slightly.
- Further work to improve the experiences of BAME staff in relation to bullying and harassment and career progression/promotion needs to continue.
- Work to improve the diversity of the Trust Board and at management grades needs to continue.

The Trust continues to be committed to closing the gap between White and BAME work life experience as detailed within the Action Plan 2022/23 (see Appendix 2).

The outcomes from the Trust's 2021/22 WRES return will be shared with the Trust's BAME Leadership Network.

6 Next Steps

The WRES Action Plan 2022/23 (in Appendix 2) details the Trust's next steps, which represents significant and ambitious plans.

7 Conclusion

The Trust's 2021/22 WRES data, shown in the WRES 2021/22 Report (see Appendix 1), continues to highlight that the lived experiences of BAME colleagues within the Trust is different to other groups.

However, the Trust is committed to addressing this and has an ambitious action plan developed in conjunction with the BAME Leadership Network Chair and BAME colleagues across the Trust to close the gap between the lived experience for BAME colleagues and other staff groups. Areas for improvement have been identified in the WRES Action Plan for 2022/23 (see Appendix 2).

8 Recommendation

The Workforce, Education and Culture Committee and Trust Board are asked to note and approve the content of this report.

Simon Nearney
Director of Workforce and Organisational Development
August 2022

Appendix 1 - Workforce Race Equality Standard (WRES) 2021/22 Report

1. Background

This report details the Trust's 2021/22 Workforce Race Equality Standard (WRES) technical data, and key findings from this data. An Action Plan, designed to address the gaps in workplace experience between White and BAME staff, is available in Appendix 2.

This report and Action Plan must be published on the Trust's external website by 27 September 2022.

2. Introduction

The Trust employed 9,138 staff at 31 March 2022. This is a decrease of 1118 staff in total compared to the previous reporting period (10,256 staff as at 31 March 2021). But it must be noted that in the region of 1,300 bank staff are excluded for the first time.

The number and percentage of staff by ethnicity is as follows:

Ethnicity	31 March 2021	31 March 2022
White	8627 (84.12%)	7433 (81.34%)
BAME	1428 (13.92%)	1558 (17.05%) (+130)
Not Stated	201 (1.96%)	147 (1.61%)
Grand Total	10,256	9,138

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

3 WRES 2021/22 Data

3.1 Indicator 1: Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and Very Senior Managers (including Executive Board members) compared with the percentage of staff in the overall workforce

Non-Clinical Staff

In the non-clinical category, there has been a total decrease of 69 staff across all ethnicities (from 2275 to 2105). Of this there has been an increase of BAME staff by 1 (from 75 to 76).

Table 1: The number and percentage of **NON-CLINICAL** staff at 31 March 2022

	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Under B1	5	100.00	0	0.00	0	0.00
B1	29	93.55	2	6.45	0	0.00
B2	898	94.83	39	4.12	10	1.06
B3	440	96.70	11	2.42	4	0.88
B4	197	96.57	6	2.94	1	0.49
B5	185	97.88	4	2.12	0	0.00
B6	100	96.15	4	3.85	0	0.00
B7	86	91.49	3	3.19	5	5.32
B8a	67	90.54	4	5.41	3	4.05
B8b	41	95.35	1	2.33	1	2.33
B8c	23	95.83	1	4.17	0	0.00
B8d	6	85.71	0	0.00	1	14.29
B9	1	100.00	0	0.00	0	0.00
VSM	27	96.43	1	3.57	0	0.00
Total	2105		76		25	

Clinical Non-Medical Staff

In the clinical non-medical category, there has been a total decrease of 940 staff across all ethnicities (from 6568 to 5628). Despite this, there has been an increase of BAME staff by 118 (from 613 to 731).

The decrease in headcount is due to the removal of Bank staff numbers. The increase in BAME numbers is due to the Trust's ongoing international Nurse recruitment programme and the predominance of International Medical Graduates, the majority of whom are BAME.

Table 2: The number/percentage of **CLINICAL NON-MEDICAL** staff at 31 March 2022

	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Under B1	67	95.71	3	4.29	0	0.00
B1	4	100.00	0	0.00	0	0.00
B2	1016	95.85	34	3.21	10	0.94
B3	497	96.13	14	2.71	6	1.16
B4	194	94.63	11	5.37	0	0.00
B5	1344	70.81	528	27.82	26	1.37
B6	906	89.53	92	9.09	14	1.38
B7	582	93.57	32	5.14	8	1.29
B8a	140	89.17	14	8.92	3	1.91
B8b	48	96.00	2	4.00	0	0.00
B8c	16	94.12	0	0.00	1	5.88
B8d	2	100.00	0	0.00	0	0.00
B9	2	100.00	0	0.00	0	0.00
VSM	11	91.67	1	8.33	0	0.00
Total	4829		731		68	

Medical and Dental Staff

There has been a total decrease of medical and dental staff across all ethnicities by 109 (from 1413 to 1304) potentially driven by the removal of Bank staff. Despite this, there has been an increase of BAME staff by 11 (from 740 to 751).

Table 3: The number/percentage of **MEDICAL AND DENTAL** staff at 31 March 2022

2021/22	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Consultants	223	46.36	245	50.94	13	2.70
Non-Consultant Career Grade	16	27.12	40	67.80	3	5.08
Trainee Grades	260	34.03	466	60.99	38	4.97
Other	0	0.00	0	0.00	0	0.00
Total	499		751		54	

Table 4: The number and percentage of **NON-CLINICAL** staff by band at 31 March 2022 using a baseline of 17.05% (% of BAME staff)

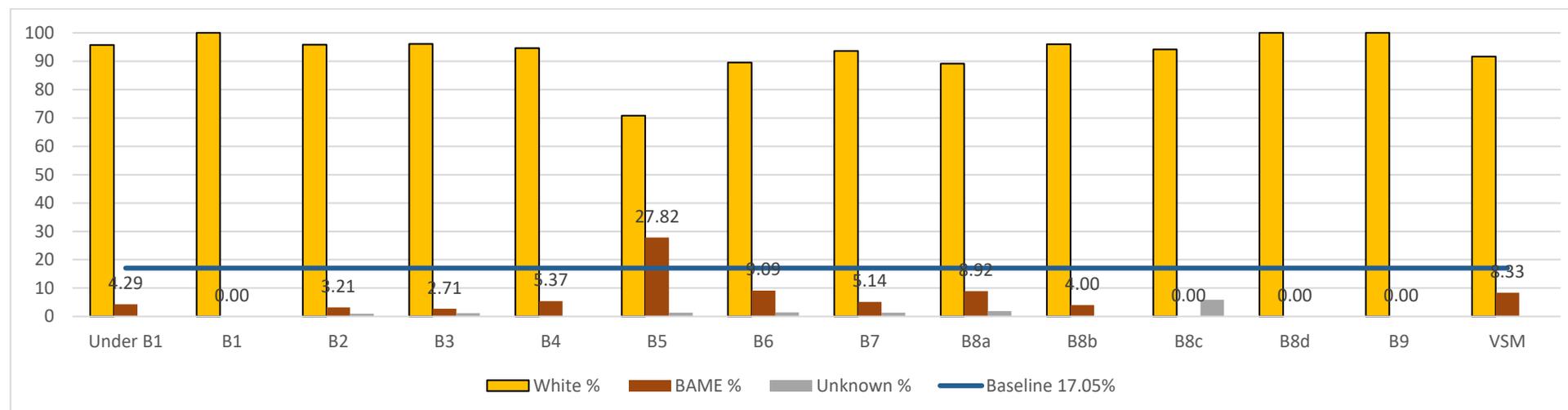


Table 5: The number and percentage of **NON-CLINICAL** staff in each band over 2 years

	2020/21		2021/22		2020/21		2021/22		2020/21		2021/22	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	8	100%	5	100.00	0	0%	0	0.00	0	0%	0	0.00
B1	38	90.48%	29	93.55	3	7.14%	2	6.45	1	2.38%	0	0.00
B2	962	94.50%	898	94.83	46	4.52%	39	4.12	10	0.98%	10	1.06
B3	469	97.51%	440	96.70	7	1.46%	11	2.42	5	1.04%	4	0.88
B4	185	97.37%	197	96.57	3	1.58%	6	2.94	2	1.05%	1	0.49
B5	172	97.18%	185	97.88	4	2.26%	4	2.12	1	0.56%	0	0.00
B6	94	95.92%	100	96.15	3	3.06%	4	3.85	1	1.02%	0	0.00
B7	91	91%	86	91.49	5	5%	3	3.19	4	4%	5	5.32
B8a	60	95.24%	67	90.54	1	1.59%	4	5.41	2	3.17%	3	4.05
B8b	42	95.45%	41	95.35	2	4.55%	1	2.33	0	0%	1	2.33
B8c	19	100%	23	95.83	0	0%	1	4.17	0	0%	0	0.00
B8d	7	87.50%	6	85.71	0	0%	0	0.00	1	12.50%	1	14.29
B9	0	0%	1	100.00	0	0%	0	0.00	0	0%	0	0.00
VSM	26	96.30%	27	96.43	1	3.70%	1	3.57	0	0%	0	0.00
Total	2173		2105		75		76		27		25	

Table 6: The number and percentage of **CLINICAL NON-MEDICAL** staff by band at 31 March 2022 using a baseline of 17.05% (% of BAME staff)

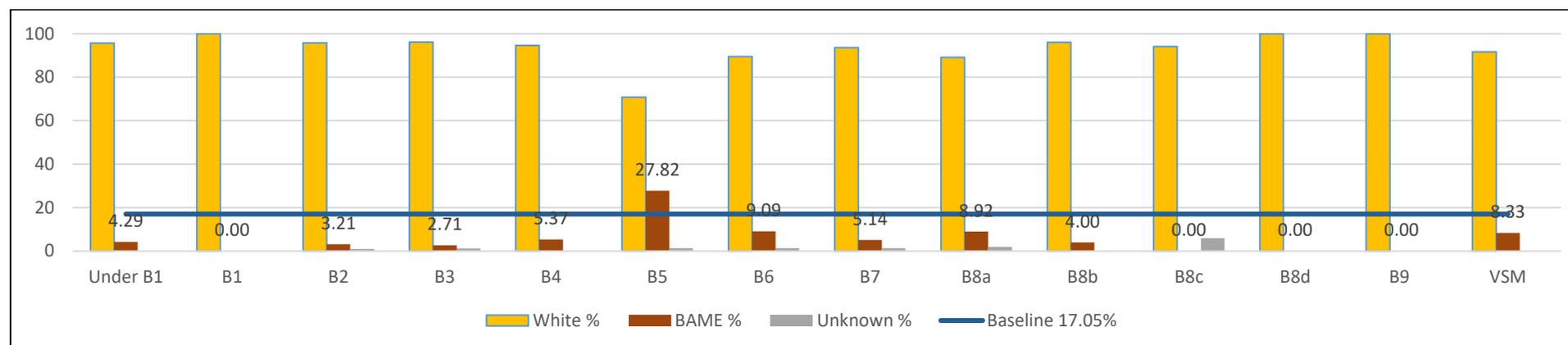


Table 7: The number and percentage of **CLINICAL NON-MEDICAL** staff in each band over 2 years

	2020/21		2021/22		2020/21		2021/22		2020/21		2021/22	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	66	94.29%	67	95.71	4	5.71%	3	4.29	0	0%	0	0.00
B1	6	100%	4	100.00	0	0%	0	0.00	0	0%	0	0.00
B2	1314	93.59%	1016	95.85	71	5.06%	34	3.21	19	1.35%	10	0.94
B3	643	95.54%	497	96.13	19	2.82%	14	2.71	11	1.63%	6	1.16
B4	282	90.10%	194	94.63	16	5.11%	11	5.37	15	4.79%	0	0.00
B5	1709	81.15%	1344	70.81	371	17.62%	528	27.82	26	1.23%	26	1.37
B6	978	90.81%	906	89.53	84	7.80%	92	9.09	15	1.39%	14	1.38
B7	623	93.83%	582	93.57	30	4.52%	32	5.14	11	1.66%	8	1.29
B8a	150	89.82%	140	89.17	14	8.38%	14	8.92	3	1.80%	3	1.91
B8b	47	94%	48	96.00	3	6%	2	4.00	0	0%	0	0.00
B8c	21	95.45%	16	94.12	0	0%	0	0.00	1	4.55%	1	5.88
B8d	4	100%	2	100.00	0	0%	0	0.00	0	0%	0	0.00
B9	2	100%	2	100.00	0	0%	0	0.00	0	0%	0	0.00
VSM	9	90%	11	91.67	1	10%	1	8.33	0	0%	0	0.00
Total	5854		4829		613		731		101		68	

Table 8: The number and percentage of **MEDICAL AND DENTAL** staff by band at 31 March 2022 using a baseline of 17.05% (% of BAME staff)

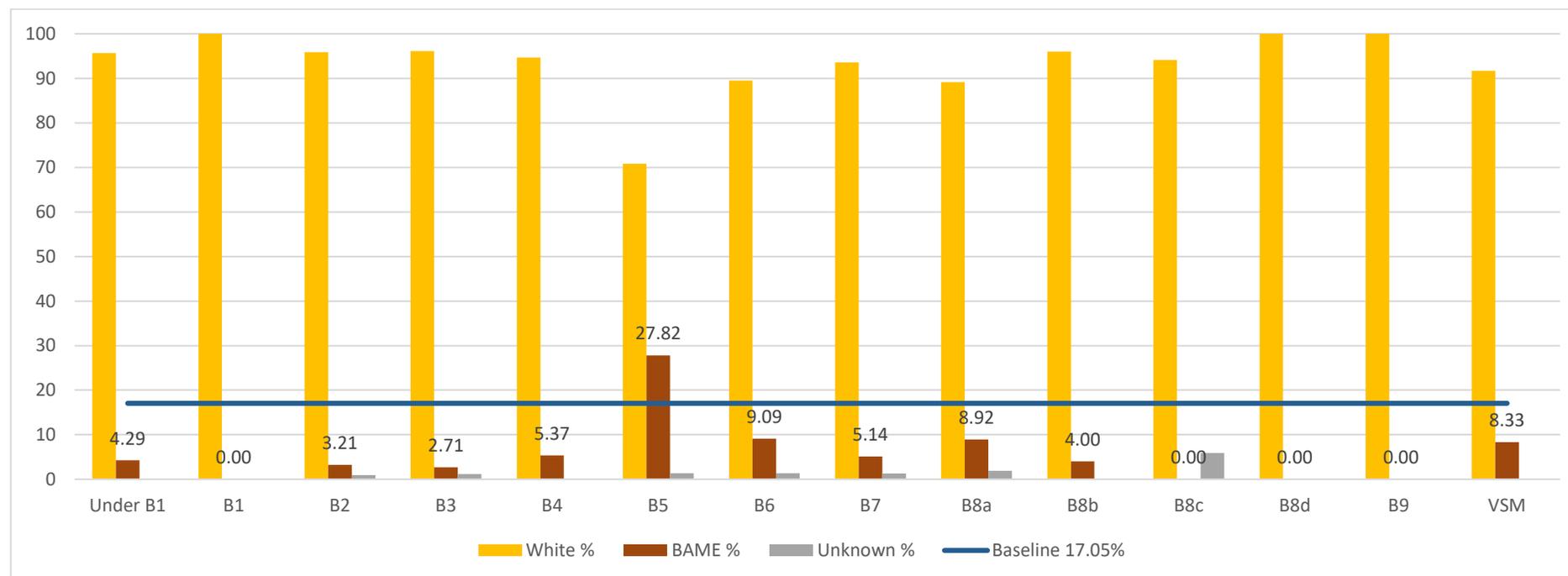


Table 9: The number and percentage of **MEDICAL AND DENTAL** staff in each band over 2 years

	2020/21		2021/22		2020/21		2021/22		2020/21		2021/22	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Consultants	241	46.08%	223	46.36	263	50.29%	245	50.94	19	3.63%	13	2.70
Non-Consultant Career Grade	22	30.14%	16	27.12	48	65.75%	40	67.80	3	4.11%	3	5.08
Trainee Grades	337	41.25%	260	34.03	429	52.51%	466	60.99	51	6.24%	38	4.97
Other	0	0%	0	0.00	0	0%	0	0.00	0	0%	0	0.00
Total	600		499		740		751		73		54	

3.2 Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts

In comparison to the 2020/21 WRES data, this year's data shows:

- 1083 BAME applicants were shortlisted and 204 appointed compared to last year (which showed 614 BAME applicants were shortlisted and 105 appointed).
- The percentage of BAME staff being appointed from shortlisting has slightly improved. This reflects through in the slight improvement in the relative likelihood of appointment. The relative likelihood is that White staff are 1.34 times more likely to be appointed from shortlisting compared to BAME colleagues.

Table 10: The percentage of staff **SHORTLISTED** and **APPOINTED** over 2 years

Ethnicity	2020/21	2021/22
White	24.46%	25.17%
BAME	17.10%	18.84%
Not Stated	25%	45.83%
Relative likelihood	1.43	1.34

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.3 Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

This indicator takes into account staff who have been through the formal disciplinary process by ethnicity. Where a collective disciplinary has occurred, multiple ethnicities are not recorded. During the reporting timeframe, there were 2 collective disciplinaries, which for the purposes of the WRES, has been included in the 'Not Stated' figures.

In comparison to the 2020/21 WRES data, the 2021/22 data shows:

- BAME staff are less likely to enter into the disciplinary process than White staff.
- The number of disciplinaries in total across all ethnicities from 1 April 2021 to 31 March 2022 has increased by 8 (from 117 to 125).
- However, the number of BAME staff entering the formal disciplinary process has increased by 1 (from 9 to 10 in total over the last year).

Table 11: Percentage of staff who entered into a **FORMAL DISCIPLINARY PROCESS**

Ethnicity	2020/21	2021/22
White	1.21%	1.52%
BAME	0.63%	0.64%
Not Stated	1.99%	1.36%
Relative likelihood	0.52	0.42

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.4 Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD

In comparison to the 2020/21 WRES data, this year's data shows:

- The number of BAME staff accessing training has decreased by 105 employees (from 1445 to 1340).
- Within the Trust, the relative likelihood shows that BAME staff are less likely to access non-mandatory training and CPD than to White staff.

NB: An outcome from the 2019/20 WRES data audit was to improve the data for this indicator. Therefore, in conjunction with the Head of Learning and Organisational Development, this was reviewed and improvements were made to the reporting in this year's report.

Table 12: Percentage of staff who accessed **NON-MANDATORY TRAINING** and **CPD**

Ethnicity	2020/21	2021/22
White	99.84%	88.04%
BAME	101.19%	86.01%
Not Stated	72.14%	88.44%
Relative likelihood	0.99	1.02

NB: Colour coded to show where the change is **positive/negative** for BAME colleagues

3.5 Indicator 5-8 Staff Survey Results

The 2021/22 Staff Survey results show in comparison to the 2020/21 data:

- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has increased for both staff groups.
- Bullying and harassment from staff has decreased for both White and BAME staff.
- The number of staff who feel that the Trust provides equal opportunities for career progression or promotion has remained the same for White staff and increased by approximately 2% for BAME staff.
- The number of BAME staff who stated that they personally experienced discrimination at work from a manager/team leader or other colleagues has increased.

Table 13: Data for Indicators 5 to 8

Staff Survey Indicators	White %		BAME %	
	2020/21	2021/22	2020/21	2021/22
Indicator 5: KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	23.5%	25.5%	26.5%	28.8%
Indicator 6: KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	26.8%	26.0%	34.1%	31.3%
Indicator 7: KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	58.7%	58.7%	42.5%	44.8%
Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues	5.6%	7.3%	15.9%	18.2%

NB: Colour coded to show where the change is **positive/negative** for BAME colleagues

3.6 Indicator 9: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

As at 31 March 2022, the Trust has 18 Board members in total, of which:

- 16 (88.9%) are of White ethnicity compared to 15 in the previous year.
- 2 (11.1%) are BAME staff members, which is an increase of 1 compared to the previous year.

Table 14: Percentage difference between the **BOARD MEMBERSHIP VS. OVERALL WORKFORCE**

Ethnicity	2020/21	2021/22
Difference (total Board – overall workforce)	-7.7%	-5.9%

4. Achievements throughout 2021/22

There have been a number of achievements in the past year, which are detailed below:

4.1 Re-Appointment to EDI Role

To embed the Trust's commitment to equality, diversity and inclusion, funding has been secured to appoint a dedicated equality, diversity and inclusion manager for the Trust, who will continue to cover all the protected characteristics but will have a focus on delivering the Trust's Zero Tolerance to Racism framework. The Trust's Senior OD Facilitator also continues to support the equality, diversity and inclusion agenda, particularly linked to issues which underpin the WRES.

4.2 Zero Tolerance to Racism

In collaboration with the BAME Leadership Network a Zero Tolerance to Racism task and finish group was established to explore ways in which the Trust could adopt an Anti-Racism stance that would improve the lived experience of BAME staff in the Trust.

The main objective of the group is to develop a methodology to enable the Trust to establish a Zero Tolerance to Racism process with a proposed launch date of August 2022.

4.3 Recruitment

The Trust has developed a proposal to introduce a Diversity in Recruitment scheme, whereby BAME employees are being trained to be able to sit on recruitment panels for the promotion into Band 6 nursing roles. It was identified that the first promotion to a management role is the most difficult progression for BAME nursing staff.

4.4 Our Voices Project

The 'Our Voices' project has now concluded, the project asked staff, volunteers and trainees to share their voices and lived experiences to improve staff experiences as measured by the national Staff Survey / feedback forums.

Amongst the successes of the project was the delivery of a cookbook including recipes from a variety of members of staff from ethnic minority backgrounds, featuring recipes from each individual's cultural background.

"We come together from around the globe. We come to Hull and the East Riding. We come together united in care. We come to serve."

"The cookbook is a celebration of our staff and the diversity we bring to our community. It is also a celebration of you. People make a place."

4.5 BAME Representation on Hearing Panels

This initiative has been introduced to try to normalise BAME representation on formal employee relations panels. When a case involving a BAME colleague is referred to panel, HR colleagues first seek BAME representation for the panel from a list of trained colleagues. When the list does not have capacity, contact is made to the Chair of the BAME Network to recommend a colleague who may be able to support the panel who will be trained accordingly.

5 Summary

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 130 (from 1428 in 2020/21 to 1558 in 2021/22) which is a positive. However, further work to provide career progression opportunities, which will include a full review of recruitment processes, to BAME colleagues (in line with the national WRES Model Employer goals) needs to continue.
- BAME staff continue to be less likely to enter into the formal disciplinary process compared to White staff.

- Within the Trust, the relative likelihood shows that BAME staff are less likely to access non-mandatory training and CPD than to White staff.

Further improvements need to be made across the following indicators:

- Although the percentage of BAME staff being appointed from shortlisting increased in the last 12 months, further work is required to reduce the gap between the overall relative likelihood of White staff being appointed from shortlisting compared to BAME staff.
- Further work to improve the experiences of BAME staff in relation to bullying and harassment needs to continue.
- Work to improve the diversity of the Trust Board needs to continue.

The Trust continues to be committed to closing the gap between White and BAME work life experience as detailed within the Action Plan 2022/23 (see Appendix 2).

Appendix 2 - Workforce Race Equality Standard Action Plan 2022/23

The Action Plan 2022/23 has been developed, based on the 2021/22 WRES technical data results, to help close the gaps in workplace experience between White and Black and Ethnic Minority (BAME) staff. A separate detailed workplan supports the Action Plan.

Action	WRES Indicator	Timescale	Lead
Develop and Launch a Zero Tolerance to Racism Framework and Reporting tool that will enable the Trust to adopt an Anti-Racist stance	Indicators 5, 6, 8	August 2022	Workforce & OD EDI Team
Establish a "Circle Group" to analyse heat maps and individual reports of Racism and Triage for meaningful interventions agreed with reporters	Indicators 5, 6, 8	August 2022	Workforce & OD EDI Team
Use the Zero Tolerance to Racism Framework to challenge Racism by Patients and Service Users so that they are held to account for unacceptable interactions with our staff	Indicators 5	August 2022	Workforce & OD EDI Team
Conduct a thorough review of the recruitment process through an EDI lens and introduce initiatives that will enable BAME staff to progress their careers on an equal basis	Indicators 1, 2, 7	March 2023	Workforce & OD EDI Team
Review Value Based Recruitment to understand if it offers equality of opportunity irrespective of cultural background. If appropriate make recommendations for changes that will make VBR representative irrespective of ethnicity.	Indicator 2, 7	March 2023	Workforce & OD EDI Team
Explore the concept of a Shadow Trust Board and how this might be established in our Trust offering the opportunity of Board mentorship to BAME staff	Indicator 1, 9	March 2023	Workforce & OD EDI Team

WRES Indicators

1. Indicator 1 - compare the data for white and BAME staff: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. KF: 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8. Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues
9. Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

Hull University Teaching Hospitals NHS Trust

Agenda Item		Meeting	Workforce Education and Culture Committee	Meeting Date	8.8.22
Title	Workforce Disability Equality Standard (WDES) Trust Submission 2022				
Lead Director	Simon Nearney, Director of Workforce and OD				
Author	Mano Jamieson, Equality, Diversity and Inclusion Manager				
Report previously considered by (date)	Chair of the Enabled Staff Network				

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	✓	Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	✓
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	✓
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:
<p>The Workforce Education and Culture Committee is asked to note the content of this report and its appendices and, subject to any amendments, endorse the WDES return and action plan for submission to the Trust Board for approval.</p>

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES) Trust Submission 2022

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2022 and proposed action plan.

2 Background

The NHS Workforce Disability Equality Standard (WDES) was commissioned in 2019 and is overseen by the NHS Equality and Diversity Council and NHS England.

The WDES is underpinned by the Social Model of Disability, which proposes that people are disabled because of societal barriers, rather than a long-term health condition. With the social model in mind, the WDES aims to help inform year on year improvements in reducing those barriers that impact most on the career and workplace experiences of Disabled staff; driving changes in attitudes, increasing employment and career opportunities and implementing long lasting change for Disabled people.

The WDES enables NHS organisations (and other organisations providing NHS services) to review their data against the ten WDES indicators and to produce action plans to close the gaps in workplace experience between disabled and non-disabled staff.

By using the WDES, NHS England expects that all NHS organisations will, year on year, improve workforce disability equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WDES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime under the 'Well-led' domain.

3 WDES Submission 2022

The Trust is required to submit a number of returns. These include:

- Data Template: The template contains validated raw data from the Trust's Electronic Staff Record for staff in post at 31 March 2022. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust is required to submit the Data Template by 31 August 2022.
- Reporting Template (see Appendix 1) which is supported by accompanying data report for Indicator 1: Staff employed across Agenda for Change Bandings (see Appendix 2).
- WDES Action Plan which is based on the outcomes from the technical data results and is intended to address disparities in the experiences of disabled staff compared to non-disabled staff (see Appendix 3).
- This report should be read in the context that only 272 staff self-reported with a disability whereas when completing the Staff Survey (December 2021) a higher number of staff reported themselves as disabled.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 31 October 2022.

4 Key Findings for 2022

The WDES seeks to ask questions in the following areas:

1. The percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers compared with the percentage of staff in the overall workforce at 31 March 2022.

2. The relative likelihood of Disabled staff compared to Non-disabled staff being appointed from shortlisting across all posts.
3. The relative likelihood of Disabled staff compared to Non-disabled staff entering the formal capability process.
4. The percentage of Disabled staff compared to Non-disabled staff experiencing harassment, bullying or abuse.
5. The percentage of Disabled staff compared to Non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. The percentage of Disabled staff compared to Non-disabled staff saying they have felt pressure from their managers to come to work when they have not felt well enough to do their duties.
7. The percentage of Disabled staff compared to Non-disabled staff saying they are satisfied with the extent to which their organisation values their work.
8. The percentage of Disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.
9. A) The staff engagement scores for Disabled staff, compared to Non-disabled staff and the overall engagement score for the organisation.
B) Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?
10. The percentage difference between the organisation's Board voting membership and its organisation's overall workforce at 31 March 2022.

The key findings from the technical data for 2022 are:

- The Trust employed 9,138 staff at 31 March 2022.
- Of the 9,138 staff, 28.29% (2,585) had not declared being disabled or non-disabled and are recorded as 'unknown or null'. This metric has improved from 29.47% (2021).
- 272 staff have reported as Disabled on ESR; a decrease from 282 staff (2021).
- The metric with the highest disparity between Non-disabled staff and Disabled staff is staff saying they are satisfied with the extent to which their organisation values their work (Staff Survey December 2021 data). This metric has decreased for Disabled staff from 37.1% (2020) to 31.6% (2021).
- The metric with the lowest disparity between Non-disabled staff and Disabled staff is staff that said the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months (Staff Survey December 2021 data). This metric has increased for Disabled staff from 39.7% (2020) to 43.0% (2021).

The data for 4 to 9 B) above is from the Staff Survey and inherently more staff report themselves as disabled when completing the staff survey compared to the staff who report themselves as disabled through ESR.

The data shows there are improvements to be made across all of the indicators and the disparity between the experience of Disabled staff measured against Non-disabled staff remains a challenge for the Trust. The integrity of the data would be increased by an improvement in the declaration of staff regarding being disabled or non-disabled on ESR.

5 **WDES Action Plan**

The draft WDES Action Plan for 2022/2023 is available in Appendix 3.

6 Recommendation

The Executive Management Committee is asked to note the content of this report and its appendices and, subject to any amendments, endorse the WDES return and action plan for submission to the Trust Board for approval.

Simon Nearney
Director of Workforce and Organisational Development
August 2022

WORKFORCE DISABILITY EQUALITY STANDARD REPORTING TEMPLATE

Workforce Disability Equality Standard

Name of organisation:	Hull University Teaching Hospital NHS Trust
Date of report:	March 2022
Name and title of Board lead for the Workforce Disability Equality Standard:	Simon Nearney, Director of Workforce & OD
Name of lead compiling this report:	Mano Jamieson, EDI Manager
Names of commissioners this report has been sent to:	Humber & North Yorkshire Health & Care Partnership ICB
Name of co-ordinating commissioner this report has been sent to:	HNY ICB
Unique URL link on which this report and associated Action Plan will be found:	www.hey.nhs.uk
This report has been signed off by on behalf of the Board on (insert name and date):	Chris Long, Chief Executive

1. Background Narrative

Any issues of completeness of data: The data has been collected from the Trust's Electronic Staff Record (ESR) however 28.29% of the workforce have not declared as disabled or non-disabled, which represents 2,585 of the total workforce.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 9,138

Proportion of disabled staff employed within the Trust at the date of the report: 2.98% of the total staff employed as self-declared through ESR.

3. Self-Reporting

The proportion of total staff who have self-reported disabled/non-disabled: 71.71%

Have any steps been taken to increase declaration rates? All new starters to the organisation are asked to complete an equality monitoring form and their details are recorded on ESR. Existing staff continue to be reminded to check their personal details and update their ESR entry where appropriate.

Are any steps planned during the current reporting period to improve the level of self-reporting? To improve the quality of data stored within ESR, ESR Self Service continues to be rolled out, highlighting to staff that they can update their personal information, including ethnicity, marital/partnership status and disability status. To support this process we are introducing a Bridging the Gap initiative to encourage declaration.

4. Workforce Data

What period does the organisation's workforce data refer to: Staff in post at 31 March 2022 and activity during the financial year 2021/22. It should be noted that to maintain consistency with the reported total staff number used in the WRES data, that has removed approximately 1,300 Bank Staff, we have replicated the same staff numbers for WDES thereby excluding Bank Staff.

5. Workforce Disability Equality Indicators

	Indicator	Data for reporting year 2021/22	Data for previous year 2020/21	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective																								
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	<p>See Appendix 2 for breakdown by pay banding (From ESR). Where disability is known for 31 March 2022:</p> <table border="1"> <tr> <td>Non-clinical workforce (Non-disabled) =</td> <td>15.70%</td> <td>Non-clinical workforce (Non-disabled) =</td> <td>13.98%</td> </tr> <tr> <td>Non-clinical workforce (Disabled) =</td> <td>0.74%</td> <td>Non-clinical workforce (Disabled) =</td> <td>0.69%</td> </tr> <tr> <td>Clinical workforce (non-medical Non-disabled) =</td> <td>41.53%</td> <td>Clinical workforce (non-medical Non-disabled) =</td> <td>42.71%</td> </tr> <tr> <td>Clinical workforce (non-medical Disabled) =</td> <td>1.96%</td> <td>Clinical workforce (non-medical Disabled) =</td> <td>1.76%</td> </tr> <tr> <td>Clinical workforce (medical and dental non-disabled) =</td> <td>11.50%</td> <td>Clinical workforce (medical and dental Non-disabled) =</td> <td>11.10%</td> </tr> <tr> <td>Clinical workforce (medical and dental Disabled) =</td> <td>0.27%</td> <td>Clinical workforce (medical and dental Disabled) =</td> <td>0.30%</td> </tr> </table>	Non-clinical workforce (Non-disabled) =	15.70%	Non-clinical workforce (Non-disabled) =	13.98%	Non-clinical workforce (Disabled) =	0.74%	Non-clinical workforce (Disabled) =	0.69%	Clinical workforce (non-medical Non-disabled) =	41.53%	Clinical workforce (non-medical Non-disabled) =	42.71%	Clinical workforce (non-medical Disabled) =	1.96%	Clinical workforce (non-medical Disabled) =	1.76%	Clinical workforce (medical and dental non-disabled) =	11.50%	Clinical workforce (medical and dental Non-disabled) =	11.10%	Clinical workforce (medical and dental Disabled) =	0.27%	Clinical workforce (medical and dental Disabled) =	0.30%		In total 70.53% of Trust staff declared themselves as disabled or non-disabled. The highest percentage of disabled employees are within the clinical workforce (non-medical) whilst the lowest percentage of disabled employees are within the clinical workforce (medical and dental)	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
Non-clinical workforce (Non-disabled) =	15.70%	Non-clinical workforce (Non-disabled) =	13.98%																										
Non-clinical workforce (Disabled) =	0.74%	Non-clinical workforce (Disabled) =	0.69%																										
Clinical workforce (non-medical Non-disabled) =	41.53%	Clinical workforce (non-medical Non-disabled) =	42.71%																										
Clinical workforce (non-medical Disabled) =	1.96%	Clinical workforce (non-medical Disabled) =	1.76%																										
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Clinical workforce (medical and dental Disabled) =	0.27%	Clinical workforce (medical and dental Disabled) =	0.30%																										
2	Relative likelihood of Non-disabled staff being appointed compared to disabled applicants from shortlisting across all posts.	Non-disabled: 0.24 Disabled: 0.21 Relative likelihood: 1.14	Non-disabled: 0.24 Disabled: 0.18 Relative likelihood: 1.31	The data shows that Non-disabled staff are more likely than Disabled staff to be appointed from shortlisting.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.																								

	Indicator	Data for reporting year 2021/22	Data for previous year 2020/21	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
3	Relative likelihood of Disabled staff entering the formal capability process compared to Non-disabled staff. This indicator will be based on data from a two year rolling average of the current year and the previous year.	Disabled: 0.0001 Non-disabled: 0.0002 Relative likelihood: 11.56	Disabled: 0.00 Non-disabled: 0.00 Relative likelihood: 6.16	The numbers of staff entering the formal capability process are low, the relative likelihood of entering the formal capability process is nil for both Disabled and Non-Disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) i	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Non-disabled: 24.6% Disabled: 30.3% (From Staff Survey December 2021)	Non-disabled: 22.5% Disabled: 29.6% (From Staff Survey December 2020)	The percentage of Disabled and Non-Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) ii	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months.	Non-disabled: 12.6% Disabled: 17.9% (From Staff Survey December 2021)	Non-disabled: 12.2% Disabled: 17.7% (From Staff Survey December 2020)	The percentage of Disabled and Non-disabled staff experiencing harassment, bullying or abuse from managers has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4 a) iii	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months.	Non-disabled: 18.5% Disabled: 27.9% (From Staff Survey December 2021)	Non-disabled: 18.8% Disabled: 30.9% (From Staff Survey December 2020)	The percentage of Non-disabled and Disabled staff experiencing harassment, bullying or abuse from other colleagues has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
4b	Percentage of staff that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	Non-disabled: 41.5% Disabled: 43.0% (From Staff Survey December 2021)	Non-disabled: 43.7% Disabled: 39.7% (From Staff Survey December 2020)	The percentage of Disabled staff reporting harassment, bullying or abuse at work has increased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2021/22	Data for previous year 2020/21	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
5	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	Non-disabled: 58.4% Disabled: 52.2% (From Staff Survey December 2021)	Non-disabled: 57.2% Disabled: 53.5% (From Staff Survey December 2020)	The percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
6	Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Non-disabled: 25.9% Disabled: 31.3% (From Staff Survey December 2021)	Non-disabled: 24.9% Disabled: 31.3% (From Staff Survey December 2020)	The Percentage of Disabled staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties has remained the same.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
7	Percentage of staff saying they are satisfied with the extent to which their organisation values their work.	Non-disabled: 41.3% Disabled: 31.6% (From Staff Survey December 2021)	Non-disabled: 52.2% Disabled: 37.1% (From Staff Survey December 2020)	The percentage of Disabled staff saying they are satisfied with the extent to which their organisation values their work has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
8	Percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work.	69.8% (From Staff Survey December 2021)	81.4% (From Staff Survey December 2020)	The percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work has decreased.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9a	Staff engagement score for Disabled staff, compared to Non-disabled staff and the overall score for the organisation.	Non-disabled staff: 6.9 Disabled: 6.4 Organisation: 6.7 (From Staff Survey December 2021)	Non-disabled staff: 7.2 Disabled: 6.7 Organisation: 7.1 (From Staff Survey December 2020)	The staff engagement score for Disabled staff continues to be lower than for Non-disabled staff.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.
9b	Has the Trust taken action to facilitate the voices of Disabled staff	Yes	Yes	The Trust has an Enabled Staff Support Network and held a Network Conference.	Please see action plan.

	Indicator	Data for reporting year 2021/22	Data for previous year 2020/21	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	in the organisation to be heard?				Actions link to EDS2 goals and the Trust Equality Objectives.
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	4.0%	5.0%	Considering the percentage of staff who have self-reported as Non-disabled and the percentage of staff who have self-reported as Disabled the disaggregated percentage difference would be expected to be very low. The Trust acknowledges that, in respect of disability, the Board is not representative of the population it serves. Within Hull and East Riding the disabled population is 19%.	Please see action plan. Actions link to EDS2 goals and the Trust Equality Objectives.

6. Are there any other factors or data which should be taken into consideration in assessing progress? No

7. Organisations should produce a detailed WDES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WDES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WDES Action Plan or provide a link to it.

The Draft WDES Action plan is attached.

				Snapshot of data as at 31st MARCH 2022							
				Disabled staff		Non-disabled staff		Disability Unknown or Null		Overall	
Metric	Indicator		Measure	# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/ Null	% Unknown/ Null	Total	
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	1a) Non Clinical Staff									
		Under Band 1	Headcount	0	0.0%	4	80.0%	1	20.0%	5	
		Bands 1	Headcount	1	3.2%	17	54.8%	13	41.9%	31	
		Bands 2	Headcount	26	2.7%	620	65.5%	301	31.8%	947	
		Bands 3	Headcount	17	3.7%	300	65.9%	138	30.3%	455	
		Bands 4	Headcount	7	3.4%	139	68.1%	58	28.4%	204	
		Bands 5	Headcount	7	3.7%	128	67.7%	54	28.6%	189	
		Bands 6	Headcount	3	2.9%	65	62.5%	36	34.6%	104	
		Bands 7	Headcount	2	2.1%	65	69.1%	27	28.7%	94	
		Bands 8a	Headcount	1	1.4%	44	59.5%	29	39.2%	74	
		Bands 8b	Headcount	1	2.3%	22	51.2%	20	46.5%	43	
		Bands 8c	Headcount	2	8.3%	9	37.5%	13	54.2%	24	
		Bands 8d	Headcount	0	0.0%	3	42.9%	4	57.1%	7	
		Bands 9	Headcount	0	0.0%	1	100.0%	0	0.0%	1	
		VSM	Headcount	1	3.6%	18	64.3%	9	32.1%	28	
		Other (e.g. Bank or Agency) Please specify in notes.	Headcount	0		0		0		0	
		1b) Clinical Staff									
		Under Band 1	Headcount	6	8.57%	61	87.14%	3	4.29%	70	
		Bands 1	Headcount	0	0.00%	3	75.00%	1	25.00%	4	
		Bands 2	Headcount	25	2.36%	771	72.74%	264	24.91%	1060	
		Bands 3	Headcount	13	2.51%	316	61.12%	188	36.36%	517	
		Bands 4	Headcount	8	3.90%	129	62.93%	68	33.17%	205	
		Bands 5	Headcount	70	3.69%	1411	74.34%	417	21.97%	1898	
		Bands 6	Headcount	36	3.56%	660	65.22%	316	31.23%	1012	
		Bands 7	Headcount	15	2.41%	331	53.22%	276	44.37%	622	
		Bands 8a	Headcount	5	3.18%	78	49.68%	74	47.13%	157	
		Bands 8b	Headcount	1	2.00%	23	46.00%	26	52.00%	50	
		Bands 8c	Headcount	0	0.00%	6	35.29%	11	64.71%	17	
		Bands 8d	Headcount	0	0.00%	1	50.00%	1	50.00%	2	
		Bands 9	Headcount	0	0.00%	1	50.00%	1	50.00%	2	
		VSM	Headcount	0	0.00%	4	33.33%	8	66.67%	12	
		Medical & Dental Staff, Consultants	Headcount	3	0.62%	314	65.28%	164	34.10%	481	
		Medical & Dental Staff, Non-Consultants career grade	Headcount	1	1.69%	40	67.80%	18	30.51%	59	
Medical & Dental Staff, Medical and dental trainee grades	Headcount	21	2.75%	697	91.23%	46	6.02%	764			
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By Voting membership of the Board • By Executive membership of the Board This is a snapshot as of at 31st March 2022.	Total Board members	Headcount	1	5.56%	11	61.11%	6	33.33%	18	
		<i>of which: Voting Board members</i>	Headcount	1	7.14%	9	64.29%	4	28.57%	14	
		<i>: Non Voting Board members</i>	Auto-Calculated	0	0.00%	2	50.00%	2	50.00%	4	
		<i>of which: Exec Board members</i>	Headcount	1	11.11%	5	55.56%	3	33.33%	9	
		<i>: Non Executive Board members</i>	Auto-Calculated	0	0.00%	6	66.67%	3	33.33%	9	
		Difference (Total Board - Overall workforce)	Auto-Calculated		3%		-8%		5%		
		Difference (Voting membership - Overall Workforce)	Auto-Calculated		4%		-4%		0%		
		Difference (Executive membership - Overall Workforce)	Auto-Calculated		8%		-13%		5%		

WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLAN 2022/2023

The Action Plan has been developed, based on the 21/22 WDES technical data results, to help close the gaps in workplace experience between Disabled & Non-disabled staff.

Action	Metric	Delivery Timescale	Lead Responsibility
<p>1. Embed the Structure for disabled staff having an input into infrastructure and estate development and projects</p> <ul style="list-style-type: none"> • Have it written into formal project scoping documents that the Disabled Staff Network will have input into ensuring infrastructure and estates developments at the very least meet building regulations in the provision of Disabled facilities. • Ensure EF&D colleagues actively use the Equality Impact Assessment process as part of capital and estate development projects as well as when considering changes to services which directly impact on staff. 	8, 9a	March 2023	Workforce & OD EDI Team
<p>2. Launch a Zero Tolerance to Disability Discrimination framework</p> <ul style="list-style-type: none"> • Learn from the Zero Tolerance to Racism framework to inform the development of a similar framework for disabled staff. • Set up a distinct QR code and Database to report and record incidents of disability discrimination. • Establish a Circle group to have overview of specific incidents, heat map areas and to triage to eliminate discrimination. 	3, 4a, 4b, 8, 9a, 9b	January 2023	Workforce & OD EDI Team

Action	Metric	Delivery Timescale	Lead Responsibility
<p>3. Review existing recruitment process through an EDI lens and overhaul as appropriate</p> <ul style="list-style-type: none"> Specifically adjust the criteria for the 'Disability Confident Scheme' as guaranteeing an interview for disabled applicants under the current shortlist criteria of an interview if meeting all essential criteria is meaningless. Conduct a full review of our Disability Confident status Design specific roles for individuals with Learning Disabilities, currently only 5% of people with Learning Disabilities are in employment. As an Anchor Network organisation we need to provide adequate and appropriate opportunities. 	2, 5	March 2023	Workforce & OD EDI Team
<p>4. Continue to encourage staff to complete/update personal information details relating to disability on ESR, through increasing disability confidence</p> <ul style="list-style-type: none"> Launch of the "Bridging the Gap" initiative to encourage and give psychological safety to staff with a disability to self identify and update ESR self service. 	All	September 2022	Workforce & OD EDI Team
<p>5. Continue promotion of the Enabled Staff Support Network through disability confidence campaigns.</p> <ul style="list-style-type: none"> Strengthen the Staff Network leadership by establishing 2 new roles of Deputy Chairs of the Network and a Mental Health lead role. 	7, 9a	July 2022	Workforce & OD EDI Team
<p>6. Develop a leadership programme to support leaders at all levels to develop their understanding and gain practical skills in relation to EDI</p> <ul style="list-style-type: none"> Programme to run alongside the update of the existing mandatory training package and will be specifically aimed at staff with a disability Launch the "WITH:Stand" leadership programme or something similar. Promotion of existing leadership programmes targeted at the recruitment of staff with a disability. 	5, 7, 9a	March 2023	Workforce & OD EDI Team

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement
Trust Submission 2021/22

Agenda Item	Meeting	Trust Board	Meeting Date	08/08/22
Title	Modern Slavery Statement			
Lead Director	Simon Nearney - Director of Workforce and Organisational Development			
Author	Sarah Dolby, Senior HR Advisor, Employment Policy and Resourcing			
Report previously considered by (date)	This report has not been received at any other meeting.			

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	✓	Commercial Confidentiality		Safe	✓	Honest Caring and Accountable Future	✓
Committee Agreement		Patient Confidentiality		Effective	✓	Valued, Skilled and Sufficient Staff	✓
Assurance		Staff Confidentiality		Caring	✓	High Quality Care	✓
Information Only		Other Exceptional Circumstance		Responsive	✓	Great Clinical Services	✓
				Well-led	✓	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

The Workforce, Education and Culture Committee and Trust Board are asked to approve the attached Trust's 2021/22 Modern Slavery Statement. This will then be published on the Trust's website.

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement Trust Submission 2021/22

1 Purpose

The purpose of this paper is to share the Trust's Modern Slavery Statement for the financial year 1 April 2021 to 31 March 2022.

2 Background

Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains.

Section 54 of the Act recommends that organisations report on the following:

1. organisational structure, business and supply chains;
2. its policies in relation to slavery and human trafficking;
3. due diligence processes in its business and supply chains;
4. parts of its business/supply chains where there is a risk of slavery and human trafficking taking place, and steps taken to assess and manage that risk;
5. effectiveness in ensuring that slavery/human trafficking is not taking place in its business or supply chains, measured against performance indicators;
6. the training about slavery and human trafficking available to its staff.

The Act requires organisations to publish a Modern Slavery Statement which has been approved and signed by the Board on their website and include a link in a prominent place on its homepage within six months of the end of the financial year.

3 The Trust's Proposed Statement for 2021/22

The Statement contained within Appendix 1 has been produced in partnership with the Modern Slavery Working Group:

- Bank Nurses/Casual Workers: Julie Bonewell
- Corporate Affairs: Rebecca Thompson
- Education and Development: Ben Greenwood
- Estates, Facilities and Development: Zara Ridge
- Human Resources: Sarah Dolby
- Procurement, Supplies: Julie Lumb
- Safeguarding: Jayne Wilson / Paula Peacock

4 Mandatory Changes to Modern Slavery Statements

As reported in the Trust's previous statements, the Government plans to introduce changes to the Modern Slavery Act 2015.

In May 2022, during the Queen's speech, it was announced that a Modern Slavery Bill will be published in this Parliamentary period, although the date is not yet known.

The new Bill is expected to:

- Strengthen the requirements on businesses with a turnover of £36 million or more to publish an annual Modern Slavery Statement which sets out the steps taken to prevent modern slavery in their operations and supply chains.
- Mandate the reporting areas to be covered in statements.
- Require organisations to publish their statements on the Government's central registry.

- Introduce civil penalties for organisations that do not comply with the requirements.

As the Bill has not yet been published, organisations are required to continue to report in line with current expectations and are encouraged to publish their statements on the Government's central registry. The Trust does not currently publish its statement on the central registry.

In April 2022, the Government¹ also announced that amendments will be made to the Health and Care Bill, to help ensure the NHS, which is the biggest public procurer in the country, is not buying or using goods or services produced by or involving any kind of slave labour. The Modern Slavery Working Group will review this once it is available to ensure the Trust is meeting its requirements.

5 Options for Executive Team Consideration

5.1 Consider and advise whether the Trust should voluntarily upload the statement to the Government's central registry prior to it becoming a mandatory requirement.

- The central registry was created to make it easier for people to find modern slavery statements.
- Currently there are over 28,000 statements on the registry, however this only includes a small number of NHS Trusts. There is no evidence of neighbouring Trusts (e.g. Humber NHS Foundation Trust, Northern Lincolnshire and Goole NHS Foundation Trust, York and Scarborough Teaching Hospitals NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust) having published their statements on the central registry.

5.2 Consider the composition of the Modern Slavery Working Group, whether the membership is correct and whether the group should be extended to cover other relevant areas.

- The Modern Slavery Working Group would benefit from being reinvigorated, and a review of the membership undertaken to enable different perspectives to be considered and challenge to be made on current processes.
- The modern slavery agenda is likely to raise in profile when the Modern Slavery Bill is launched and there is likely to be more of a spotlight on organisations to evidence where improvements have been made to mitigate risks in areas where slavery may occur.
- Therefore it would seem appropriate for the review to take place when the Bill is launched, with consideration being given to the benefit of having more senior members in the group to influence and support changes to practices across the Trust.

6 Recommendation

The Workforce, Education and Culture Committee and the Trust Board are asked to:

- Consider and advise on options as outlined in section 5; and,
- Note, approve and sign off the content of the Trust's 2021/22 Modern Slavery Statement.

The statement will then be published on the Trust's website as soon as possible, and by the very latest, the 30 September 2022.

Simon Nearney, Director of Workforce and Organisational Development
August 2022

¹ <https://www.gov.uk/government/news/government-aims-to-eradicate-modern-slavery-from-nhs-supply-chains>

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement 1 April 2021 to 31 March 2022

1. Introduction

The Modern Slavery Act 2015 requires organisations to publish an annual Modern Slavery Statement on their website within six months of the end of the financial year (i.e. for the Trust this would require the statement to be published by 30 September).

With the Home Office² reporting that “12,727 potential victims of modern slavery were referred to the Home Office in 2021”, which is an increase of 20% compared to the previous year, it is imperative that organisations continue to take all the necessary steps to ensure that modern slavery is not taking place in any part of its own business or supply chains.

This statement sets out the steps that Hull University Teaching Hospitals NHS Trust has taken over the financial year 1 April 2021 to 31 March 2022 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains.

The statement covers the following:

- Organisational structure and business
- Policies in relation to slavery and human trafficking
- Due diligence and managing risks in the Trust’s business and supply chains
- Training and performance indicators

The Trust is committed to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking.

2. Organisational Structure and Business

Hull University Teaching Hospital NHS Trust is a large acute NHS Trust situated in Kingston upon Hull and the East Riding of Yorkshire. The Trust employs just over 8,300 whole time equivalent staff, has an annual income of circa £794m million and operates over two main sites; Hull Royal Infirmary and Castle Hill Hospital. Outpatient services are also delivered from locations across the local health economy area.

Further details regarding the Trust’s business and structure can be found in the Annual Report and Accounts 2021/22, available on the Trust website <https://www.hey.nhs.uk/about-us/corporate-documents/#annual-report>.

3. Policies in Relation to Slavery and Human Trafficking

The Trust has a number of policies to support staff in relation to modern slavery, including

- Raising Concerns at Work (Whistleblowing) Policy.
- Equality, Diversity and Inclusion in Employment Policy.
- Policy for Staff Conflict Resolution and Professionalism in the Workplace.

The Trust has also continued to publish a broad range of safeguarding policies and factsheets, for both service users and staff, during the last financial year, which include:

- Modern slavery resources in response to humanitarian crisis in Ukraine.
- Independent Anti-Slavery Commissioner Annual Report 2021-2022.
- How to prevent modern slavery. A report by USEEN UK.
- Covid-19 Modern Slavery Resources.

² <https://www.gov.uk/government/statistics/modern-slavery-national-referral-mechanism-and-duty-to-notify-statistics-uk-end-of-year-summary-2021/modern-slavery-national-referral-mechanism-and-duty-to-notify-statistics-uk-end-of-year-summary-2021>

Any new campaigns/policies in relation to modern slavery and trafficking are published on the Trust intranet.

All Trust policies go through a robust consultation and ratification process and are available on the Trust's internal website.

4. Due Diligence Processes in the Trust's Business and Supply Chains

4.1 Due Diligence in Business

The Trust is committed to preventing slavery and human trafficking in corporate activities and ensuring that workers are not exploited, that they are safe and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to. To support staff, the following steps are taken:

- All staff are employed on employment contracts which comply with UK law.
- Pre-employment checks are undertaken on all workers directly and non-directly employed by the Trust (e.g. employees, Agency staff, contractors, volunteers, students and trainees on work experience etc.).
- All staff undertake mandatory safeguarding training, which covers modern slavery.
- As an equal opportunities employer, the Trust is committed to creating an inclusive working environment for all staff, which enables staff to feel confident that they can raise concerns without any risk to themselves via a number of avenues, e.g. via the Freedom to Speak up Guardian etc.
- A comprehensive range of modern slavery and safeguarding information for service users and staff is available for staff on the Trust intranet.
- All active agencies who supply staff to the Trust are asked to provide assurance that they are compliant with the Modern Slavery Act 2015 on an annual basis.

From a safeguarding perspective, the Trust continually looks at ways in which staff and service users can be supported and protected from modern slavery and human trafficking. Steps taken to ensure this include:

- After previously being out on hold due to the COVID-19 pandemic, the Safeguarding Champion role will be reviewed and refreshed to improve dissemination of safeguarding updates and information.
- The Trust continues to have strong links with the Humber Modern Day Slavery Partnership, with representatives from both the Safeguarding Children's Team and Safeguarding Adult's Team sitting as part of a strategic group within the partnership.
- The Trust continues to evolve, learn and develop new processes to safeguard the organisation and the population it serves against modern slavery.
- For key partners involved in cases of modern slavery, a multi-agency agreement to hold an emergency/short notice strategy meeting with key partner representatives is now in place. Key partners include the Trust's Safeguarding Adults Team, the Local Authority Safeguarding Adults Team, Independent Domestic Violence Advocate/Hull DAP, Domestic Abuse Team, PVP Unit/Humberside Police, the Hospital Social Work Team and the Mental Health Service. The Safeguarding Children's Team also follow a similar process for children under 18 years of age, who may be potential victims of modern slavery.
- The Trust continues to record safeguarding adult concerns on DATIX submitted by staff via the staff intranet (in the last financial year 5 were received).
- The Trust continues to refer safeguarding adult concerns to the Local Authority following quality checking by the Trust Safeguarding Team to ensure compliance with the Care Act, Mental Capacity Act and Consent.
- The Trust continues to monitor the number of enquiries made to the Safeguarding Adults Team from staff who have disclosures or concerns about modern slavery for one of their patients (in the last financial year 6 queries were received).

- The Trust continues to refer all safeguarding children concerns, including those related to modern slavery, to the Local Authority Children's Social Care Services.

4.2 *Due Diligence in Supply Chains*

The Trust's Procurement and Supplies Department is responsible for spending £142m non-pay which includes:

- £28,304,986 through the Supply Chain (compared to £17m in the previous year);
- £70,426,238 from goods ordered directly (not Supply Chain) through goods and service maintenance contracts (compared to £68m in the previous year);
- £44,284,800 on other contracts, for example; car park and security, transport and all other service type contracts (compared to £40m in the previous year).

NB: It must be noted that these figures are approximate and will fluctuate year on year.

The Trust currently has 1004 active contracts, covered by 455 individual suppliers. Of the 455 individual suppliers, 367 (80%) have provided information in relation to the Modern Slavery Act, as follows:

- 235 contracts/suppliers have provided assurance that they are compliant with the requirements of the Modern Slavery Act, compared to 161 in the previous year.
- 132 contracts/suppliers have confirmed that they do not meet the criteria which requires them to complete an annual Modern Slavery Statement (i.e. annual turnover is below £36m), compared to 51 in the previous reporting period. However, the Trust still expects that they conduct their business with due regard to the Modern Slavery Act.

The Trust does not enter into business with any organisation, in the UK or abroad, which knowingly supports or is found to be involved in slavery, servitude and forced or compulsory labour. Steps taken to reduce the risk of modern day slavery occurring within the supply chain include:

- Ensuring the Selected Questionnaire document, tender document and quotation document are up-to-date.
- Continue to request tenderers to provide assurance that they adhere to the Modern Slavery Act 2015 and continue to monitor the number of those that are or are not compliant on the department's central database.
- Continue to ensure there are robust processes in place to mitigate risks associated with procuring goods and services outside of the tendering process, including:
 - All goods purchased outside the tendering process must adhere to the Trust's Standing Financial Instructions and are subject to the Purchase Order Version of the Terms and Conditions for both goods and services (January 2018) which references modern slavery.
 - All purchases where the expenditure is over £10k and less than £50k must have 3 official quotations.
 - Going forwards, when requesting information for values lower than the £10k referenced in the Standing Financial Instructions, suppliers will also be requested to complete the Trust's formal quotation form, which includes reference to modern slavery.
- The Trust continues to review major suppliers, with a view to obtaining their ongoing commitment that they comply with the Modern Slavery Act 2015. As contracts are renewed, organisations will continue to be asked to provide this assurance.

5. **Training and Performance Indicators**

Compliance with the Trust's modern slavery agenda is measured by reviewing the number of staff who have completed the following mandatory courses/eLearning packages (which include modern slavery):

- Safeguarding Adults
- Safeguarding Children

As of March 2022, in excess of 85% of Trust staff are compliant with the required training, which is consistent with previous years.

In addition to the mandatory training, the Safeguarding Teams provide ad-hoc training and day to day support around modern slavery when requested. Modern slavery is also embedded within other relevant training programmes which staff can choose to enrol on, including but not limited to:

- Modern Slavery and Human Trafficking
- Introduction to Migration
- Children Vulnerable to Abuse and Exploitation

6. Summary

The Trust continues to be committed to preventing slavery and human trafficking in any part of its business or supply chains. The Trust is committed to:

- Continuing to educate staff on the importance of preventing modern slavery and to meet the obligations under the national modern slavery agenda.
- Monitoring and reviewing ongoing modern slavery legislation and best practice.
- Obtaining assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015 and record and monitor these as required.
- Reviewing Trust policies and including references to modern slavery where appropriate.

The Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed
Chairman

Signed
Mr Chris Long
Chief Executive

Dated

Dated

Agenda Item		Meeting	Trust Board	Meeting Date	13 th September 2022
Title	Freedom to Speak Up Guardian report – Q1 2022/2023 report				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Frances Moverley, Head of Freedom to Speak Up				
Report previously considered by (date)	N/A				

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval		Commercial Confidentiality		Safe		Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective		Valued, Skilled and Sufficient Staff	X
Assurance	X	Staff Confidentiality		Caring		High Quality Care	X
Information Only		Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led	X	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

- The Trust Board are asked to receive and accept this annual report of the work and activities of the Trust's Freedom to Speak Up Guardian.
- The Trust Board are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Q1 2022/2023

1. Purpose of the paper

The National Guardian's Office requires Freedom to Speak Up Guardians (FTSUG) in NHS Trusts to report directly to their Trust Board.

This report provides an update on the concerns raised by staff, students, trainees or volunteers through HUTH's Freedom to Speak Up Guardian during Q1, including an overview of themes and the activities undertaken by the Trust's FTSUG.

Furthermore, the report aims to provide assurance to the Board on promoting a 'speaking up' culture at the Trust for staff and complying with Key Line of Enquiry 3 as part of the CQC Well-Led domain.

2. Introduction

Following the Francis Review, all Trusts are required to have a Freedom to Speak Up Guardian (FTSUG) in place. This role acts impartially and provides staff, students, trainees and volunteers with an option to raise concerns in a confidential manner.

There are a number of processes in place that allow staff to raise concerns. These include:

- Formal Raising Concerns and Whistleblowing Policy
- Anti-fraud service
- Through their line manager
- Through the Staff Conflict Resolution and Professionalism in the Workplace Policy or the Grievance Policy
- Freedom to Speak Up Guardian

There are other routes as ways in which staff can receive support if they are experiencing difficulties at work, for example Occupational Health and other staff support services.

In addition, professional organisations such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) also issue guidance which sets out the GMC's expectations that all doctors will, whatever their role, take appropriate action to raise and act on concerns about patient care, dignity and safety.

3. FTSUG Activities during Q1 2022/2023

A summary of the activities of the FTSUG are detailed below:

- Coordinated and provided a training and awareness session to the Paediatric International Medical Graduates across Yorkshire and the Humber. Worked in partnership with the FTSUGs at Sheffield Children's Hospital NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust to deliver the event and received excellent feedback.
- Linked in with the Chaplain responsible for Staff Support to discuss the FTSUG role and promote mutual referrals.
- Met with the new Staff Support Psychologist to discuss each other's roles and promote mutual referrals and joint working.
- Continued to support the Zero Tolerance to Racism Framework task and finish group and with the launch of the new reporting tool.
- Preparing for the launch of the new Trust network of FTSU Champions, in line with the guidance from the National Guardian Office and to attract expressions of interest in the role.
- Successfully completed the new mandatory training modules required by the National Guardian Office.

4. Future activities planned for Q2:

- Provide induction presentations, including for the rotation of new F1s Medical staff and Nursing staff on the 'Let's Get Started' programme.
- Launch of the recruitment to Speak Up Champions network, in line with the National Guardian Office guidance, including specialist training and establishing a peer support network.
- Involvement with the 'circle group' supporting the Zero Tolerance to Racism Framework.
- Attendance at the HR Business Partner, HR Manager and HR Advisor meeting across all Health Groups to share learning and partnership working.
- See section 5 below.

5. NHS England new national policy and Board self-reflection

NHS England have published the new national Freedom to Speak Up policy and in conjunction with the National Guardian Office, a revised self-reflection tool for Boards. The FTSUG has commenced an initial review, including commencing discussions with the HR Team.

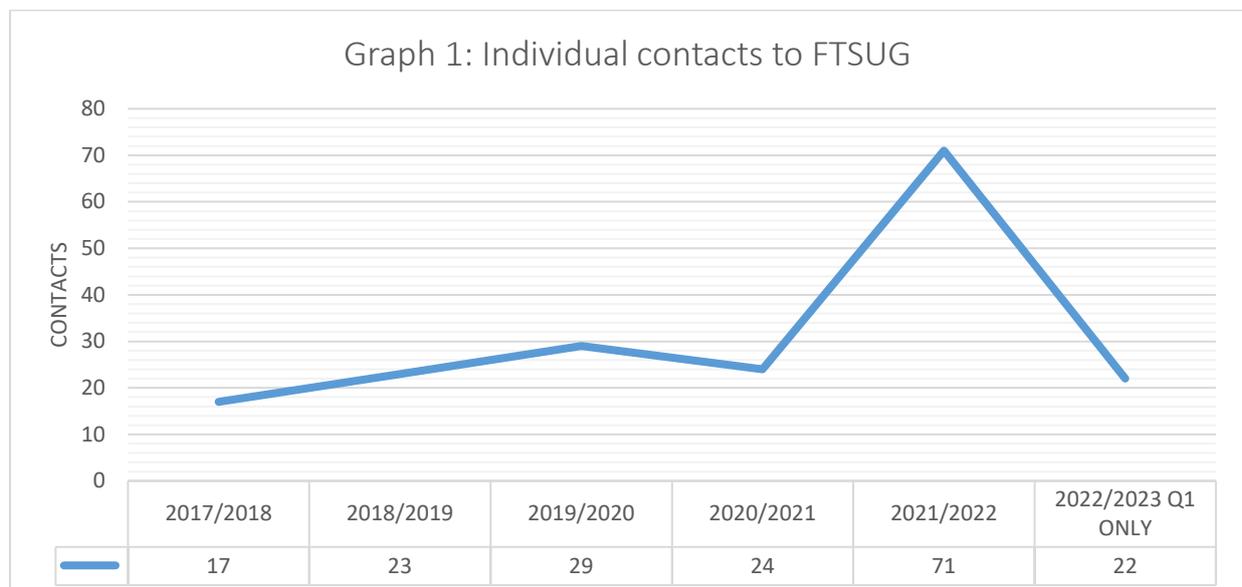
NHSE are asking all Trust Boards to be able to evidence by the end of January 2024:

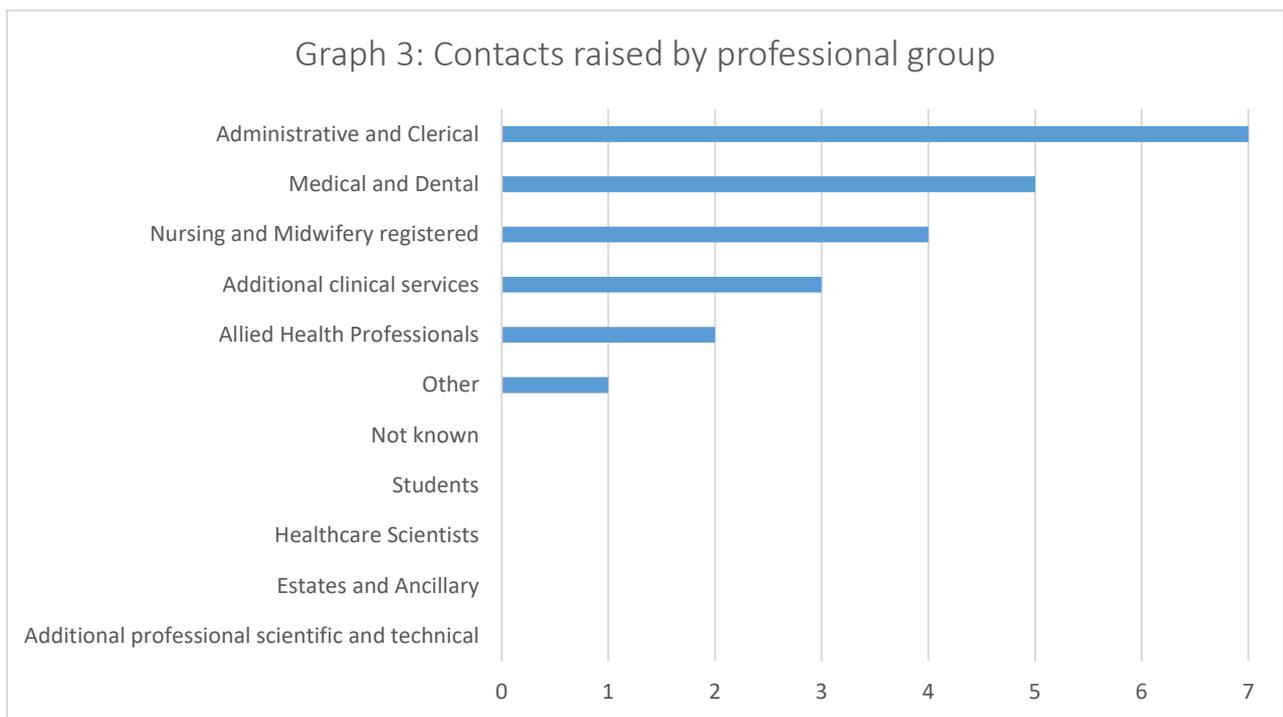
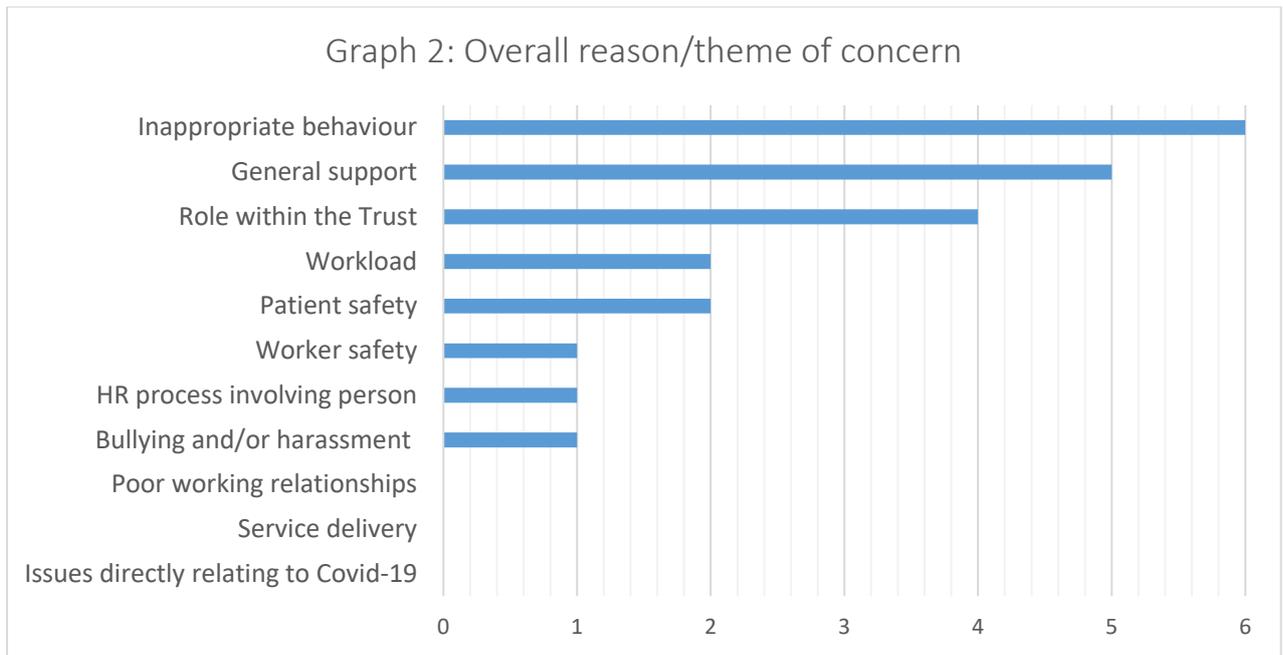
- An update to their local Freedom to Speak Up policy to reflect the new national policy template.
- Results of their organisation's assessment of its Freedom to Speak Up arrangements against the revised guidance and;
- Assurance that it is on track implementing its latest Freedom to Speak Up improvement plan.

6. Trust contacts during 1st April 2022 to 30th June 2022

The FTSUG reports on individual contacts received from members of staff, students, trainees and volunteers, to the Trust Board each quarter in the public board meeting. It is also the responsibility of the FTSUG to submit the quarterly data to the National Guardian Office.

The graphs below show the number of individuals contacting the FTSUG (Graph 1), the main theme of the concerns (Graph 2) and the professional group (Graph 3), during Q1 2022/2023. Graph 1 provides a comparison with previous annual data since 2017.





Comments and observations:

- The number of individual's contacting the FTSUG during the Q1 in 2022/2023 (22) is comparable to the average number of annual contacts, during 2017 to 2021. Q2 year to date is already recording a similar number of individuals contacting the FTSUG, indicating the upwards trend of contacts will continue.
- The most common reason raised with the FTSUG continues to be inappropriate behaviours (6).
- The concerns raised continue to be on a 'local' level and staff have been provided with appropriate options to raise their concerns, or the FTSUG has escalated concerns themselves.
- Two individuals who approached the FTSUG during Q1 consented to their experience being shared with the Board below:

Case study 1:

“Thank you for hearing me out and being so kind and friendly. It has made all the difference.”

Case study 2:

“Throughout my training I experienced incidents of aggressive behaviours towards me, most of which I felt were racially motivated. The first was just a few weeks in, and these hostile behaviours had a negative impact on me and my training experience. I knew I needed help and support.

After much searching, I was eventually advised to contact the BAME Network Chair and the Freedom to Speak Up Guardian.

Speaking to them felt like a breath of fresh air because it was the first time I felt heard and understood. My concerns were taken seriously and immediately acted upon. I was also well supported throughout the rest of my training.

I’m glad that the BAME Network is developing an improved system of reporting racially-aggravated behaviours within the Trust so that hotspots can be identified and steps taken to tackle this issue.

I’d also encourage others who have experienced aggressive or micro aggressive workplace behaviours to report these incidents to the BAME Network Chair and the Freedom to Speak Up Guardian as they’re the best people to contact for further support.”

7. Conclusions

It is positive that the number of individuals approaching the FTSUG continues to increase. The FTSUG has worked extensively to build working relationships with key individuals and teams across the Trust, and referrals between the FTSUG and other staff support services.

The majority of cases are isolated and on an individual level and the most common reason for raising a concern during Q1 was inappropriate behaviours.

8. Recommendation

The Trust Board is asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust’s Freedom to Speak Up Guardian arrangements.

Fran Moverley
Head of Freedom to Speak Up
September 2022

**Report to the Board in Public
Workforce, Education and Culture Committee August 2022**

Item: Workforce Race Equality Standard (WRES)	Level of assurance gained: Reasonable
<p>Progress has been identified in areas and further development in others. An action plan has been developed and some actions already achieved.</p> <p>Bank staff have been removed from this years report, which accounts for the difference in figures in relation to last years. With the increase in international nurses and medical graduates the numbers will rise. Noted was that there is a lack of BAME representation within management and board level.</p> <p>Over the last two years there has been development for;</p> <ul style="list-style-type: none"> • BAME Network • Career Progression • Bullying and Racism • Launched Zero Tolerance <p>The committee acknowledged the achievements of the network.</p>	
Item: Workforce Disability Equality Standard (WDES)	Level of assurance gained: Reasonable
<p>Bank staff have been removed from this years report, which accounts for the difference in figures in relation to last years.</p> <p>The Trust now have an established network with established peer support and links with occupational health and capital projects.</p> <p>There is a piece of work being undertaken called Bridging the gap which aims to reduce the gap of disclosure of disability between ESR and the staff survey and provide psychological safety for staff to disclose.</p> <p>The committee recognised the work that has been undertaken by the network and the improved collaboration with estates.</p> <p>It was noted that the medical school has been linking in with the medical education department to look at supporting students with support dogs and wheelchair users to plan ahead of students arriving and will link with the network for support and role models.</p>	
Item: Modern Day Slavery Report	Level of assurance gained: N/A
<p>Paper was submitted to the committee for approval.</p> <p>The Trust reviews policies to ensure they abide by modern day slavery and also review supply contracts, 80% of organisations have their own statements and there have been no reported issues in the past 12 months.</p> <p>The committee approved the paper.</p>	
Item: Leadership, Capability & Capacity	Level of assurance gained: Reasonable
<p>The report commissioned by the Trust regarding Talent Management was not received and the team are currently reviewing how to progress with this area and if we need to commission further review or continue with the work that has been started.</p> <p>The Trust has a number of leadership courses now in place, which are accessed by staff. There is some work to be undertaken on appraisals to assist with identifying talent and success as well as supporting staff to look at career planning and making it inclusive.</p>	

There have been positive conversations happening about qualifications and barriers to professions, as well as providing opportunities for staff to be able to have the skills to successfully step into a role.

Item: People Management Performance Report

Level of assurance gained: Reasonable

The report shared key figures for the committees information and narrative was shared.

- The Trust's vacancy rate is low at 4.1%
- Turnover was 12.1% on investigation at health group level for turnover there were no significant issues raised.
- Trust is just above the sickness target rate, but continues to improve with covid absences reducing.
- Job plans, appraisals and mandatory training are all on an upward trajectory as things continue to move towards business as usual.

Item: Nursing and Midwifery Staffing Report

Level of assurance gained: Reasonable

The report will be presented with an updated format for the next meeting and will focus on the key work ongoing.

- The organisation is hoping to close a no criteria to reside ward.
- 51 International nurses are now beginning to receive their PIN, with a further 29 awaiting PINS or results.
- 129 adult nursing students and 14 child branch students, conditional offers have been given to commence employment with the Trust September 2022.
- 19 Midwifery students have also now been successfully recruited for appointment in September 2022.

The apprenticeship programmes continue with;

- 31 Registered Nurse Degree Apprentices, 8 of which qualify in September 2022.
- 23 Apprentice Health Care Support Worker with 14 currently finalising their course and 10 going on to their nursing degree.
- 43 Trainee Nursing Associates, 14 are currently awaiting their PIN and further recruitment has taken place of 23 new to commence in September.

Care Hours per Patient Day continues to be reviewed, with a decrease seen since the previous report.

Item: Variable Pay

N/A

The report provided an overview of agency, bank and overtime spend and reflected that the Trust utilised bank rather than agency, which keeps costs down. All NHS Trusts have a directive to reduce agency spend, we have spent £11.5m and £6.5m of which was medical staff. The figures in comparison to other Trust's is low.

Item: HEE Provider Self-Assessment 2022

N/A

The HEE Provider assessment was shared with the committee and highlighted areas to be aware of;

- Training quality vs service pressures
- Placement extensions and impact
- Good practice of simulation training through the pandemic to maintain training
- Foundation Level 2 trainees have started to lead their training, picking up what is important and supported by medical education.
- Phlebotomy service.

Agenda Item	Meeting	Trust Board	Meeting Date	13/09/22
Title	Performance Report			
Lead Director	Ellen Ryabov – Chief Operating Officer			
Author	Louise Topliss – Assistant Director of Operations (Operational Performance)			
Report previously considered by (date)				

Purpose of the Report	Reason for submission to the Trust Board private session	Link to CQC Domain	Link to Trust Strategic Objectives 2021/22
Trust Board Approval	Commercial Confidentiality	Safe	Honest Caring and Accountable Future ✓
Committee Agreement	Patient Confidentiality	Effective ✓	Valued, Skilled and Sufficient Staff ✓
Assurance ✓	Staff Confidentiality	Caring	High Quality Care ✓
Information Only	Other Exceptional Circumstance	Responsive ✓	Great Clinical Services ✓
		Well-led	Partnerships and Integrated Services ✓
			Research and Innovation
			Financial Sustainability ✓

Key Recommendations:
The Trust Board members are asked to receive, discuss and accept this update on key performance issues.

Performance and Activity Report

July 2022 Performance

June 2022 for Cancer data

Produced August 2022

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1. Executive Summary

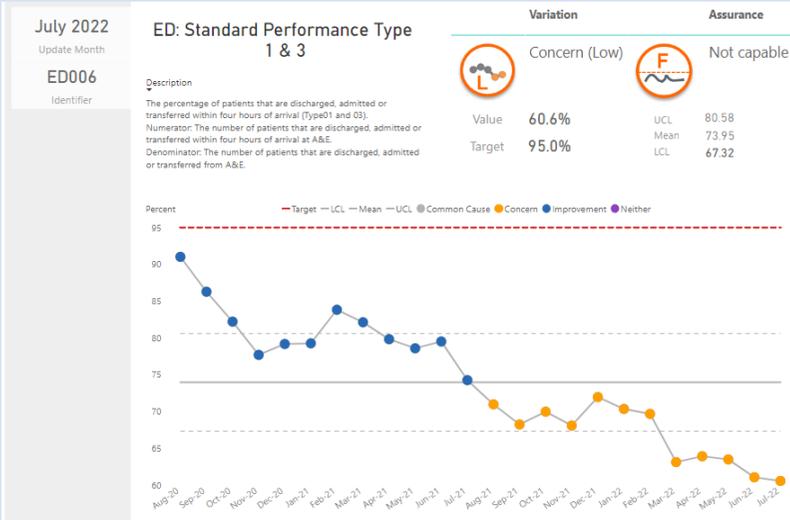
Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	<ul style="list-style-type: none"> • Ambulance handover position remains highly challenged with numbers of lodged patients within ED, routinely between 20 and 30 patients at the start of the day. • Ground floor PDSA cycle commenced 11 July 2022 for a four week period; early evaluation is to continue with new ways of working, embed the elements where successful as Business As Usual (BAU) before winter, and continue to refine other aspects in order to maximise the potential benefits for flow and patient turnaround • YAS and HUTH have agreed a Cohorting procedure that uses the fracture clinic space out of hours to enable Ambulance crews to be released to support the community. The decision to implement cohorting lies with YAS, as/if required YAS will staff the area. • The number of patients in July 2022 with No Criteria to Reside continues to be the single largest factor affecting performance with an average of 169 (+28 on last month) patients per day remaining within the Hospital who have no medical need for acute services.
Cancer performance	<ul style="list-style-type: none"> • Overall cancer performance remains comparable with previous months, and whilst 2ww referrals have increased by 3% compared to the same period last year, there is no significant increase in confirmed cancers for any tumour site. • 2 of 9 cancer waiting times' national standards were achieved. • The number of patients on the 62 day from referral to treatment pathway has started to reduce (at its highest it was ~1,800 and lowest ~1,500) with the latest PTL number ~1,695; this continues to require focussed support to maintain improvement performance which is starting to deliver. • The Trust performance with regards to the 62 day treatment pathways and overall cancer PTL have flagged as an outlier through the NHSE assurance processes – following significant improved performance, this is now rated at a much lower risk. In line with the on-going review of patients on an RTT pathway over 104 weeks, cancer performance is a continued focus of the 2/52 NHSE assurance and recovery meetings.

	<ul style="list-style-type: none"> • The Trust Cancer transformation programme is beginning to tackle some of the diagnostic waiting time issues for colorectal patients, as a result additional CT colon capacity which came on line in July 2022 and is already showing improvement in the Lower GI (colorectal) pathway. Further changes at the front end of the colorectal pathway are subject to approval through the speciality and cancer leadership. • Specific additional performance meetings and support from the Operational Service Improvement Team has been directed to support recovery of CT waiting times. These meetings continue and some progress is being realised (e.g. CTC additional capacity).
<p>Recovery of elective activity</p>	<ul style="list-style-type: none"> • Recovery of elective activity in July 2022 against the operational plan was broadly in line with the submitted activity numbers except for Ordinary elective at 82% of plan. The indicative activity requirement of 110% of 19/20 baseline was not delivered in any of the PODs. • The operational plan also includes a reduction of outpatient follow-ups by 25% by March 2023. In July 2022 follow up activity was 89% of baseline and 100% of plan; further work is required to transform outpatient pathways to support this operational requirement. There has been a counting change in Clinical Support Services HG for Radiotherapy which has shifted approximately 17,000 new outpatients per year to follow up activity which in part accounts for the variance, which equates to 80% shift from new to follow up in Clinical Oncology. • The capacity required to support Covid+ patients increased during late June and into July 2022, which together with the number of patients with No Criteria to Reside (NCTR) across HRI and CHH, has required the opening of a further ward area (H1). The combined impact continues to restrict the ability to deliver further increases in elective work with circa 23 beds lost at CHH during July 2022 as a result of oncology being out lied to C9 during essential works at the Queens Centre. • Mutual aid continues to progress focussing on any provider with shorter waiting times inside and out with the HNY to not only improve waiting times but to support the reduction of the overall size of the Trust's PTL.
<p>Improving treatment times for long waiting patients</p>	<ul style="list-style-type: none"> • For 2022/23 Quarter 1, the starting position was 794 patients to treat, who had breached/or were at risk of breaching 104-weeks by the end of June 2022. The Trust has been designated a Tier 1 organisation and were required to meet weekly with NHSE national leads, as a result of our improvement this has now been reduced to fortnightly meetings.

	<ul style="list-style-type: none"> • At the end of July 2022, there were 20 (a reduction of 8 on last month) patients who had waited over 104 weeks for treatment – mostly orthodontics as a result of capacity constraints (all of whom had declined the transfer to an alternative provider), 1 patient choice (UGI) and 1 complex patient (Cardiac). • Enhanced internal governance processes continue to support the daily monitoring against the trajectories and on-going work to identify capacity internally and seek/take up offers of mutual aid from other providers. • There are 5,208 (+280 on last month) patients who have waited more than one year, although this number has reduced significantly in the last 12 months. • Text validation of 31,000 patients commenced in early July 2022 in order to identify if their listed appointment and/or treatment is still required. To date 10,794 texts have been sent, of which 97% were delivered to a Smart Phone. Of those, 6,756 have been read with 5,529 responses. There is currently a 9.5% removal/delay rate on the non-admitted pathways and 6.7% on the admitted pathways.
<p>Reducing the delays in people leaving acute setting</p>	<ul style="list-style-type: none"> • Nationally, there has been an increase in the number of patients who no longer “meet the criteria to reside in an acute hospital” – i.e. are medically fit from an acute perspective, but may still have other care needs – and are delayed in receiving that care, either moving home with care, or to a community or care home setting for their needs. • Across HUTH, at the end of July 2022 there were 169 NCTR, around 15% of our general and acute beds as a total and 22% at HRI, (total G&A beds 680 HRI and 347 CHH) are occupied by patients who no longer need acute care and should be receiving appropriate care elsewhere with the support of other partner organisations or settings. • The Interim Deputy Chief Nurse leads a weekly meeting to review any patient who has been delayed for 7-days or more. • The CHCP Bee @ Home service is beginning to increase capacity with a target of 50 patients supported at October 2022. • East Riding CCG provided a senior manager to support the progression of all patients who have had ‘no criteria to reside’ (NCTR) for 20+ days – the report is being presented to the System Oversight Group.

- All patients over 30 days NCTR are discussed weekly between the System Chief Operating Officers and Directors of Adult Social Services.

2. Emergency Care Standards – 4 hour Performance



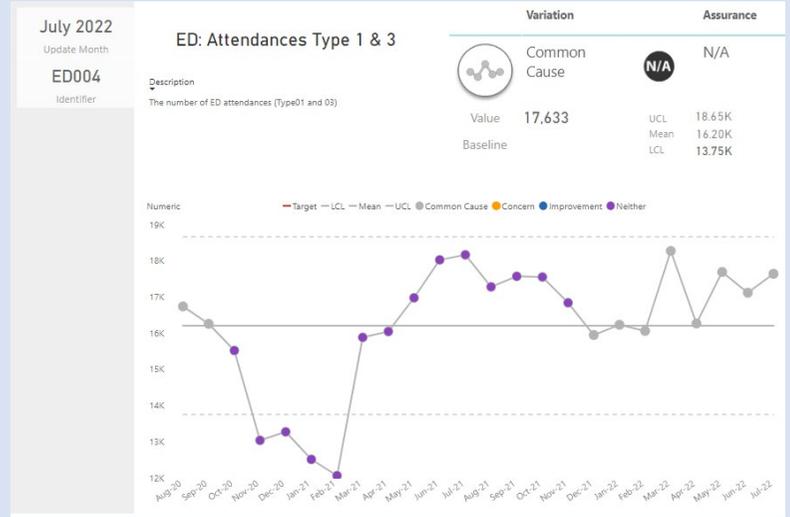
What the chart tells us

4-hour performance has been relatively stable for the last three months, albeit that it is significantly below the required standard and in July 2022 was 60.6% for all Types.

ED attendances are increasing and were above the mean at 17,633 (mean 16,000) in July 2022.

Intervention and Planned Impact

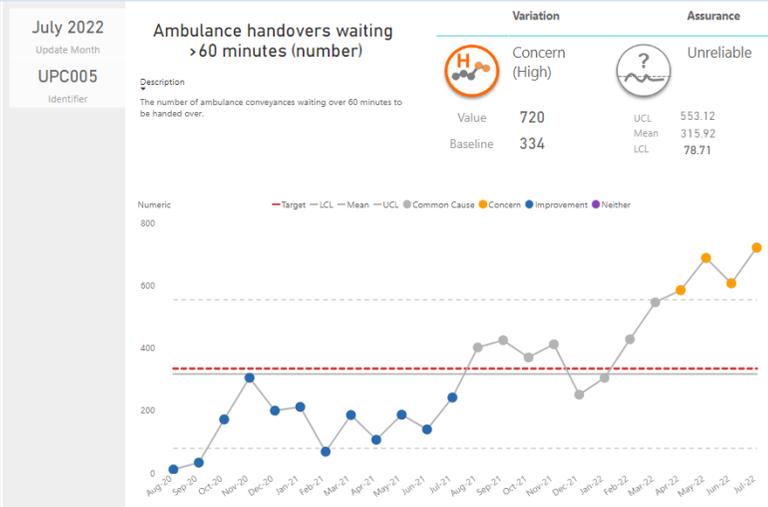
- A multi-professional Trust-wide workshop was held in June 2022 to consider potential improvement options by focussing on the delivery of same day emergency care. There was unanimous support to redesign our emergency pathways with a 4-week PDSA cycle which started on the 11 July 2022. Early evaluation following this 4-week period is to continue with new ways of working, embed the areas which have been successful as BAS before winter, and continue to refine other aspects in order to maximise the potential benefits for flow and patient turnaround
- In discussion with the Executive team, the EMHG is looking at a new model of rapid assessment and triage and streaming in ECA from September 2022 onwards, taking a significant amount of learning from the four-week trial period where different ways of working have been piloted – the model and plan are being drawn up, including a staffing model to support this
- Recruitment is underway to enable the creation of an Urgent Care stream within ED, it is anticipated this will take until September 2022 to be fully implemented. This will further enhance the developments from the workshop.



Risks / Mitigations

- Continued delays in flow and discharge delays are a significant impediment to an improvement in the initial assessment and majors area, with some impact on ECA – patients are lodging in ED in excess of 12 hours 13% of the time, which significantly compromises flow and ability to work to the four-hour target
- The focus on elective recovery, supported by a return to the core elective capacity at CHH, has reduced the ability to outlie into the surgical bed base and relieve non-elective pressure. This is particularly an issue for trauma and orthopaedics where the bed-base is constrained by oncology using C9.
- Further waves of Covid are contributing to a reduction in flow both across and out of the Trust.

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 720 (+124 on previous month) over 60 minute ambulance handover delays in July 2022 which equated to 23%; this is a further increase on previous months which highlights the on-going challenge.

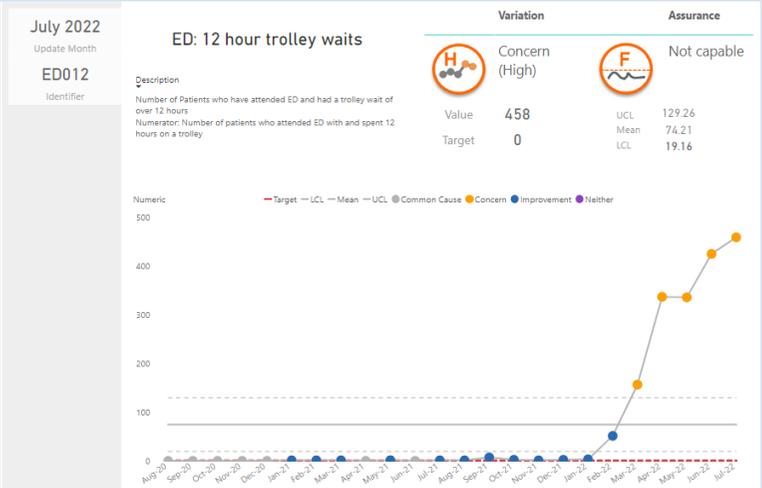
Intervention and Planned Impact

- A further test of change in initial assessment began in June 2022 with crews ‘pinning out’ in the cubicle in real time, rather than having to go to a separate screen within the ED. This will act as the intermediary step while awaiting the EPR interface to automate the data capture. *(Pinning out – the process followed by YAS is: clinical handover, pinning out, clear & then available for the next allocated job).*
- Long Stay Wednesday reviews of all patients who have been delayed in hospital over 7-days has commenced and is conducted by the DCN/DCOO and Senior Matrons/Divisional Managers.
- A full update to the System-wide Hull and East Riding Ambulance Improvement Plan will take place in August 2022; it is recognised that further actions in-hospital and out of hospital are necessary to impact on ambulance handover times.

Risks / Mitigations

- No Criteria to reside patients continue to occupy a significant number of acute beds thereby reducing availability of capacity and an ability to appropriately manage flow in a timely manner out of the ED.
- Continued delays in flow and discharge delays are a significant impediment to improvement in the initial assessment and majors area, with some impact on ECA – patients are lodging in ED in excess of 12 hours 13% of the time, which significantly compromises flow and ability to work to the four-hour target
- The additional wards remain open thereby placing additional pressure on Nurse and Medical Staffing.

4. 12 Hour Trolley Waits (from DTA to Depart)



Period: 7/1/2022 to 7/31/2022

Day of Week Number	1	2	3	4	5	6	7	Total
	Mon	Tue	Wed	Thu	Fri	Sat	Sun	
ED Departures (Type 01)	1,466	1,506	1,348	1,398	1,721	1,599	1,697	10,735
ED 12 Hour Trolley Breaches	50	59	58	62	71	91	67	458
ED 4 Hour Standard Performance (Type 01)	48.2%	47.7%	52.3%	44.1%	44.0%	48.4%	47.1%	47.3%

ED 12 Hour Trolley Breaches by Date

What the chart tells us

There were 458 x12 hour trolley wait breaches in July 2022 with the longest wait from Decision to Admission (DTA) of 28 hours. In July 2022, Saturday was the highest daily figure for patients affected by trolley waits in excess of 12 hours.

The national standard now measures total wait from arrival in department and not from DTA for those waiting over 12 hours. Performance against that standard for July 2022 was that 13.1% of patients (1,405 patients) waited over 12 hours against a national tolerance of 2%.

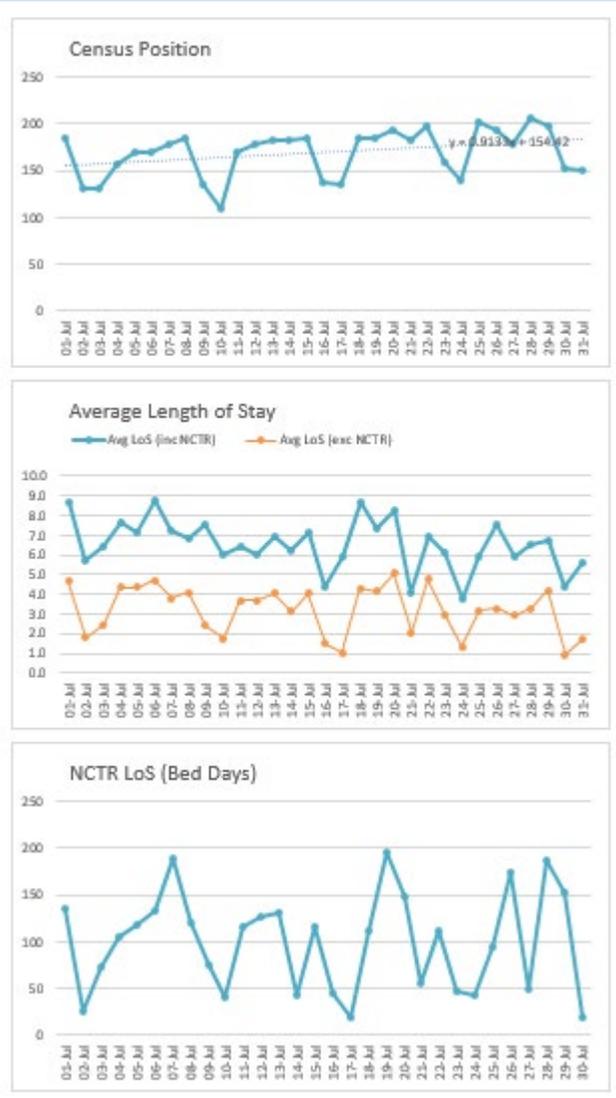
Intervention and Planned

- Additional CCG support was provided in June 2022 to work across all system partners and initially focus on patients with 20+ days LoS of having ‘No Criteria to Reside’
- A report of the findings and improvement actions to go to the System Oversight Group to agree priorities.
- Following the ground floor workshop, all patients referred via GP after contact with a speciality will be streamed directly to the specialty assessment area away from ED.
- Changes to the Emergency Pathway to be supported as a PDSA from 11 July 2022 for 4 weeks.
- Standardisation of Board and Ward rounds in Medicine to support the identification of early discharges, thereby creating capacity earlier in the day has commenced in August 2022.

Risks / Mitigations

- High numbers of No Criteria to Reside patients continue to occupy acute beds thereby reducing the capacity for acute work
- Reinforce the requirements for escalation and implementation of professional standards for service delivery across all teams to support flow and management of risk.

5. No Criteria to Reside



What the chart tells us

On average, there were 169 patients per day with No Criteria to Reside in July 2022. There was an average impact of 3.3 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 3,087 2,811 lost bed days in July 2022, which is an increase of 276 on June 2022.

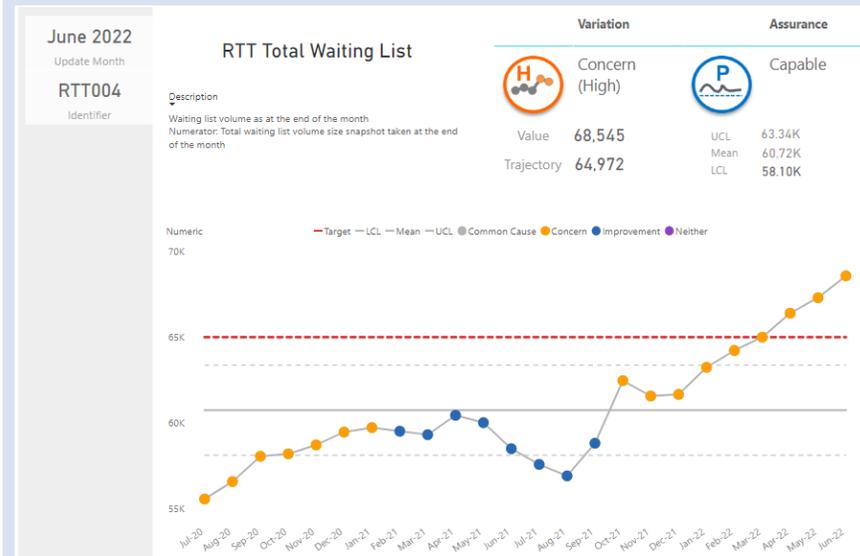
Intervention and Planned Impact

- CHCP launched the Bee @ Home Service in July 2022 with an agreement to take 50 patients per week from the Trust by October 2022; starting with 20 per week in July 2022. The Business Model was based around offering 2-3 care calls per day/client with 1 carer.
- During July 2022 it became apparent that patient referrals required 3-4 care calls per day with 2 carers which limited capacity so CHCP were unable to reach the target discharges.
- CHCP have recruited circa 50% of the workforce and continuing to recruit and increases in numbers are looking favourable.
- Following discussions with HUTH COO, CHCP have remodelled the service to provide hours of care rather than number of discharges to ensure transparency and consistency of approach.
- CHCP now receive the NCTR report and have implemented a pull model from 8 August 2022.
- During July CHCP accepted 26 patients and rejected 9. To date for August (at 11/08/2022), CHCP have accepted 12 and rejected 5 and are expecting these figures to increase.

Risks / Mitigations

- ERoYC Social Services remained challenged with staffing throughout July 2022, with increased numbers of NCTR patients & increased time to assessment. The team have worked to mitigate this and are just under their baseline target – with 10 assessments awaiting allocation as of 11 August 2022.
- Covid outbreaks closing community capacity with increased prevalence seen in July 2022.
- Domiciliary capacity remains lower than demand.

6. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) continues to increase; with 9 data points above the mean. At the end of July 2022, the provisional position is 71,310 (+1,765 on last month). The total WLV is above the trajectory of 65,471. The sustainable list size to achieve 92% incomplete performance is circa. 36k. The total WLV is currently above the 2022/23 trajectory for July 2022; the final submission is due on 19 August 2022.

Referrals in July 2022 were the same as the previous year (June 2021). The operational plan for 2022/23 assumes no further increase in referrals.

Intervention and Planned Impact

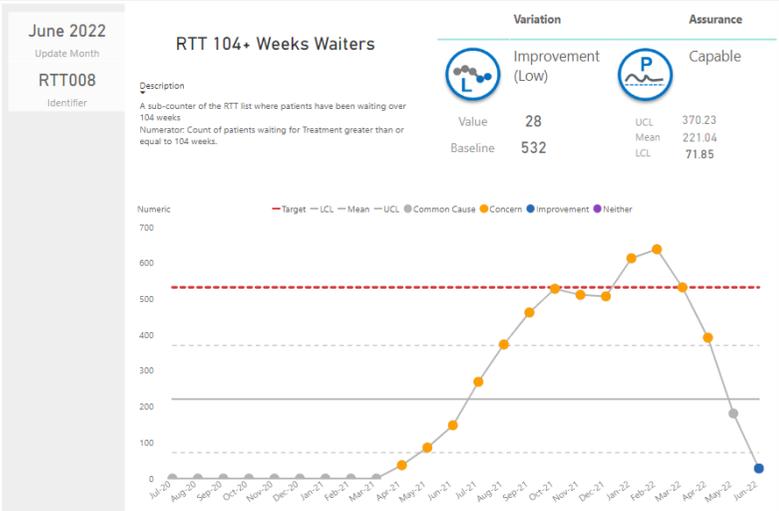
- Continued focus to reduce the 104-week risks to zero with the exception of a number of Orthodontic patients who cannot receive a treatment which stops their clock due to capacity constraints. All of these patients were offered to opportunity to receive treatment at another provider and declined.
- Targeted speciality meetings to focus on the risks related to achievement of no patient waiting more than 70-weeks at 31 March 2023 continue.
- Internal milestones have been set: zero x 90 week waits at 30 September 2022 (except orthodontics) and zero x +52 week non-admitted waits at 31 March 2023; both initiatives will progress reductions on the Total WLV
- Mutual aid from other providers is supporting the total WLV reduction overall.
- Capacity alerts in pressured specialities – final communications with ICB/PCNs
- Progressing transfers to a range of Independent Sector Providers
- Insourcing from a range of providers with additional support for Gynaecology as a priority.
- Reduced (70%) theatre timetable for summer aims to protect pressured specialities where possible.
- Text validation to patients on 31,000 pathways commenced at the end of June 2022 delivered by Healthcare Communications; this process will focus on patients confirming whether they still require treatment. Good progress being made – removal rate at circa 7%.
- RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced.

Risks / Mitigations

- Further increase in GP referrals – referral triage and A&G in place to mitigate

- Orthopaedic bed base reduction (-15) due to oncology using C9 offset by support from C15 – Executives have confirmed that C9/9A (35 beds) will be returned to orthopaedics/neurosurgery in September 2022.
- Patients with No Criteria to Reside does not reduce
- Covid and Covid Contacts does not start to increase, staff absence does not increase
- Increase in non-elective demand displacing elective capacity

7. 104 Week Waits & Planned Trajectory



What the chart tells us

At the end of July 2022 there has been a decrease in actual 104 week waits to 20 (-8 on previous month). This was against a declared position of no worse than 21 breaches at the end July 2022.

20 breaches analysis: 19 patient choice (declined mutual aid or chose to wait) and 1 clinically complex patient.

Intervention and Planned Impact

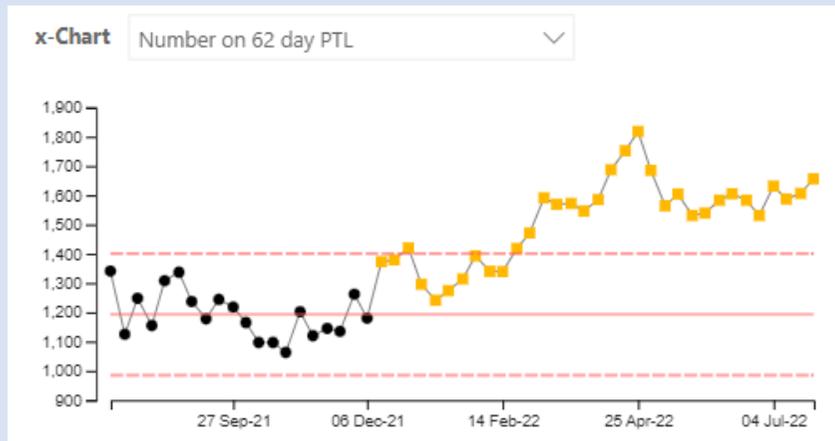
- Continued focus at speciality level of patients dated and/or risks now focussed to 31 December 2022 to achieve and maintain zero 104-week waits (except orthodontics) from 31 July 2022.
- Internal milestone set: zero x 90 week waits at 30 September 2022 (except orthodontics).
- Revised Trust trajectory confirmed to NHSE on 12 August 2022 – all orthodontic breaches due to capacity constraints, and worsened by resignations
- 31 August 2022 x 17 (was 14)
- 30 September 2022 x 17 (was 5)
- 31 November 2022 x 9 (was 0)
- 31 December 2022 x 9 (was 0)
- 31 January 2023 x 4 (was 0)
- 28 February 2023 x2 (was 0)
- 31 March 2023 x 0
- Clinical Admin Service continue to proactively contact patients with TCIs/appointments to check they are attending/if treatment is still required – small number of removals
- Hull & East Riding system plan to create additional care home/intermediate bed capacity to further reduce NCTR – reduced nurse staffing to elective ward areas

- Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities.

Risks / Mitigations

- Current patients dated are treated as planned – delivered through micro-management
- Covid (staff absence & patient numbers)
- Staff absence increases or does not reduce
- Monkey Pox, NCTR and/or non-elective (winter) demand increases – impacting on elective bed base
- Priority 2, cancer and trauma demand – including ICU capacity & delays in repatriation (in & out of network)
- Patient choice & willingness to accept alternative providers and/or do not meet criteria
- Validation – no long wait “pop-ups”
- July to September 2022 much reduced risk of patients tipping to 104- weeks, now at 60 (- 86 on last month at 8/8/2022 – and being tracked).
- Speciality capacity risks:
 - Colorectal (cancer demand & HOB bed requirements)
 - ENT (surgeon & complex operating time)
 - Plastic Surgery (ward based enhanced monitoring requirements)
 - Orthopaedics (bed base)
 - Neurosurgery (P2/acute demand, theatres & bed base)
 - Orthodontics (clinical capacity)
 - Oral Surgery (surgeon capacity)
 - Cardiac Surgery (acute demand, P2 volume and ICU capacity)
- Procurement issues (global and nationally)

8. Cancer 62 day Waiting List Volume



What the chart tells us

The number of patients waiting to start treatment on a 62-day pathway has decreased over the last month from a peak of 1,818 (April 2022) to 1,539 at the end of May 2022; and 1,695 on 10 August 2022.

The pre-Covid sustainable list size was c.900 – work is underway to calculate a new sustainable list size based on referrals and national cancer waiting times.

At week commencing 8 August 2022, Colorectal, Skin, Gynae and Urology tumour sites continue to make up the largest percentage of the overall PTL, as follows:

- Colorectal (643/40%) with 16% over 63 days (a further 4% reduction since last report)
- Skin (298/17.6% an increase of 3%)
- Gynaecology (182/12.7% an increase of 2%)
- Urology (182/10.7% - and increase of 0.7%)

Intervention and Planned Impact

The capacity and/or pathway issues fall into 4 broad categories.

Imaging/Diagnostic - waiting times/capacity review underway supported by the Operational Improvement Team and enhanced performance management meetings with the CSSHG Imaging Division to address:

- CT Colon additional capacity has been identified from the beginning of July into August 2022 to address the backlog and reduce from 11-week wait (now reduced to approximately 8-weeks) and improvement is noticeable in the Lower GI tumour site performance
- Service improvement support to improve CT colon utilisation and admin processes in progress
- CT Colon mutual aid being provided by NLAG and Spire – the teams are working to maximize this capacity
- There is some evidence to support shorter waiting times for CT following the radiology department intervention however, reporting times have not yet reduced
- Colonoscopy waiting times - have increased and will form part of the colorectal transformation improvement plan

Histology capacity/delays – continue to be significant for Gynae-onc, colorectal and skin, the following actions remain current

- Daily results file has been made available to tracking staff
- Escalations to the SHYPS manager are communicated where results remain outstanding
- Support to identify mutual aid for histology through the NEY Regional Clinical Leads continues with monthly meetings however the impact is yet to be seen in the backlog
- Summer holiday annual leave for administration has been raised as a risk and HUTH will try to support
- Unplanned consultant histopathologist absence is a risk offset by on-boarding of consultants who are committed to weekend reporting

Tracking capacity and decision making

- PTL validation by the Trust Lead Cancer Manager is complete – the PTL is clean, patients are genuine; systems will be put in place to remove patients who have a benign diagnosis
- Thorough review of 104+ days is being undertaken to ensure all guidance is applied where appropriate in the case of patient deferment
- Tracker annual leave is noticeable – consideration for a “floating” tracker to manage planned absences
- Transfers to other cancer specialities centres i.e. Leeds will be removed from the HUTH PTL as this is a double count when considered nationally (similar benefit within the ICB)
- Skin tumour site removal from the PTL when excision complete and before histology will be progressed with the National Cancer team

Radiotherapy capacity/delays

- Staffing vacancies and long term sickness continue to be a considerable challenge albeit recruitment has been successful with new starters due to commence in November 2022
- Increased workload since the recovery plan was developed and implemented during COVID-19 (2021/22)
- Clinical Oncology workforce shortages remains a challenge

The result of these challenges is that Radiotherapy and Chemotherapy waiting times for treatment have declined to a point where the Cancer Waiting Times performance is adversely affected (Subsequent Radiotherapy 31 day target failed to achieve the target of 94%) for the

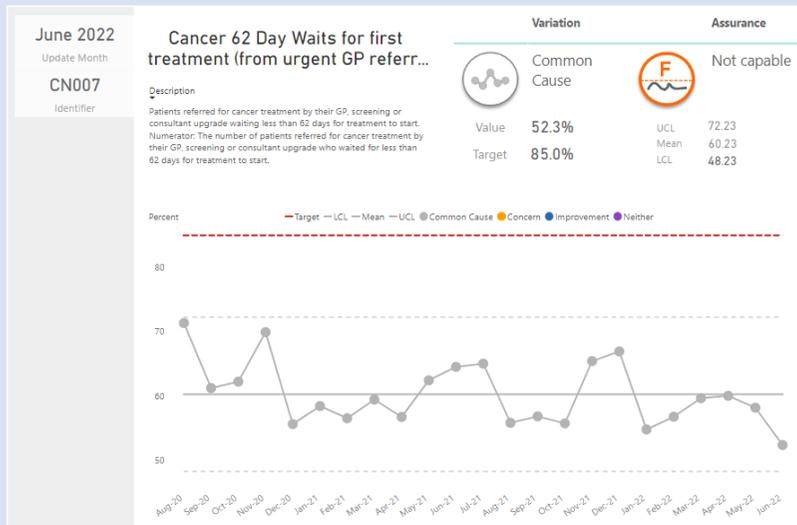
first time in the life of the Cancer Waiting Times targets in May 2022. Performance is not expected to improve for the remainder of the calendar year.

Meeting held with national cancer lead – good assurance that the Trust is addressing all the improvement opportunities.

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- Staff gaps (vacancies and absence) further impact on diagnostic capacity & waiting times
- Histology tracking systems implemented locally to prioritise long-wait patients
- Mutual aid sourced for CT Colon with some success
- Additional internal CT Colon capacity has been secured and implemented from beginning of July 2022
- Mobile CT capacity continues to be provided by the IS
- Radiotherapy delivery continues to deteriorate

9. Cancer 62 day Performance



What the chart tells us

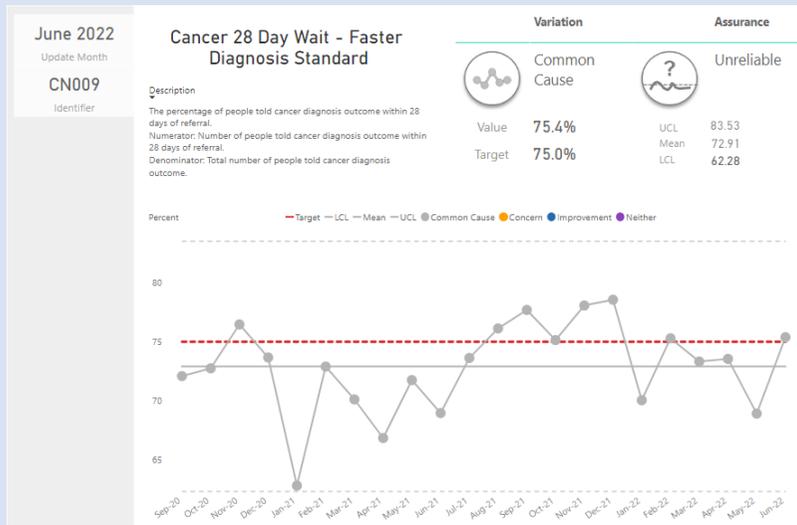
Performance for June 2022 was 52.3% which is lower than May 2022 (58%), performance has not been achieved for some time.

The Faster Diagnosis Standard (combined) June 2022 achieved the target with performance of 75.4%.

Intervention and Planned Impact

Largely the same as Section 8. Above.

- Additional CT Colon capacity has been secure to address the backlog of patients
- Administration processes continue to be reviewed and actions implemented
- CT colon mutual aid from NLAG and Spire
- Improved access to CT Colon internally should have a direct impact on FDS performance for colorectal which in turn will support the overall Trust performance. It is anticipated that it will be September 2022 when a change will be demonstrated
- Deep dive into Faster Diagnosis Standard in key tumour sites has been completed – benign letter process to be implemented for the Lung tumour site
- Radiotherapy capacity and patient prioritisation will continue to adversely affect performance with no mutual aid available in the region



Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times
- Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times
- Histology tracking systems implemented locally to prioritise long-wait patients – concern that improvements in timeliness of results have not yet been seen
- Mutual aid sourced for CT Colon with some success
- Additional internal CT Colon capacity has been secured throughout the summer
- Mobile CT capacity continues to be provided by the IS

10. Elective Recovery Fund

HG	POD	Target	104%	104%	104%	104%	Q1 Total	Q2 Total	Grand Total
		DATA	Apr-22	May-22	Jun-22	Jul-22			
Trust	01 Day Case	2019-20 M10 FOT Baseline	3,998,784	4,182,793	3,969,884	4,353,054	12,151,461	4,353,054	16,504,515
		22-23 Baseline Plan	3,843,745	4,165,689	4,296,249	4,331,771	12,305,683	4,331,771	16,637,454
		Actuals	3,514,907	4,427,167	4,101,189	4,352,544	12,043,264	4,352,544	16,395,807
		Baseline 19/20 %	88%	105.8%	103%	100%	99%	100%	99%
		Baseline 22/23 %	91%	106.3%	95%	100%	98%	100%	99%
		Indicative Gain/Loss	(482,871)	57,797	(20,618)	130,974	(445,692)	130,974	(576,666)
		2019-20 M10 FOT Baseline	5,300,060	5,427,515	5,777,549	5,708,744	16,505,124	5,708,744	22,213,868
		22-23 Baseline Plan	5,638,397	6,041,690	5,922,764	6,147,276	17,602,851	6,147,276	23,750,128
		Actuals	4,113,219	4,957,945	4,909,909	5,047,635	13,981,074	5,047,635	19,028,709
		Baseline 19/20 %	78%	91%	85%	88%	85%	88%	86%
Baseline 22/23 %	73%	82.1%	83%	82%	79%	82%	80%		
Indicative Gain/Loss	(1,049,133)	(515,003)	(824,057)	(667,094)	(2,388,192)	(667,094)	(3,055,286)		
Trust	05 Outpatient Firsts	2019-20 M10 FOT Baseline	2,607,607	2,724,736	2,629,368	2,917,934	7,961,711	2,917,934	10,879,644
		22-23 Baseline Plan	2,574,058	2,814,196	2,770,035	2,855,984	8,158,289	2,855,984	11,014,273
		Actuals	2,625,270	3,048,020	2,450,975	2,953,494	8,124,265	2,953,494	11,077,759
		Baseline 19/20 %	101%	112%	93%	101%	102%	101%	102%
		Baseline 22/23 %	102%	108.3%	88%	103%	100%	103%	101%
Indicative Gain/Loss	(64,981)	160,721	212,676	60,867	(116,936)	60,867	(177,803)		
Trust	06 Outpatient Followups	2019-20 M10 FOT Baseline	2,524,573	2,731,211	2,569,005	2,897,068	7,824,789	2,897,068	10,721,857
		22-23 Baseline Plan	2,689,532	2,980,184	2,919,880	2,969,272	8,589,595	2,969,272	11,558,867
		Actuals	2,834,608	3,168,168	2,864,115	3,094,817	8,866,891	3,094,817	11,961,707
		Baseline 19/20 %	112%	116%	111%	107%	113%	107%	112%
		Baseline 22/23 %	105%	106%	98%	104%	103%	104%	103%
Indicative Gain/Loss	-	-	-	-	-	-	-	-	
Trust	Outpatient Procedures	2019-20 M10 FOT Baseline	1,192,279	1,298,115	1,170,726	1,391,424	3,661,120	1,391,424	5,052,544
		22-23 Baseline Plan	966,527	1,067,967	1,033,990	1,036,990	3,068,483	1,036,990	4,105,473
		Actuals	999,528	1,187,991	1,047,273	1,090,824	3,234,792	1,090,824	4,325,616
		Baseline 19/20 %	84%	92%	89%	78%	88%	78%	86%
		Baseline 22/23 %	103%	111.2%	101%	105%	105%	105%	105%
Indicative Gain/Loss	(180,331)	(121,537)	(127,712)	267,193	(429,580)	267,193	(696,773)		
Trust Overall		2019-20 M10 FOT Baseline	15,623,302	16,364,370	16,116,532	17,268,224	48,104,205	17,268,224	65,372,429
		22-23 Baseline Plan	15,712,259	17,069,725	16,942,918	17,341,293	49,724,902	17,341,293	67,066,195
		Actuals	14,087,533	16,789,292	15,373,460	16,539,314	46,250,285	16,539,314	62,789,599
		Baseline 19/20 %	90%	103%	95%	96%	96%	96%	96%
		Baseline 22/23 %	90%	98%	91%	95%	93%	95%	94%
Indicative Gain/Loss	(1,777,315)	(418,021)	(1,185,062)	(1,126,128)	(3,380,399)	(1,126,128)	(4,506,527)		

What the chart tells us

Recovery of elective activity in July 2022 against the operational plan was broadly in line with the submitted activity numbers except for Ordinary elective at 82% of plan. The indicative activity requirement of 110% of 19/20 baseline was not delivered in any of the PODs.

Overall financial position delivered 95% of the plan in July 2022.

Intervention and Planned Impact

Increases in the elective bed base have supported recovery improvement in colorectal however the fragile nature of the access to HOB and ICU capacity is limiting further increase in IP, as is the use of C9 for oncology rather than orthopaedics.

Day case delivery achieved for May 2022 – however the summer theatre timetable has reduced to 70% of pre-Covid until September 2022 largely due to anaesthetic shortfalls, and this has impacted on July 2022 performance.

OP 1st attendances have improved in May 2022, however this was not sustained in June 2022, with July 2022 being over 100% of the plan but marginally under the 19/20 baseline requirements.

OPFU continue to over-perform at 107% of the 22/23 plan and 104% of the 19/20 baseline – income is capped at 85% of 19/20 baselines. Focused review of OPFU rates and comparison to regional and national performance is continues with the development of OP Transformation Plans at speciality level.

Risks / Mitigations

- Theatre timetable reductions for summer 2022
- Elective activity and elective bed base is not ring-fenced through winter or Covid surges
- OPFU continue to be in excess of 75% of 19/20 baseline at March 2023
- The new day surgery centre does not come on line in January 2023

Agenda Item		Meeting	Trust Board	Meeting Date	13.09.22
Title	Finance Report – 2022/23 - Month 4				
Lead Director	Lee Bond, Chief Finance Officer				
Author	Stephen Evans, Deputy Director of Finance				
Report previously considered by (date)					
Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain	Link to Trust Strategic Objectives 2021/22
Trust Board Approval		Commercial Confidentiality		Safe	Honest Caring and Accountable Future
Committee Agreement		Patient Confidentiality		Effective	√ Valued, Skilled and Sufficient Staff
Assurance	√	Staff Confidentiality		Caring	High Quality Care
Information Only		Other Exceptional Circumstance		Responsive	√ Great Clinical Services
				Well-led	√ Partnerships and Integrated Services
					Research and Innovation
					Financial Sustainability
					√
Key Recommendations to be considered:					
<p>a) The reported deficit of £0.9m at month 4, £1.5m away from plan.</p> <p>b) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback in the second half of the year.</p> <p>c) The uncovered risk of £7.5m in the year-end forecast and the actions needed if the Trust is to deliver its plan.</p> <p>d) The need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.</p> <p>e) The underlying deficit of £41m</p>					

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

FINANCIAL UPDATE 2022/23 – MONTH 4

1. Purpose of Paper

To update the Trust Board on the financial position at month four and the year-end forecast.

2. Background

The Trust has submitted a balanced financial plan for 2022/23. This largely resulted from agreement of additional income for the Trust in 2022/23 of £14.8m plus agreement on some further balance sheet flexibilities and anticipated reserve slippage of £4.3m. £10.9m of the additional income has been given non-recurrently and alongside the non-recurrent actions in the original plan means that the Trust has an underlying deficit of £41m.

3. Month 4

The table in appendix 1 shows the month 4 reported position against the revised NHSI plan, at health group level. The Trust is reporting a deficit of £0.9m at month 4, which is £1.5m worse than the plan. This is an increase of £0.2m in month.

Income

Confirmation has been given that, there will be no clawback of Elective Recovery Funding (ERF) in the first six months of the financial year. This removes the risk of the Trust losing up to £6m in the first half of the year due to activity value being below 104% target. The rules on clawback are expected to commence from month 7.

The Trust plan assumes receipt of Salix grant income but this is subject to a bidding process and nothing has been received to date. This does not affect the Trust reported performance position.

Expenditure

Health groups and corporate areas are reporting that they have a deficit of £3.5m at month 4. This is an increase of £0.3m in month.

CRES shortfall is £1.1m at month 4. This is unchanged from month 3. Most health group CRES shortfall has increased in line with previous trends but this is offset by improvement in Medicine health group reported position. Medicine position has improved due to recognition of non-recurrent savings from vacant posts. The breakdown by Health Group is as per the following table:

	YTD CRES Plan £'k	YTD CRES Actual £'k	YTD CRES Variance £'k	% Achieved YTD
Medicine	887	796	-91	90%
Emergency Medicine	126	83	-43	66%
Surgery	965	739	-226	77%
Family & Womens Health	559	327	-232	58%
Clinical Support Services	717	325	-392	45%
Corporate	557	406	-151	73%
Estates, Facilities & Development	162	162	0	100%
Energy	1,716	1,716	0	100%
Central	119	119	0	100%
TOTAL	5,808	4,673	-1,135	80%

Surgery Health Group has the biggest pressure excluding CRES delivery with a further £1.0m overspend (£0.1m in month). The main areas are the pressures on Junior Doctors (£0.5m) which remains under review, Anaesthetic Consultant sessions to support theatre lists (£0.4m) and loss of private patient income (£0.1m). There is also pressure on non-pay costs and work is being undertaken to determine how much relates to inflation and what is activity related.

Medicine has additional costs due to the opening of two unfunded wards to support NCTR patients and has non-pay pressures. Deficit increased by £0.1m in month.

Clinical Support Health Group position improved by £0.2m in month despite the increased CRES shortfall of £0.1m. Position driven by level of vacancies.

High cost drugs within the block commissioner contract improved by £0.1m in month and remains under constant review as it still shows £0.5m overspent.

Family and Women's Health Group is £0.6m over-spent with main driver the high level of Wet AMD cases (£0.4m). There is also pressure on medical staffing but this is offset by vacancies in other staff groups. The in-month overspend was £0.1m.

EF&D have shortfalls on Catering (£0.4m) and car parking income (£0.3m), which have not returned to pre-Covid19 levels. The Trust is not currently charging staff for car parking but is looking to commence from 1st October 22. These cost pressures are being offset, to some extent by vacancies. Funding for new Allam building at HRI and new ICU is to be finalised.

The Trust has reserves available, which it expected to use to offset some of these pressures, as they were included in the initial plan. This amounts to £1.8m.

In summary the month 4 position is:

Unidentified CRES	(£1.1m)
Other Health Group Pressures	(£2.4m)
Reserves and other areas	£2.0m
Total shortfall	(£1.5m)

The key actions needed are identifying plans to reduce the level of unidentified CRES and the need to increase in house productivity to ensure the Trust delivers the ERF income.

4. Forecast

The Trust is currently reporting that it will deliver its financial plan for 22/23. This includes two major risks.

- a) £7.5m of uncovered risk within Health Group expenditure plans.
- b) ERF target of 104% activity value is delivered or funding is not clawed back in second half of the year.

The £7.5m expenditure risk can be broken down into the following areas.

Forecast CRES Shortfall	£1.8m
ERF Capacity	£3.3m
NCTR wards	£0.7m
Income Shortfalls	£1.3m
Wet AMD activity	£1.6m
High Cost Drugs	£1.0m
Various Underspends	(£2.2m)
Total	£7.5m

Action will need to be taken to address the risk. This will include:

- a) Continue to push for identification and delivery of CRES schemes through Productivity and Efficiency Board
- b) Increase in-house productivity to reduce need for additional capacity in final 6 months of the year to limit IS usage.
- c) Continue to review reserves/balance sheet for further slippage/offsets.

Work is ongoing to confirm the underlying deficit and at this stage remains at around £41m.

5. Statement of Financial Position (SOFP) and Statement of Cash flow (SOCF)

The SOFP and SOCF for month 4 are reported in appendices 2 and 3.

Capital

The reported capital position at month 4 shows gross capital expenditure of £3.7m against a plan of £6.1m. The main areas of expenditure relate to the Digestive Disease Scheme; Day Surgery Scheme and PFI lifecycle costs. The variance from

plan is a profiling issue on the Salix grant scheme as the forecast capital spend for the year is in line with the annual plan.

The planned capital expenditure for 2022/23 (incl PFI/IFRIC12 impact) is £34.9m, although this does not include any assumptions on the Trust receiving PDC allocations. The Trust has recently submitted PDC Capital bids in relation to a CT scanner; Gamma Camera and NICU development and we are currently developing a business case for Phase 2 of the Day Surgery scheme (TIF2).

The planned capital expenditure also includes an assumption on the Trust receiving a Salix Grant of £10m. This is not yet confirmed and is subject to a bidding process.

Cash

The Trust's liquidity position remains healthy with a cash balance of £90.0m at the end of July 22. This will reduce gradually in the year, as balance sheet flexibility is released into the SOCI position, in support of plan delivery.

To date the Trust has paid 96.1% by volume and 85.1% by value of non-NHS invoices within best practice terms. In July, the figures were 95.9% and 88.3% respectively.

Debtors

The Trust currently has £3.6m of debt that is over 90 days, a reduction of £0.4m from month 3. The main debtors are as follows:

	June 22	July 22	Change
	£	£	£
Debtors Over 90 days			
Northern Lincolnshire And Goole Nhs Ft	404,106	386,125	-17,981
York & Scarborough Teaching Hospitals Nhs Ft	458,586	353,336	-105,250
City Health Care Partnership	258,112	208,492	-49,620
Humber Teaching Nhs Foundation Trust	240,148	184,454	-55,694
Spire Healthcare Group	137,540	137,960	420
East Riding Fertility Services Ltd	99,473	101,630	2,157
Fresenius Medical Care Renal Services Ltd	77,505	77,505	0
Crawford & Company Adjusters (Uk) Ltd	70,320	70,320	0
Ge Healthcare	51,962	51,962	0
University Of Hull	59,823	47,467	-12,355
Other	1,744,651	1,585,252	-159,399
Total	3,602,226	3,204,872	-397,353

Discussions are ongoing with East Riding Fertility services regarding payment arrangements as they have asked for some more time to pay the outstanding balance. Fresenius, Crawford and GE Healthcare have all been chased for an update on when payment will be made.

Stocks

Stock levels are at £16.2m, an increase of £0.3m since year-end.

As part of the 2021/22, audit recommendations there will be a review of the Trust stock-take procedures during the year.

The full table is not included this month due to the problems experienced with the system.

6. Recommendations

The Trust Board is asked to note the following:

- a) The reported deficit of £0.9m at month 4, which is £1.5m away from plan chiefly driven by unidentified CRES and additional wards to support NCTR patients. This is an increase of £0.2m in month.
- b) The risk on elective recovery income if value of activity is below plan and NHSEI enact the clawback in the second half of the year.
- c) The uncovered risk of £7.5m in the year-end forecast and the actions needed if the Trust is to deliver its plan.
- d) The need to increase in-house productivity and to continue to identify CRES opportunities to reduce the unidentified balance.
- e) The underlying deficit of £41m

Stephen Evans
Deputy Director of Finance
August 2022

APPENDIX 1

Financial Year 2023 Month 4

	Annual Budget £000	Budget £000	Actual £000	Variance £000	Month 3 £000	Change In Month	Forecast £000
Nhs Contract Income	650,620	217,261	217,275	14	(14)	28	(201)
ERF Income	19,718	6,573	6,573	0	1	(1)	0
Nhs Other Clinical Income	209	70	78	8	6	2	24
Education + Training Income	21,138	7,046	7,048	2	0	2	621
Other Income	2,320	773	812	39	119	(80)	117
Donated/Grant Income	10,460	2,000	0	(2,000)	(1,000)	(1,000)	0
Total Income	704,465	233,723	231,786	(1,937)	(889)	(1,049)	561
Surgery	(144,339)	(49,009)	(50,252)	(1,243)	(1,085)	(158)	(3,753)
Medicine	(87,863)	(29,898)	(30,198)	(300)	(162)	(138)	(3,110)
Clinical Support Services	(98,760)	(33,181)	(33,405)	(224)	(431)	207	(756)
Pass through drugs	(68,159)	(22,761)	(23,233)	(472)	(567)	95	(1,039)
Family + Womens Health	(86,410)	(29,442)	(30,066)	(624)	(537)	(87)	(1,614)
Corporate Directorates	(76,690)	(25,710)	(25,763)	(53)	(42)	(11)	(779)
Reserves	(19,851)	(4,744)	(2,951)	1,793	1,712	81	2,565
Other Operating Expenditure	(6,475)	(2,154)	(2,149)	5	16	(11)	39
Emergency Care Health Group	(18,491)	(6,001)	(5,940)	61	59	2	(86)
Estates Facilities & Developmt	(51,732)	(16,493)	(17,149)	(656)	(467)	(189)	0
Unaddressed Risk	0	0	0	0	0	0	7,520
Total Operating Expenditure	(658,770)	(219,393)	(221,106)	(1,713)	(1,504)	(209)	(1,013)
Donated Asset Income	(10,460)	(2,000)	0	2,000	1000	1,000	0
EBITDA	35,235	12,330	10,680	(1,650)	(1,393)	(258)	(452)
Depreciation	(22,161)	(7,386)	(7,388)	(2)	(11)	9	0
Interest Payable	(6,236)	(2,053)	(2,140)	(87)	(59)	(28)	(160)
Interest Receivable	217	72	221	149	103	46	412
Pdc Dividends	(8,195)	(2,732)	(2,732)	0	0	0	0
Profit / Loss On Disposal	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0
Total Non Operating Expenditure	(36,375)	(12,099)	(12,039)	60	33	27	252
Net Surplus/Deficit	9,320	2,231	(1,359)	(3,590)	(2,360)	(1,231)	(200)
Donated Asset Adjustment (NEW)	(9,320)	(1,620)	460	2,080	1,061	1,019	200
Adjusted Financial Performance before Profit/Loss Adjustment	0	611	(899)	(1,510)	(1,299)	(212)	0
Profit/Loss Disposal Assets Adjustment	0	0	0	0	0	0	0
Adjusted Financial Performance Surplus/Deficit	0	611	(899)	(1,510)	(1,299)	(212)	0

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF FINANCIAL POSITION

	Accounts 31/03/2022 2021/22 £000	Actual 31/07/2022 YTD £000	Movement from 31/03/22 £000
Non-current assets			
Intangible assets	8,790	9,433	643
Property, plant and equipment: on-SoFP IFRIC 12 assets	63,165	62,664	(501)
Property, plant and equipment: other	322,078	316,737	(5,341)
Right of use assets - leased assets for lessee (excludes PFI/LIFT)		8,728	8,728
Investment property	100	100	0
Investments in joint ventures and associates			0
Other investments / financial assets	536	536	0
Receivables: due from NHS and DHSC group bodies	1,338	1,398	60
Receivables: due from non-NHS/DHSC group bodies	1,953	1,887	(66)
Other assets			
Total non-current assets	397,960	401,483	3,523
Current assets			
Inventories	15,867	16,200	333
Receivables: due from NHS and DHSC group bodies	17,732	16,486	(1,246)
Receivables: due from non-NHS/DHSC group bodies	15,227	18,279	3,052
Other investments / financial assets	0	0	0
Other assets	0	0	0
Non-current assets for sale and assets in disposal groups	0	0	0
Cash and cash equivalents: GBS/NLF	79,415	89,975	10,560
Cash and cash equivalents: commercial / in hand / other	13	20	7
Total current assets	128,254	140,960	12,706
Current liabilities			
Trade and other payables: capital	(32,732)	(8,494)	24,238
Trade and other payables: non-capital	(108,479)	(134,844)	(26,365)
Borrowings	(2,989)	(5,179)	(2,190)
Other financial liabilities	0	0	0
Provisions	(3,997)	(3,949)	48
Other liabilities: deferred income including contract liabilities	(3,277)	(12,316)	(9,039)
Liabilities in disposal groups	0	0	0
Total current liabilities	(151,474)	(164,782)	(13,308)
Total assets less current liabilities	374,740	377,661	2,921
Non-current liabilities			
Trade and other payables	0	0	0
Borrowings	(51,377)	(55,655)	(4,278)
Other financial liabilities	0		0
Provisions	(2,924)	(2,924)	0
Other liabilities	0	0	0
Total non-current liabilities	(54,301)	(58,579)	(4,278)
Total assets employed	320,439	319,082	(1,357)
Financed by			
Taxpayers' equity			
Public dividend capital	330,863	330,863	0
Revaluation reserve	26,537	26,538	1
Financial assets at FV through OCI reserve	536	536	0
Other reserves	0	0	0
Merger reserve	0	0	0
Income and expenditure reserve	(37,497)	(38,855)	(1,358)
Others' equity			
Non-controlling Interest	0	0	0
Charitable fund reserves	0	0	0
Total taxpayers' and others' equity	320,439	319,082	(1,357)

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

STATEMENT OF CASH FLOWS

	Accounts 31/03/2022	Actual 31/07/2022
	£000	YTD £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	14,669	3,300
Operating surplus/(deficit) of discontinued operations		
Operating surplus/(deficit)	14,669	3,300
Non-cash or non-operating income and expense:		
Depreciation and amortisation	18,210	7,388
Impairments and reversals	15,919	0
Income recognised in respect of capital donations (cash and non-cash)	(17,454)	(1)
Amortisation of PFI deferred income / credit	0	0
On SoFP pension liability - employer contributions paid less net charge to the SOC	0	
(Increase)/decrease in receivables	(11,730)	(1,800)
(Increase)/decrease in other assets	0	0
(Increase)/decrease in inventories	(885)	(334)
Increase/(decrease) in trade and other payables	38,392	484
Increase/(decrease) in other liabilities	2,547	9,039
Increase/(decrease) in provisions	1,031	(48)
Corporation tax (paid) / received		
Movements in operating cash flows of discontinued operations		
Other movements in operating cash flows	(1)	
Net cash generated from / (used in) operations	60,698	18,029
Cash flows from investing activities		
Interest received	41	221
Purchase of financial assets / investments		
Proceeds from sales / settlements of financial assets / investments		
Purchase of intangible assets	(3,062)	(743)
Proceeds from sales of intangible assets		
Purchase of property, plant and equipment and investment property	(71,910)	(3,692)
Proceeds from sales of property, plant and equipment and investment property	136	0
Receipt of cash donations to purchase capital assets	12,249	0
Prepayment of PFI capital contributions (cash payments)		
Cash flows attributable to investing activities of discontinued operations		
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		
Cash movement from disposals of business units and subsidiaries (not absorption transfers)		
Net cash generated from/(used in) investing activities	(62,546)	(4,214)
Cash flows from financing activities		
Public dividend capital received	38,616	0
Public dividend capital repaid	0	0
Movement in loans from the Department of Health and Social Care	(1,260)	0
Movement in other loans	0	0
Other capital receipts		0
Capital element of finance lease rental payments	(56)	(666)
Capital element of PFI, LIFT and other service concession payments	(1,583)	(557)
Interest on DHSC loans	(395)	0
Interest on other loans		
Other interest (e.g. overdrafts)		
Interest element of finance lease	(4)	(19)
Interest element of PFI, LIFT and other service concession obligations	(5,520)	(2,005)
PDC dividend (paid)/refunded	(7,450)	0
Cash flows attributable to financing activities of discontinued operations		
Cash flows from (used in) other financing activities		
Net cash generated from/(used in) financing activities	22,348	(3,247)
Increase/(decrease) in cash and cash equivalents	20,500	10,568
Cash and cash equivalents at 1 April - brought forward	58,927	79,427
Prior period adjustments		
Cash and cash equivalents at 1 April - restated	58,927	79,427
Cash and cash equivalents at start of period for new FTs	0	
Cash and cash equivalents transferred by absorption	0	
Unrealised gains/(losses) on foreign exchange		
Cash transferred to NHS foundation trust upon authorisation as FT	0	0
Cash and cash equivalents at Month (Year) End	79,427	89,995

Agenda Item		Meeting	Trust Board Committee	Meeting Date	13 th August 2022
Title	Premises Assurance Model (PAM)				
Lead Director	Director of Estates, Facilities & Development				
Author	Director of Estates, Facilities & Development				
Report previously considered by (date)	Estates, Facilities & Development Management Committee 10 th May 2022				

Purpose of the Report		Reason for submission to the Trust Board private session		Link to CQC Domain		Link to Trust Strategic Objectives 2021/22	
Trust Board Approval	√	Commercial Confidentiality		Safe	√	Honest Caring and Accountable Future	
Committee Agreement		Patient Confidentiality		Effective	√	Valued, Skilled and Sufficient Staff	
Assurance	√	Staff Confidentiality		Caring		High Quality Care	
Information Only		Other Exceptional Circumstance		Responsive	√	Great Clinical Services	
				Well-led	√	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

NHS Standard Contract 2022/23 (Service Condition 17.9) states that:

'The Provider (if it is an NHS Trust or an NHS Foundation Trust) must complete the NHS Premises Assurance Model (PAM) and submit a report to its Governing Body in accordance with the requirements and timescales set out in the NHS Premises Assurance Model, and make a copy available to the Co-ordinating Commissioner on request'.

There is also a requirement to upload the individual self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

The Trust Board are requested to:

1. Receive the report,
2. Note the internal NHS PAM self-assessment outcomes for information and assurance,
3. Give retrospective approval for the submission of the PAM self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

TRUST BOARD COMMITTEE

PREMISES ASSURANCE MODEL (PAM) REPORT

1. PURPOSE OF THE PAPER

The purpose of the paper is to inform the Trust Board of the outcome of the self-assessments allied to the Premises Assurance Model (PAM) annual assessment and the outcome ratings for each self-assessment question (SAQ), undertaken in 2021/22. It further seeks approval to submit the PAM self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

2. BACKGROUND

The Trust estate and its related services are integral to the delivery of high-quality clinical care. Therefore, it is essential that the Trust provide a safe, high quality, efficient and effective estate. The NHS Premises Assurance Model (PAM) is a national Estates and Facilities benchmarking tool designed to be used by NHS organisations for Board reporting, and externally to provide assurance to Regulators and Commissioners. Completion of NHS PAM was made mandatory for all NHS Trusts from April 2020.

The objectives of NHS PAM is to support the NHS constitution pledge:

“To provide services from a clean and safe environment that is fit for purpose based on national best practice” and the current regulatory requirements to ensure that “service users are protected against risks associated with unsafe and unsuitable premises”.

NHS PAM is a self-assessment management tool, designed to provide a nationally consistent approach to evaluate NHS premises performance against a set of common indicators. NHS PAM has six domains:

- Safety (Hard),
- Safety (Soft),
- Patient Experience,
- Efficiency,
- Effectiveness,
- Governance.

The PAM has 47 Self-Assessment Questions (SAQ's) with a range of sub questions (prompts) for each SAQ. The SAQ's are listed in Appendix 1. The response to the prompt questions are scored/rated with due regard to the evidence gathered in relation to the following requirements:

- **Relevant guidance and legislation:** Policies, procedures, working practises etc. should comply with any relevant guidance and legislation,
- **Evidence should demonstrate:** The approach (policies, procedures etc.) is understood, operationally applied, embedded, adequately recorded, reported on, audited and reviewed.

Once the evidence available is considered a self –assessment rating is determined for that prompt question. Ratings are awarded as follows:

- Blue – Outstanding
- Green Good
- Yellow – Minor Improvement Required
- Amber – Moderate Improvement Required
- Red – Inadequate
- Grey – Not Applicable

3. CURRENT POSITION

3.1 PROCESS

The process applied within the EF&D directorate is that each SAQ is assigned a 'Professional Lead'. The 'Professional Lead' will determine which officers will be members of the 'Expert Group'; this will obviously depend on the discipline of the SAQ.

The 'Professional Lead' will then discuss the evidence and views gathered from/by the 'Expert Group' to the EF&D PAM Facilitator and propose a self-assessment rating.

The most recently issued PAM self-assessment guidance contains more comprehensive information and guidance as to what evidence might be required for each sub-question for the SAQ's. This has resulted in some of the previous self-assessment ratings decreasing. Where this is, the case actions to strengthen compliance have been identified. One of the pre-requisites of the PAM is that in order to be rated 'Good or Outstanding' there should be no actions identified for improvement.

The action plan progress will be monitored at the Non-Clinical Quality Committee.

3.2 SUMMARY OF ASSESSMENT OUTCOME 2021/2022

When comparing the year on year level of assurance the last two years has seen a decrease in the level of assurance.



The PAM for 2021/22 was undertaken during the COVID-19 response and it should be noted that the COVID-19 Command & Control arrangements have been ongoing for almost 2 years. The Trust was for the duration in a command and control situation, with managers and staff focusing on the safety and wellbeing of patients and staff during this stressful period.

Furthermore, the directorate underwent a significant restructure in 2021/22 with new senior and middle managers being appointed to key posts. This could have affected the continuity of some of the actions previously identified and brought in new oversight and opinions of assurance and performance.

In addition, the PAM facilitators were more informed on what does 'good look like' and therefore the challenges were more rigorous and robust. These may be considered as potential contributory factors to new PAM ratings for 2021/22.

When reviewing the overall SAQ ratings it identifies that:

- 14 have improved when compared to the previous year's PAM
- 8 have remained the same compared to the previous year's PAM
- 25 have decreased when compared to the previous year's PAM

- One SAQ has been assessed as inadequate
- No SAQ have been rated as Outstanding
- 2 SAQ's have been rated as Good
- 7 SAQ's have been rated as Requiring Minimal Improvement
- 37 SAQ's have been rated as Requiring Moderate Improvement

The detailed SAQ ratings are included in Appendix 2

The SAQ rated as inadequate overall, is SH18 – Safety in Other Premises. This is when HUTH operates out of premises not owned by the Trust and is typical of 'outreach clinical services'. The weakness in assurance is considered an organisational issue and not solely isolated to EF&D. It has been self-assessed as part of the PAM as the Property Manager resides within the EF&D directorate. The root cause is due mainly to Health Groups occupying facilities in other 'landlord's premises', in order to deliver services close to the patient. However, this is invariably undertaken without any Heads of Terms, lease or rental agreement being put in place. This has the potential to put HUTH staff at risk, as they may be unaware of local procedures and arrangements, e.g. fire alarms and evacuation, health and safety arrangements, lone working, key handling, etc.

The assurance in the Safety Hard and Safety Soft domains can be strengthened by the development and approval of discipline specific policies and procedures. Improvement in the management of risk assessments will also serve to underpin the level of assurance.

In the Governance domain, there are two key drivers to the commencement of the journey to strengthen assurance; they are the implementation of a governance framework and the leadership and culture in the directorate.

The governance arrangements are essential to strong assurance, the old adage 'from Ward to Board' the 'Golden Thread'. Clear lines of escalation with opportunities and accountabilities at different levels to resolve and manage issues. Strong and impactful lines of communication are evident leading to positive two-way communications. Accountability and responsibility will be set at the appropriate level, trusting staff to make the decisions and allowing learning when things do not go as planned.

The Head of Information & Governance was tasked with understanding how the governance structure worked in the Estates & Facilities directorate at North Lincolnshire & Goole Hospitals (NLaG). This was completed and mirrored as to what this might look like if implemented within the EF&D directorate at HUTH. It has been made available to the EF&D Management team for their comment/consideration. However, it should be noted it includes, not only good and sound governance practice but also recommendations made in HTM's and other NHS publications.

The Leadership & Culture domain is also an area requiring attention. The Staff Survey has been an indicator of concern for the EF&D directorate, with only the Emergency

Care Health Group scoring less overall. There is clear evidence of the need to listen, trust and respect our staff and look to develop an improvement plan that will strengthen staff morale and improve productivity and culture. It the responsibility of all managers and staff in the directorate to work towards improving the staff survey results.

In the Performance Management / improved Efficiency / Continuous Improvement domains assurance was reduced due to the lack of a committee structure that would receive such reports from the services. This is a direct correlation to the need to review and strengthen the governance arrangements in the directorate. This was most likely weakened due to the postponement of most committees and meetings pan-Trust in order to free up resources and management effort in co-ordinating the Trusts response against the COVID-19 outbreak and the impact on the NHS. As we transition into the 'living with COVID-19' stage this is the ideal opportunity for the senior management team to consider what governance arrangements are required in order to strengthen overall assurance for the directorate.

In order to ensure that the assurance is strengthened overall, an action plan has been established. The progress against the action plan will be monitored at the Non-Clinical Quality Committee.

4. RISK

The outcome of the 2021/22 self-assessment does highlight some risks to the organisation with regards to the management of the estate and provision of hard and soft FM services. The domains requiring immediate attention are as follows:

- Asbestos Management
- Safety in other Premises
- Estates and Facilities Document Management
- Performance Management
- Improving Efficiency in Operational Services
- Continuous Improvement
- Effective Sustainability
- Governance Process

The required improvement actions for the majority of these risk areas have been identified in section 3 above.

5. COSTS

The PAM process acknowledges that investment may well be the bottleneck to strengthening assurance. Whilst undertaking the 2021/22 PAM self-assessments the 'Professional Leads' identified the following costs in order to improve assurance.

Ref	PAM Domain	Cost to Improve Assurance		Comments
		Capital	Revenue	
SH6	Medical Gas Systems	£40,000	£23,500	<ul style="list-style-type: none"> • Investment in portable vacuum pumps (resilience) • Training in gas isolation (Nursing staff) • Update schematic drawings
SH14	Fire Safety	£0	£141,000	<ul style="list-style-type: none"> • Appointment of Authorising Engineer (Fire Safety) • Contract for fire annual stopping inspections

				• Training for Fire Safety Advisors (new legislation)
SH18	Safety in Other Premises	£0	£80,000	Appointment of Junior Surveyor
SS1	Catering Services	£0	£4,000	HACCP Training
SS4	Cleanliness & Infection Control	£0	£200,000	Rectify gap analysis in order to meet new NHS Cleaning Standards
SS5	Laundry & Linen Services	£20,000	£0	New linen storage facility at HRI
SS8	Pest Control	£0	£1,000	Staff training
P4	Access & Car Parking	£0	£10,000	New site wayfinding maps (BPA audit action)
E4	Sustainability	£0	£10,000	• CHP Certification • Costs to permit borehole extraction • Dangerous Goods Transportation training
Overall costs		£60,000	£469,500	

6. BENCHMARKING

It is not possible to compare our level of assurance against that of other Trusts, as the PAM ratings are not published. Additionally, they do not form part of the Model Hospital information dataset at present.

7. RECOMMENDATIONS

The Trust Board is asked to:

- Receive the report,
- Note the internal NHS PAM self-assessment outcomes for information and assurance,
- Give retrospective approval for the submission of the PAM self-assessment ratings to the NHS England / NHS Improvement (NHSE/I) PAM portal.

Duncan Taylor

Director of Estates, Facilities & Development

August 2022

Appendix 1 Self-Assessment Questions

Safety Hard: (Reportable)

- SH1 – Estates and Facilities Operational Management
- SH2 – Design, Layout & Use of Premises
- SH3 – Document Management
- SH4 - Health & Safety at Work
- SH5 – Asbestos Management
- SH6 – Medical Gas Systems
- SH7 – Natural Gas & Specialist Piped Systems
- SH8 – Water Safety Systems
- SH9 – Electrical Systems
- SH10 – Mechanical Systems e.g. lifting equipment
- SH11 – Ventilation, Air Conditioning and Refrigeration Systems
- SH12 – Lifts, Hoists & Conveyancing Systems
- SH13 – Pressure Systems
- SH14 – Fire Safety
- SH15 – Medical Devices and Equipment
- SH16 – Resilience, Emergency and Business Continuity Planning
- SH17 – Safety Related Systems
- SH18 – Safety in Other Premises
- SH19 – Contractor Management

Safety Soft: (Reportable)

- SS1 – Catering Services
- SS2 – Decontamination Services
- SS3 – Waste Management
- SS4 – Cleaning & Infection Control
- SS5 – Laundry & Linen Services
- SS6 – Security Management
- SS7 – Transport Services
- SS8 – Pest Control
- SS9 – Portering Services
- SS10 – Telephony & Switchboard

Patient Experience: (Reportable)

- P1 – Service User Involvement
- P2 – Condition, Appearance & Maintenance
- P3 – Cleanliness
- P4 – Access & Car Parking
- P5 – Grounds & Gardens
- P6 – Catering Services

Effectiveness:

- E1 – Clear, Vision & Strategy
- E2 – Town Planning
- E3 – Management of Land and Property
- E4 – Suitable Sustainable Approach

Efficiency:

- F1 – Performance Management

- F2 – Improved Efficiency in Operational Services
- F3 – Improved Efficiencies in Capital; Procurement
- F4 – Robust Financial Management
- F5 – Continuous Improvement & Sustainability Ensured

Governance:

- G1 – Governance Framework
- G2 – Leadership, Culture & Vision
- G3 – Professional Advice



Ref	NHS Premises Assurance Model: Safety Domain (Hard FM)	Policy & Procedures
		2021
SH1	Estates and Facilities Operational Management	3
SH2	Design, Layout and Use of Premises	2
SH4	Health & Safety at Work	4
SH5	Asbestos	2
SH6	Medical Gas Systems	2
SH7	Natural Gas and specialist piped systems	3
SH8	Water Systems	3
SH9	Electrical Systems	2
SH10	Mechanical Systems e.g. Lifting Equipment	3
SH11	Ventilation, Air Conditioning and Refrigeration Systems	2
SH12	Lifts, Hoists and Conveyance Systems	2
SH13	Pressure Systems	3
SH14	Fire Safety	4
SH15	Medical Devices and Equipment	4
SH16	Resilience, Emergency and Business Continuity Planning	4
SH17	Reporting and implementing Premises and Equipment issues	3
SH18	Safety in Other Premises	1

Ref	NHS Premises Assurance Model: Safety Domain (Hard FM)	Policy and procedures
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		2021
SH19	Contractor Management	3

Ref	NHS Premises Assurance Model: Safety Domain (Hard FM)	Document Management System in Place
		2021
SH3	Estates and Facilities Document Management	2

Overall Score For Domain (Hard FM)

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Ref	NHS Premises Assurance Model: Safety Domain (Soft FM)	Policy & Procedures
		2021
SS1	Catering Services	2
SS2	Decontamination Processes	3
SS3	Waste and Recycling Management	3

SS4	Cleanliness and Infection Control	3
SS5	Laundry Services and Linen	3
SS6	Security Management	3
SS7	Transport Services and access arrangements	2
SS8	Pest Control	3
SS9	Portering Services	3
SS10	Telephony and Switchboard	2

Overall Score For Domain (Soft FM)

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Ref	NHS Premises Assurance Model: Patient Experience Domain	2021
P1	Engagement and involvement	Views & Experiences 3
P2	Condition, appearance, maintenance and privacy and dignity perception	PLACE Assessments 3
P3	Cleanliness	PLACE Assessments 3
P4	Access and car parking	PLACE Assessments 4
P5	Grounds and gardens	PLACE Assessments 3
P6	Catering services	Policy and procedures 2

Overall Score For Domain (Patient Experience)

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Ref	NHS Premises Assurance Model: Efficiency Domain	2021
F1	Performance management	Analysing Performance 2
F2	Improving efficiency - running	Business Planning 2
F3	Improving efficiency - capital	Capital Procurement 3
F4	Financial controls	Policy & Procedure 4
F5	Continuous improvement	Quality and Sustainability 2

Overall Score For Domain (Efficiency)

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Ref	NHS Premises Assurance Model: Effectiveness Domain	2021
		E1
E2	Town planning	Local Planning 4
E3	Land and property management	Disposal of Freehold & Property 4
E4	Sustainability	SDMP 3
Overall Score For Domain (Effectiveness)		

Ref	NHS Premises Assurance Model: Governance Domain	2021
		G1
G2	Leadership and culture	1. Effectiveness 3
G3	Professional advice	1. Professional Advice 4
Overall Score for Domain (Governance)		

Overall Score for Premises Assurance Model

SAQ / PROMPT QUESTIONS

Roles & Responsibilities	Risk Assessments	Maintenance	Training & Development	Emergency & Business Continuity	Review Process	
2021	2021	2021	2021	2021	2021	2021
3	3	2	3	4	3	
4	4	3	4	4	4	
3	2	n/a	4	2	3	
2	2	n/a	4	4	2	
3	4	4	4	3	4	
4	3	4	4	4	4	
3	3	4	4	4	3	
4	4	4	4	3	3	
4	4	4	4	4	3	
2	3	2	4	4	4	
3	4	4	3	3	4	
2	4	4	3	4	4	
3	3	4	4	4	3	
2	4	3	4	4	4	
3	4	2	4	n/a	3	
3	4	n/a	n/a	4	4	
2	1	1	1	1	1	
Roles and responsibilities	Risk Assessment	Maintenance	Contractor Compliance	Resilience, Emergency & Business Continuity Planning	Review Process	
2021	2021	2021	2021	2021	2021	
4	4	4	3	3	3	
Approval of Document	Review of Documents	Availability of Documents	Legibility of Documents	Document Control	Obsolescence	
2021	2021	2021	2021	2021	2021	
3	3	4	n/a	3	2	

Roles & Responsibilities	Risk Assessments	Maintenance	Training & Development	Emergency & Business Continuity Planning	Review Process	
2021	2021	2021	2021	2021	2021	2021
3	3	3	3	3	4	
3	3	4	3	4	4	
3	4	4	4	3	4	

3	4	4	4	4	4	
3	3	4	4	4	4	
4	4	4	3	4	4	
4	3	4	4	4	4	
4	4	4	3	4	4	
4	3	4	4	3	4	
2	4	3	4	3	3	

2021	2021	2021	2021	2021	2021	2021
Engagement	Staff Engagement	Prioritisation	Value			
3	3	3	3			
Other Assessments						
3						
Other Assessments	Cleaning Schedules					
3	4					
Other assessments						
2						
Other assessments						
3						
Regulation	Choice	Equality issues	Information	PLACE Assessment	Other assessments	Legal Standards
1	4	4	4	3	3	3

2021	2021	2021	2021	2021	2021	2021
Benchmarking						
2						
Estate Optimisation	Commercial Opportunities	Partnership Working	New Technology	PFI and LIFT contracts		
2	2	4	3	3		
Capital Procurement Efficiencies	Flexibility	Identification and disposal of surplus land				
3	4	3				
Review Process						
3						
Financial Pressure	Continuous Improvement	Quality Improvement	Recognition	Use of Information		
2	3	4	4	2		

2021	2021	2021	2021	2021	2021	2021
Strategy	Development	Vision & Values Understood	Strategy Understand	Progress		
3	3	3	3	3		
Neighbourhood Planning	Planning Control	Special Interest	Enforcement			
4	4	4	4			
Disposal of leasehold land property	Granting Leases	Acquisition of freehold land & property	Acquisition of leasehold land & property			
n/a	4	4	n/a			
Energy	Waste	Air Pollution	Water	Climate Change Adaption	Procurement	
3	2	2	3	3	3	

2021	2021	2021	2021	2021	2021	2021
2. Roles	3. Partners	4. Review	5. Assurance	6. Monitoring	7. Audit	8. Mitigation
2	4	2	2	2	1	4
2. Challenges	3. Visibility	4. Relationships	5. Respect	6. Behaviours	7. Culture	8. Honesty
4	3	3	3	4	4	3
2. In-house Advisors	3. External Advisors					
4	3					

		Not Applicable
		Outstanding
		Good
		Requires Minor Improvement
		Requires Moderate Improvement
		Inadequate

			Actual %		Costs to achieve compliance 2022	
2021	2021	2021	2021	Trend	Capital	Revenue
			60.00	↓		
			71.43	↓		
			60.00	↔		
			53.33	↔		
			68.57	↑	£40,000	£23,500
			74.29	↔		
			68.57	↓		
			68.57	↓		
			74.29	↓		
			60.00	↓		
			65.71	↔		
			68.57	↓		
			71.43	↑		£141,000
			68.57	↓		
			66.67	↑		
			72.00	↑		
			22.86	↓		£80,000
			Actual %		Costs to achieve compliance 2022	
2021	2021	2021	2021	Trend	Capital	Revenue
			68.57	↑		
			Actual %		Costs to achieve compliance 2022	
2021	2021	2021	2021	Trend	Capital	Revenue
			56.67	↑		
			64.22	↓	£40,000	£244,500

			Actual %		Costs to achieve compliance 2022	
2021	2021	2021	2021	Trend	Capital	Revenue
			60.00	↓		£4,000
			68.57	↔		
			71.43	↓		

	74.29	↓		£200,000
	71.43	↔	£20,000	
	74.29	↑		
	71.43	↑		
	74.29	↑		£1,000
	71.43	↓		
	60.00	↓		
	69.71	↑	£20,000	£205,000

2021	2021	2021	2021		Costs to achieve compliance 2022	
			Actual %	Trend	Capital	Revenue
			60.00	↑		
			Actual %			
			60.00	↔		
			Actual %	Trend	Capital	Revenue
			66.67	↓		
			Actual %	Trend	Capital	Revenue
			60.00	↑		£10,000
			Actual %	Trend	Capital	Revenue
			60.00	↓		
			Actual %	Trend	Capital	Revenue
			60.00	↓		
			61.11	↓	£0	£10,000

2021	2021	2021	2021		Costs to achieve compliance 2022	
			Actual %	Trend	Capital	Revenue
			40.00	↓		
			Actual %	Trend	Capital	Revenue
			57.78	↓		
			Actual %	Trend	Capital	Revenue
			65.00	↓		
			Actual %			
			70.00	↔		
			Actual %	Trend	Capital	Revenue
			56.67	↑		
			57.89	↓	£0	£0

2021	2021	2021	2021		Costs to achieve compliance 2022	
			Actual %	Trend	Capital	Revenue
			63.33	↓		
			Actual %	Trend		
			80.00	↑		
			Actual %	Trend	Capital	Revenue
			80.00	↔		
			Actual %	Trend		
			54.29	↑		£10,000
			69.40	↑	£0	£10,000

2021	2021	2021	2021		Costs to achieve compliance 2022	
9. Alignment			Actual %	Trend		
3			48.89	↓		
9. Safety & Wellbeing	10. Healthier Workplace	11. Collaboration	Actual %	Trend	Capital	Revenue
3	4	3	67.27	↓		
			Actual %	Trend	Capital	Revenue
			73.33	↔		
			63.16	↓	£0	£0

			64.69	↓	£60,000	£469,500
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**Report to the Board in Public
Performance and Finance Committee
August 2022**

Item: Performance Report	Level of assurance gained: Limited
<p>The performance report was provided and covered the key performance areas;</p> <ul style="list-style-type: none">• No significant changes were noted, we remain consistently challenged and the metrics remain stable.• The PDSA cycle in ED produced some green shoots and there is a logistical group to move processes forward to business as usual, although sustainable staffing is an issue.• No criteria to reside patients is at 157, and expected to rise during the week, a lot of work being done to improve the situation but remains a significant challenge.• Regional summit was attended on the 11th August, which resulted in actions set around improving discharge and ambulance handover times.• The cancer PTL continues to reduce, 2ww referrals have increased but no additional cancer cases confirmed.• The 104 week wait have reduced to 20 with those primarily orthodontics. Work continues to work through the waiting list to continue to reduce waits and mutual aid continues.• Length of stay has increased which puts pressure on the bed base and occupancy levels.	
Item: Financial Report & CRES Delivery 2022/23	Level of assurance gained: Limited
<p>The committee received an update on the cyber attack position, which resulted in systems being shut down to ensure safety. NHSE will need to assure themselves before will give the ok to for the systems to be back online.</p> <p>The month 4 finance report and the CRES delivery update was shared with the committee with the highlights being;</p> <ul style="list-style-type: none">• Overspend reduced in July although the Trust is reporting a deficit of £0.9m at month 4, which is £1.5m worse than the plan.• CRES shortfall is £1.1m at month 4• The Trust is currently reporting that it will deliver its financial plan for 22/23 but this includes two major risks in the second half of the year – Health Group expenditure and Elective Recovery Fund (ERF).• The Trust currently has £3.6m of debt that is over 90 days, a reduction of £0.4m from month 3.• It was noted that inflation avoidance was not possible this year due to the continuing increases and this is already being seen in procurement.	
<p>The following reports were shared for information:</p> <ul style="list-style-type: none">• Capital Resource Allocation Committee Minutes <p>The following contracts were approved;</p> <ul style="list-style-type: none">• Contract Recommendation Paper For The Supply Of Inventory Management POCT Asset Sterile Supplies And Patient Belongings• Contract Extension Recommendation Paper For The Supply of Da-Vinci Robotic Surgery Consumables• Contract Recommendation Paper For The Provision of a Microsoft Enterprise Subscription Agreement (ESA) For 2022/23• Contract Recommendation Paper For The Supply Of Neurosurgical Spinal Implants	