Hull University Teaching Hospitals NHS Trust

TRUST BOARD PUBLIC SEPTEMBER 2023

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12 September 2023

09:00 GMT+1 Europe/London

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

1 - Trust Board Agenda September 2023.pdf

Hull University Teaching Hospitals NHS Trust
Trust Board Meeting in Public
Tuesday 12 September 2023
The Boardroom, HRI, Alderson House

No	Agenda Item	Lead	Format	Purpose	Time
Standing Items					
1	Welcome and Apologies	Chair	Verbal		9am
2	Declarations of Interest/Conflicts of interest with any agenda items	Chair	Verbal		
3	Minutes of the meeting held July 2023	Chair	Attached	Approval	
4	Action Tracker	Chair	Attached	Approval	
5	Board Work Programme	Head of Corporate Affairs	Attached	Information	
6	Board Development Framework	Head of Corporate Affairs	Attached	Information	
7	Patient Story	CEO	Verbal	Assurance	9.10am
8	Report from the CEO	CEO	Attached	Assurance	9.30am
Board Committees Highlight Reports					
9	9.1 Escalation from the Quality Committee	Chair of Committee	Attached	Assurance	9.40am
	9.2 Escalation from the Performance and Finance Committee	Chair of Committee	Attached	Assurance	9.55am
	9.3 Escalation from the Workforce Education and Culture Committee	Chair of Committee	Attached	Assurance	10.10am
	9.4 Escalation from the Audit Committee	Chair of Committee	Attached	Assurance	10.25am
	9.5 Escalation from the Group Development Committees in Common	Chair	Attached	Assurance	10.30am
Governance and Assurance					
10	10.1 Board Assurance Framework	Director of Quality Governance	Attached	Assurance	10.40am
	10.2 Fit and Proper Persons Test	Director of Workforce and OD	Attached	Information	11.00am
	10.3 Freedom to Speak Up Guardian Report	Freedom to Speak up Guardian	Attached	Assurance	11.10am
Items for Approval					
11	11.1 Use of the Trust Seal	Head of Corporate Affairs	Attached	Approval	11.20am
	11.2 Protecting and Expanding Elective Activity	Chief Operating Officer	Attached	Approval	11.25am
	11.3 Modern Slavery Report	Director of Workforce and OD	Attached	Approval	11.40am
	11.4 Workforce Disability Equality Standard/Workforce Race Equality Standard	Director of Workforce and OD	Attached	Approval	11.45am
	11.5 HUTH Responsible Officer Statement of Compliance	Chief Medical Officer	Attached	Approval	11.55am
Any Other Business					

12	Any Other Business	Chair	Verbal		12pm
13	Date and time of the next meeting: Tuesday 14 November 2023, 9am – 1pm, The Boardroom, Alderson House	Chair	Verbal	Information	12pm
Supporting Documents					
	Quality				
	Quality Report	CMO/CN/DQG	Attached	Assurance	
	Maternity Report	CN	Attached	Assurance	
	Safeguarding Children and Vulnerable Adults Report	CN	Attached	Assurance	
	Mortality – Learning from Deaths Update	CMO	Attached	Assurance	
	End of Life Care Annual Report	CMO/CN	Attached	Assurance	
	Performance				
	Performance Report	COO	Attached	Assurance	
	Finance				
	Finance Report	CFO	Attached	Assurance	
	Workforce				
	Workforce Report	DW+OD	Attached	Assurance	
	Under Graduate Education Report	CMO	Attached	Assurance	

Attendance 2023/24

Name	09/05	21/06	11/07	12/09	14/11	13/02	12/03				Total
Sean Lyons	✓	✓	✓								3/3
S Hall	✓	✓	✓								3/3
T Zepherin	x	x	x								0/3
J Hawkard	-	-	-								0/0
T Curry	x	✓	x								1/3
U MacLeod	x	x	✓								1/3
M Robson	✓	✓	✓								3/3
L Jackson	✓	✓	✓								3/3
A Pathak	✓	✓	✓								3/3
D Hughes	✓	✓	-								2/2
C Long	✓	✓	✓								3/3
L Bond	✓	✓	✓								3/3
M Purva	✓	✓	✓								3/3
J Ledger	✓	✓	✓								3/3
S Nearney	✓	✓	✓								3/3
E Ryabov	x	x	✓								1/3
I McConnell	x	✓	x								1/3
S Rostron	✓	x	x								1/3
S McMahon	✓	x	✓								2/3
R Thompson	✓	✓	✓								3/3

WELCOME AND APOLOGIES

DECLARATIONS OF INTEREST

MINUTES OF THE MEETING HELD JULY 2023

REFERENCES

Only PDFs are attached

3 - Draft minutes July 2023 TB.pdf

Hull University Teaching Hospitals NHS Trust
Minutes of the Trust Board
Held on 11 July 2023

Present:	Mr S Lyons	Chair
	Mr S Hall	Vice-Chair
	Mr T Curry	Non-Executive Director
	Prof U Macleod	Non-Executive Director
	Mr M Robson	Non-Executive Director
	Dr A Pathak	Associate Non-Executive Director
	Mrs L Jackson	Associate Non-Executive Director
	Mr C Long	Chief Executive Officer
	Prof M Purva	Chief Medical Officer
	Mr L Bond	Chief Financial Officer
	Mrs E Ryabov	Chief Operating Officer
	Mrs J Ledger	Interim Chief Nurse
	Mr S Nearney	Director of Workforce and OD
	Mrs S McMahon	Joint Chief Information Officer
In Attendance:	Mrs G Johnson	Director of Infection Prevention and Control
	Ms F Moverley	Freedom to Speak Up Guardian
	Mrs R Thompson	Head of Corporate Affairs (Minutes)

No	Item	Action
1	**Apologies and Welcome** Mrs T Zepherin, Non-Executive Director, Mrs S Rostron, Director of Quality Governance, Tony Curry, Non-Executive Director, Ivan McConnell, Joint Director of Strategy	
2	**Chair's Opening Remarks** Mr Lyons welcomed the Board and guests to the Trust Board in public and advised that in reviewing the board papers it would be beneficial to highlight the key issues relating to Quality, Performance, Finance and People. Mr Long highlighted the VRE outbreak, patient harm due to falls and pressure ulcers, crowding in ED, the staff survey, cancer backlogs and the underlying financial problem as the areas he was concerned about. He added that the Board must also have good communication channels with the ICB, CQC and other health partners. Prof Purva stated that the ongoing Group Model working underpinned everything and would affect both Trust's quality of care and cultures. Mr Bond wanted to explore the Board's risk appetite regarding clinical risks, patient safety and the financial agenda. He wanted the Board to be clear which risks should be tolerated and which ones would not be tolerated. Mrs Jackson highlighted ED and the additional £10m cost improvement programme as her areas of concern. Dr Pathak added that more targeted focus on results was required. Digital solutions were discussed and Mrs McMahon highlighted bringing the two Trust's systems together rather than running two systems for both was key.	

Mr Nearney highlighted the pressures that staff were under and suggested that the move to the Group Model would give staff a new focus to get behind.

Mrs Ryabov spoke about the ED and how the ground floor model was progressing and the priorities required to achieve improvements. Mr Robson added the partnership working to reduce patients with no criteria to reside would assist with flow through the department. Mrs Ledger expressed her concerns regarding falls and pressure ulcers causing patient harm as well as sustained performance leading into Winter.

3 Declarations of Interest

3.1 Changes to Directors' interests since the last meeting

There were no declarations made.

3.2 To consider any conflicts of interest arising from this agenda

There were no conflicts raised.

4 Minutes of the meeting held 9 May 2023

Mr Bond to review section 10.1 and re-word. This related to the underlying financial position.

Following this change the minutes were approved as an accurate record of the meeting.

Minutes of the meeting held 21 June 2023 (accounts approval)

Item 3.1, the figure should read £425m not £425.

Following this change the minutes were approved as an accurate record of the meeting.

4.1 Board Work Programme 2022/23

Mrs Thompson advised that there had been no changes to the work programme.

4.2 Board Development Framework

Mrs Thompson highlighted the Board Assurance Framework discussion to be held in August and the Board focus on risk appetite.

4.3 Matters Arising

There were no matters arising from the minutes.

4.4 Action Tracker

Mrs Thompson advised that the Ground Floor Model was being presented to the Performance and Finance Committee in July 2023.

5 Patient Story

The Board heard a patient story relating to the maternity service. The Board discussed the CQC report relating to the maternity service and how the patient story highlighted both good and bad aspects of the patient's care.

Mr Long advised that the Trust was very good at managing patients once in front of a clinician but the lead up to and after the appointments could be better. Dr Pathak added that poor communication with patients was a

common theme in many areas, but that labour wards were very good at managing emergencies even when staff were under great stress.

Mr Hall expressed his concern regarding the patient's 8 hour wait and how she was triaged and monitored. He added that reassuring patients was important as although staff knew where the patient was in the pathway, the patient was left unknowing.

The CQC maternity action plan was now in place and work was ongoing to address the issues raised.

6 CEO Report

Mr Lyons thanked Mr Long on behalf of the Board for his great work as CEO and keeping the organisation running over the last 9 years. This Board meeting was to be his last as he was retiring in August 2023.

Mr Long thanked the Board and advised that he had visited the new Day Surgery unit at Castle Hill Hospital and reported that the facility was fantastic and had the potential to increase throughput greatly.

The Zero 30 programme was making really good progress but further work and investment was required for the Trust to become carbon neutral.

6.1 Development Group Committees in Common Summary

Mr Lyons presented the summary and advised that the ICB public meeting regarding the Acute Services Review consultation was to be held tomorrow and he was attending. It was hoped the consultation would start in September 2023.

6.2 Audit Committee Summary

Mr Robson presented the summary and advised that the Audit Committee had recommended that the Board approve the Annual Accounts for 2022/23 which the Board did at its June 2023 meeting.

The Annual Governance Statement and Annual Report were also approved at the June 2023 Board meeting.

6.3 Year-end Board and Committee Review

Mrs Thompson presented the review which showed the workplans, terms of reference and effectiveness reviews for each committee. Mrs Thompson highlighted the deep dive and effectiveness review carried out for the Quality Committee and the actions in place to improve the effectiveness.

Mrs Thompson also presented the NED and Executive roles and responsibilities and asked that Board members highlight any changes in responsibilities.

The Group Model meeting dates were still under review and would be presented to the Board once finalised.

6.4 Register of Gifts and Interests Annual Update
Mrs Thompson presented the register of gifts and interests annual update and advised that there were no gaps in governance controls and that the Audit Committee scrutinised the registers on a quarterly basis.

6.5 Standing Orders
Mrs Thompson asked the Board to approve retrospectively the use of the Trust Seal relating to the construction and letting of premises known as the new cyclotron and radio pharmacy facility at Castle Hill.

6.6 Health and Safety Annual Report
Mrs Thompson presented the Health and Safety Annual report to the Board for information.

The Board discussed falls and assaults on staff and both of these areas would be discussed at the Health and Safety Committee.

Mr Hall asked when the Safety Focal Person training would resume and Mrs Thompson agreed to email the Board with the response.

Action: Mrs Thompson to email the Board with the dates when training for the Safety Focal Person resumes.

6.7 Summary from the Charitable Funds Committee
Mr Robson presented the Charitable Funds Committee summary and advised that the Trust was in the process of running down the balances and transferring responsibility to the WISHH Charity.

7 Strategy

7.1 Board Assurance Framework Q1 2023/24
Mrs Thompson presented the Board Assurance Framework and highlighted BAF 3.1 which had been changed to achieve a 'Good' CQC rating rather than 'Outstanding'. She also highlighted BAF 3.2 and advised that the Quality Committee were recommending increasing this risk rating to 25 due to the issues with patient harm and to link it to the ED crowding risk on the Corporate Risk Register.

Mr Bond stated that he struggled with the Trust causing catastrophic harm but Mrs Ledger advised that it related to the changes to the ground floor not being embedded with crowding and long waits still occurring. Mrs Jackson added that this suggested the mitigations in place were not working. Mr Long and Prof Macleod stated that the risk should be kept at the high level.

It was agreed that the Board was not confident with the mitigations in place but had apposing views as to the level of the risk rating.

Action: It was agreed to increase the risk rating relating to 3.2 but the risk to be discussed in detail at the BAF Board Development session in August 2023.

8 8.1 Quality Report

Prof Purva presented the Quality report and advised that there had been an increase in patient safety incidents but the numbers remained within the control limits.

A thematic review using the new PSIRF methodology had taken place relating to delays for patients on the TAVI waiting list.

The SHMI continued to reduce which was positive but pneumonia, sepsis and stroke where being monitored closely.

The Complaints Team had eliminated the backlog of complaint responses and the new team had grip on the new cases coming into the Trust.

More staff had been QSIR trained and the Human Factors Hub was developing.

Mrs Ledger advised that the pressure ulcer figures were reducing and training in initial assessment was being carried out. Mrs Ledger was promoting a zero tolerance to avoidable hospital acquired pressure ulcers. She stated that the numbers in the Quality report were un-validated and this would be corrected for next month's report. Device related skin damage was to be shown separately in the report.

Mrs Ledger advised that although the number of falls was reducing the Trust was reporting an increase in moderate harm which had led to concern from the Coroner. A significant amount of work was being undertaken to address the issues including training, fortnightly meetings and monitoring of the times the majority of falls took place and why.

Mr Lyons expressed his concern regarding the new PSIRF process and asked if there was a risk that serious incidents were not being identified and reported. Prof Purva reassured the Board that although it was still early in the development all safety incidents were being captured and reviewed. After action reviews were taking place as well as safety huddles and thematic reviews. She added that the reporting would start to come through which would show how the incidents reported on Datix reached their end points. Prof Purva advised that all Trusts would be expected to move by October 2023.

Mr Hall shared his nervousness about not seeing Serious Incidents being declared and Prof Purva suggested a Board Development session to show specific examples of how incidents were now being reviewed and actioned. This would be evidenced by after action and thematic reviews.

Action: Board Development session to include a working example of a patient safety incident investigation.

8.2 CQC Update

Prof Purva presented the update which related to the CQC action plans for ED, Surgery and Maternity.

The Emergency Care Team were reviewing the new Ground Floor model and had an improvement trajectory in place. A new HOB unit would also

be in place by September 2023.
Surgery Health Group were working through their actions and would present a further update at the private Board meeting.

Maternity had 41 actions to complete and one action relating to the roll out of Badgernet had been delayed until February 2024 due to supplier issues. External support, assurance visits and attendance at the Safety Oversight Group was ensuring progress was being made. Prof Purva was confident that significant improvements would be seen in the next few months.

The Board discussed the advantages of digital systems but also the need to follow clear procedures in the meantime and to engage staff in the improvement work.

Mrs Jackson was surprised at how quickly the actions were being completed and Mrs Ledger reported that actions would not be signed off fully until sustainable change was embedded.

8.3 Infection Prevention and Control Annual Report
Mrs Johnson presented the IPC annual report which highlighted the work and improvements made by the team.

During 2022/23 the Trust performed at or better than the benchmark in all cases with the exception of hospital onset MSSA BSIs and GNBSIs and these will be a priority for 2023/24.

Work was ongoing regarding the antimicrobial stewardship programme to develop prescribing guidance.

Another priority for 2023/24 would be to review line related infections due to the Trust being the highest placer of vascular lines in the region.

The biggest challenge currently was the outbreaks of VRE and CPE and a business case for additional screening was being developed. Mrs Johnson also stated that vaccine preventable infections such as measles was also a concern.

8.4 Infection Prevention and Control Board Assurance Framework
Mrs Johnson reported that the IPC BAF was being developed and gaps in assurance identified and aligned with the Trust risk register.

Action: The IPC BAF would be presented to the Trust Board in September 2023 for review. The Strategic Infection Reduction Committee would scrutinise the BAF on a regular basis.

8.5 Annual Review of the Quality Strategy
The item was deferred until the report had been scrutinised at the Quality Committee.

8.6 Summary from the Quality Committee
Prof Macleod presented the Quality summary and advised that the Committee was reviewing assurance levels and would not be assured by action plans in place but completed and embedded actions

9 Workforce

9.1 Workforce/People Strategy Update

Mr Nearney presented the report and advised that sickness was at 4.5% and the vacancy position was 2%. Agency and bank expenditure was low compared to others.

Following the staff survey results a number of actions around leadership, just culture and learning not to blame were being developed. Mr Nearney spoke of his presentation to the Joint Board relating to the Golden Rules that would be at the forefront of leadership development in the future.

Mr Nearney highlighted that the OD Team were working with the maternity, ED and ICU teams to support staff.

Mr Nearney reported that the Golden Hearts was a brilliant event showcasing the good work being carried out in the Trust as well as highlighting outstanding individuals.

The first LGBTQ+ conference had been held and was a success. Conference attendees spoke openly and work was ongoing to build on the networks already in place.

The Board discussed accountability of staff and the command structure that was still in place following the pandemic. Mr Nearney reported that the mood of staff highlighted in the staff survey did not reflect the mood of all staff. He advised that it was the intention to increase the take up of staff completing the survey to 60% which would make a real difference to the results and capture more positive views as well as the negative views.

Action: Mr Bond asked where the ODP and Nurse Associate vacancies sat and Mr Nearney agreed to email the Board to clarify.

9.2 Trade Union Facility Time Reporting Requirements Regulations 2023 Report
Mr Nearney presented the report and requested approval from the Board to upload the report to the Trust's website.

Resolved: The Board approved uploading the report to the Trust's website.

9.3 Freedom to Speak Up
Mrs Moverley presented the Annual Report and advised that the numbers had increased to 100 cases compared to 71 in the previous year. This was reflective of the increase in the national numbers.

Mrs Moverley advised that the type of concerns had changed and were of a more general nature with concerns relating to roles being the highest.

Activities undertaken in year included establishment of the champions network, working with Northern Lincolnshire and Goole NHS FT and participating in a focus group with the Chair of the Independent Committee on Standards in Public Life.

Mr Lyons thanked Mrs Moverley for her hard work.

9.4 Guardian of Safe Working Report
The Guardian of Safe Working Report was presented to the Board for

information. The report had been received at the Workforce Education and Culture Committee in June 2023.

9.5 Summary from the Workforce, Education and Culture Committee
The summary was received by the Board.

10 Performance Report
Mrs Ryabov advised that performance had not changed significantly but the ED Team had been working through and delivering their CQC actions and had improved safety. Despite this the issues around crowding and flow had not been resolved. Mrs Ryabov advised that there were objectives in place to achieve the 75% trajectory by March 2024, but this required the Ground Floor plan to move at pace and roles and responsibilities to be clear. Ambulance handovers had improved and were close to achieving trajectory but results were variable.

Mrs Ryabov reported that cancer performance was still a challenge and the target of 148 patients by the year end was proving difficult. Diagnostic capacity and an increase in referrals was compounding the problem. Mrs Ryabov was liaising with the Cancer Alliance to ensure external oversight of the long waits for radiotherapy.

The waiting list was improving slightly regarding elective recovery and day cases were marginally behind plan and had been impacted by the industrial action.

The Trust had 160 no criteria to reside patients and length of stay is increasing. Mrs Ryabov was discussing this issue with the PLACE directors. The 13th Floor was now operational and the Paragon Suite was awaiting CQC registration.

10.1 Elective Care Priorities
Mrs Ryabov presented the report relating to the elective care priorities to the Board. She advised that this would be scrutinised by the Performance and Finance Committee.

10.2 Finance Report
Mr Bond presented the item and highlighted that the best way to reduce costs would be to reduce length of stay. By closing some beds it frees up staffing and helps with safety issues meaning that efficiencies are made. He added that the new Day Surgery unit should be utilised fully to reduce the waiting list.

Mr Bond also highlighted outpatient follow ups and that the Trust was doing increasingly more which was eating into capacity.

The Trust' financial position was away from plan mainly due to unidentified CRES and the cost of the industrial action.

Mr Bond advised that the team was preparing a return relating to how much the Trust had invested in staffing since 2019/20 and this would be presented to the Performance and Finance Committee.

10.3 Premises Assurance Model

Mr Bond presented the report and advised that the Board was to note the internal PAM self-assessment outcomes for assurance and approve the submission to the NHS England portal.

Resolved: The Board approved the submission of the PAM self-assessment ratings to NHS England.

10.4 Summary from the Performance and Finance Committee
Mr Robson advised that the Committee was not quorate in June 2023 but that the Committee had been assured that there were a number of actions in place that should result in performance improvements in due course.

11 Questions from the public relating to today's agenda
There were no questions raised.

12 Chairman's summary of the meeting
Mr Lyons thanked the Board for their discussions regarding the worry topics and this would be followed up in the private session of the Board.

13 Any Other Business
There was no other business discussed.

14 Date and time of the next meeting:
Tuesday 12 September 2023

ACTION TRACKER

REFERENCES

Only PDFs are attached

4 - Action Tracker September 2023.pdf

Hull University Teaching Hospitals NHS Trust
Trust Board Action Tracking List (September 2023)

Actions arising from Board meetings

Action NO	PAPER	ACTION	LEAD	TARGET DATE	NEW DATE	STATUS/ COMMENT
May 2023						
01/05	Patient Story	Patient backlog Board Development session date to be agreed	MP	October 2023		
04/05	Maternity Update	Monitoring growth restriction missed cases – update to the Board	LC	September 2023		
COMPLETED						
02/05	CQC Update	Ground Floor model Board Development session date to be agreed	SL/RT	August 2023		
		Quality Committee CQC focus meeting invite to all Board Members	RT	August 2023		

Actions referred to other Committees

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

BOARD WORK PROGRAMME

REFERENCES

Only PDFs are attached

5 - Trust Board Work Programme 2023.xlsx

BOARD DEVELOPMENT FRAMEWORK

REFERENCES

Only PDFs are attached

6 - Board Development Framework 2023.pdf

Hull University Teaching Hospitals NHS Trust
Board Development Programme 2023

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
February 2023									Freedom to Speak Up
April 2023	Trust Strategy								
June 2023				BAF 3.2: Patient Harm/Recovery	BAF 4: Risks to recovery plan				Staff Survey
August 2023		BAF 1: Board Leadership/ Leadership and culture						BAF 7: Financial sustainability	Board Assurance Framework
October 2023			BAF 2: Staffing	Waiting list – patient harm reviews - MP		BAF 5: ICS			IPC BAF
December 2023				BAF 3.1: High Quality Care			BAF 6: Research and Innovation		

Other topics for discussion:

- **Group Model**
- **CQC**
- **Winter Pressures**
- **Quality Improvements (Deep Dives)**
- **Performance issues**

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

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.

- 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

PATIENT STORY

REPORT FROM CEO

REFERENCES

Only PDFs are attached

8 - Group CEO Report September 2023.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
Title	Group CEO Report				
Lead Director	Jonathan Lofthouse, Chief Executive Officer				
Author	Jonathan Lofthouse, Chief Executive Officer				
Report previously considered by (date)	This report has not been considered 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:

Recommendation:
The Board is asked to receive the attached report.

Hull University Teaching Hospitals NHS Trust

September 2023

1. **Purpose of the Report**
   The purpose of the report is to inform the HUTH Trust Board of my initial reflections, HUTH Performance and good news stories during my first weeks as Group Chief Executive of HUTH and NLAG.

2. **Initial Reflections**
   In my first weeks at the Trust I visited the Emergency Department, the Maternity Team and the Mortuary Services Team as well as the new ITU building, the Allam Diabetes Centre and a number of wards in the Tower Block. I've also visited the theatres at Hull Royal Infirmary and part of Outpatients. I have spent time with Dr Abaoymi Salawu who talked me through the leading edge treatment option that the team are employing on the surgical corridor. Patients on the Rehab ward are clear that their lives have been transformed by the care they have received.

   I have met some amazing people and witnessed some great care.

3. **Group Model**
   Since starting with the Trust on 14 August 2023 work has begun to develop the Group Leadership Structure blending the HUTH and NLAG Executives. The proposal has been shared with the Executive Teams and a consultation period will start on 5 September 2023 and close on 4 October 2023. The new structure will be in place by the end of October 2023.

4. **Care Quality Commission**
   In August the Trust received a number of presentations at its Quality Committee relating to the CQC Inspection in October 2022 and the actions and improvements implemented to date. The Committee received presentations relating to NATSSIPS 2, Theatres, Consent and Never Events.

   The ED Safety Champions continue to receive and scrutinise the performance against the outcome measures in the ED action plan, Surgery's action plan is reviewed fortnightly at the Safety Oversight Group and Medicine have a monthly check and challenge meeting to review progress on their actions.

   Work is ongoing regarding the Maternity Section 31 urgent action plan and weekly check and challenge meetings are in place. A new interim Head of Midwifery has been appointed to strengthen the senior leadership team.

   Detailed reports are regularly received at the Quality Committee and the Quality Improvement Group for scrutiny, and the Trust Board for assurance.

5. **HUTH Performance Matters**
   ED Performance
   As at 29 August 2023 ED Performance year to date was:
   - 52.20% for ED Type 1 Performance
   - 65.36% for Combined Sitrep Performance

   The Trust has a £2.8m allocation for a new primary care/minor injuries service under CHCP and this will be developed pre winter on the Hull Royal Infirmary site.

   Risk
   The highest risk on the Corporate Risk Register is still Crowding in the Emergency Department and how patient care can be compromised by this. It is hoped that the

new Rosmore Suite (rehabilitation step-down facility) will improve discharge and in turn flow through the hospital.

Finance
The Trust has reported a £3.1m deficit in July 2023 which is £2m worse than plan. £1.8m of the shortfall relates to the cost of covering the Junior Doctor's industrial action, which continues to be subject to national debate.

Capital
The Capital Plan, approved at the April 2023 Performance and Finance Committee is well underway. Plans for a Community Diagnostic Centre and the ongoing Day Surgery works at Castle Hill are all being worked through.

The public are being asked to give their thoughts regarding moving the Story Street walk-in centre in Hull city centre to a new location close to the ED at Hull Royal Infirmary. The proposed move would be from November 2023 and create additional minor injury and diagnostic capacity.

The HDigital Team are developing the new EPR Business Case. The new EPR will span both HUTH and NLAG to ensure services are aligned.

Workforce
The Junior Doctor and Consultant Industrial Action continues. There is useful information on Pattie for members of staff that are striking and also staff providing cover. The picket lines will not block or impede access for patients attending appointments, staff getting to work or visitors accessing the site.

The BMA have announced two more days of industrial action on 19/20 September 2023.

Continuous Quality Improvement
Development of the 2024/25 Quality Service Improvement and Redesign training programme continues. The development of the training programme will include:

- A rebrand of the training packages in place - training will still utilise the QSIR teaching and resources but in a way that will support staff to choose the level of training that best suits their needs
- How we can build and strengthen our training capability across the Trust
- How we can support senior staff to lead on improvement and support staff to undertake improvements – this supports a board to ward and ward to board approach where improvement becomes business as usual
- How we support a return on investment following training and demonstrate where improvements have made an impact on including patient safety, cost savings and improved staff experience/satisfaction

Fit and Proper Persons Test
There has been new guidance released regarding the Fit and Proper Persons Test applied to all Executives and Directors that sit at the Trust Board. A detailed paper is attached with the Board papers and the changes will be implemented from October 2023.

6. Other Matters

Lucy Letby
A special bulletin was issued in response the sentencing of Neonatal Nurse Lucy Letby for the crimes she committed against vulnerable new born babies at the Countess of Chester Hospital. This has led me to remind staff of the Freedom to

Speak Up Guardians at both Trusts (HUTH/NLAG) who are trained to offer advice and support if any member of staff has patient safety or staff welfare concerns.

Jo Ledger, Interim Chief Nurse and Fran Moverley, Freedom to Speak Up Guardian at HUTH are holding a drop in session for any staff who might have concerns to raise on this matter or any others.

Covid 19
In August there has been a very slight increase in Covid-19 within the Trust and it has been reported nationally that there is spread of a new strain.

Staff with symptoms must inform their line manager and if line managers see two or more cases amongst staff at the same time, they should contact the Infection, Prevention and Control Team. Staff should feel well enough to work before coming back, but there is no longer a defined exclusion period or requirement for a negative test. Staff members working with patients should wear a mask.

The exception is staff working in the Queen's Centre and renal unit due to significantly immunocompromised patients. Staff will be redeployed or given Non-Clinical duties.

The Winter Flu and Covid-19 vaccination programmes will commence in September 2023.

7. Good News Stories

Virtual Reality Experiences for Patients
Hull patients will be offered custom virtual reality experiences to optimise their preparation for planned surgery. My Pre-op Assistant has been designed to prevent last-minute operation cancellation and to improve surgery outcomes whilst offering an improved experience to patients.

The Safeguarding team at NLaG is down to the final three submissions in the Safety Improvement through Technology category in the Health Service Journal (HSJ) Patient Safety Awards, for its work with WebV on a new electronic referral.

The Emergency Department at HUTH has been shortlisted for the Patient Safety Award at the HSJ Awards for improving the diagnostic detection of thoracic aortic dissection at Hull Royal Infirmary.

The Hospital at Home team at Grimsby hospital has been shortlisted in the Community and General Practice Nursing category of the Royal College of Nursing (RCN) Nursing Awards, for its work treating children who would normally be in hospital in their own home.

The HUTH Practice Development Team are finalists in both the RCN and the Nursing Times Workforce Awards this year for their 'Welcome to Ours – Wrap Around Recruitment' project in the Best International Recruitment Category.

The extraordinary achievements of our Practice Development Nurse, Michio Schuck have been recognised and she was nominated in the 'Unsung Hero' category of our Golden Hearts Awards and was part of the top three finalists.

While Michio may not have secured the top spot, her exceptional dedication, unwavering commitment and selfless contributions to our organisations and community are truly deserving of recognition.

8. Recommendation:
The Board is asked to receive the attached report.

Jonathan Lofthouse
Group Chief Executive Officer
September 2023

ESCALATION FROM THE QUALITY COMMITTEE

REFERENCES

Only PDFs are attached

- 9.1 - Quality Committee Summary August 2023.pdf
- 9.1 - Quality Committee Summary July 2023.pdf

Report to the Board in Public
Quality Committee
August 2023

The meeting held was a Quality Deep Dive session and not the standard Committee format

Item: NATSSIPS 2 – Deep Dive	Level of assurance gained: Limited

CQC Actions:

- The service must ensure all staff are engaged with and participate in all steps of the World Health Organisation (WHO) surgical safety checklist, the checklist is fully completed, and observational and record audits are undertaken to monitor compliance.
- The service must improve its monitoring and auditing of surgical safety checklists and ensure the finding of these audits are shared with staff.
- The service should ensure that recent safety and performance audits for each ward are visible

Challenges included; lack of clinical engagement with checklist completion, teams stated checklists are complicated and additional quality of completed forms and audit processes.

Progress to date
The new checklists will be implemented in October 2023, with the new audit process being implemented in November 2023. The digital checklist being available within nerve centre in February 2024 which will feed a live BI dashboard.

The Committee discussed the length of time that had passed since the inspection and it was agreed that the pace of change was not acceptable. It was requested that priorities in terms of the digital requirements for theatres were reviewed and potentially reprioritised.

Item: Controlled Drugs – Deep Dive	Level of assurance gained: Reasonable

CQC Findings in November 2022 included:

- The service must ensure a robust audit plan is in place and key audits are conducted, including record keeping, medicines management and infection prevention and control audits. The service must ensure relevant actions identified by local audits are acted on. (Regulation 17 (1) (2) (a) (b)).
- The service must ensure all staff are aware of and consistently follow the service policy to safely prescribe, administer, record and store and dispose of medicines. (Regulation 12 (1) (2) (g))
- We found concerns with medicine management as part of our inspection and saw further poor practice. We also intervened to prevent a patient receiving medications in error
- We reviewed the controlled drugs records in theatre one and saw signatures were missing on the 30th September and the 5th October. Staff told us they had contacted the doctor who was required to sign at the time of administration, but this had not been addressed at the time of inspection.
- The fridges we reviewed were within their required temperature range. However, we found staff personal food items in one fridge at HRI

Actions were put into place and the recent audit findings were positive. There was good senior staff engagement, good fridge management, good security/safety of keys when in working hours and overall good security/safety of medicines when theatres are not in use.

Next steps for Interventional Radiology included Abloy Cliq Digital key trial in C14.
Rainbow Trays have been implemented 8th August 2023 with support of anaesthetics/ODP to improve safe management of anaesthetic drugs.

Item: Consent – Deep Dive	Level of assurance gained: Limited

The Committee received a presentation relating to consent and patients without capacity.

A Task and Finish working group had been established and would be responsible for:
· Identify and act on any learning in relation to consent from external sources e.g. Care Quality Commission (CQC), other Trust investigations or peer reviews etc. and ensuring consent aligns with the 2022 CQC inspection and action plan.

· Organising consent audits to establish current practice of consent implementation across the trust.
· Review the current process of consent for patients whom do not have capacity to consent to the procedure during various stages of their pathway.
· Provide recommended tools to assess mental capacity when doubts are present prior to undertaking the consent process.
· Advise where policies/procedures require updating and develop standard operating procedures where appropriate.
· Trust wide sharing of established best practice for holding best interest meetings as per Mental Capacity Policy (CP354)
· Ensuring initial resources are available to support implementation, training, and ongoing engagement.
· Engaging with staff working in areas where consent implementation is required and empowering them to take ownership of building and implementing consent form 4.
· Define how to measure successful implementation.
· Identify and explore potential barriers to the implementation of safe consenting with the relevant Health Groups (HGs).
· Engaging with staff working in all areas who undertake the consent process to improve awareness of the Mental Capacity Act and ensure good compliance with the HUTHT policy on consent.
· Ensure that the Consent process is integrated into any current and new Trust policies and or Standard Operating Procedures (SOPs), with appropriate review dates that support implementation.
· Develop processes to ensure sustained delivery once the implementation group has been disbanded.

The following actions would be taken; consent audits organised in all services, ensure MCA training compliance, consent training for all junior doctors, share HUTH consent policy will all staff, share lessons from incidents reported and review the quality of consent documentation.

Post meeting update: Consent audits are on the mandatory section of the clinical audit for the Surgery Health Group and are in the process of being added to other relevant Health Groups once clinical leads are allocated.

Item: Never Events Learning and Assurance – Deep Dive	Level of assurance gained: Limited

At the time of the inspection

- There had been 6 Never Events, largely within theatre settings
- A learning forum had been held by the CMO with over 150 attendees in August 2022
- A Never Events thematic review had been presented to Quality Committee in September 2022
- The Surgery Health Group had held 'Safe September' which included practice and learning in theatres
- There were 2 further Never Events in the 22/23 reporting period following the learning forum (1 pre the inspection and 1 in December 2022)
- Simulation was undertaken for five of the investigations chaired by the Chief Medical Officer
- One look back exercise undertaken on two previous Never Events of a similar type
- Thematic review undertaken to identify commonalities, paper 9/22 Quality Committee
- Presentation of Never Event Thematic Review Next Steps Nursing & Midwifery Executive Committee 11/22
- Health Group Initiatives (all prior to inspection)
    - Surgery Health Group – Improvement Month 'Safe September'
    - Family & Women's Health Group – digit ring marking poster to address the repeat theme if administration of local anaesthetic to the wrong digit
    - Clinical Support Health Group – 'Stop the Line' awareness and benefits poster
- Action plan developed incorporating all above actions to monitor and measure success of learning from Never Events

Assuring ourselves that Never Event actions have been completed by

- Developing, trialling , testing and finalising a theatre audit form
- Observational audits in Theatres
- Speaking to staff
- There has been 1 Never Event in this financial year

Areas of Action Plan Focus

- Prevention of Wrong Site Surgery
- Who Safety Checklist Process
- Review of Guidance/Policies/SOPs

- Prevention of Medication Errors-noted work is being managed via Practice Development Matron/ Pharmacy
  (Trust has 53 theatres/procedure rooms* according to definition including day case/ robotics)

Next steps

- Associated work-streams continue for theatre pathways
- Need to focus on preventing Never Events – introduction of a Never Events assurance framework with identified near miss incident analysis and audits of guidance aligned to each Never Event (assurance required in all areas, not theatre work-streams alone). To commence in September as a rolling programme
- Further embedding of learning responses, learning events and PSIRF overall
- Full implementation of patient safety champion model

Common themes across all of the presentations were:

- Culture
- Pace of change

Report to the Board in Public
Quality Committee
June 2023

Item: Falls presentation – Deep Dive	Level of assurance gained: Limited

Overall number of falls between January and July = 2146, harm levels were 40 moderate, 24 major and 2 catastrophic
Risks include: aging population, funding for essential equipment, poor attendance at training sessions, incident validation (addressed by dedicated falls weekly patient summit), Coroner scrutiny and escalation to the CQC and ICB
Actions include: create an established Falls Prevention Team, National Falls Prevention week (raise awareness), AFLOAT (assessment tool), on-line training
Successes: Fundamental standards audits in place to monitor compliance, development of a virtual ward, digital lying and standing BP assessment tool, new SWARM document

Item: VTE Update – Deep Dive	Level of assurance gained: Reasonable

The trust's compliance with VTE risk assessment has remained stable at approximately 90% since January of 2023 and further improvement work is in progress in order to reach the desirable target of 95%. The following actions are in place:

1. Adaptation of the acute surgical culture shift across other health groups
2. Focus on improvement in VTE prophylaxis prescription
3. Improvement initiatives to "close the loop" between risk assessment and prophylaxis prescribing
4. Simplify current dashboard to allow clinicians to easily visualise compliance with VTE risk assessment and VTE prophylaxis prescription
5. Inclusion of a mandatory VTE assessment prior to being able to prescribe in the EPMA of the trust's future electronic patient record
6. Adapt and apply positive lessons to other quality and safety issues in the organisation

Item: ED Department Outcome Measures and Impact of CQC Actions – Deep Dive	Level of assurance gained: Reasonable

The ED presented to the Committee and focussed on the most acutely unwell patients in the ED, the environment (was it safe) and new actions in place.
Identification of unwell patients in ED

- Sepsis Task and Finish, pathway mapping, High Acuity Bay
- Nursing assessment completion and escalation of patients
- Digital safety huddle – live NEWS2 scores and completion of assessment
- Detailed work on ambulance handovers – handover clinical information, release paramedic crew, complete first assessment in 15 minutes
- Streaming role at front of ECA
- Increased nurse staffing numbers in ECA for treatment and triage; increased HCA (temporary) for cares in Majors

Environment

- Estates work – new treatment area in ECA, majors cubicles 4 & 5 re: ligature points, works in ECA assessment room for mental health patients
- Mental health risk assessment completion monitoring
- Matrons handbook fully updated; weekly and monthly checks, qualrterly assurance review with Deputy Director of Nursing
- External assurance visits

Most recent actions

- Opening of Humber Suite (mental health assessment space)
- High acuity bay in Initial Assessment/resus
- Adaptation of Manchester/Northumbria triage tool
- ECA "re-set"/rapid improvement work

Item: CQC Actions Progress	Level of assurance gained: Limited

The Committee received CQC updates relating to:

- ED Action Plan, ED Safety Champions and Measures of Success

- Surgery Action Plan
- Medicine Action Plan
- Trust-wide Action Plan
- Maternity section 31 Action Plan, Badgernet Maternity System update
- Assurance visits
- Quality Improvement Group updates
- HM Area Coroner Letter

Item: Risk Management Annual Report	Level of assurance gained: Reasonable

The Annual Report was presented to the Committee. Work was ongoing with the Health Groups to ensure action plans were in place for all risks on the registers and that risks were reviewed appropriately. A Risk Management refresh would take place in 2023/24 and as improvement work continues, the Risk Management Policy will also be reviewed to capture any new practices.

Item: Safeguarding Annual Reports – Adults and Children	Level of assurance gained: Reasonable

The Safeguarding Annual Reports were presented to the Committee. Partnerships had been established with a range of external agencies to improve the care and treatment of patients with vulnerabilities including those under legal detention.
The Trust continues to support the Learning Disabilities Mortality Review programme.
Nurse Directors get a high level Safeguarding report twice weekly, identifying vulnerable adults in the Trust.
Identification of staff training needs for mental health. 26 face to face MCA/DOLs training sessions have been delivered through HEY247

Item: Maternity	Level of assurance gained: Limited

The Committee received maternity reports relating to CNST, GAP, PMRT and ATAIN. 2 Patient Safety Incident Investigations were also presented.

- One theme to come from the PMRT reviews is the lack of capacity in the Preterm Birth Clinic. Work is ongoing with the clinical Director to explore job plans and increase clinic capacity (wider consultant expansion work)

Vacancies June 2023
Number of Registered midwives currently in post is 168.23 WTE against a budget of 187WTE = (18.77 WTE) vacancy coupled with:

maternity leave 17.42WTE if we recruit to 60% = (10.45WTE)

Total vacancy of = **29.22WTE** registered midwifery posts

Maternity leave and workforce issues are impacting on:

- 1:1 care in labour
- Ability to provide home birth service
- cancelation of planned activity in community mainly booking appointment which has a potential to impact on targets for AN screening,
- Delay to induction of labour
- Specialist midwives working clinical shifts to maintain safe staffing levels – impacting on delivery of mandatory training, CNST year 5 standards

Item: Patient Experience Update	Level of assurance gained: Reasonable

The Committee received the Q1 figures for PALS, Complaints, Friends and Family Test, PROMs and Volunteers

- During 2022-23 96 complaints were re-opened as a second (504 complaints received in total so 19% reopened). 204 complaints were closed in Q1 2023/24, with 32 re-opened as a second, which is a slight reduction at 15% in comparison.
- Correlated the link between the increase in complaints closed (longstanding and within expected timeframes) with the slight increase in the number of complaints re-opened as a second

Next Steps/Actions

- Continue to drive improvements through the weekly backlog meetings with leadership from the Nurse Directors and support from the Patient Experience Team
- Health Groups to focus on addressing the backlog of complaints open over 40 day but to also ensure the new complaints are investigated and closed within the target.
- Undertake a review of all complaint outcomes, missing outcomes and actions and work with the Health Groups to address the required improvements
- Continue to gather feedback from complaints on their experience of the complaints process and use the intelligence to inform improvements to the way we manage our complaints as we continue to adopt the PHSO NHS Complaint Standards
- Continue to adopt the PHSO NHS Complaint Standards via the Steering Group

Review a selection of complaints closed at the Complaints Reflective Practice Group in August 2023 and include feedback in the Q2 PET report

The committee received the following updates for assurance, there were no escalations raised;

- Operational Update
- CQUIN Update
- Clinical Effectiveness Update
- Patient Experience Sub-Committee
- Quality Indicator Report
-

ESCALATION FROM THE PERFORMANCE AND FINANCE COMMITTEE

REFERENCES

Only PDFs are attached

9.2 - PAF Summary July 2023.pdf

Report to the Board in Public
Performance and Finance Committee
July 2023

Item: Performance	Level of assurance gained: Limited

- For June 2023, the Ambulance handover position improved against May although remained slightly under the Improvement trajectory. Delivering 64.9% of Handovers within 30mins (target 68.6%). The average time for Handover improved to 34mins against 38 minutes in May.

- ED achieved the improvement trajectory for the 4hr Quality Standard in June 2023 (62.7%) for Type 1 & 3 activity.

- The number of patients in June 2023 with No Criteria to Reside continues to be the single largest factor affecting performance (although beginning to see a slight decrease) with a daily average of 191 patients per day remaining within the hospital who have no medical need for acute services.
- Overall cancer performance remains comparable with previous months. Year to date there has been an 11.1% increase in 2WW referrals received.

- Consultation has begun regarding moving the Story Street UTC to HRI, the Duchess of Kent building would be used for minor injuries and any other non-emergency issues. The Trust was working with CHCP and was subject to funding.

- Recovery of elective activity in June 2023 against the operational plan:
    - New Activity 101%
    - Follow up Activity 104%
    - Day Case Activity 89%
    - Ordinary Elective Activity 89%

- At the end of June 2023, the Trust reported zero x 104 week waits and 26 x 78 week wait breaches, a reduction from the position at May 2023. The Trust is forecasting zero breaches for the end of July 2023.

- The Trust's total waiting list volume has increased marginally, impacted by bank holidays and industrial action during 2023/24 Q1. At the end of June 2023, the waiting list volume was 69,559. The total WLV is above trajectory of 68,334.

- Ground Floor Plan – Implementation Board has been established and 3 main objectives set; improve flow, reduce crowding in ED and manage the Acute Medical Take

- The new Day Case Surgery unit at Castle Hill was now open with 4 theatres operational.

Item: Financial Report Month 4	Level of assurance gained: Limited

- The Trust reported an in month deficit of £1.17m, £0.93m adverse against plan

- The year-end forecast is in line with plan at £7.2m deficit

- The underlying deficit is £49m. This has improved by £2.2m from month 3

- Capital Expenditure is £5.7m against a year to date plan of £10m

- The ICB reported a £0.3m overspend at month 2 with a forecast breakeven position by year end

Item: Capital Resource Allocation Committee	Level of assurance gained: Reasonable
CRAC had approved the following: • a software refresh for the Cardiology Information System • Urgent Treatment Centre re-allocation • Community Diagnostic Hub	
The following reports were also shared: • Costing Report – Finance teams working through the new guidance • Ground floor plan implementation The following contracts were received: • Contract recommendation paper for the supply of orthopaedic trauma, hand and wrist implants along with associated equipment	

ESCALATION FROM THE WORKFORCE COMMITTEE

REFERENCES

Only PDFs are attached

9.3 - WECC Summary Jun 23.pdf

Report to the Board in Public
Workforce, Education and Culture Committee June 2023

Item: Staff Support Services Update	Level of assurance gained: Reasonable
A Trust Health and Wellbeing Lead has been appointed on a 12-month secondment, currently there is no funding for this role after 12 months which is a risk for the Trust. The staff psychology support has been in place for 2 years and has expanded to support both individuals and teams. Permanent space for staff wanting to be seen for 121 psychological support on HRI site is a challenge. REACT training will soon be launched, which is similar to mental health first aid to provide staff with the skills to provide peer to peer support.	
Item: Talent Management	Level of assurance gained: Limited
The talent management team have redeveloped appraisals to include toolkits and conversation guides, supported career progression within nursing and commissioned positive action programmes for BAME and Disability leadership programmes. The OD team are under significant pressure and do not currently have the capacity to progress new developments and run structured talent management programmes.	
Item: Medical Undergraduate Progress Report	Level of assurance gained: Reasonable
The Trust performance for Year 1-3 teaching has improved over the last two years. One of the challenges is the delivery of Year 4 teaching, particularly in Women's Health (WH). Two new consultants have been appointed with 1 PA in their job plans to deliver teaching. An ST6 trainee from WH has taken 12 months out of training to work as a CTF to support students with teaching. Physical space is a challenge for teaching due to the increase in student numbers additional to the loss of dedicated teaching rooms. An audit will be completed to identify what teaching rooms are available across the site. A joint piece of work will be undertaken by the Clinical Dean, Interim Chief Nurse and Head of Learning & OD to assess training space within the Trust.	
Item: Guardian of Safe Working Q4 & Annual Report	Level of assurance gained: Reasonable
The Trust is having discussions with the JDF and BMA regarding junior doctor additional pay rates. Multiple exception reports have been received regarding foundation doctors and GP trainees being unable to use their self-development time. The roll-out of eRoster is progressing. The issue of trainee's having to complete ECGs that was thought to be resolved still remains an issue The new Junior Doctors Mess has opened in HRI and has been well received by the junior doctors.	
Item: Staff Survey Update	Level of assurance gained: Limited
The Director of Communications presented the progress to date of the actions from the staff survey and a number of actions taken by the Health Groups.	
Item: Employee Relations Progress Report	Level of assurance gained: Substantial
The average length of cases has increased due to a number of cases that have time constraints that are not within the Trust's control, a stop the clock will be implemented going forwards. The data shows that male colleagues are more likely to be included in employee relations cases. The data shows that BAME colleagues are no more likely to be involved in a disciplinary process than white colleagues. EF&D have more employee relations cases than they have staff in the Trust proportionately.	
Item: Trade Union Facility Time Requirements	Level of assurance gained: Substantial

No issues were raised regarding the Trade Union Facility Time Requirements report.	
Item: Nursing and Midwifery Staffing Report	Level of assurance gained: Substantial
The Interim Chief Nurse advised the number of CHPPD significantly increased in April 2023, there was a reduction in patients but the reduction was not proportionate to the increase. The nursing workforce has the potential to be over-established by September 2023, which will provide resilience for winter.	
Item: People Strategy Performance Report	Level of assurance gained: Substantial
The Director of Workforce and OD advised that an action plan is in place to improve statutory / mandatory training and appraisal levels.	

ESCALATION FROM THE AUDIT COMMITTEE

REFERENCES

Only PDFs are attached

9.4 - Audit Committee Summary to the Board - July 2023 - Public.pdf

Report to the Board in Public
Audit Committee July 2023

Item: Internal Audit Report – Data Security and Protection (DSP) Toolkit	Assurance: Reasonable
The review of the Trust's DSP Toolkit received a rating of 'Moderate Assurance' and resulted in a number of actions being raised, all of which were agreed by management. Improvements were noted in a range of areas on the Toolkit, but five actions remained outstanding from the previous years review. The Committee heard that this had been the first year of working across both HUTH and NLAG and that the new Chief Technology Officer would oversee both submissions next year and the two organisations will be working closely together to share knowledge, best practice, etc.	
Item: Internal Audit Report – Follow-Up	Assurance: Reasonable
This review looked at 60 management actions across 12 reviews previously undertaken by Internal Audit. The review concluded that 47% had been implemented/superseded, 15% were WIP, 8% had not been implemented and 28% had received no responses from the relevant action owners as to their status so were considered as open and overdue. Linked to this the Committee received a new summary report on all overdue agreed management actions arising from Internal Audit work since 2019/20. This indicated that 53% of management actions were outstanding. Internal Audit are working actively with the Trust to ensure that all overdue recommendations are reviewed and implemented as necessary and updated on the electronic tracking system to ensure effective reporting. This report will be a regular feature at each Audit Committee meeting going forward to monitor the position with overdue recommendations and ensure implemented in line with agreed timescales.	
Item: Counter Fraud Progress Report	Assurance: Good
The Committee received a routine progress report from the new Local Counter Fraud Specialist outlining proactive and reactive work performed since the previous meeting in April 2023, including the submission of an overall Green rating for the Counter Fraud Functional Standard Return 2022/23, meetings with key officers/teams and details of a new referral received.	
Item: Annual Review of Board Assurance Framework (BAF) Process	Assurance: Reasonable
The Committee received the report to provide assurance on the process by which the BAF is used by the Board and its Committees. The Committee discussed the extent to which the BAF is actively used for its intended purpose given there are so many competing priorities and considered that there is still some work to do to hone it, in order to receive sufficient assurance. The Committee heard that a Board development session is being planned on the BAF.	
Item: Risk Management Strategy Update	Assurance: Good
The Committee heard that work continues with the Health Groups to provide them with risk management support. All slow moving risks are being reviewed with the Risk Owners. Good risk management training is being rolled out across the organisation to increase understanding and effectiveness in this area.	
Item: Clinical Audit and Effectiveness Annual Report 2022/23 (inc. Clinical Audit Plan 2023/24)	Assurance: Good
The Committee were informed that 97% of clinical audits have commenced. A discussion took place around seeing the outcomes from clinical audits performed, and it was noted that the Quality Account captures some such outcomes. Full oversight of clinical audit activity is performed by the Quality Committee.	

Item: Legal Services Annual Report 2022/23	Assurance: Good
The Committee received and discussed the annual report on the Trust's Legal Services setting out activity in this area during 2022/23.	
Routine reports received for assurance by the Audit Committee were: • Gifts, Hospitality and Sponsorship, Declarations of Interest; • Review of Credit Card Expenditure – Q1 2023/24; • Committee Minutes: Performance and Finance, Quality, Workforce Education and Culture and Charitable Funds;	

ESCALATION FROM THE GROUP DEVELOPMENT COMMITTEES IN COMMON

REFERENCES

Only PDFs are attached

9.5 - Group Development CIC Highlight Report - September 2023.pdf

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item	9.5	**Meeting**	Trust Board - Public	**Meeting Date**	12 September 2023
Title	**Group Development Committees-in-Common Highlight Report**				
Lead Director	Sean Lyons, Chair				
Author	Linda Jackson, Vice Chair				
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	
Assurance	X	Staff Confidentiality		Caring	X	High Quality Care	
Information Only	X	Other Exceptional Circumstance		Responsive		Great Clinical Services	
				Well-led		Partnerships and Integrated Services	X
						Research and Innovation	
						Financial Sustainability	

Key Recommendations to be considered:

To provide a summary of the matters considered by the Group Development Committees-in-Common Meeting on 24th August 2023. The Trust Board is asked to note the key points outlined with the report.

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Highlight Report to the Trust Board

HUTH Trust Board	12.09.2023
Report From:	Group Development Committees in Common

Highlight Report:

Humber & North Yorkshire (H&NY) Integrated Care System/Collaborative of Acute Providers (ICS/CAP)

A discussion took place about how best to contribute, influence and meet the demands of the external environment as a Group. It was noted there was the possibility of a restructure within the Integrated Care Board (ICB) which would need to be considered when scoping the best approach. The Group Chief Executive (CEO) supported by the Interim Joint Director of Strategy will seek clarity on potential changes at both ICS and Place level and report back to the committees.

The Committees were informed that there had been a new workstream set up under the CAP to oversee Diagnostics. A Programme Director has been appointed from the region and it is envisaged this workstream will oversee the implementation of the community diagnostic hubs along with cancer performance and pathology. This workstream will sit alongside the existing Planned and Urgent and Emergency Care (UEC) workstreams already established.

Humber Acute Services Review (HASR)

The Committees received an update on the Pre-Consultation Business Case (PCBC) that sets out the preferred option for the delivery of UEC and pediatrics services with primary focus on Diana, Princess of Wales Hospital (DPoWH) and Northern Lincolnshire & Goole NHS Foundation Trust (NLaG). The team are currently finalising the revenue savings that may occur from the change (which will form a key part of the Decision-Making Business Case (DMBC) along with the capital estimates based on the preferred option. Work is also continuing with the development of The Consultation Document and Consultation Questionnaire and Analysis ready for the launch of the consultation process in September.

A high level workplan has been developed to support the communication and engagement elements of the consultation. Senior operational resource has been allocated to lead on the development of the implementation plan. There were a number of key risks flagged which are currently being worked through prior to implementation at the end of March 2024 (subject to ICB board approval in January 2024) being: Resourcing, risk of challenge, a general election, and media management.

The committee also noted that the maternity and neonatal services were removed from the consultation at the request of the ICB/ NHS England (NHSE). It was acknowledged that these services remain fragile and there may be a need to undertake a temporary service change. The Interim Joint Director of Strategy was requested to work with key members of the Executive team to map out what the triggers would be to enact any temporary change.

Community Diagnostic Centres (CDC's)
The committee were updated on the progress to date to increase Diagnostic capacity within a community setting. When combined Hull University Teaching Hospital (HUTH) and NLaG have received £45.6m of capital funding for CDC's:

- Hull hub – £16m potential site Albion Place
- Scunthorpe hub - £19.6m on Lindum Street Car Park
- Grimsby Spoke – Freshney Place

The Grimsby Spoke must go live from the CDC site from 1 April 2024, the Scunthorpe Hub from the end of June 2024 and the Hull Hub must go live 1 April 2025.All schemes however must provide activity from 1 December 2023 (this can be from a different site as long as it is not an acute NHS trust building).

The Committees were informed of the risks associated with the programme delivery and implementation being:

- CDC mobilising and opening - risk of delay to the build and mobilisation, availability of contractors, risk of kit notably Computerised Tomography / Magnetic Resonance Imaging (CT/MRI).
- CDC Impact – increased activity and demand across Place. The resourcing of the workstreams- clinical pathways/workforce/digital enablers/financial impact.

Programme governance has now been revised and fits within an ICB structure with all schemes reporting from Place to a ICB Diagnostic Board and through the CAP – which brings with it potential risk of duplication and lack of focus.

Updates from the Joint Development Board

- **Humber Clinical Collaboration Programme (HCCP) –** formerly known as Interim Clinical Plan. The HCCP has the primary focus of the 10 fragile and vulnerable specialties. The programme was launched in late 2020 and had been through multiple iterations of focus and leadership. An internal stock take has been undertaken of the work carried out to date highlighting successes and areas of focus. The work on moving this programme forward was paused in July whilst the Group Structure and Operating model is announced. A further consideration is the work now being undertaken by the CAP – (Planned Care Framework and Recovery being two key areas of focus).

  It was agreed that as work progresses with the Group Operating Model that there is consideration of what is being done on each of these programmes and whether HCCP is required in current or revised format within the Group Structure.

- **Consultant Engagement** – The Committees were updated on the joint consultant engagement session that recently took place facilitated by Mark Lansdown from Get It Right First Time (GIRFT). There were 37 clinical leads present and good debate and discussion took place about how the two Trusts can work better together. There are a further three sessions planned on September, October and November 2023 – September being a joint consultant conference. Further events will cover topics such

as Electronic Patient Record (EPR) and digital, the operational model and clinical pathways.

Group Leadership Structure
The committees were informed that the meeting schedule for 2024 will be ready to be distributed by the end of August, with automatic diary invites to follow. The new schedule moves the Trust Board meetings to a Thursday, keeps Board development on a Tuesday and all committees of the Boards will occur Wednesday-Thursday. The plan is to move to a pilot of the committee in common structure from 1 January – 31 March 2024 with full implementation on 1 April 2024.

In the next two months the review and alignment of the Board Reporting Framework and Board Committee work plans will be undertaken. This will be followed by the development of a committees-in-common principles framework and alignment of the terms of reference and harmonisation of reporting templates.

The Group CEO informed the committees that the formal consultation period on the proposed Group Executive Structure will be launched in September for a four-week period with interviews planned for the middle to end of October. He also updated that a range of options on the Group operating model were being drafted for further review and agreement.

Action Required by the Trust Board:

The Trust Board is asked to note the key points outlined with the report.

Sean Lyons
Chair

BOARD ASSURANCE FRAMEWORK

REFERENCES

Only PDFs are attached

10.1 - BAF Q1 July Board 2023.pdf

Agenda Item		Meeting	Quality Committee	Meeting Date	11.07.23
Title	Board Assurance Framework				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Rebecca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	The Board Assurance Framework is received quarterly at the Board Committees and the 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:

The Committee is asked to:

- Approve the Q1 risk ratings
- Approve the risk appetite scores in Table 1
- Decide if sufficient assurance has been provided

Hull University Teaching Hospitals NHS Trust
Quality Committee
Board Assurance Framework Q1 2023/24

1. Purpose of the Report

The purpose of the report is to present the Q1 Board Assurance Framework to the Trust Board.

2. Background

The Board agreed at its meeting in May 2023 that the 2022/23 Q4 risks would be carried over into the first 6 months of 2023/24 due to the Group Model development and potentially new strategic objectives. It was agreed that a Board Assurance Framework Development session would be held in Quarter 2.

3. Current Status of the Board Assurance Framework

An overview of all BAF risks is provided in the table below. The risks are considered, discussed and challenged at the appropriate Board Committees and with meetings held between the Head of Corporate Affairs and the named Executive lead. The full Board Assurance Framework is appended to this report.

Q1 Risk Ratings

The table below shows all risks and risk ratings for Q1 2023/24. Section 5 in this report gives a brief overview of the risks.

Table 1

Risk	Inherent Risk (L x I)	Current Risk (L x I)				Target Risk	Risk Appetite
BAF 1 - The Trust does not make progress towards further improving a positive working culture this year	5 x 4 = 20	Q1 4 x 4 = 16				3 x 4 = 12	Low
BAF 2 - The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust	4 x 5 = 20	Q1 4 x 4 = 16				3 x 4 = 12	Low
BAF 3.1 – There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating.	4 x 4 = 16	Q1 4 x 4 = 16				3 x 4 = 12	Low
BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED and Patients with No Criteria to Reside require partnership working to determine improvement plans.	5 x 5 = 25	Q1 5 x 5 = 25				4 x 4 = 16	Low
BAF 4 - There is a risk to access to Trust Services following the residual impact of Covid	5 x 5 = 25	Q1 4 x 5 = 20				4 x 4 = 16	Low
BAF 5 - That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System due to recovery, primary care and social care constraints	4 x 4 = 16	Q1 3 x 4 = 12				2 x 3 = 6	Moderate
BAF 6 – There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	4 x 4 = 16	Q1 3 x 4 = 12				2 x 4 = 8	Moderate

BAF 7.1 - There is a risk that the Trust does not achieve its financial plan for 2022/23	5 x 4 = 20	Q1 4 x 4 = 16				2 x 4 = 8	Moderate
BAF 7.2 - There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year	4 x 5 = 20	Q1 4 x 5 = 20				4 x 5 = 20	Low
BAF 7.3 - There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability	4 x 5 = 20	Q1 3 x 5 = 15				2 x 5 = 10	Moderate

Risk Appetite Matrix

Appetite	None	Low	Moderate	High	Significant
Tolerance	Minimal – risks will not be taken	Low – very limited risks with no significant impact	Low/Medium – will take some risks but only with high probability of predicting the outcome	Medium – willing to take risks, innovate, invest to achieve the strategic objective	High – actively seeks out risks/opportunities, pursues innovation, invests
Target Risk Rating	Reduction planned/expected	Reduction planned/expected	Reduction planned/expected	Rating likely to stay the same in year	Rating may increase during the year

4. Actions Update

A number of actions have been taken in Quarter 1 and these are shown in the Appendices.

5. Risk ratings

Following discussions at each of the Committees and with the Executive leads the following year-end risk ratings are proposed:

BAF 1 – Honest, caring and accountable culture

Due to the staff survey results and what staff are reporting, redeployment and high sickness levels, the opinion is that the risk has not been mitigated. Work to address this risk has begun and will be monitored through the Workforce, Education and Culture Committee.

The recommendation is that the risk remains the same for Q1.

BAF 2 – Valued, skilled and sufficient staff

The Workforce, Education and Culture Committee discussed the risk and highlighted the Trust's vacancy rates are in a good position but pressures in the hospital are still causing capacity issues and staff sickness.

The recommendation is that the risk remains the same for Q1.

BAF 3.1 – High Quality Care

The proposed risk rating has is due to a number of concerns raised by the CQC in relation to patient safety, both in ED and Maternity Services resulting in a section 31 letter. Action plans are in place and are being scrutinised by external support, the ICB and the CQC. The Quality Committee and the Board are receiving updates against the action plans at each meeting.

A Quality session has been established in the Private Board meeting to discuss the quality issues with the Health Group leadership teams.

The Quality Committee recommend that the Risk Rating remains the same for Q1 but the wording of the risk be changed to reflect the aim of a 'good' CQC rating rather than 'outstanding'. The Committee also recommend that the risk appetite be changed to low.

BAF 3.2 – Harm Free Care
The Quality Committee discussed the ED rating on the Corporate Risk Register (Appendix 2) and agreed that the risk rating on the BAF should be linked and increased to 25 as there are still major issues relating to over-crowding and access to services. The ED risk on the Corporate Risk Register is rated at 25. There was also ongoing operational pressures regarding the patients with no criteria to reside.

Therefore the Quality Committee are recommending that BAF risk 3.2 is uplifted to 5 x 5 = 25 and the target rating be uplifted to 4 x 4 = 16. This will be reviewed on a quarterly basis.

The Quality Committee also recommended removing Mental Health from the risk description due to the opening of the Mental Health Hub.

BAF 4 – Great Clinical Services
The Performance and Finance Committee discussed performance and the measures in place to mitigate this risk.

Issues that remain include patients with no criteria to reside, ambulance handovers and flow through the hospital meaning that the 4 hour target is still not at the required standard.

The Committee discussed a number of initiatives that should begin to show improved performance which included: the Mental Health patient hub opening, the new sepsis pathway, the opening of Rosmore 2 and the new Day Surgery Unit opening at Castle Hill Hospital.

The Committee recommends the risk rating remains the same for Q1.

BAF 5 – Partnerships
The Trust is fully engaged with the ICS as well as the development of the Group Model with Northern Lincolnshire and Goole NHS Foundation Trust. Work is progressing through the Joint Boards and Group Development Committees in Common.

The Humber Acute Services review has changed to the Humber Clinical Collaborative Programme and the learning from the services already working together captured.

However there are still recovery issues being impacted by Primary Care and Social Care constraints.

It is recommended that the Q1 risk rating remains the same.

BAF 6 – Research and Innovation
There has not yet been a definitive change to secure recurrent investment/funding from the Trust to underwrite research and innovation activities. This is compounded further by anticipated financial pressures for the Trust in 2023/24 and the likely continuation of clinical pressures stretching the already limited resources and associated delivery and support services.

It is recommended that the Q1 risk rating remains the same.

BAF 7.1 – Finance
The risk will be monitored at the Performance and Finance Committee against the 2023/24 financial plan.

The Performance and Finance Committee recommends a risk rating of 16 in Q1 with a view that this will improve each quarter if the financial plan is achieved.

BAF 7.2 – Underlying Financial Position
The underlying deficit will be monitored at the Performance and Finance Committee. The key

issues are linked to in-year pressures and un-identified CRES.

The Performance and Finance Committee recommends a risk rating of 20 due to the ongoing underlying issues.

BAF 7.3 – Capital and Infrastructure
The risk will be monitored at the Performance and Finance Committee against the 2023/24 capital plan.

The Performance and Finance Committee recommends a risk rating of 15 in Q1 with a view that this will improve each quarter if the capital plan is achieved.

6. Timetable

The Committees will continue to review the risk ratings in Q2 in the usual way and these will be presented to the September 2023 Board meeting. A Board Assurance Framework development session will be held in Q2.

7. Corporate Risk Register

Attached at Appendix 2 is the Corporate Risk Register for information and review. This is attached to ensure the Board and Committees can see the high level risks and how they are being managed and mitigated.

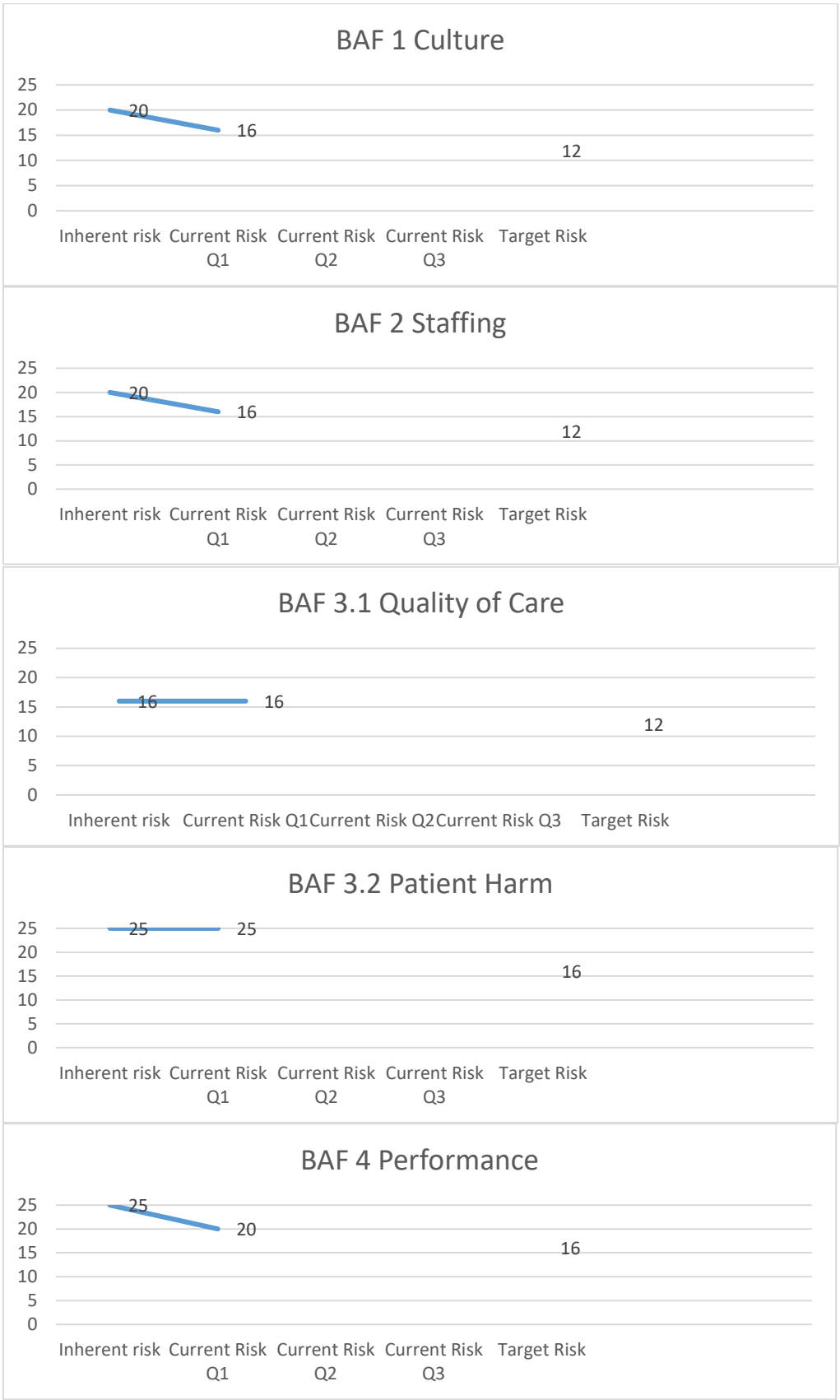
8. Recommendations

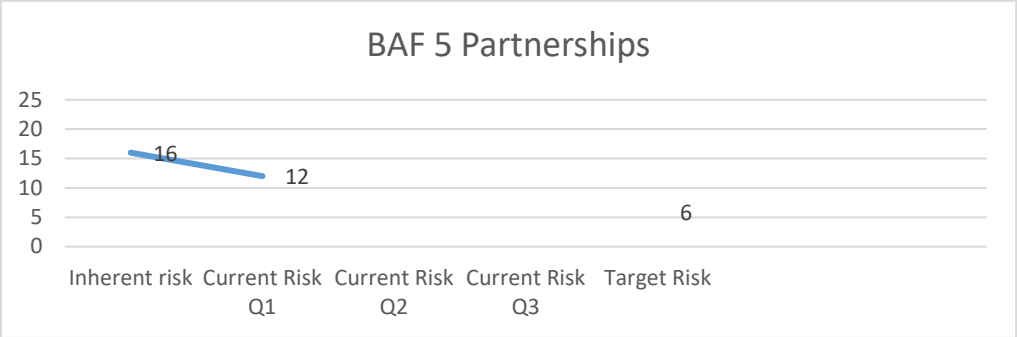
The Committee is asked to:

- Approve the Q1 risk ratings
- Approve the risk appetite scores in Table 1
- Decide if sufficient assurance has been provided

Rebecca Thompson
Head of Corporate Affairs
July 2023

BAF Risk movement throughout 2023/24




BAF 5 Partnerships
25
20
15
10
5
0
16
12
6
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Target Risk


BAF 6 Research and Innovation
25
20
15
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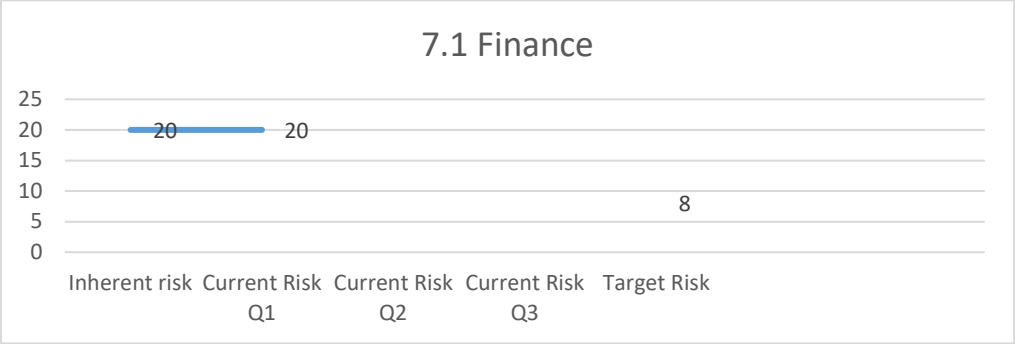
16
12
8
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Target Risk


7.1 Finance
25
20
15
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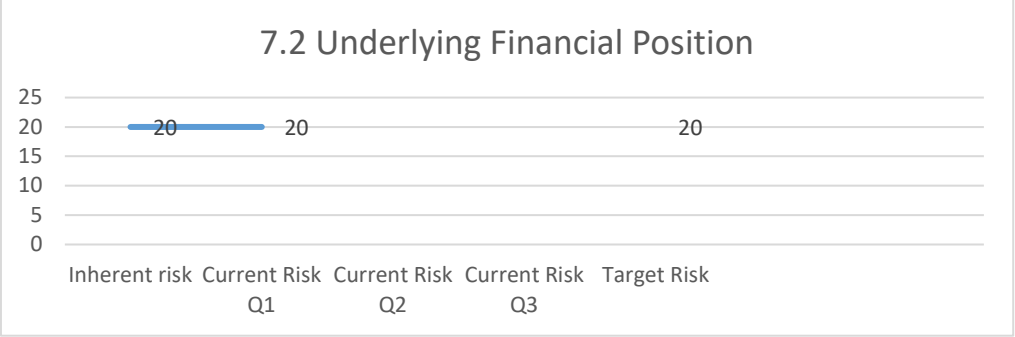
20
8
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Target Risk


7.2 Underlying Financial Position
25
20
15
10
5
0
20
20
20
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Target Risk


7.3 Capital
25
20
15
10
5
0
20
15
10
Inherent risk
Current Risk Q1
Current Risk Q2
Current Risk Q3
Target Risk

Agenda Item		**Meeting**	Operational Risk and Compliance Sub-Committee	**Meeting Date**	10 May 2023
Title	Corporate Risk Register				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	Chris Richards, Risk Manager				
Report previously considered by (date)	The report is considered at The Executive Management Committee bi-monthly				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2022/23**	
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 Operational Risk and Compliance Sub-Committee is asked to:

- Receive the Corporate Risk Register and offer any challenge to the movement, risk ratings or mitigating actions.
- Advise if any more information or scrutiny is required.
- Review High Operational risks for possible escalation onto the Corporate Risk Register for EMC oversight.
- 4031 current risk rating amended from 20 High to 12 Moderate. De-escalated onto the operational Risk Register

Hull University Teaching Hospitals NHS Trust

Corporate Risk Register Report
Operational Risk and Compliance Committee
May 2023 - (Updated June 2023)

1. Open Risks on the Corporate Risk Register

There are currently 11 open risks on the Corporate Risk Register. Full details can be found in Appendix 1.

Open risks on the Corporate Risk Register by Health Group:

	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Corporate Functions	4	3	2	0	0	0	0	0
Clinical Support - Health Group	2	2	2	2	1	1	1	1
Emergency Medicine - Health Group	2	2	2	2	2	2	2	2
Family and Women's Health - Health Group	3	2	2	2	2	2	2	2
Medicine - Health Group	1	0	0	0	0	0	0	0
Trustwide	5	5	5	5	6	3	6	6
Total	17	14	13	11	11	8	11	11

Current Open risks on the Corporate Risk Register by Risk Subtype:

	Infection Prevention & Control	Patient Safety & Quality of Care	Regulatory inc. Health and Safety	Total
Clinical Support - Health Group	0	1	0	1
Emergency Medicine - Health Group	0	1	1	2
Family and Women's Health - Health Group	0	2	0	2
Trustwide	1	5	0	6
Total	1	9	1	11

2. Closed Risks

There have been no risks closed off the Corporate Risk Register since the last report.

3. De-escalated from Corporate Risk Register Back to the Operational Risk Register

There have been no risks de-escalated from the Corporate Risk Register back to the Operational Risk Register since the last report.

4. Changes to Risks and Risk Ratings

March
4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing. Review with Senior IPC Matron Current RR amended from 20 High to 12 Moderate. Target

RR amended from 10 to 6 Low.

5. Operational Risks Escalated for Inclusion on the Corporate Risk Register

There have been no risks escalated for inclusion onto the Corporate Risk Register since the last report.

6. Risks on the Corporate Risk Register Over Two Years Old

Risk Type	ID	Opened	Title	Rating (current)
Clinical	2789	16/12/2014	Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service	16
Clinical	3044	18/01/2017	Shortage of Breast Pathologist	16
Clinical	3439	04/09/2019	Crowding in the Emergency Department	25

7. Operational High Risks - for information only (Appendix 2)

There are currently 47 High risks on the Operational Risk Register that have not been escalated for inclusion onto the Corporate Risk.

8. Risk Management – Areas of Ongoing Improvement

1. Following a Risk Maturity Review in March, work and education around the quality of the risk title and descriptors has been a key focus.
2. Action plans are not always utilised to maximise focus and movement of the risks.
3. Although improvements are being seen, risks are not always reviewed within timescales.

Risk Management training has commenced covering fundamentals and the risk register. This has so far been well received and improvements have already been seen in the quality and management of some risks.

9. Recommendations

The Operational Risk and Compliance Committee is asked to:

- Receive the Corporate Risk Register and offer any challenge to the movement, risk ratings or mitigating actions.
- Advise if any more information or scrutiny is required.
- Review High Operational risks for possible escalation onto the Corporate Risk Register for EMC oversight.
- 4031 current risk rating amended from 20 High to 12 Moderate. De-escalated back onto the operational Risk Register

Chris Richards
Risk Manager

Appendix 1 – Corporate Risk Register Open Risks

Risk ID	Risk Description	Risk Owner	Date Identified	Inherent Risk Score (SxL)	Current Risk Score (SxL)	Target Risk Score (SxL)	Commentary & Action Updates
2789 - Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service (F&W)							
Condition: Patients may suffer irreversible loss of vision due to the lack of capacity in the intra-vitreal injection service Within the Ophthalmology Department the capacity for intra-vitreal injections has been limited for a number of years. The target for a new patient is to be seen and treated within 2 weeks of the date of referral and the follow up injection must be performed in a timely manner or there is a risk of disease reactivation /progression with resulting sight loss. **Cause:** Additional causes to this risk are: 1. The significant expansion in the numbers of retinal	Downey, Ms Louise	16/12/2014	20 4 x 5	**16** **4 x 4**	8 4 x2	**Links** Strategic Goal 2 – Valued, skilled and sufficient workforce BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm Linked Risks - 2665, 1817 **Updates** February 2023 Reviewed at Speciality Governance. Awaiting submission and approval of business case. Risk remains the same. **Open Actions** Action 2 - Recruit to nursing, medical and technical staff.

diseases that can be treated with this therapy. 2. Difficulties with recruitment and retention of Consultant staff. 3. Issues with Nursing capacity to support this service **Consequence:** The consequence of this risk is that there is a delay in patients receiving their treatment which could adversely affect their vision.						
3044 – Shortage of Breast Pathologists (F&W)						
Condition: The Trust has 2 Consultant Pathologists who do Breast pathology. The crisis has been precipitated by one Consultant going off with a long term illness. **Cause:** The service is dependent on one Consultant, if she were to go off for any reason, not only will the symptomatic breast service collapse the breast screening service would also.	Brendan Wooler	18/01/2017	16 4 x 4	**16** **4 x 4**	8 4 x 2	**Links** Strategic Goal 2 – Valued, skilled and sufficient workforce BAF Risk 2 – The Trust does not effectively manage its risks around staffing levels **Updates** March 2023 Current breast pathologist due to leave the Trust on 10.03.23. Escalate to Health Group that the trust has one consultant pathologist. Anything suspicious of cancer check for receptors. Any screening results cannot go to outsourcing. The service to check.

Consequence: There is likely to be a delay in turnaround time for biopsies and resection specimens that can potentially lead to cancer breaches and delay in treatment.						May 2023 Risk discussed at specialty. Currently down 1 consultant in Pathology. Require a plan from clinical support as to if they are appointing. A meeting with Angela Carling to be arranged. Reports not being finalised on Lorenzo. **Open Actions** None
3439 – Crowding in the Emergency Department (EM)						
Condition: There is an issue that patient care is compromised due to the emergency department being crowded. **Cause:** 1. Mismatch between demand and capacity 2. Flow through the department 3. Exit block **Consequence:** 1.Increased Mortality 2. Increased length of stay 3. Reduced quality of care 4. Poor Patient experience 5. Staff Burnout 6. Difficulty in recruiting and retaining staff	Rayner, Dr Ben	04/09/2019	25 5 X 5	**25** **5 x 5**	6 3 x 2	**Links** Strategic Goal 2 – Valued, skilled and sufficient workforce Strategic Goal 3 – High Quality Care Strategic Goal 4 – Great Clinical Services BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm BAF Risk 4 - There is a risk to access to Trust services due to the impact of Covid-19 Linked Risks – 4056, C3044, 3295, 3296, 3646, 3991, 4008, 3607, 2906, 4002, 2960, 4010, 2898, **Updates** June 2023 ED monthly risk meeting Crowding and flow still in issue, increase in 12HR DTAs in May, no update currently

						May 2023 ED monthly risk meeting Despite a reduction of 12HR DTAs in April - crowding still an issue - evident in the 12hr DTAs logged already in May. This is an ongoing issue which is been managed on a shift to shift basis depending on demand and capacity. **Open Actions** None
3994 - Discharges and Patient Flow with impact on quality and safety (Trustwide)						
Condition: There is a risk to quality of care and patient safety as a result of delayed discharges and poor patient flow **Cause:** Delay in discharge impacts on patient flow which contributes to delays in access to treatment **Consequence:** Deterioration in the health of patients and their Risk and poorer clinical outcomes. Poor patient experience and possible regulatory action	Paul Walker	09/09/2021	20 4 x 5	**16** **4 x 4**	6 3 x 2	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm **Updates** May 2023 Summary taken from March Performance and Activity Report: In March the daily average of NCTR patients increased slightly from February to 207 per day. This is 19% of general and acute beds and 31% of HRI beds. From April DCOO (Urgent and Emergency Care) has a daily meeting with HGs to reduce delays for patients on Pathway 0 with NCTR. Good progress meant that 2 of the 4 Health Groups were stood down from this process wef 11 April 2023.

						Open Actions None
3997 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E (EM)						
Condition: There is a risk that patients may come to unintended harm **Cause:** Prolonged waiting times within the ED in excess of the 4-hour target **Consequence:** Deterioration of Risks, poorer clinical outcomes, delays in access to specialist treatment and possible regulatory action	Ramsay, Carla	09/09/2021	25 5 x 5	**20** **5 x 4**	10 5 x 2	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.2 - There is a risk that patients suffer unintended or avoidable harm Linked Risks – 4056, 3683, 3687 **Updates** June 2023 ED monthly risk meeting did not meet target - 49.3% for May 23 - despite this, department is feeling a bit better and work is still ongoing. mapping work being done on the pt journey to find where time is wasted in the timeline. this risk is directly effected by crowding issue. no update to rating May 2023 ED monthly risk meeting Improvements in meeting the 4 hour target are still being made but remain dependent on demand and space across the organisation as this links with the ED crowding risk. Targets were met in April 23 at 54% and a target of 56% was made for May 23. Improvements

						across the department are being managed within the task and finish groups held within the department. **Open Actions** None
3998 - Quality issues identified due to handover delays (Trustswide)						
Risk: Quality issues identified due to handover delays causing unintentional harm to patients **Cause:** Number of ambulances waiting at A&E due to lack of Community Care, GPs and Urgent Care Treatment Centres. **Consequence:** Unintentional patient harm	Paul Walker	09/09/2021	25 5 x 5	**20** **5 x 4**	9 3 x 3	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services BAF Risk 3.2 - Quality issues identified due to handover delays **Updates** March 2023 Summary from March 2023 Performance and Activity Report; March position - increased numbers of delayed handovers from February due to lodged patients in ED but time reduced from 1:06hr to 53 minutes. The use of cohorting has increased and use of the Atrium continues (risk assessed). NCR continues to be single largest factor affecting performance with daily average of 207 patients with no medical need for acute services.

						Open Actions None
4110 - There is a risk to patient safety as a result of the Pharmacy aseptic unit being unable to meet the required service demands (CS)						
Condition: There is a risk that the aseptic unit is on the verge of collapse, partial or totally. **Cause**: As a highly regulated area, the pharmacy aseptic unit needs to meet strict criteria to ensure low risk of harm to the patients. This is assessed by the EL(97)52 audit regularly undertaken by the QA regional team. Our unit has always enjoyed as low risk status and the "issues found" have mostly been able to be resolved easily. Our quality and safety has always been paramount. Unfortunately there are many contributing factors that are putting the aseptic unit at risk: The list comprise:	Antonio Ramirez	21/09/2022	**20** 4 x 5	**16** 4 x 4	**4** 2 x 2	**Links** Strategic Goal 3 – Valued, skilled and sufficient workforce Strategic Goal 4 – Great clinical services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm. **Updates** <u>March 2023</u> Risk to be included in IPC reports for oversight. <u>March 2023</u> Advertised twice for assistants and initially managed to over recruit, all new staff need training and validation. The business case for day unit and aseptics has been approved and we can go out to advertise again. The air handling unit had an unplanned shutdown during the first week in March forcing us to do a full cleaning and to cancel over 40 chemotherapy treatments for the day. It's a symptom of the lack of regular maintenance and planned shutdowns during the year due to pressures but that will need to be addressed

-Increased number of patients -External compounders unable to meet market demand -Insufficient staff levels -Poor performance and quality of the isolators -Poor performance of the unit's air handling unit (AHU) and need for replacement, including unit's closure -Radiopharmacy pressures **Consequence:** If the service continues as it is, there is a possibility that during the next audit visit (scheduled for October 2022) our quality systems prove insufficient and the risk rating could increase from low to moderate or high. . If that happens, we would need to invest more staff resources to achieve low risk again, reducing our manufacturing capacity furthermore. There is also the possibility of total or partial closure of the unit for some time, the reduction of the expiry dates for our						April 2023 Reviewed Pharmacy Governance. 3 new band 3 and 1 band 2, however 1 band 3 has handed in notice. They are in the process of being trained. The number of bought in products has been reviewed and a list of drugs available from every provider compiled. Once the Aseptic unit shut down has been completed, this piece of work will be taken forwards. Fluorouracil pumps and paclitaxel pumps, have been sourced for purchase, so will no longer need to be made in the Aseptic Unit. **<u>Open Actions</u>** Action 1 – Appoint an Assistant Action 2 – increase bought in drugs Action 3 – update isolators replacement programme

products (making preplanning near to impossible) or the reduction of number of items we can prepare.						
4178 - Delivering the improvement trajectories for screening programmes delivered by the Trust (Trust wide)						
Condition: There is a risk of unintended or avoidable harm to patients if the timeframe for the delivery of screening to patients is delayed/outside of the screening round length. **Cause:** Extended screening round length as a result of the organisation responding to Covid-19 when screening programmes were paused/delayed. **Consequence:** Potential deterioration in patient conditions which impacts on quality of life, i.e. loss of vision, undetected cancer, leading to increased mortality and morbidity	Julia Mizon	Date opened 13/02/2023	20 4 Major x 5 Almost Certain	**12** **4 Major x Possible 3**	6 3 Moderate x 2 Unlikely	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm BAF Risk 4 - There is a risk to access Trust services following the pandemic and during the recovery of elective services Linked Risks – 3999, 4008, 2668, 2960, 3128, 4011, 4013 **Open Actions** None

4179 - Delivering on the Operational Plan requirement to reduce the backlog of long-waiting patients (Trust wide)						
Condition: There has been increase in the number of patients on the Trust's waiting list, which has impacted on the number of long-waiting patients who are at risk of breaching the operational plan target, as a result of the organisation responding to Covid-19, the demand for acute, P2 & cancer cases, and the number of patients with no criteria to reside in the bed base at HRI & CHH. **Cause:** Delayed access to clinical services i.e. ICU beds, base ward beds, outpatient 1st and follow-ups and diagnostic testing. **Consequence:** Increased numbers of patients waiting >78 weeks (by March 2023) and >65 weeks (by March 2024) waiting for treatment with the potential for clinical harm.	Julia Mizon	Date opened 13/02/2023	20 4 Major x 5 Almost Certain	**12** **4 Major x Possible 3**	6 3 Moderate x 2 Unlikely	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm **Update** New risk to replace 3995 - Significant waiting list issues including access to screening and follow-up programmes **Open Actions** None

4180 – Risk of avoidable harm for patients who have waited 63+ days for a 1st definitive cancer treatment (Trust wide)						
Condition: The number of patients who have waited 63+ days for a 1st definitive treatment for cancer is higher than the trajectory agreed in the Operating Plan. **Cause:** Delayed access to clinical services partly as a result of the organisation responding to Covid-19, i.e. ICU beds, base ward beds, outpatient 1st and follow-ups and diagnostic testing, and increased 2WW referrals. **Consequence:** Deterioration in patient conditions/delayed treatment with potential for clinical harm.	Julia Mizon	Date opened 13/02/2023	20 4 Major x 5 Almost Certain	**12** **4 Major x Possible 3**	6 3 Moderate x 2 Unlikely	**Links** Strategic Goal 3 – High quality care Strategic Goal 4 – Great clinical services Strategic Goal 5 – Partnership and integrated services BAF Risk 3.1 – There is a risk that the Trust is not able to make progress in continuously improving the quality of patient care and reach its long-term aim of an 'outstanding' rating. BAF Risk 3.2 – There is a risk that patients suffer unintended or avoidable harm BAF Risk 4 - There is a risk to access Trust services following the pandemic and during the recovery of elective services Linked Risks – 4000, C3996, 2898, 4010, 2960, 4002, 2906, 3607, C3044, 3295, 3296, 3646, 3991, 3205, 4008 **Updates** New risk to replace risk 4000 as now out of date. **Open Actions** None

Appendix 2 – For Information Only - Operational High Risks not escalated for inclusion onto the Corporate Risk Register

ID	Specialty	Title	Rating (initial)	Risk level (initial)	Rating (current)	Risk level (current)	Rating (Target)	Risk level (Target)
3646	Clinical Haematology (Ward)	Haematology Medical Staffing locally and regionally	25	High	20	High	8	Moderate
2982	Paediatric Surgery	Lack of Anaesthetic cover for Under 2's out of hours	20	High	20	High	10	Moderate
4163	A and E	Patient safety measures vs. flow in the Emergency Department	20	High	20	High	8	Moderate
4032	Radiotherapy	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	25	High	20	High	5	Low
4068	Orthopaedics (Elective)	Risk to patient safety due to reduction in ability to treat elective Orthopaedic & Neurosurgery (Spinal) patients @ CHH	20	High	20	High	10	Moderate
4122	Theatres	Risk to patient safety due to the urgent replacement of Air/Oxygen gas blenders for the heart lung machines.	20	High	20	High	4	Low
4071	Occupational Therapy	There is a risk that patients assessment and therapy requirements within OT are not identified due to capacity and demand issues	25	High	20	High	6	Low
3983	Radiotherapy	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	25	High	20	High	8	Moderate
4148	Diabetes and Endocrinology	Capcity Shortfalls in DEXA scanning	20	High	16	High	8	Moderate
4207	A and E	Crowding in the Paediatric ED	20	High	16	High	8	Moderate
4002	Gynaecology Oncology	Delayed gynaecology cancer pathways *(inherent RR being checked)*	12	Moderate	16	High	4	Low
3919		E-Radiology Results System: Results not being Actioned Appropriately	16	High	16	High	4	Low
4120	Systems and Applications	Inability for HUTH to meet the NHSx mandate of one EPR for the ICS by March 2025	16	High	16	High	1	Very Low
3918	Acute Medicine	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	16	High	16	High	4	Low
4037	Cardiology	Lack of Suitably Trained Staff to Perform Cardiac Stress Testing	16	High	16	High	1	Very Low

3988	Radiotherapy	Lack of Therapeutic Radiographer Staffing	20	High	16	High	3	Very Low
3125		Multiple junior doctor vacancies - risk to patient safety and care	20	High	16	High	8	Moderate
4141	Systems and Applications	Network shares (passwords in clear text, sensitive patient data, backups, logs, world writable shares, etc)	16	High	16	High	4	Low
4208	A and E	Patient safety is being compromised due to long stays in the ED causing pressure sores on trolleys that are unfit for prolonged	16	High	16	High	8	Moderate
4056	A and E	Reduced medical staffing numbers (doctors, ACP's etc) leading to increased waiting time for patients and workload on existing cl	20	High	16	High	12	Moderate
4170	Major Trauma	Risk of increased morbidity and mortality for elderly MTC patients due to inadequate DME support for Major Trauma Centre	25	High	16	High	10	Moderate
4169	Cardiology	Risk to Continuity of TAVI service due to staffing shortfalls	16	High	16	High	4	Low
4041	Orthopaedics (Trauma)	Risk to patient outcomes from delays due to bed capacity for Priority 1b trauma patients	16	High	16	High	4	Low
4076	Radiotherapy	The risk is patient harm and/or impact on long-term outcomes due to the timeliness of receiving radiotherapy from DTT	20	High	16	High	8	Moderate
3945	Infection Control	There is a risk that patients develop a preventable Healthcare Associated Infection during an inpatient/outpatient episode	20	High	16	High	6	Low
3946	Nuclear Medicine	There is a risk to patient safety due to the inability to meet the current demand for mps imaging	20	High	16	High	2	Very Low
4030	Nuclear Medicine	There is a risk to service continuity within Nuclear Medicine due to a lack of technical staffing	20	High	16	High	1	Very Low
4134	Systems and Applications	Weak passwords (Domain Users)	16	High	16	High	4	Low
4160	Cardiology	Absence of 8A Matron support within Cardiology at HUTH	15	High	15	High	6	Low

4137	Business Intelligence and Information	Accuracy of Data of Business Decision Making	15	High	15	High	5	Low
4138	Systems and Applications	Annual Penetration Testing Delayed	15	High	15	High	5	Low
3962	Radiology	Cardiac CT demand outstripping capacity	15	High	15	High	6	Low
4013	Ophthalmology	Clinical risk to patients referred as new patients into new Medical Retina patient assessment clinic due to lack of capacity iss	20	High	15	High	6	Low
4012	Ophthalmology	Clinical risk to patients referred as new patients into the new wet macular degeneration pathway	20	High	15	High	6	Low
4011	Ophthalmology	Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity	20	High	15	High	6	Low
3475	Gynaecology	Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology	20	High	15	High	5	Low
4132	Systems and Applications	Cyber Security vulnerabilities	15	High	15	High	5	Low
4115	Ear Nose and Throat (use this one)	ENT Laser replacement	15	High	15	High	3	Very Low
3291	Radiotherapy	Failure to update the Dosimetry Check Patient Transit Dose System	15	High	15	High	2	Very Low
4203	Neurosurgery	Inability to consistently provide complex neurosurgery due to microscope instability.	15	High	15	High	4	Low
4200	Community Paediatrics	Increased risk of harm to patients and families due to inadequate co-located psychology support to children and young people.	20	High	15	High	5	Low
4173	Chest Medicine	Nintedanib Change in guidance impacting on clinical capacity to deliver increasing numbers of patients	15	High	15	High	6	Low
3979	Radiology	Patient care is being compromised within General Radiology because of staff shortages	15	High	15	High	3	Very Low
3252	Ophthalmology	Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight	15	High	15	High	6	Low

4033	Radiotherapy	Potential inability to deliver Colorectal Contact Radiotherapy due to equipment related issues	25	High	15	High	5	Low
4067	Orthopaedics (Elective)	Risk to Patient safety and outcomes due to lack of dedicated operating lists for ortho-plastic cases & impact on trauma capacity	25	High	15	High	10	Moderate
3416	A and E	Staff working in the Emergency Care Area feel vulnerable when there are violent and aggressive patients in the department	15	High	15	High	3	Very Low

Strategic objective: Honest, caring and accountable culture
Assurance Committee: Workforce Education and Culture Committee
Executive Lead: CEO
CQC Domain: Well-Led
Enabling Strategies/Plans: People Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: Condition: The Trust does not make progress towards further improving a positive working culture this year. Cause: Staff behaviours Low staff engagement Workforce engagement with ICS/HASR Consequence: Trust unable to achieve Outstanding CQC rating and Well Led domain	Trust People Plan 2019/22 approved and in place Work being carried out around recruitment and retention Staff Development programmes Leadership Development programmes Staff wellbeing services during the recovery phase Positive relationships with JNCC and LNC (Trade Unions) Monthly Health Group Performance and Accountability meetings to ensure workforce targets are being met Health Group and Directorate management manage workforce KPIs Wellbeing Centre opened at CHH – September 2021 Freedom to Speak up Zero Tolerance Policy Established BAME network Diversity in recruitment implemented	Staff survey – engagement scores have reduced	Workforce, Education and Culture Committee Workforce Transformation Committee Rise and Shine programme – emerging leaders to commence 2021/22 Disability Network established	Long term effects of Covid Recovery processes – returning to business as usual Flexible working must be embedded (work/life balance) Junior Doctor Training Line managers creating the right environment – culture issues Trust is not meeting its target for Turnover Staff Survey 2022	Review and relaunch of the staff charter. This is well underway and will be ratified at Workforce Transformation Committee Relaunching the PACT training. This will be mandatory for all staff. All staff will receive a 90 minute session on civility, the relaunched staff charter and expectations of managers. The session contains a new section on how to raise concerns and challenge behaviours. We are identifying staff to deliver the training including clinical and medical leaders. Briefing all 700 B6/B7+ managers at the trust in a series of sessions throughout July and August on the staff charter and PACT training. This will set out, clearly, expectations of managers in challenging and dealing with poor behaviours. Launching a reporting tool (piloted in maternity and cardiology). This will be rolled out across the Trust and has input and support from HR, FTSUG, and OD.Staff can report anonymously or 'on the record' and receive support for tackling issues. Marketing campaign – BAD BEHAVIOUR DOESN'T WORK – to go out in the next couple of months, promoting the charter, the reporting tool and highlighting poor behaviours and their impact.	

Strategic Theme: Culture
Appetite: Low
Risk: 1

	Risks from Risk Register: There are no direct risks on the Corporate Risk Register			**Metrics:** Performance against People Strategy Quarterly and National Staff Survey Results People Report monitoring/ Board and Workforce committees Independent / semi-independent: NHSE/I CQC Internal Audits	**Outcomes:** Staff Survey 2022 37% of staff (3160) completed the survey compared with 2021 (44%) The Trust is below the national average for all of the 9 key themes in the Staff Survey		

Inherent Risk			**Risk position as at 30.06.23 (Q1)**			**Planned target risk position by 31/03/2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
5	**4**	**20**	**4**	**4**	**16**	**3**	**4**	**12**

Strategic Theme: Workforce
Appetite: Low
Risk: 2

Strategic objective: Valued, skilled and sufficient staff
Assurance Committee: Workforce Education and Culture
Executive Lead: Director of Workforce and OD
CQC Domain: Safe, effective, well-led
Enabling Strategies/Plans: People Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **Condition:** The Trust does not effectively manage its risks around staffing levels, both quantitative and quality of staff, across the Trust Lack of affordable five-year plan for 'sufficient' and 'skilled' staff to meet demand **Cause:** National and international shortages Impact of Brexit on availability of international workers Covid impact on staff health including long term trauma and burnout **Consequence:** Insufficient staff to deliver services **Risks from Risk Register:** 2789 – Capacity in the intra-vitreal injection service 3439 – ED staff recruitment 3990 - Shortage of staff is a serious issue in the department of cardiothoracic surgery 3044 – Consultant Pathologist shortages (Breast Pathology) 4110 – Pharmacy Aseptic staffing issues	People plan in place which sets out the changing workforce requirements Remarkable People, Extraordinary Place brand – targeted recruitment Golden Hearts, Moments of Magic rewards Monthly monitoring of Health Group plans – Performance and Accountability meetings Nurse safety brief to ensure safe staffing Guardian of Safe Working reports to the Workforce Committee and Board Focus on staff wellbeing Workforce planning forms part of business plan to understand and predict workforce trends Freedom to speak up International nurse PINs due by the end of August New University registrants on last placement & will start Sept, with their PINs being gained by the end of October	Medical staffing levels including Junior Doctors Variable (agency and overtime) pay Absence of WiFi in educational buildings Maintenance of time for training for both trainees and trainers in the light of service recovery Sickness/absence levels Continuity of Carer – challenges around pay uplifts, number of midwives required, upskilling of midwives.	Monitoring of Workforce assurances through the Workforce Transformation Committee and Workforce Education and Culture Committee Vacancy position reported in every Board meeting	Certain medical specialities struggle to recruit due to national/international shortages Managers thinking innovatively about new roles to new ways of working (ACP/PA) Obstetric workforce risk – 3 consultants recruited Nurse safe care briefings held 4 times per day Late Matron pastoral role now in post to support staff and help on wards, Mon-Fri Task and finish group set up to facilitate Ward Sisters being involved in staffing decisions Trust wide Same Task and finish group also reviewing how we can facilitate Sisters to work weekend shifts on a rota basis, to support and carry out wellbeing checks with staff	People Strategy Refresh Lets get Started` Induction programmes for RN`s & 'Where Care Begins' for the Nursing Assistants. Keep in touch days for all newly qualified/International Nurses throughout the year Matron late shift (till 10pm Mon – Fri) to visit wards and deliver pastoral care/support to staff Non Registered Development Programme/Induction and Preceptorship Programme Clinical Lead Physiotherapy – Integration of Critical Care and Surgery Therapy Services to create joint services and a shared vision. Work is ongoing to expand the project across the services.	
			Metrics: Staff Survey People Performance Report **Independent / semi-independent:** CQC NHS England/Improvement Internal Audits	**Outcomes:** Q1 Trust adjusted vacancy rate = 2.1% Turnover 11.9% against a target of 9.3% Less than 1 year leavers = 21.3% Consultant job plans = 77.8% Sickness = 4.5%		

					Appraisals Medical = 92.9% Appraisals AFC staff = 68.4%		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	4	16	3	4	12

Strategic Theme: High Quality Care Appetite: Low Risk: 3.1	Strategic objective: We will achieve a rating of 'Good' in the next 5 years Assurance Committee: Quality Committee Executive Lead: CMO/CN/DQG CQC Domain: All/Well-led Enabling Strategies/Plans: Quality, Patient Safety, Improvement						
	Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
	Strategic risk: **Taken from the Trust's strategy:** *The Trust has a well embedded approach to monitoring and improving the fundamental standards of nursing and midwifery care in its inpatient and outpatient areas* **Condition:** There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of an 'outstanding' rating. **Cause:** The Trust does not develop its patient safety culture and become a learning organisation Insufficient focus, resource and capacity for continuous quality improvement for quality and safety matters Poor governance arrangements That the Trust is too insular to know what outstanding looks like **Consequence:** Patients do not receive the level of care and clinical outcomes that we strive to provide	Quality committee structure & work-plans Health Group Governance Performance Management Meetings Patient Safety Specialist role IPC arrangements Safeguarding processes Fundamental Standards programme Quality Strategy/Quality Improvement Plan Serious Incident Management Clinical Audit programme CQC improvement plans External agency register and process Horizon scanning Integrated Performance Report – BI Reporting Support from the Health Groups via the Weekly Patient Safety Summit (WPSS) in the support of timely completion of Rapid Review Reports (RRR) and early identification of statement providers/memory capture and immediate Safety Oversight Group CQC Action Plans in place	Greater scrutiny required for clinical audits, improvement plans and outlier reports VTE Compliance Mental Health Services Ambulance turnaround times and the impact on patients ED Crowding NCTR wards – extra staffing required Increase in Falls in December – Falls Committee reviewing whether this is due to patients having multiple falls and increased length of stays PALS increased activity continues, the main themes are delays, waiting times and cancellations	Management assurance: Reports to Quality Committee Quality/outcome data Self-assessments Infection Control Annual Report Quality Accounts Associate Director of Quality appointed Operational Risk and Compliance Committee Learning from Deaths Reports CQC Inspection Internal Audit Reports	CQC Report – Requires Improvement rating ED, Medicine and Surgery inspections result 'inadequate' for safe CQC Maternity Inspection – Section 31 imposing conditions on the Trust's registration	Transition to PSIRF from April 2023. Targeted work with HGs regarding complaints is ongoing. Implementation of new PHSO complaints framework underway Development of a CQI public facing website commenced Development of Human Factors Hub to commence and launched in April 2023 Tissue viability – eLFH modules 1 and 2 have been added to HEY 24/7 and a draft template has been developed for each directorate to report to the Safer Skin Committee to identify actions to reduce pressure damage incidents CQC ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. However, sufficient training has not yet been provided. The competency sign off and training started from a 0% position. At the time of writing, this has increased to 62% and is on trajectory for 90% by the end of May 2023. ED3.2: This action was not completed as stated because the staff were moved to H130 as part of opening additional capacity for patients with no criteria to reside. This is remaining under review as part of the gold command meetings. Once the intermediate discharge unit is in place, this action will be reviewed. ED5.4: The task and finish group was up and running from December 2022 as per the action. It was decided to keep this action under review due to the vast amount of work being undertaken. An update report was presented	

						to the February 2023 Quality Committee. If Board members would find a copy of this useful, it can be found in the upload from February 23 in the shared area. The following actions have been undertaken since the implementation of the digital task and finish group: All ED Digital Nursing Records reviewed and revised, now in live with integrated clinical notes populating clinical record: • ED Safeguarding • Mental Health Triage • ED Nursing Assessment • ED Infection • ED Moving & Handling • Purpose -T [pressure ulcer prevention • SPACES – Intentional rounding • Acuity • Sepsis Introduction of Clinical Dashboards • ED Overview • ED Safety Huddle • ED Sepsis Clinical Escalations is planned to be rolled out in ED by the end of April 2023 [automated escalations of NEWS2 score to ED Safety Dr and ED Safety Nurse] Manchester Triage – currently in test with plan to review mid-April. All of the above work has been supported by appropriate training and support for staff. The following action has been completed as planned; however, there is a further update to add and is reported below. ED5.5: This relates to the cohorting of patients waiting with an ambulance crew. This action was completed as planned; however, a further update to this and following the ICB assurance review in ED was for the glass in the Atrium to be frosted, this has now been completed. CQC Trustwide actions TW1: The trust must ensure care and treatment of service users must only be provided with the consent of the relevant	

						person. (Regulation 11 (1) (2) (3) (4)). TW2: The trust must ensure that mandatory training compliance, including training, meets the trust target. (Regulation 12 (1) (2) (c)). TW3: The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. (Regulation 12 (2) (c)). TW4: The trust must ensure where responsibility for the care and treatment of service users is shared with, transferred to other persons, or working with such other persons, service users and other appropriate persons that timely care planning takes place to ensure the health, safety and welfare of the service users. (Regulation 12 (2) (i)).	
	Risks from Risk Register: 3460 - Availability of Radiology Support for Paediatric & Neonatal Services. 3282 - Failure in the Trust systems to ensure requested test results, pathology and radiology, are reviewed & actioned by the requester 3450 - There is a risk of increased pressure damage to patients due to failing or lack of pressure relieving mattresses			**Metrics:** National Audit Benchmarking Harm Free Care Patient Experience Survey **Independent / semi-independent:** CQC inspections Internal audits External reviews (e.g. NHSEI)	**Outcomes:** Q1 PSIRF now in place – the weekly patient safety summit continue to meet to review patient safety incidents.		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	4	4	16	3	4	12

Strategic Theme: High Quality Care/Great Clinical Services
Appetite: Low
Risk: 3.2

Strategic objective: We will increase harm free care
Assurance Committee: Quality Committee
Executive Lead: CMO/CN
CQC Domain: Safe
Enabling Strategies/Plans: Recovery Plan and work-streams, Patient Safety

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: *Taken from the Trust's strategy: The Trust is the only local provider of secondary emergency and elective healthcare services for a population of 600,000. These people rely on us to provide timely, accessible, appropriate care and look after them and their families at times of great vulnerability and stress.* **Condition:** There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED, Ambulance handovers and Patients with No Criteria to Reside require partnership working to determine improvement plans. **Cause:** Delayed access to services due to the increased waiting lists as part of the pandemic, patient flow, human error, clinical guidance not adhered to, poor compliance with fundamental standards. **Consequence:** Deterioration of conditions for patients, poor quality of life, loss of sight. Patient experience, clinical outcomes, timely access to treatment and regulatory action.	Clinical harm review process Prioritisation of P1 patients Fundamental Standards programme CHCP Community Beds Patient Access Team Weekly Patient Safety Summit Quality Strategy Integrated Performance Report	Clinical Harm Reviews – not possible to review every patient Crowding in ED/Flow Radiology capacity issues 104 week waits performance 52 week waits performance Ophthalmology experiencing a delay in meeting outpatient appointments Cardiology staffing – plan for 4 wte HUTH and 4wte NLAG Obstetrics staffing Complaints backlog The ED targets and the ambulance handover times Patients with no criteria to reside CHCP Bed model still being agreed Cancer 2ww referrals have increased by 6.6%	**Management assurance:** Reports to Quality Committee Clinical harm data and reports Performance Reports to the Performance and Finance Committee CQC Reports	Diagnostic waiting times GP Capacity and increased referrals The RTT trajectory **CQC Report actions** HUTH Flow Model (Bristol Model) implemented. RAT and Epic role fully embedded in department and positive feedback from staff. Board rounds are completed every 4 hours, There is an awareness of who is in ambulances and the escalation and board are working well. Additional work identified to ensure no loss of oversight of medical in-reach patients 60 bedded area for patients with no criteria to reside being built on the old helicopter site – due to be opened July 2023 Targeted speciality meetings continue to support the achievement of a Trust internal milestone of no patient waiting more than 70-weeks at 31 March 2023 (national target is zero +78-week at 31 March 2023). Capacity alerts in x6 pressured specialities are live – with monitoring arrangements to consider the effectiveness and impact (2x specialities – referrals have increased) Clinical Admin Service continue to proactively contact patients with TCIs/appointments to	Transition to PSIRF from April 2023 will transform the approach to patient safety investigations Confirm outstanding competency check requirements for ED staff Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved. Continue with the close monitoring of the delivery of the fundamentals of care in a timely response Tissue Viability Nurses to review the impact of any delayed skin assessments on patient outcomes Continue with the interim support arrangements from the Deputy Chief Nurse Continually review the impact of the HOB opened on the 13th floor and agree the requirements for a HOB on the Acute Assessment Unit Continue with the plans to introduce the 90 day plan of the ground floor model designated mental health assessment area adjacent to ED now open	

					check they are attending/if treatment is still required – small number of removals 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 from Risk Register: 2675 - Insufficient capacity within Radiology to accommodate increasing demand			**Metrics:** Patient Safety incidents Waiting list numbers Reduction in Trust preventable infections and complications **Independent / semi-independent:** CQC inspections Internal audits – Waiting lists, recovery included in schedule	**Outcomes:** **Q1** 4 hour performance = 66.6% Waiting list = 69,263 104 week wait = 0 380 over 60 minute ambulance handovers 167 breaches - 12 hour trolley waits patients per day with no criteria to reside = 209 78 week breaches = 77 The number of patients waiting to start treatment on 62 pathway has reduced to 1,325 1 of 9 cancer standards were met in April 2023		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/24		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	5	5	25	4	4	16

Strategic Theme: Performance
Appetite: Low
Risk: 4

Strategic objective: Great Clinical Services
Assurance Committee: Performance and Finance
Executive Lead: COO
CQC Domain: Effective
Enabling Strategies/Plans: Operating Plan

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: There is a risk to access to Trust services **Condition:** There is a level of uncertainty regarding the scale and pace of recovery that is possible and the impact of national guidance Planning guidance being released in stages across the year **Cause:** Delayed access to services **Consequence:** Deterioration of conditions for patients	Performance and Accountability meetings Clinical harm reviews taking place Partnership working with ICS/HCCP Clinical triage of all new referrals to ensure patients/GPs receive advice and guidance and diagnostics where available whilst awaiting first appointment Trust Escalation Policy The 4-hour delivery action plan continues to be further developed, and associated service change will be implemented rolled out alongside an implementation plan for an UTC type facility on the HRI site.	Mismatch between demand and capacity Flow through the ED department Patients with NCTR Ambulance handover position Cancer performance 12 hour trolley wait standard changed to 12 hours from arrival in ED leading to an increase in breaches.	Monthly performance report to the Performance and Finance Committee Bi-monthly Board Report Health Group Performance and Accountability meetings monitor recovery plans in place	Trust Recovery Plans Paragon Suite rehabilitation facility Waiting list	Continued focus at speciality level of patients dated and/or risks now focussed to achieve and maintain zero 104-week waits. 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 Progressing mutual aid support from providers within and without of H&NY and continuing to in-source capacity where possible to support pressured specialities Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will need recurrent support from the 23/24 & 24/25 growth for cancer Increasing numbers of 2WW referrals received with a FIT test result will enable more patients to be effectively triaged; locally at +60% which continues to be monitored and on-going discussions with primary care planned to further improve uptake by GPs	
Risks from Risk Register: 3439 - There is an issue that patient care is compromised due to the emergency department being crowded 3960 - Risks associated with Mental Health patients managed in the Emergency Department 3994 - There is a risk to quality of care and patient safety as a result of delayed discharges and poor patient flow 3995 - Significant waiting list issues including access to screening and follow-up programmes – risk of patient harm 3997 - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E 3998 - Quality issues identified due to handover delays			**Metrics:** Health Group recovery plan trajectories **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit	**Outcomes:** Q1 Waiting list 69,263 Ambulance handover position 64.9% in less than 30 minutes 104 week wait = 0 78 week wait = 77 Patients with no criteria to reside = 209 per day 1 out of 9 cancer waiting times national standards achieved		

	3999 - > 52 week wait 4000 - HGB - Maximum 62-day wait for first treatment from an urgent GP referral for suspected cancer. NHS cancer screening referral 4031 - Patient transmitting hospital acquired infections due to inadequate bed spacing 4110 - There is a risk to patient safety as a result of the Pharmacy aseptic unit being unable to meet the required service demands							

Inherent Risk			Risk position as at 30.06.23 (Q4)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	5	25	4	5	20	4	4	16

Strategic Theme: Strategy
Appetite: Moderate
Risk: 5

Strategic objective: Partnerships and Integrated Services
Assurance Committee: Trust Board
Executive Lead: Director of Strategy and Planning
CQC Domain: Well-led, Effective, Safe
Enabling Strategies/Plans: Trust Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **Condition:** That the Trust will not be able to fully contribute to the development and implementation of the Integrated Care System and Humber Clinical Collaborative Programme due to recovery constraints **Cause:** The recovery programme slows down the progress to become an Integrated Care System **Consequence:** Reputational damage Relationships with other care providers are not forged	Acute Workforce Maternity models Models delivering improvements for Constitutional and Clinical standards Assurance Reviews Digital enablers	Delays and timing of implementation of services/deliverability of models Out of hospital programme at various stages of development	Bi-monthly reports detailing progress to the Committees in Common Group Development Committees in Common Joint Board meeting 28 June 2023	Out of hospital care Impact of displacement to neighbouring areas/systems Travel and accessibility of services Cost and resourcing of multiple business cases Cost of external support e.g financial and legal Political challenge Lack of ability to influence	**Cardiology** Cardiac CT working group established and work plan under development NLAG validation to prevent duplicate/repeat echo requests now embedded Agreement to progress with Heart Failure workstream with project team support **Dermatology** Service Strategy approved at FWHG and Medicine Divisional Board Activity profile and baseline metrics for 2022/23 received **ENT** Development of specialty level Delivery Group and Operational Groups to mobilise planned activities Time out to be arranged for HUTH and NLAG clinical, nursing and operational teams. **Gastroenterology** Scoping meetings held with NLAG and HUTH clinicians QIP to review current processes for suspected cancer pathways	
Risks from Risk Register: There are no direct risks on the Corporate Risk Register			**Metrics:** Recovery rate Outcomes of Service Reviews **Independent / semi-independent:** NHS E/I CQC ICS HASR Acute Collaborative	**Outcomes:** Humber Acute Services Review has changed to Humber Clinical Collaborative Programme		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/24		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	3	6

Strategic Theme: Research and Innovation
Appetite: Moderate
Risk: 6

Strategic objective: Research and Innovation
Assurance Committee: Quality Committee
Executive Lead: CMO
CQC Domain: Safe
Enabling Strategies/Plans: Research and Innovation Strategy

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: There is a risk that R&I support service is not delivered operationally to its full potential due to lack of investment **Cause:** Funding is unavailable **Consequence:** Impact on R&I Investment Impact on R&I capacity	Strengthened partnership with the University of Hull Infection Research Group ICS Research Strategy	Reduction in support services due to activity delivery Loss of commercial research income as well as other income as non-Covid activity was paused Additional research due to Covid without additional investment in staff The inevitable reduction of support services capacity (i.e. imaging, labs, pharmacy) dealing with clinical service delivery backlogs which may limit the ability to take on some new research activity as well as slowing down existing activities. This is being addressed on a national level by DHSC and NIHR but local strategies are needed. Legacy of COVID activity and follow-ups – the success of our COVID research activity means we will have the burden of additional workload into early 2022-23. Without additional investment in delivery staff, this will impact upon research specialties in the delivery of their existing and planned activities. 2021-22 has shown our staff have worked incredibly hard to ensure our recovery from a 'COVID legacy' is ahead of trajectory. Service pressures resulting in issues with the recruitment and retention of staff. Opportunities for staff to join research teams via secondments ad other shared models is becoming increasingly difficult, creating challenges for the deployment of suitable staff across research vacancies. Capital developments will need to ensure research and innovation activities can be accommodated and staff appropriately housed. Demand for IT and Digital innovation is increasing. This brings an inevitable increase in the demand for the	Successful portfolio of Covid studies managed in 2020/21 2316 patients involved in clinical research as at August 2021 Continuing working with HYMS and the ICS	Scale of ambition vs deliverability Current research capacity hampered due to the recovery plan Funding availability Consideration of the development and implementation of an agreed R&I investment strategy covering the next 3 years (protected research time for staff, providing core budgets for increased admin and other costs) is critical in taking the next step on this journey of development and supporting the research collaborations as a leading partner in the Humber and North Yorkshire Health and Care Partnership. Major risk is that without investment we will reach a ceiling point in our capacity which in turn will limit new activity from collaborators and this could spark a decline in activity in the coming years as we are forced to decline participation in studies. This is not the current position in Q2 but is something we are monitoring closely. Demand for IT and Digital innovation is increasing. This brings an inevitable increase in the demand for the associated skills in the workforce and from our dedicated H-Digital Teams.	Q1 Joint RDI working between HUTH and NLAG Joint strategy to be agreed	

			associated skills in the workforce and from our dedicated H-Digital Teams.				
	Risks from Risk Register: No risks highlighted			**Metrics:** Recovery Activity R&I Capacity **Independent / semi-independent:** NHS E/I HASR CQC ICS	**Outcomes:**		

Inherent Risk			**Risk position as at 30.06.23 (Q1)**			**Planned target risk position by 31/03/2024**		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**4**	**16**	**3**	**4**	**12**	**2**	**4**	**8**

Strategic Theme: Financial
Appetite: Moderate
Risk: 7.1

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: CFO
CQC Domain: Effective
Enabling Strategies/Plans: Financial Plan 2022/23

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **Condition:** Expenditure incurred exceeds income by greater than agreed control total **Cause:** Health Groups and Corporate Departments do not deliver services within agreed budgets and do not achieve Cash Releasing Efficiency Savings Capped and block contract arrangements limit scope for payment Additional activity delivered may not result in increased income; due to levels of activity or coding issues **Consequence:** Impact on investment in quality Inability to meet regulatory requirements Reputational damage Impact upon recruitment	Health Group Budgets in place 2022/23 Financial Performance Review meetings in place with Health Groups Monthly scrutiny of the Balance Sheet by the Performance and Finance Committee Realistic and achievable plan in place developed with staff input and sustainability funds identified	Ongoing development of accountability of Health Groups – further improvements required Gap in identified CRES schemes and required level	Performance Committee and Boards Finance Performance Reviews with Health Groups	Divisional awareness of spend within new structures as budget centres have shifted Clarity of ownership of schemes Pace of delivery The struggle to identify efficiency schemes Junior Doctor operational pressures Locums in Clinical Support (Oncology and Haematology) Lung Health check	The Trust has a planned deficit of £7.2m for 2023/24	
Risks from Risk Register: No direct risks on the Corporate Risk Register			**Metrics:** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** Deficit of £1.7m reported at month 1, £1.4m worse than plan		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

Strategic Theme: Finance
Appetite: Low
Risk: 7.2

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: CFO
CQC Domain: Effective
Enabling Strategies/Plans: Financial Plan 2022/23

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **Condition:** There is a risk that the Trust does not plan or make progress against addressing its underlying financial position over the next 3 years, including this year. **Cause:** Lack of achievement of sufficient recurrent CRES or make efficiencies Impact of Covid-19 finances and recovery planning **Consequence:** The Trust does not achieve its Financial Plan or make efficiency savings	Financial Plan NHS Finance sees performance being measured at a system (ICS) level CRES Schemes Balanced Financial plan	Ability to deliver a 2-3 year plan to tackle underlying financial position relies on system-level control and contribution Need to agree a process to ensure resources are transferred appropriately between Trusts as a result of the developing acute service reviews CRES delivery	Regular update reports to the Performance and Finance Committee	Lost income due to Junior Doctors strike	Ongoing development of accountability of Health Groups	
Risks from Risk Register: No direct risks on the Corporate Risk Register			**Metrics:** Run rate I&E position CRES position Activity performance against plan Cash flow **Independent/semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:** reported deficit of £1.7m at month 1, £1.4m worse than plan		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	4	5	20

Strategic Theme: Financial
Appetite: Moderate
Risk: 7.3

Strategic objective: Financial Sustainability
Assurance Committee: Performance and Finance
Executive Lead: CFO
CQC Domain: Effective
Enabling Strategies/Plans: Capital Plan 2022-2025

Risk to Objective	Controls	Gaps in Controls	Sources of Assurance	Assurance Outcomes/Gaps	Action Plan	Progress/Timescales
Strategic risk: **Condition:** There is a risk over the next 3 years of failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability **Cause:** Lack of sufficient capital and revenue for funds for investment to match growth, wear and tear, to support service reconfiguration, to replace equipment. **Consequence:** Lack of capital funding impacting on services Lack of investment impacting on patient and staff safety	Capital programme in place and risk assessed Comprehensive maintenance programme in place Capital Resource Allocation Committee in place to allocate funds Service level business continuity plans in place	Supplier price increases and delays to building works to be managed Energy and Decarbonisation funding not yet secured	Monthly updates to the Performance and Finance Committee Regular updates to the Board	Building works impacting on patients and staff	Capital Plan Phase 1 of Day Surgery Scheme	
Risks from Risk Register: 4078 - In year achievement of the Capital plan 1747 - Backlog maintenance issues impacting on Clinical Service Delivery			**Metrics:** Capital performance and expenditure against the plan **Independent / semi-independent:** NHSE/I CQC Internal Audit External Audit Local Counter Fraud Specialist	**Outcomes:**		

Inherent Risk			Risk position as at 30.06.23 (Q1)			Planned target risk position by 31/03/2024		
Likelihood	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**	**Likelihood**	**Impact**	**Score**
4	**5**	**20**	**3**	**5**	**15**	**2**	**5**	**10**

Actions taken, planned and draft assurance rating (AR)

BAF Risk 1		Culture The Trust does not make progress towards further improving a positive working culture this year.							
		Inherent Risk Rating 5 x 4 = 20		Current Risk Rating 4 x 4 = 16			Target Risk Rating 3 x 4 = 12		
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
Review and relaunch of the staff charter. This is well underway and will be ratified at Workforce Transformation Committee Relaunching the PACT training. This will be mandatory for all staff. All staff will receive a 90 minute session on civility, the relaunched staff charter and expectations of managers. The session contains a new section on how to raise concerns and challenge behaviours. We are identifying staff to deliver the training including clinical and medical leaders. Briefing all 700 B6/B7+ managers at the trust in a series of sessions throughout July and August on the staff charter and PACT training. This will set out, clearly, expectations of managers in challenging and dealing with poor behaviours. Launching a reporting tool (piloted in maternity and cardiology). This will be rolled out across the Trust and has input and support from HR, FTSUG, and OD.Staff can report anonymously or 'on the record' and receive support for tackling issues. Marketing campaign – BAD BEHAVIOUR DOESN'T WORK – to go out in the next couple of months, promoting the charter, the reporting tool and highlighting poor behaviours and their impact.									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 2		Workforce The Trust does not effectively manage its risks around staffing levels in both quality and quantity of staff across Trust							
		Inherent Risk Rating		Current Risk Rating				Target Risk Rating	
		4 x 5 = 20		4 x 4 = 16				3 x 4 = 12	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**		**AR**	**Q4 Actions**	**AR**	**Year End Position**
People Strategy Refresh Lets get Started` Induction programmes for RN`s & 'Where Care Begins' for the Nursing Assistants. Keep in touch days for all newly qualified/International Nurses throughout the year Matron late shift (till 10pm Mon – Fri) to visit wards and deliver pastoral care/support to staff Non Registered Development Programme/Induction and Preceptorship Programme Clinical Lead Physiotherapy – Integration of Critical Care and Surgery Therapy Services to create joint services and a shared vision. Work is ongoing to expand the project across the services.									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 3.1		High Quality Care There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' rating							
		Inherent Risk Rating 4 x 4 = 16			Current Risk Rating 4 x 4 = 16			Target Risk Rating 3 x 4 = 12	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
CQC ED1.2: Sepsis training and competencies. Implementation commenced as planned in November 2022. However, sufficient training has not yet been provided. The competency sign off and training started from a 0% position. At the time of writing, this has increased to 62% and is on trajectory for 90% by the end of May 2023. ED3.2: This action was not completed as stated because the staff were moved to H130 as part of opening additional capacity for patients with no criteria to reside. This is remaining under review as part of the gold command meetings. Once the intermediate discharge unit is in place, this action will be reviewed. ED5.4: The task and finish group was up and running from December 2022 as per the action. It was decided to keep this action under review due to the vast amount of work being undertaken. The following actions have been undertaken since the implementation of the digital task and finish group: All ED Digital Nursing Records reviewed and revised, now in live with integrated clinical notes populating clinical record: • ED Safeguarding • Mental Health Triage • ED Nursing Assessment • ED Infection • ED Moving & Handling • Purpose -T [pressure ulcer prevention • SPACES – Intentional rounding • Acuity • Sepsis Introduction of Clinical Dashboards • ED Overview • ED Safety Huddle • ED Sepsis Clinical Escalations is planned to be rolled out in ED by the end of April 2023 [automated escalations of NEWS2 score to ED Safety Dr and ED Safety Nurse] Manchester Triage – currently in test with plan to review mid-April. All of the above work has been supported by appropriate training and support for staff. The following action has been completed as planned; however, there is a further update to add and is reported below.									

ED5.5: This relates to the cohorting of patients waiting with an ambulance crew. This action was completed as planned; however, a further update to this and following the ICB assurance review in ED was for the glass in the Atrium to be frosted, this has now been completed. CQC Trustwide actions TW1: The trust must ensure care and treatment of service users must only be provided with the consent of the relevant person. TW2: The trust must ensure that mandatory training compliance, including training, meets the trust target. TW3: The trust must ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. TW4:The trust must ensure where responsibility for the care and treatment of service users is shared with, transferred to other persons, or working with such other persons, service users and other appropriate persons that timely care planning takes place to ensure the health, safety and welfare of the service users.								

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 3.2		Harm Free Care There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED, Ambulance handovers, Patients with No Criteria to Reside and Mental Health patients require partnership working to determine improvement plans.							
		Inherent Risk Rating			Current Risk Rating			Target Risk Rating	
		5 x 5 = 25			5 x 5 = 25			4 x 4 = 16	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
Transition to PSIRF from April 2023 will transform the approach to patient safety investigations Confirm outstanding competency check requirements for ED staff Continue assurance visits and Safety Oversight Group for February, considering any changes required for ensuring actions are sustained and outcomes achieved. Continue with the close monitoring of the delivery of the fundamentals of care in a timely response Tissue Viability Nurses to review the impact of any delayed skin assessments on patient outcomes Continue with the interim support arrangements from the Deputy Chief Nurse Continually review the impact of the HOB opened on the 13th floor and agree the requirements for a HOB on the Acute Assessment Unit Continue with the plans to introduce the 90 day plan of the ground floor model Continue to raise awareness of and deliver the MCA training Work to continue with the development of the designated mental health assessment area adjacent to ED									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 4		Great Clinical Services There is a risk to access to Trust Services							
		Inherent Risk Rating			Current Risk Rating			Target Risk Rating	
		5 x 5 = 25			4 x 5 = 20			4 x 4 = 16	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
CDU for Nurse Led pathways to be implemented from 22nd May 2023. These pathways historically breach in ECA as awaiting timed treatment/results. Mental Health Streaming facility to open by end of May 2023, expecting to reduce breaches by 1 per day but significantly improve the patient experience. From 10th April 2023 day-time cohorting was provided by HUTH From 10th April 2023, a 2nd Nurse was allocated to work in Initial Assessment to be able to take concurrent handovers. An initial meeting was held on the 27th March 2023 to agree a joint Rapid Programme Improvement supported by both YAS and HUTH QI teams. Date currently being agreed to commence 8 week observation period followed by a 5-day workshop in June/July 2023. This has been delayed YAS have a number of improvement programmes to be prioritised. A trajectory of improvement has been agreed for the percentage of Ambulances released within 30mins of arrival; the target for April 2023 is 53.5%. we delivered 64.9% PSC have been commissioned by the system to provide project support for delivery of a Discharge to Assess (D2A) process. Working groups have begun and are currently exploring current issues for prioritisation. Targeted HG & speciality meetings continue to reduce waiting Internal milestones set to reduce maximum waits									

Mutual aid/in-sourcing and out-sourcing to support the total WLV reduction. Capacity alerts in x6 pressured specialities are live – monitoring arrangements to consider the effectiveness and impact (5x specialities – referral rate reducing, with ENT referral rate flat) Additional support for Gynaecology was prioritised with capacity on-stream in March 2023 and continuing in April, into May 2023. This will be required into Q2. Text validation delivered as a business as usual validation process for the remainder of 2022/23 & into baseline from 2023/24. RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning.								

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 5		Partnerships There is a risk to the development of the ICS and HCCP due to recovery constraints							
		Inherent Risk Rating 4 x 4 = 16		Current Risk Rating 3 x 4 = 12		Target Risk Rating 2 x 3 = 6			
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
Cardiology Cardiac CT working group established and work plan under development NLAG validation to prevent duplicate/repeat echo requests now embedded Agreement to progress with Heart Failure workstream with project team support **Dermatology** Service Strategy approved at FWHG and Medicine Divisional Board Activity profile and baseline metrics for 2022/23 received **ENT** Development of specialty level Delivery Group and Operational Groups to mobilise planned activities Time out to be arranged for HUTH and NLAG clinical, nursing and operational teams. **Gastroenterology** Scoping meetings held with NLAG and HUTH clinicians QIP to review current processes for suspected cancer pathways Pause and review of Humber Clinical Collaborative Programme									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 6		Research and Innovation There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment							
		Inherent Risk Rating			Current Risk Rating			Target Risk Rating	
		4 x 4 = 16			3 x 4 = 12			2 x 4 = 8	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**		**AR**	**Q4 Actions**	**AR**	**Year End Position**
Joint RDI working between HUTH and NLAG Joint strategy to be agreed									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 7.1		Financial Expenditure incurred exceeds income by greater than agreed control total							
		Inherent Risk Rating		Current Risk Rating		Target Risk Rating			
		5 x 4 = 20		4 x 4 = 16		2 x 4 = 8			
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
The Trust has a planned deficit of £7.2m for 2023/24									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 7.2		Financial Sustainability The Trust does not plan or make progress against addressing its underlying financial position over the next 3 years							
		Inherent Risk Rating			Current Risk Rating			Target Risk Rating	
		4 x 5 = 20			4 x 5 = 20			4 x 5 = 20	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
Ongoing development of accountability of Health Groups The Trust started the year with an underlying deficit of £43.5m (assuming ERF and Covid19 income are non-recurrent). Including the level of non-recurrent CRES (£4.4m) and additional in-year pressures has moved this to a position of £51.2m.									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust's control or circumstances outside of Trust's control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

BAF Risk 7.3		Financial Sustainability Failure of critical infrastructure (buildings, IT, equipment) that threatens service resilience and/or viability							
		Inherent Risk Rating			Current Risk Rating			Target Risk Rating	
		4 x 5 = 20			3 x 5 = 15			2 x 5 = 10	
Q1 Actions	**AR**	**Q2 Actions**	**AR**	**Q3 Actions**	**AR**	**Q4 Actions**	**AR**	**Year End Position**	
Capital Plan The initial programme for 2023/24 is an assessment based on a “do minimum” basis and makes provision for base allocations for Medical Equipment (£2.5m); IM&T (£2.5m) and Backlog Maintenance (£2.5m).									

Red	Target risk unlikely to be met – insufficient or ineffective actions taken by Trust.
Amber	Target risk may not be met – actions required outside of Trust’s control or circumstances outside of Trust’s control
Green	On track to achieve target risk rating
Blue	Target risk rating achieved.

Likelihood Score	Impact Score 1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood Descriptions		Score
Rare	This will probably never happen / recur. Not expected to occur for years.	1
Unlikely	Do not expect it to happen / recur but it is possible it may do so. Expected to occur at least annually.	2
Possible	Might happen or recur occasionally. Expected to occur at least monthly.	3
Likely	Will probably happen / recur but it is not a persisting issue. Expected to occur at least weekly.	4
Almost Certain	Will undoubtedly happen / recur, possibly frequently. Expected to occur at least daily.	5

Impact Domains	Impact Score and Examples of Descriptions 1	2	3	4	5
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical / psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality / Equality / Complaints / Audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory Duty / Inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Impact Domains	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Business Objectives / Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including Claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service / Business Interruption / Environmental Impact	Loss/interruption of >1 hour Minimal or no impact on the environment No impact on other services	Loss/interruption of >8 hours Minor impact on environment Impact on other services within the Division	Loss/interruption of >1 day Moderate impact on environment Impact on services within other Divisions	Loss/interruption of >1 week Major impact on environment Impact on all Divisions	Permanent loss of service or facility Catastrophic impact on environment Impact on services external to the Trust
Information Security / Data Protection	Potential breach of confidentiality with less than 5 people affected Encrypted files	Serious potential breach of confidentiality with 6 – 20 people affected Unencrypted clinical records lost	Serious breach of confidentiality with 21 – 100 people affected Inadequately protected PCs, laptops and remote device	Serious breach of confidentiality with 101 – 1000 people affected Particularly sensitive details (i.e. sexual health)	Serious breach of confidentiality with over 1001 people affected Potential for ID theft

FIT AND PROPER PERSONS TEST

REFERENCES

Only PDFs are attached

10.2 - FPPT Report September 2023.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
Title	New Fit and Proper Person Framework 2023				
Lead Director	Simon Nearney, Director of Workforce and OD/Suzanne Rostron, Director of Quality Governance				
Author	Rebeca Thompson, Head of Corporate Affairs				
Report previously considered by (date)	This report has not previously been considered 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 asked to:

- Receive the document relating to the FPPT changes
- Board members are asked note that approval will be required to use their personal data.

Hull University Teaching Hospitals NHS Trust
Trust Board
Fit and Proper Persons Test Framework (FPPT)

1. Purpose

A new Fit and Proper Persons Test Framework has been published by NHS England (August 2023) and this report highlights what is required by the Trust Board.

2. Background

In November 2014, the CQC introduced Regulation 5: Fit and Proper Persons Test. CQC Regulation 5 places a duty on the Trust not to appoint anyone to a post with Board level responsibilities who does not meet their Fit and Proper Persons Test. The Trust applies this test to all new Board appointments and to Trust Directors; the process is carried out by the Trust for Chief/Directors and is started by NHS Improvement (and documented by the Trust) for Non-Executive Directors.

Following recommendations made by Tom Kark KC in his 2019 review of the FPPT, NHS England has developed a new Fit and Proper Person Test Framework. The framework will introduce a means of retaining information relating to testing the requirement of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS Board and extension of the applicability to some other organisation including NHS England and the CQC.

The changes are for all Board members including non-voting members who attend the Trust Board meeting on a regular basis.

3. New Fit and Proper Person Test Framework (August 2023)

Guidance for the new FPPT has been published and is aimed primarily at the Chair of the organisation who has overall accountability for FPPT. The guidance and supporting documents are attached to this report.

It is also aimed at those who will be responsible for implementing, carrying out and signing-off the FPPT. The new details will be recorded on ESR. At the moment the Executive and Non-Executive files are held by HR and the Head of Corporate Affairs respectively.

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). Board members will be written to so that consent for using their data for FPPT purposes can be confirmed. Regional directors will also have sight of them.

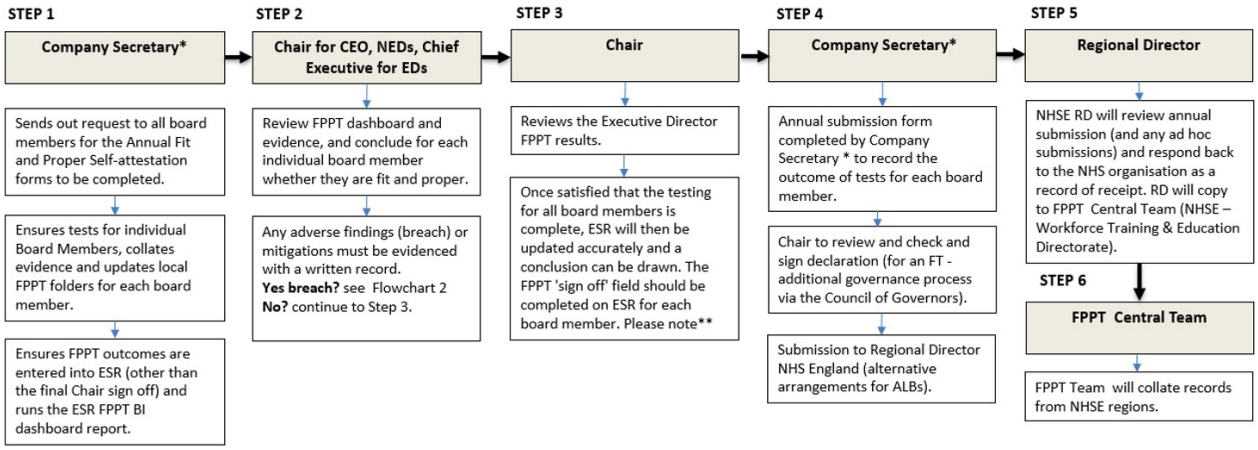
The launch of the Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023. By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary.

The FPPT assessment on initial appointment of a Board member will cover all points mentioned below:

- First name
- Surname
- Organisation (current employer)

- Staff group
- Position title
- Employment history
- Training and development
- References
- Last appraisal and date
- Disciplinary findings
- Any ongoing and discontinued investigations relating to disciplinary/grievance/whistleblowing/employee behaviour
- Type and date of DBS
- Disqualified directors register check
- Date of medical clearance (Occupational Health Assessment)
- Date of professional register check
- Insolvency check
- Self-attestation form signed
- Social Media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference
- Sign off by Chair/CEO

Process
The process for carrying out the FPPT checks is shown in the diagram below.



*Or senior member of staff nominated by and behalf of, the Chair, eg HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
SID = Senior Independent Director
ESR= Electronic Staff Record

Joint Roles
The host Trust of each Executive/Non-Executive Director will carry out the FPPT with the understanding that both HUTH and NLAG's nominated persons will have sight of the Board files.

Reporting Arrangements
Clear reporting arrangements will be in place which will include an annual update to the Board and consideration by the Audit Committee.

4. Recommendation

The Trust Board is asked to:

- Receive the document relating to the FPPT changes
- Board members are asked note that approval will be required to use their personal data.

Rebecca Thompson
Head of Corporate Affairs
August 2023

Classification: Official

Publication reference: PRN00238_i

NHS England Fit and Proper Person Test Framework for board members

2 August 2023

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

In the foreword to his review, Tom Kark KC stated that “The culture and management of each hospital Trust flows from the management team. Thus, the quality and culture of the management team is of the greatest significance to the ethos and success of the hospital, the effectiveness, and the working conditions (in the widest sense) of its staff, and ultimately the care, comfort, and safety of the patients to whom the Trust provides health services.”

The framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

This framework should be read in conjunction with associated guidance documents.

Contents

Section 1: Introduction

1.1 Background

The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This included looking at how effective the FPPT is:

> "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors."

The review highlighted areas that needed improvement to strengthen the existing regime.

The specific recommendations from the Kark Review (2019) have been detailed in Appendix 1.

1.2 Purpose and benefits

This document supports the implementation of the recommendations from the Kark Review, and promotes the effectiveness of the underlying legal requirements by establishing a Fit and Proper Person Test Framework (also known as the 'Framework'). The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

The Framework should be read in conjunction with the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework for leaders at board level. This Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective

appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

The Framework will be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.

Ensuring high standards of leadership in the NHS is crucial – well-led NHS organisations and better-led teams with both strong teamwork and strong governance translate into greater staff wellbeing and better clinical care. This requires accountable board members with both outstanding personal conduct and professional capabilities to effectively oversee NHS organisations that are often under significant financial restraint and operating in a highly regulated environment with public and political scrutiny.

As the FPPT assessment is on an individual basis, rather than in relation to the board as a whole, it is envisaged that aspirant board members who can demonstrate the characteristics described above should not be deterred from seeking to join the board of a more challenged NHS organisation. The FPPT assessment is one of general competence to act as a board member, and situational context should therefore be taken into account.

Ensuring that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

1.3 Applicability

The Framework applies to the board members of NHS organisations. Within this guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments

- those individuals who are called ‘directors’ within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

Within this guidance, the term ‘NHS organisations’ refers to those institutions to which the Framework will apply; for the purposes of this Framework, this includes:

- NHS trusts
- NHS foundation trusts
- integrated care boards (ICBs)
- the following arm’s length bodies in the first instance:
  - Care Quality Commission (CQC)
  - NHS England.

ICB chairs will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members.

1.4 Personal data

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual’s own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

Although, as set out below, NHS England will not have day-to-day access to the system or its content, NHS England recognises that it may be considered a (joint) controller of the ESR fields because as the commissioner of the ESR module and author of the Framework, it has a role in determining the nature and purposes of processing.

The organisations that are uploading the content (and determining what is said about each board member), and the NHS Business Services Authority (as the main commissioner of ESR), will also each be a data controller. For the purposes of Article 26 UK GDPR, NHS England has put in place 'transparent arrangements' to set out its responsibilities in this respect.

NHS England has established that the most relevant lawful basis for processing the FPPT data contained in ESR is set out in Article 6(1)(e) UK GDPR. This is on the basis that the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (that is, the employer, or indeed NHS England in connection with any role it fulfils as a joint controller).

The aim of the maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the organisation concerned.

As special category data would be processed as part of the maintenance of the ESR FPPT data fields, controllers will also rely on one of the lawful bases for processing set out in Article 9 UK GDPR: Articles 9(2)(b) – employment; 9(2)(g) – statutory/public functions; and 9(2)(h) (read with Schedule 1, paragraph 2 of the Data Protection Act 2018). This covers processing that is 'necessary for the management of the health service.'

NHS England recognises the requirements of Article 5(1) UK GDPR, and that personal data should be processed lawfully, fairly and transparently. In line with all other ESR data fields, fair processing information will be available to the users of the ESR system. Current ESR fair processing information can be found in the NHS Electronic Staff Record (ESR) privacy notice. The Framework and related guidance documents also help discharge transparency-related obligations.

Information that is the personal data of the applicant is exempt from the Freedom of Information Act under section 40(1) and any request should be processed under section

7 of the DPA. Regulation 5(3) of the EIR is the equivalent provision and has the same effect.

Arrangements for dispute resolution or request for review of content of data (in ESR and local records), or relating to the FPPT assessment outcome, are set out in the guidance document for chairs.

The launch of the Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023. By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary. An example of a board member FPPT privacy template is attached at Appendix 6. Organisations should ensure that an appropriate policy document is in place in relation to special category data.

Section 2: Context

2.1 Current fit and proper persons regulations

In 2014, the government introduced a 'fit and proper person' requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulations').

This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC, which includes all licence holders and other NHS organisations to which licence conditions apply. For the purposes of this guidance, we have referred to these individuals as 'board members'.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a) the individual is of good character

b) the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed

c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

e) none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland

f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Integrated care boards (ICBs) are statutory bodies with the general function of arranging for the provision of services for the purposes of the health service in England and are NHS bodies for the purposes of the 2006 Act. The main powers and duties of ICBs are to commission certain health services as set out in sections 3 and 3A of the 2006 Act.

ICBs, together with the CQC and NHS England, are within scope of this Framework. One of the recommendations made by Tom Kark KC was to extend the scope of the FPPT into certain arm's length bodies (ALBs) to:

> "…bolster the strength and width of the test, as well as to put a stop to 'the revolving door,' the FPPT should be extended to commissioners as well as other arms-length bodies. It was described as 'incongruous' that it did not apply to commissioners."

2.2 Related principles and values

This section summarises relevant principles and values that underpin the Framework and provide additional context to understand its aims.

2.2.1 NHS Constitution

The NHS Constitution states:

> The NHS belongs to the people.
>
> It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.
>
> It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

2.2.2 NHS guiding principles

The seven guiding principles that govern the way the NHS operates, and define how it seeks to achieve its purpose:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities, and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair, and sustainable use of finite resources.
7. The NHS is accountable to the public, communities, and patients that it serves.

2.2.3 NHS values

These principles are underpinned by the core NHS values, which have been derived from extensive discussions with staff, patients and the public. The values are integral to creating a culture where patients come first in everything the NHS does.

These values are not intended to be limiting. Individual NHS organisations should use them as a basis on which to develop their own values, adapting them to local circumstances. The values should be taken into account when developing services with partner NHS organisations, patients, the public and staff.

The six core values are:

1. Working together for patients.
2. Respect and dignity.
3. Commitment to quality of care.

4. Compassion.
5. Improving lives.
6. Everyone counts.

2.2.4 The Nolan Principles of Standards in Public Life

NHS board members, in their capacity as public office holders, are expected to abide by the 'Nolan Principles' as defined by the Committee on Standards in Public Life:

1. Selflessness
   - Holders of public office should act solely in terms of the public interest.
2. Integrity
   - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.
3. Objectivity
   - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. Accountability
   - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. Openness
   - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
6. Honesty
   - Holders of public office should be truthful.
7. Leadership

- Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Section 3: FPPT Framework

The Framework sets out:

- When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).
- New appointment considerations (section 3.4).
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences (section 3.5).
- The role of the chair in overseeing the FPPT (section 3.6).
- The FPPT core elements to be considered in evaluating board members (section 3.7).
- The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).
- The requirements for a board member reference check (section 3.9).
- The requirements for accurately maintaining FPPT information on each board member in the ESR record[1] (section 3.10).
- The record retention requirements (section 3.11).
- Dispute resolution (section 3.12).
- Quality assurance over the Framework (section 4).

Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation.

Throughout this document and the associated guidance, the term ‘ESR’ refers to the FPPT data fields in ESR. It is important to note that:

- Information held in ESR about board members is accessible by a limited number of senior individuals within their own organisation only.
- There is no access to FPPT information about board members in one organisation by another organisation or individual.

ESR provides a tool for individual organisations to record that testing has been carried out for the chair, who has overall accountability for the FPPT within their organisation. It

[1] For the purpose of the FPPT framework, ‘ESR’ refers to the FPPT data fields in ESR.

also records that testing is complete and enables reports to be run at local level as an audit trail of completed testing and sign off.

ESR is not a public register – there is no access to it by the public/externally. It provides a tool to help support chairs record some of their key FPPT requirements and provides a sign-off facility in one place. It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in the annual report or elsewhere on their websites.

3.1 FPPT overview

The duty to take account of 'fit and proper person' requirements is pervasive, continuous and ongoing. However, for the purposes of the Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis, that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside the annual appraisal.

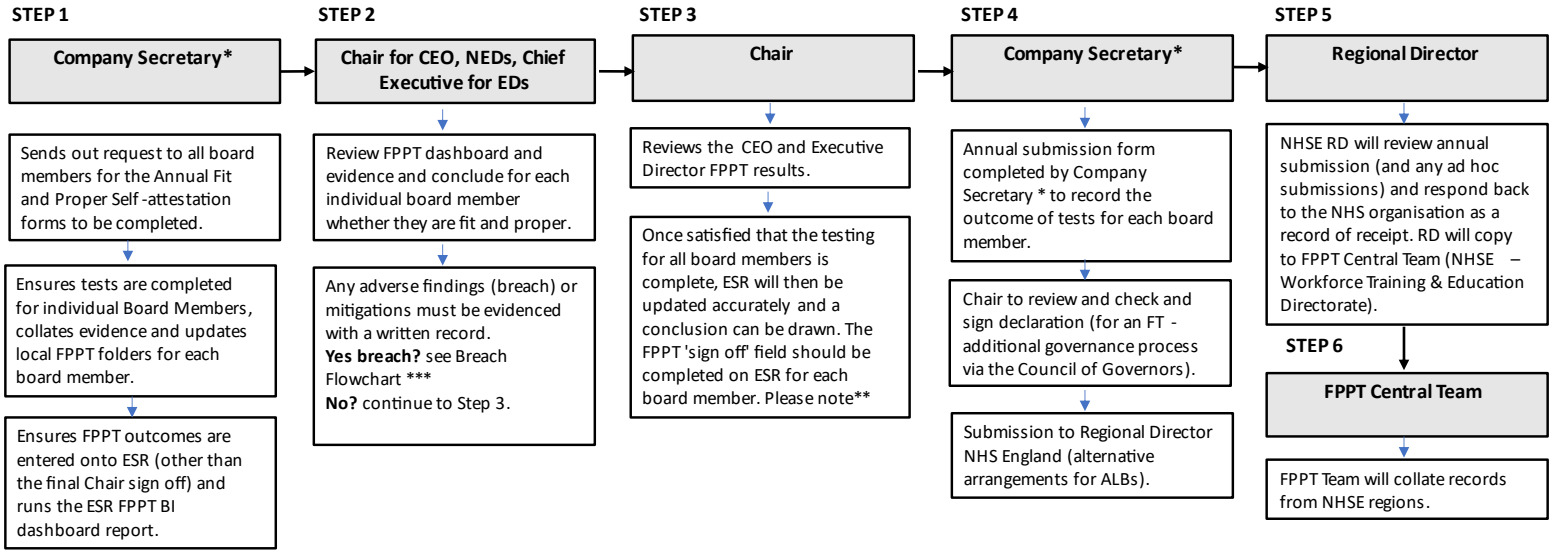
Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper (that is, the board members meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in Schedule 4 of the regulations.

Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes.

As such, the chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT (in line with the list in section 3.2 below) to ensure board members are, and remain, suitable for their role.

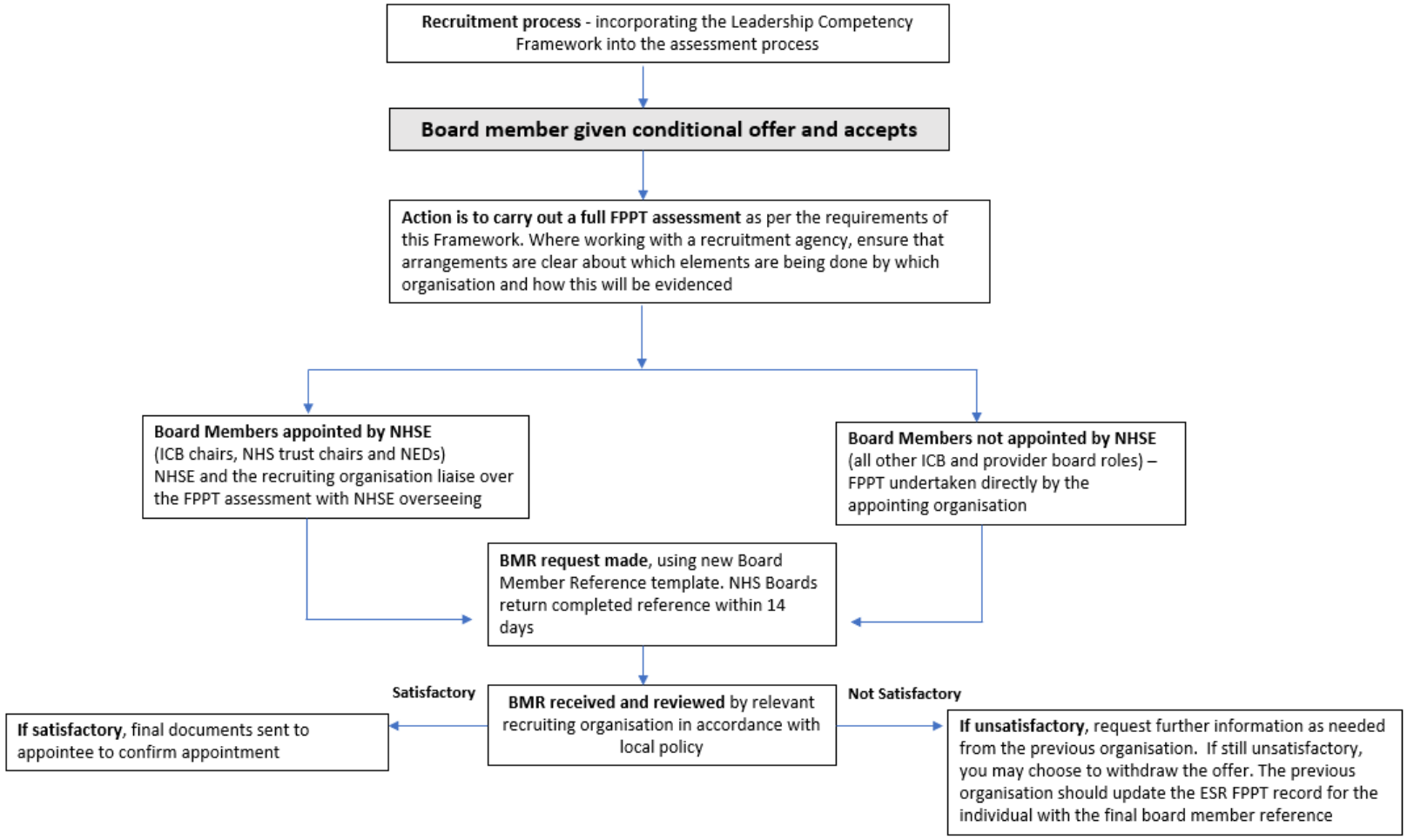
In evaluating a board member's fitness, a decision is expected to be reached on the fitness of the board member that is in the range of decisions that a reasonable person would make. NHS England recognises that chairs will need to make judgements about the suitability of board members and will support balanced judgements made in the spirit of the Framework.

The suggested approach to the assessment, including the Board Member Reference process, is set out in the three flow charts below and is also described in more detail in the supporting chairs' guidance document.

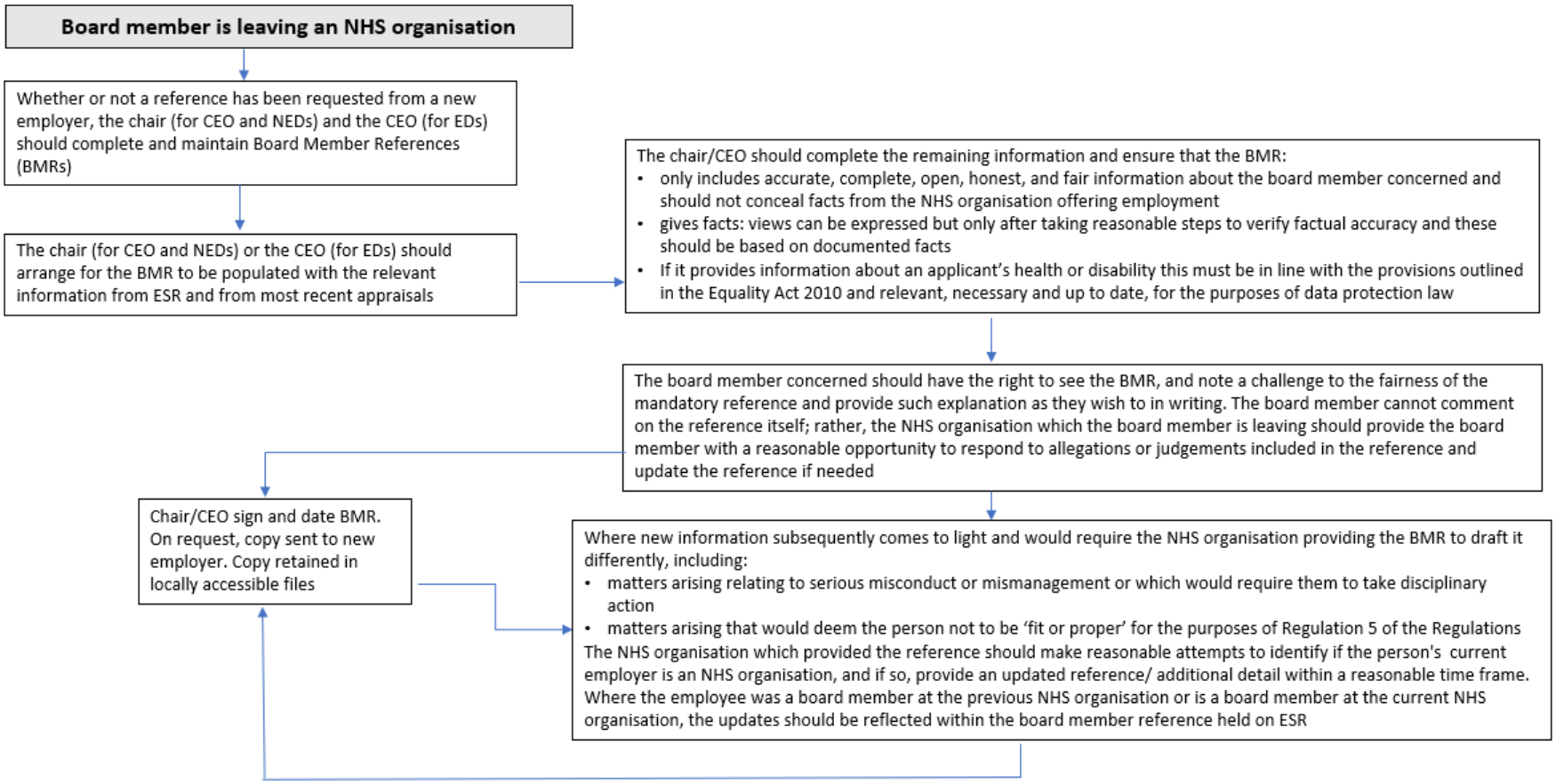


*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

Board Member Reference (BMR) – for appointments



Board Member Reference (BMR) – for leavers



3.2 Full FPPT assessment

A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:
    a. new appointments that have been promoted within an NHS organisation
    b. temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
    c. existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
    d. individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

2. When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, eg chief financial officer).

3. Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points 1a, 1b and 1c above (new appointments) the full FPPT will also include a board member reference check (see section 3.9).

For points 2 and 3 above, the board member reference check will not be needed.

The exact requirements for the initial FPPT assessment versus the annual FPPT assessment thereafter are detailed in section 3.10.1.

3.3 Self-attestation

Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment (see Appendix 3).

3.4 New appointments

NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process.

As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in section 3.7 of this document.

As part of conducting the initial appointment process for a board member, an inter-authority transfer (IAT)[2] could be submitted to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements could be made to collate the relevant information. This should also help identify any potential duplicate employment accounts for the appointee, eg when someone has more than one NHS role on ESR.

For the initial appointment of NHS trust chairs and ICB chairs only, once the NHS organisation has obtained board member references and completed the fit and proper person assessment, FPPT approval should be sought from the NHS England Appointments Team before they commence their role.

3.5 Additional considerations

There will be additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence. These additional considerations have been detailed below.

3.5.1 Joint appointments across different NHS organisations

Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system.

For instance, where joint appointments of a board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care. Joint appointments may occur where:

- two or more NHS organisations want to create a combined role

[2] An IAT is an electronic way of gathering information from an employer for an applicant's previous or current NHS service using the ESR system. How to complete an Inter Authority Transfer (IAT) check in NHS Jobs user guide (nhsbsa.nhs.uk)

- two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role.

In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix 4) to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation(s).

For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

3.5.2 Shared roles within the same NHS organisation

Where two individuals share responsibility for the same board member role (eg a job share) within the same NHS organisation, both individuals should be assessed against the FPPT requirements in line with sections 3.2 and 3.3.

3.5.3 Temporary absence

For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (eg sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same board member. As such there is no requirement to approve another permanent individual for the role of board member.

Where there is a temporary absence, it is expected that the HR director/company secretary will liaise with the chair and chief executive to ensure temporary cover is provided; and to ensure that local internal systems are adequately updated to record the start and projected end date of the temporary absence.

Where an individual is appointed as temporary/interim cover and is not already assessed as fit and proper, the NHS organisation should ensure appropriate supervision by an existing board member.

A full FPPT assessment should be undertaken for an individual in an interim cover role exceeding six weeks. Therefore, if the interim cover is expected to be in post for longer than six weeks, the NHS organisation should look to commence the FPPT assessment as soon as possible. Where the period of temporary absence is extended beyond six weeks, the FPPT assessment should commence as soon as the NHS organisation is aware of the extension. This FPPT assessment should be carried out in line with the requirements under section 3.2.

3.6 Role of the chair in overseeing FPPT

Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees.

In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern.

It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

3.6.1 Overseeing the role of the chair

Chairs will be subject to the same FPPT requirement, as per sections 3.2 and 3.3. In completing their own annual self-attestation, chairs will effectively be confirming that they have adequately addressed points a), b), c), e), f) and h) of section 3.6 above.

The accountability for ensuring that chairs in NHS trusts, foundation trusts and ICBs meet the FPPT assessment criteria will reside with NHS England regional directors, as is also the case for the chairs' annual appraisals.

For the chairs of NHS England and the CQC, this accountability will reside with the Department of Health and Social Care (DHSC).

Annually, the senior independent director (SID) or deputy chair will review and ensure that the chair is meeting the requirements of the FPPT.

If the SID and deputy chair are the same individual, another NED should be nominated to review the chair's FPPT on a rotational basis.

Once the NHS organisation has completed their annual FPPT assessment of the chair, they should sign this off within ESR. The annual FPPT submission, which summarises the results of the FPPT for all board members in the organisation, is then sent to the relevant NHS England regional director.

In relation to foundation trusts, there are no proposed changes to the Council of Governors' responsibilities in relation to the chair's FPPT assessment as it is not within the scope of the Framework to do so. However, as the chairs' annual appraisals are presented to the Council of Governors for information, the same should be the case for a summary of the outcome of the FPPT for non-executive board members.

This information can be retained by the Council of Governors as part of future considerations for any reappointments. Similarly, the Council of Governors should be informed of a satisfactory initial FPPT assessment for new chair and NED appointments.

3.7 FPPT assessment – core elements

This section of the Framework details the core elements that should be included in an FPPT assessment. The checks that underpin the core elements reflect the assessment criteria per Regulation 5 and Schedule 4 of the Regulations.

The full FPPT assessment will constitute an assessment against each of the core elements detailed below and should be conducted in accordance with section 3.2. Individual board members should complete self-attestations to confirm they are fulfilling the core elements of the FPPT assessment, as described below.

NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

- Good character.
- Possessing the qualifications, competence, skills required and experience.
- Financial soundness.

Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the NHS organisation's recruitment and selection procedures and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, Google searches, proof of qualifications, proof of identity, right to work, etc.

The section below, which considers both Regulation 5 and Schedule 4 of the Regulations, explains matters that the NHS organisation should take account of in relation to the three core elements.

When an NHS organisation assesses a board member against these core elements in relation to being a fit and proper person, they should consider the nature, complexity and activities of their NHS organisation.

3.7.1 Good character

There is no statutory guidance as to how 'good character' in Regulation 5 of the 2014 Regulations should be interpreted. Chairs should be aware of the elements to consider when assessing good character (as detailed below).

To encourage openness and transparency, these should not be considered as a strict checklist for compliance, but rather as points for a conversation between the chair (or chief executive for executive board members) and a prospective board member during the appointment process. This will in turn emphasise the ongoing benefits of openness and transparency among board members.

When assessing whether a person is of good character, NHS organisations should follow robust processes to make sure that they gather appropriate information, and must have regard to the matters outlined in Part 1 and Part 2 of Schedule 4, namely:

- Convictions of any offence in the UK.
- Convictions of any offence abroad that constitutes an offence in the UK.
- Whether any regulator or professional body has made the decision to erase, remove or strike off the board member from its register, whether in the UK or abroad.

As such, NHS organisations should conduct:

- A search of the Companies House register to ensure that no board member is disqualified as a director.
- A search of the Charity Commission's register of removed trustees.
- A Disclosure and Barring Service (DBS) check in line with their local policy requirements:
  - each NHS organisation should outline within their local policy the relevant DBS check (basic, standard, enhanced or enhanced with barred lists) required for each individual board member role
  - in defining the required DBS level, NHS organisations should identify those board roles that fall within the definition of a 'regulated activity', as defined by the Safeguarding Vulnerable Groups Act 2006, as required barred list checks.
- A check with the relevant professional bodies where appropriate.

It is not possible to outline every character trait that a person should have, but it is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law.

Furthermore, in considering that a board member is of 'good character,' the relevant NHS organisation should also consider the following in relation to the individual in question:

- Compliance with the law and legal processes.
- Employment tribunal judgements relevant to the board member's history.

- Settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy.
- A person in whom the NHS organisation, CQC, NHS England, people using services and the wider public can have confidence.
- Adherence to the Nolan Principles of Standards in Public Life.
- The extent to which the board member has been open and honest with the NHS organisation.
- Whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate.
- Whether the person has been involved – as a director, partner or concerned in management – with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession.
- Whether the person has been a director, partner or concerned in the management of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection.
- Whether the person involved as a director, partner or concerned with management of a company has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately.
- Any other information that may be relevant, such as an upheld/ongoing or discontinued (including where a board member has left the NHS organisation prior to an investigation being completed):
  - disciplinary finding
  - grievance finding against the board member
  - whistleblowing finding against the board member
  - finding pursuant to any trust policies or procedures concerning board member behaviour.

3.7.1.1 Serious mismanagement or misconduct

To comply with Regulation 5, consideration of good character should also ensure, as far as possible, the individual has not been responsible for, contributed to or facilitated any

serious misconduct or mismanagement (whether unlawful or not) in the course of delivering CQC-regulated activity, in England or equivalent activities elsewhere.

In determining what amounts to 'serious misconduct or mismanagement,' beyond the decision by a court or professional regulators regarding individuals, context is paramount. Normally these would require to be findings of serious misconduct or mismanagement that are upheld after a disciplinary process.

NHS organisations should consider the mismanagement and misconduct behaviours in relation to the services they provide, the role of the board member/individual and the possible adverse impact on the NHS organisation or confidence in its ability to carry out its mandate and fulfil its duties in the public interest.

As part of reaching an assessment as to whether any actions or omissions of the board member amount to 'serious misconduct or mismanagement', NHS organisations should consider whether an individual board member played a central or peripheral role in any wider misconduct or mismanagement.

The NHS organisation should also consider whether there are any aggravating or mitigating factors; for instance (including but not limited to):

- The extent to which the conduct was deliberate and reckless.
- The extent to which the conduct was dishonest.
- Whether the issues are frequent or have continued over a long period of time.
- If lack of experience contributed to the issue that has been remediated through training.
- The extent to which the board member (or aspirant board member) demonstrates insight and self-reflection in relation to the conduct/issues identified.

Although NHS organisations have information on when convictions, bankruptcies or similar matters are to be considered 'spent', there is no time limit for considering serious misconduct or responsibility for failure in a previous role, for the purposes of Regulation 5.

Below are some examples of misconduct and mismanagement that NHS organisations would be expected to conclude as amounting to serious misconduct or

mismanagement, unless there are exceptional circumstances that make it unreasonable to determine that there is serious misconduct or mismanagement.

It is impossible to produce a definitive list of all matters that would constitute serious misconduct or mismanagement and, as such, the list below is not exhaustive.

This list sets the minimum expectations and should be read in conjunction with local policy expectations/requirements to determine whether or not a board member has been involved in serious misconduct or mismanagement:

- Fraud or theft.
- Any criminal offence other than minor motoring offences at work (although this and the issues set out in this section may be relevant to assessing whether an individual is of good character more generally).
- Assault.
- Sexual harassment of staff.
- Bullying or harassment.
- Discrimination as per the Equality Act 2010.
- Victimisation (which falls within the scope of the Equality Act 2010) of staff who raise legitimate concerns.
- Any conduct that can be characterised as dishonest, including:
  - deliberately transmitting information to a public authority or to any other person, which is known to be false
  - submitting or providing false references or inaccurate or misleading information on a CV.
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues.
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies or accepted practices.
- Continued failure to develop and manage business, financial or clinical plans.

In assessing whether misconduct or mismanagement was ‘serious’, regard should be had to all the circumstances. For instance, an NHS organisation could consider isolated

incidences of the following types of behaviour to amount to misconduct or mismanagement that does not reach the threshold of seriousness:

- Intermittent poor attendance.
- Failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects or were for a benevolent or justifiable purpose.

3.7.2 Qualifications, competence, skills required and experience

NHS organisations need to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required.

For instance, where possible, checking the websites of the professional bodies to confirm that where required the board member holds the relevant and stated qualification.

Where NHS organisations consider that a board member role requires specific qualifications (for example, the chief financial officer being an accredited accountant, or the chief medical officer being a GMC-registered doctor), they should make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional body.

As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships. These should be reviewed to ensure that they are appropriate and tailored for each board role.

In assessing competence, skills and experience for the purposes of the FPPT, the NHS organisation should look to use the outcome of their appraisal processes for board members, which will be based on the NHS Leadership Competency Framework (LCF) for board level leaders: a framework that will apply to all NHS organisations.

Given the appraisal process will feed into the full FPPT assessment, the appraisal process should be of an appropriate frequency and should give due consideration to assessing good character and conduct (that is, a behavioural assessment).

The NHS LCF provides guidance for the competence categories against which a board member should be appointed, developed and appraised. The LCF covers the following six competence categories:

- Setting strategy and delivering long term transformation.
- Leading for equality.
- Driving high quality, sustainable outcomes.
- Providing robust governance and assurance.
- Creating a compassionate and inclusive culture.
- Building trusted relationships with partners and communities.

In assessing whether a board member has the competence, skills and experience to be considered fit and proper, the FPPT assessment will:

- not just consider current abilities, but also have regard to the formal training and development the board member has undergone or is undergoing
- take account of the NHS organisation (its size and how it operates) and the activities the board member should perform
- consider whether the board member has adequate time to perform and meet the responsibilities associated with their role.

Regarding formal training:

- NHS organisations should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
  - As such, a tailored learning development plan and training framework should support board members.
  - Both the development plan and training should be updated and delivered respectively with an appropriate frequency.

- Training constitutes continued development for board members.
  - Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures.
  - In turn, this may mean that a board member is not fit and proper.

3.7.2.1 Reasonable adjustments

In assessing if a board member can properly perform tasks to the requisite level of competence and skill for the office or position for which they are appointed,

consideration will be given to their physical and mental health in accordance with the demands of the role and good occupational health practice.

This means all reasonable steps must be made to make adjustments for people to enable them to carry out their role. As a minimum, these must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010; to prevent discrimination as defined by the Act.

Hence when appointing a person to a role, NHS organisations should have processes for considering their physical and mental health in line with the requirements of the role.

As such, NHS organisations should undertake occupational health assessments (OHA) for potential new board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks (eg medical assessment questionnaire).

The results of the OHA should be evaluated, and relevant reasonable adjustments should be made in line with the requirements under the Equality Act 2010, so an individual can carry out their role.

While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process checks to ensure that the NHS organisation can demonstrate that they have taken account of and made any such reasonable adjustments for those in board member roles. This obligation is ongoing in relation to those with disabilities for the purposes of the Equality Act 2010.

The statutory duty to make reasonable adjustments must be considered on an ongoing basis and applies where a disabled person is put at a substantial disadvantage.

3.7.3 Financial soundness

NHS organisations must seek appropriate information to assure themselves that board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulations.

Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.

3.8 Breaches to core elements of the FPPT (Regulation 5)

Regulation 5 will be breached if:

1. A board member is unfit on the grounds of character, such as:
   - an undischarged conviction
   - being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries
   - being prohibited from holding a relevant office or position (see section 3.7.1).

2. A board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity.

3. A board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.

4. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.

5. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.

6. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

With regards to the above points, it is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications.

In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director (Appendix 5 part 2).

Furthermore, there may be a limited number of exceptional cases where a board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member.

In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises.

The NHS organisation shall determine breaches based on points 1 to 4, whereas any regulatory inspections, such as a CQC inspection will determine breaches of points 5 and 6.

3.9 Board member references

3.9.1 Content of the references

A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS.

The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

The Leadership Competency Framework will help inform the ‘fitness’ assessment in FPPT. This is in line with the Kark Review’s (2019) recommendations on professional standards.

The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives.

The competency domains in the Leadership Competency Framework should be taken into account when the board member reference is written. It is recognised that no board director will be able to demonstrate how they meet all the competencies in the framework. What is sought as part of the board member reference is evidence of broad

competence across each of the six competency domains, and to ensure there are no areas of significant lack of competence which may not be remedied through a development plan.

Board level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This attestation will be reviewed by the board director's line manager and overseen by the organisation's chair. The attestation record will be captured on ESR.

The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. (A board member appraisal framework will be published ahead of the 2023/2024 appraisal process to support this process.) The annual appraisals of the past three years will then be used to guide the board member's reference.

NHS organisations will need to request board member references, and store information relating to these references (see section 3.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.
b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

It is important that board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. In particular, the process should be undertaken fairly, and the information generated should be accurate and up to date.

Requests for board member references should not ask for specific information on whether there is a settlement agreement/non-disclosure agreement in place.

The board member reference request instead asks for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Information on settlement agreements should be retained locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question.

If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations should seek permission from all parties prior to including any such information in a board member reference.

Going forward, NHS organisations should consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence.

The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be a board member.

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

- Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).

- Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct.

- Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

Investigations (irrespective of reason for discontinuance) should be limited to those which are applicable and potentially relevant to the FPPT, and examples are as follows (this is not an exhaustive list and consideration will be needed on a case-by-case basis):

- Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework).
- Reckless mismanagement which endangers patients.
- Deliberate or reckless behaviour (rather than inadvertent behaviour).
- Dishonesty.
- Suppression of the ability of people to speak up about serious issues in the NHS, eg whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals.
- Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, eg falsification of records or relevant information.

The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request i.e., as part of any disciplinary procedures/action. NHS organisations should develop local policy about who provides references, when they are provided and what will/will not be included.

NHS organisations should take any advice that they deem necessary in an individual case where they have assessed that the employee or prospective employer is likely to bring a claim.

3.9.2 Obtaining references

At least one board member reference should be obtained when an NHS organisation is appointing a board member.

- For board members:
  - An NHS organisation should obtain a minimum of two board member references (using the board member reference template) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time.
  - These two references should come from different employers, where possible.

- For an individual who moves from one NHS board role to another NHS board role, across NHS organisations:
  - Where possible one reference from a separate organisation in addition to the board member reference for the current board role will suffice.
  - This is because their board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when a board member departs.

- For a person joining from another NHS organisation:
  - The new employing/appointing NHS organisation should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years.
  - These references should establish the primary facts as per the board member reference template.

- Where an employee is entering the NHS for the first time or coming from a post which was not at board member level:

- The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements.
- In this scenario, the NHS organisation will determine their own reasonable steps to satisfy themselves they have pursued relevant avenues to obtain the information on potential incoming individuals through alternative means.
- For example, if a chief financial officer is joining from financial services, they can check the financial services register, or request for a mandatory reference under the financial services regulations.

It is acknowledged that where the previous employer is not an NHS organisation, there may be greater difficulty in obtaining a standardised NHS board member reference.

Nonetheless, for new appointments from outside of the NHS, employers should seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made.

In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought. Character and personal references should be sought from personal acquaintances who are not related to the applicant, and who do not hold any financial arrangements with that individual.

References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process.

NHS organisations should aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and/or, where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role.

If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

An NHS organisation should obtain references before the start of the board member's appointment. The NHS organisation requesting the reference should make it clear that this is being requested in relation to a person being appointed to the role of board member, or for other purposes linked to the board member's current employment.

The obligation to obtain a reference for a potential candidate for employment/ appointment in the role of board member applies irrespective of how the previous employment ended, for instance, resignation, redundancy, dismissal or fixed term work or temporary work coming to an end.

Where a potential candidate for employment/appointment in the role of board member has a gap between different employments, all reasonable efforts should be made to ensure that references covering those periods/gaps are obtained.

References should be obtained in writing (either via hardcopy or email) and NHS organisations will need to satisfy themselves that both the referee and the organisation are bona fide.

From time to time the information provided in a reference may contradict the information provided by board members.

There may be a reasonable explanation for apparent discrepancies and NHS organisations should proceed sensitively to seek the necessary assurances directly with the board member. In exceptional circumstances where there is serious misdirection, employers may feel it appropriate to report their concerns to the NHS Counter Fraud Authority.

Where an NHS organisation is unable to fully evidence that the incoming board member is fit and proper because of gaps in the board member reference, they may continue to hire the individual but should clearly document within ESR the gaps in relation to the board member reference and the reasons/mitigations for being comfortable with employing/appointing the board member.

In this scenario, the employing NHS organisation also should be able to demonstrate that they have exercised all reasonable attempts to obtain the missing information.

3.9.3 Providing references

An NHS organisation should aim to provide a reference to another NHS organisation within a 14-day period, which starts from the date that the reference request was

received. However, it should be acknowledged thar there are occasions of exceptional circumstances, and references may take more than 14 days to provide.

The references referred to above are for a request made in relation to the individual being appointed to the role of board member, or for other purposes linked to the board member's current employment.

Where a current board member moves between different NHS organisations, a board member reference form following a standard format (Appendix 2) should be completed by the employer and signed off by the chair of that NHS organisation.

The previous NHS organisation should provide information in relation to that which occurred:

- in the six years before the request for a reference
- between the date of the request for the reference and the date the reference is given
- in the case of disciplinary action, serious misconduct and/or mismanagement at any time (where known).

NHS organisations should also consider when providing the reference:

- That the process captures accurate, complete, open, honest and fair information about the board member concerned.
  - As such, references should not conceal facts from the NHS organisation offering employment.
- References should give established facts that are part of the history of the person.
  - It is unfair to give partial facts if those result in the offer being withdrawn, for example where this causes the recipient NHS organisation to assume the information is missing because it is negative, so the offer is withdrawn.
  - Views can be expressed but only after taking reasonable steps to verify factual accuracy and should be based on documented facts.
- The reference should be fair, such that the employee concerned should have the right to note a challenge to the fairness of the mandatory reference and provide such explanation as they wish to in writing.
  - This does not mean that the board member can comment on the reference itself; rather, that the NHS organisation (which the board member is leaving)

has provided those board members with a reasonable opportunity to respond to allegations or judgements upon which the reference is based.

  - Hence a board member's opinions are not required to be included within the reference, but should be appropriately considered when drafting them.
  - Where the NHS organisation providing the reference has not offered the employee the opportunity to previously (at the time the matter occurred) comment on the allegation, they ought to do so before including that allegation within the reference, rather than leaving the allegation out of the reference.
- Where the reference provides information about an applicant's health or disability this must be in line with the provisions outlined in the Equality Act 2010 and be relevant, necessary, and up to date, for the purposes of data protection law.

3.9.4 Revising references

If an NHS organisation has provided a reference to another NHS organisation about an employee or former employee, and has subsequently:

- become aware of matters or circumstances that would require them to draft the reference differently
- determined that there are matters arising relating to serious misconduct or mismanagement
- determined that there are matters arising which would require them to take disciplinary action
- concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations,

the NHS organisation that provided the reference should make reasonable attempts to identify if the person's[3] current employer is an NHS organisation and, if so, provide an updated reference/additional detail within a reasonable timeframe.

Where the employee was a board member at the previous NHS organisation or is a board member at the current NHS organisation, the updates should be reflected within the board member reference.

[3] For the avoidance of doubt, this refers to executive board members employed by an NHS organisation and non-executive board members who have been appointed.

Revised references between NHS organisations should cover a six-year period from the date the initial board member reference was provided, or the date the person ceased employment with the NHS organisation, whichever is later. The exception to this are matters that constitute serious misconduct or mismanagement: details of such events should be provided irrespective of time period.

3.9.5 Board member reference template

The board member reference template provided should be used by NHS organisations.

This Framework, along with the board member reference template, sets out the minimum requirements for a reference. An NHS organisation can provide information in relation to additional matters if it deems it necessary to do so.

If references are provided for the role of board member, or for other purposes linked to the board member's current employment, the NHS organisation providing the reference should look to complete all sections of the template even where the NHS organisation requesting the reference does not specifically ask for it.

As mentioned previously, NHS organisations should maintain board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.

Therefore, the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire.

Often in these circumstances the individual may go on to act in the capacity of a board member at a future date, even if it is just on a temporary basis, for example to cover staff shortages.

3.10 Electronic Staff Record (ESR)

NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care.

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

ESR will hold information about each board member in line with the criteria detailed below in section 3.10.1.

NHS England will use its network of regional directors in a direct oversight role to ensure that individual NHS organisations (within the designated regions) are completing their FPPT, via annual submissions to the NHS England regional directors.

The CQC will continue in its regulatory role and as such may determine that reviews are required over the data integrity and controls that a particular NHS organisation has in relation to the records held in ESR.

There should be limited access to ESR in accordance with local policy and in compliance with data protection law. It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

- chair
- chief executive officer (CEO)
- senior independent director (SID)
- deputy chair
- company secretary
- human resources director (HRD)/chief people officer (CPO).

Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The ESR FPPT data fields need to be maintained to ensure information about the serving board member is current. This will mean that ESR is specifically updated for:

- all board members within an NHS organisation
- new board members who have been appointed within an NHS organisation
- whenever there has been a relevant change to one of the fields of FPPT information held in ESR (as per section 3.10.1 below)
- updates for annual completion of the full FPPT
- annual completion of FPPT confirmed by chairs.

It will be the responsibility of each NHS organisation to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum it is expected

that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation.

NHS organisations will need to establish policies and procedures for collating the relevant information in an accurate, complete and timely manner for updating ESR.

NHS organisations will need to establish a process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law.

3.10.1 Information held in ESR

The information that ESR will hold about board members is detailed below and also summarised in the FPPT checklist.

The supplementary guidance document provides specific step-by-step instructions for NHS organisations to update and maintain ESR.

The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name*
- Second name/surname*
- Organisation* (that is, current employer)
- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
  - This would include detail of all job titles, organisation departments, dates, and role descriptions.
  - Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- Training and development
- References:*

  - Available references from previous employers, board member references, including resignations or early retirement.
- Last appraisal and date
- Disciplinary findings
  - That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
- Date DBS received* †
- Disqualified directors register check
- Date of medical clearance* (including confirmation of OHA)
- Date of professional register check (eg membership of professional bodies)
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference*
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

The annual FPPT requires an NHS organisation to validate all fields above – except for:

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

† While not requiring annual validation, DBS checks will be done on a three-year cycle.

3.11 Record retention

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by each individual NHS organisation.

As such, an NHS organisation should establish, implement and maintain adequate policies and procedures to comply with GDPR and the NHS Records Management Code of Practice.

The NHS Records Management Code of Practice sets out expectations in relation to retaining actual staff documents/records for a period of six years.

However, NHS organisational case documents/records may be retained for longer than the standard six years, based on the facts of the case. This will be a local decision for each NHS organisation.

When determining how long to retain documents/records in relation to disciplinary and similar cases and where applicable, NHS organisations should make an assessment as to the severity of the misconduct and/or mismanagement and its impact to the FPPT. The more serious the issue the longer the retention period should be.

In relation to ESR, the information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the board member.

3.12 Dispute resolution

1. Data and information

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and NEDs and ICB Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the SID or deputy chair who would establish a process proportionate to

the matter being considered; for example, establishing a panel with at least one independent member.

- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
  - referring the matter to the ICO
  - (For executive director roles only*) taking the matter to an employment tribunal (ET)
  - instigating civil proceedings.

2. Outcome of FPPT assessment

Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
  - Where this results in a board member being terminated from their appointed role, a BMR** must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
  - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

At any point, employees have the right to take the matter to an ET*.

* Chair and non-executive board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.

** Exit BMR to be drafted by local chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.

Section 4: Quality assurance and governance

To ensure that the FPPT is being adequately embedded within NHS organisations there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

4.1 CQC quality assurance

The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

- quality of processes and controls supporting the FPPT
- quality of individual FPPT assessments
- board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
- collation and quality of data within the database and local FPPT records.

In doing so the CQC will have regard to the evidence that exists as to whether the board members meet the FPPT. For example, this includes, but is not limited to, checking the following forms of evidence:

- That the NHS organisation in question is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice.
- Personnel files of recently appointed board members (including internal appointments of existing staff).
- Information or records relating to appraisals for board members.
- References and personal development plans.

The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of a board member to the relevant NHS organisation.

The CQC will notify NHS organisations of all concerns relating to their board member and ask them to assess the information received. The board member to whom the case refers will also be informed.

NHS organisations should then detail the steps they have taken to assure the fitness of the board member and provide the CQC with a full response within 10 days. The CQC will then carefully review and consider all information.

Where the CQC finds that the NHS organisation's processes are not robust, or an unreasonable decision has been made, they will either:

- contact the NHS organisation for further discussion
- schedule a focused inspection
- take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

4.2 NHS England quality assurance

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

4.3 Internal audit/external review

Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews.

4.4 Governance

For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme

- relevant information to the Council of Governors (CoG) in an NHS foundation trust as described in section 4.5 below.

4.5 NHS foundation trusts – appointment and removal of the chair and non-executive directors

The document 'Your statutory duties- A reference guide for NHS foundation trust governors' refers to the role of the CoG in appointing and removing the chair and NEDs. The FPPT Framework should be considered alongside this document and the local trust constitution. The CoG in an NHS foundation trust:

- Should continue to make chair and NED appointments in accordance with their statutory duties and local constitution. These continue to be subject to satisfactory recruitment checks, and this will now include consideration of the initial FPPT assessment.
- Should continue to '…receive performance information for the chair and other non-executive directors as part of a rigorous performance appraisal process …' in accordance with their local constitution. Performance appraisals will now include application of the LCF in accordance with the Framework.
- Should be advised of any outcome from a non-executive board member (including the chair) FPPT assessment as 'not fit and proper.' Dependent on the circumstances and in accordance with the local constitution, the CoG would be involved as appropriate with any subsequent removal process, where applicable.

The CoG should receive support from the SID and/or the company secretary and use the governance arrangements already in place in their trusts, such as the nomination committee.

4.5 Integrated care boards

ICBs should apply the Framework alongside relevant statutory requirements and the existing requirements of their organisation's constitution.

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

This publication can be made available in a number of alternative formats on request.

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Appendix 1: Recommendations from the Kark Review (2019)

This appendix is part of the NHS England Fit and Proper Person Test Framework for board members (https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/).

Publication (/publication)

Content

The table below summarises the recommendations in the Kark Review (2019), and the response from the Secretary of State (SofS) for Health and Social Care.

	Recommendations	**SofS response**
1	All directors should meet specified standards of competence to sit on the board of any health-providing organisation. Where necessary, training should be available.	Accepted
2	That a central database of directors should be created to hold relevant information about qualifications and history.	Accepted
3	A mandatory reference requirement for each director should be introduced.	Accepted
4	The FPPT should be extended to all commissioners and other appropriate arm's length bodies.	Accepted

5	The power to disbar for serious misconduct.	Not accepted
6	Remove the words ‘privy to’ from regulation.	Accepted
7	Examine how FPPT works in social care.	Not accepted

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Appendix 2: The board member reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)

B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS**	Yes □	No □

• **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 3: New starter/annual NHS FPPT self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to [complete as applicable, eg the company secretary] on behalf of the chair.

Fit and Proper Person Test annual/new starter* self-attestation

[NAME OF NHS ORGANISATION]

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Appendix 4: Letter of confirmation

The following wording is given as an example. It may not be applicable in every case and may consequently need addition or amendment. For example, a confirmation at the time of initial appointment may be different to the annual core testing.

[**LEAD EMPLOYING ORGANISATION**[1] **LETTERHEAD**]

[**DATE**]

Dear [**CHAIR NAME**[2]],

Fit and Proper Person Test

This confirmation letter is provided in connection with [**name of board member, job title of board member, organisations that the joint board member post covers**] for [**year of test, eg 2023/24**] as at [**date of conclusion of annual**[3] **FPPT for the individual**] for the purpose of the Fit and Proper Person Test.

As Chair of [**lead employer**], I confirm that I have carried out the Fit and Proper Person Test for [**name of board member**].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [**name of board member**] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework.

In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [**name of board member**] is fit and proper as at [**date of conclusion of test**], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

---

[1] This is the organisation which holds the contract/employs the board member who works jointly across more than one organisation.
[2] This is the name of the chair of the other organisation that the joint board appointment is made with.
[3] It should be noted that while there will be an annual assessment of being fit and proper, it is a pervasive and ongoing process at all times. Any relevant matter related to the board member being fit and proper should be reported as soon as it arises.

I confirm that I have received the outcome for the FPPT for [**name of board member**] and that I have provided any necessary information for you to reach this conclusion.

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: FPPT outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:		
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:		
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				
Chair signature:				
Date signed:				

For the regional director to complete:	
Name:	
Signature:	
Date:	

Appendix 6: Template Board Member FPPT Privacy Notice

[organisation name] is required to provide you with details on the type of personal information which we collect and process. In addition to any other privacy notice which we may have provided to you, this notice relates to the information collected and processed in relation to the FPPT.

The FPPT in ESR is commissioned by NHS England.

Contact:	[name in organisation who leads on this, eg SIRO]
Address:	[for the person or team above]
Phone Number	[for the person or team above]
E-mail:	[for the person or team above]

The type of personal information we collect is in relation to the FPPT for board members and is described below, much of which is already collected and processed for other purposes than the FPPT:

1. Name, position title (unless this changes).
2. Employment history – This would include detail of all job titles, organisation, departments, dates, and role descriptions.
3. References.
4. Job description and person specification in their previous role.
5. Date of medical clearance.
6. Qualifications.
7. Record of training and development in application/CV.
8. Training and development in the last year.
9. Appraisal incorporating the leadership competency framework has been completed.

10. Record of any upheld, ongoing or discontinued disciplinary, complaint, grievance, adverse employee behaviour or whistle-blow findings.

11. DBS status.

12. Registration/revalidation status where required.

13. Insolvency check.

14. A search of the Companies House register to ensure that no board member is disqualified as a director.

15. A search of the Charity Commission's register of removed trustees.

16. A check with the CQC, NHS England and relevant professional bodies where appropriate.

17. Social media check.

18. Employment tribunal judgement check.

19. Exit reference completed (where applicable).

20. Annual self-attestation signed, including confirmation (as appropriate) that there have been no changes.

Processing of this data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller.

For CQC-registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.

How we get the personal information and why we have it

Most of the personal information we process is provided to us directly by you as part of your application form and recruitment to satisfy recruitment checks and the FPPT requirements.

[If applicable] We may also receive personal information indirectly, from the following sources in the following scenarios:

- References when we have made a conditional offer to you.
- Publicly accessible registers and websites for our FPPT.
- Professional bodies for FPPT to test registration and or any other 'fitness' matters shared between organisations.
- Regulatory bodies, eg CQC and NHS England.

We use the information that you have given us to:

- conclude whether or not you are fit and proper to carry out the role of board director
- inform the regulators of our assessment outcome.

We may share this information with NHS England, CQC, future employers (particularly where they themselves are subject to the FPP requirements), and professional bodies.

Under the UK General Data Protection Regulation (UK GDPR), the lawful bases we rely on for processing this information are:

- We need it to perform a public task.

How we store your personal information

Your information is securely stored. We keep the ESR FPPT information including the board member reference, for a career long period. We will then dispose of your information in accordance with our policies and procedures [insert].

Your data protection rights

Under data protection law, you have rights including:

- Your right of access – You have the right to ask us for copies of your personal information.

- Your right to rectification – You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- Your right to erasure – You have the right to ask us to erase your personal information in certain circumstances.
- Your right to restriction of processing – You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- Your right to object to processing – You have the right to object to the processing of your personal information in certain circumstances.
- Your right to data portability – You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.
- You are not required to pay any charge for exercising your rights. If you make a request, we have one month to respond to you.

Please contact us at [insert email address, phone number and or postal address] if you wish to make a request.

How to complain

If you have any concerns about our use of your personal information, you can make a complaint to us at [Insert your organisation's contact details for data protection queries]. You can also complain to the ICO if you are unhappy with how we have used your data.

The ICO's address

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Helpline number: 0303 123 1113 ICO website: https://www.ico.org.uk

Appendix 7: FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/Surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff Group	✓	x	✓	x – unless change	✓	✓		
Job Title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation Code	✓	x	✓	x – unless change	✓	✓		
Position Title	✓	x	✓	x – unless change	✓	✓		
Employment History Including: • job titles • organisation/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and Development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role
Last Appraisal and Date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS Disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received	✓	✓	✓	✓	✓	✓	ESR	
Date of Medical Clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of Professional Register Check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	Eg NMC, GMC, accountancy bodies.	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Insolvency Check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register Check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a Charity Trustee Check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement Check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social Media Check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

FREEDOM TO SPEAK UP GUARDIAN

REFERENCES

Only PDFs are attached

10.3 - FTSUG 2023 2024 Q1 Trust Board.pdf

Agenda Item		Meeting	Trust Board	Meeting Date	12th September 2023
Title	Freedom to Speak Up Guardian report – Quarter 1 2023/2024				
Lead Director	Suzanne Rostron, Director of Quality Governance				
Author	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 Quarter 1 2023/2024 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 Quarter 1 2023/2024

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 and/or volunteers through HUTH's FTSUG during Quarter 1 (Q1) of the 2023/2024 year, including an overview of themes and the activities undertaken by the 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 organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at HUTH in place that allow staff to raise concerns. These include:

- Line manager or senior manager
- FTSUG
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Counter Fraud Plus (CFP) Team

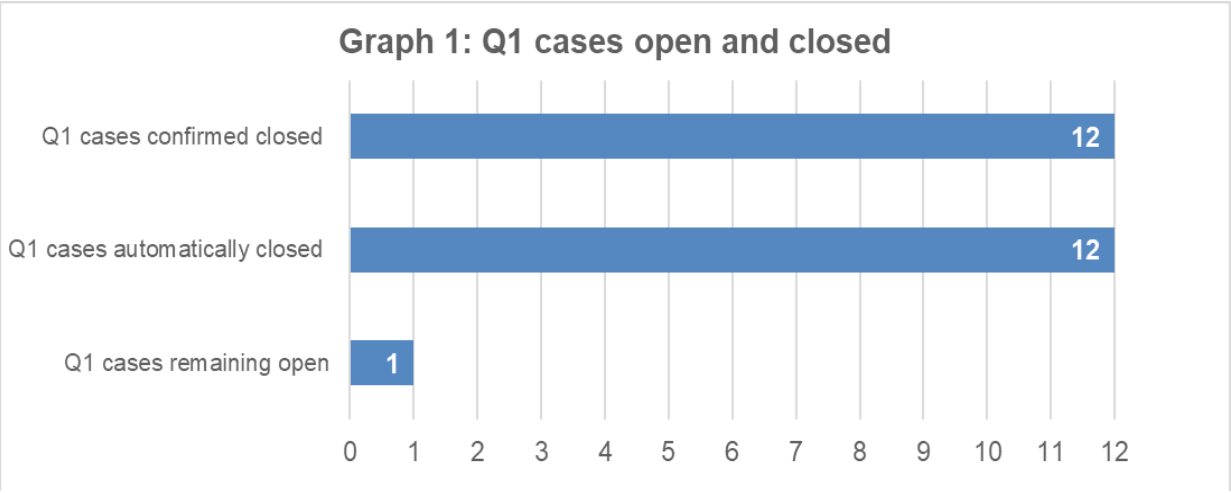
There are other routes as ways in which staff can receive support if they are experiencing difficulties at work, for example Occupational Health and other staff support services.

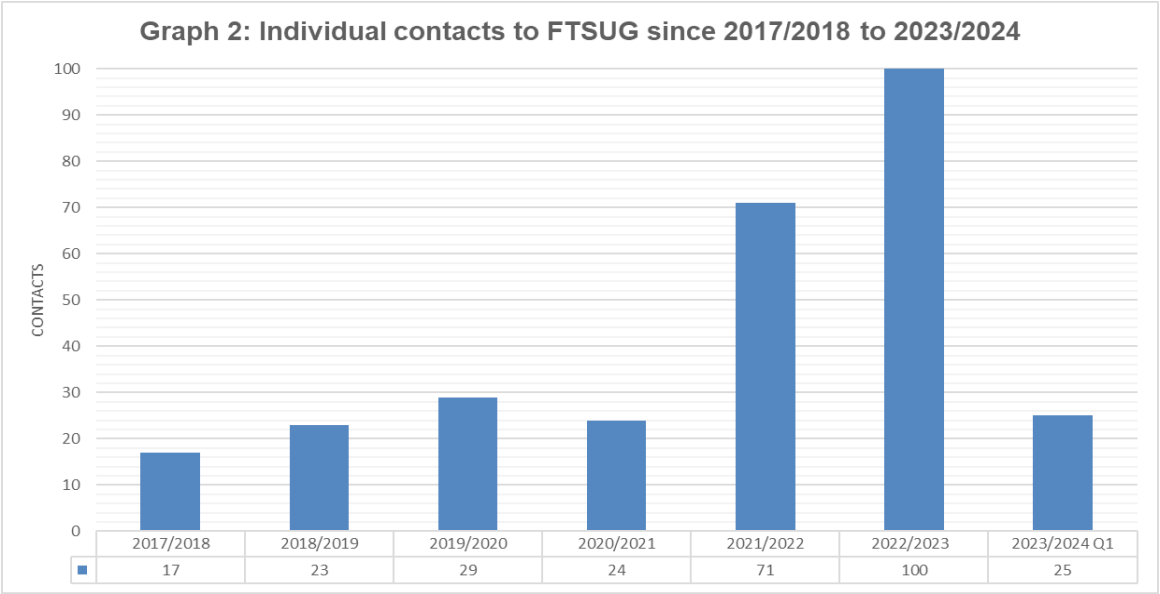
In addition, professional organisations such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) also issue guidance which sets out the expectations on healthcare professionals to take appropriate action to raise concerns about patient care, dignity and safety.

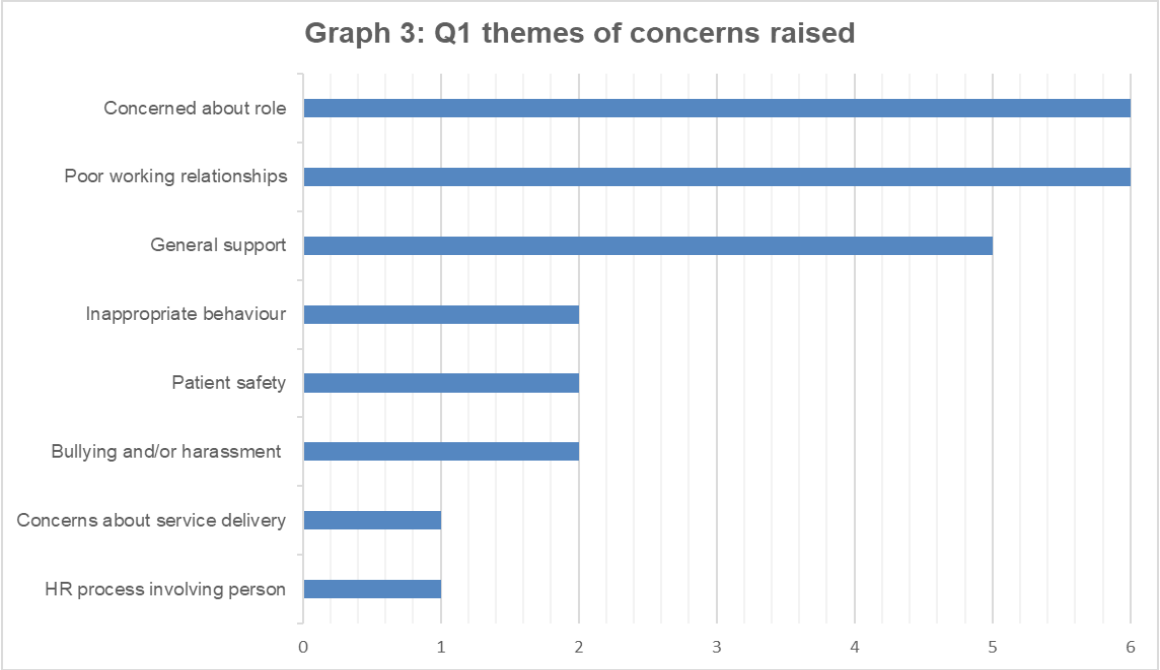
3. Contacts during 1st April 2023 to 30th June 2023 (Q1)

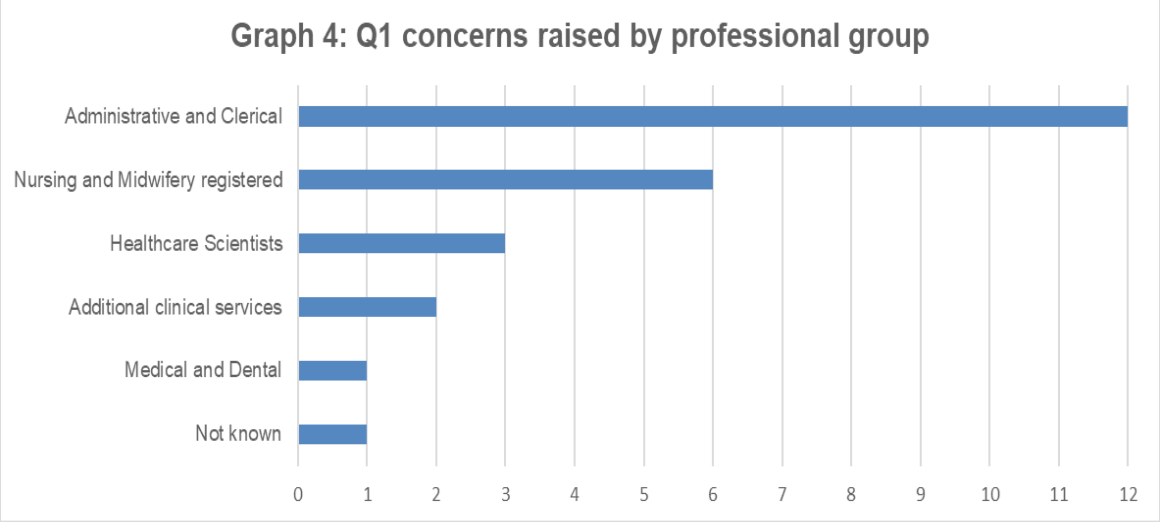
The FTSUG reports on individual contacts received from members of staff, students, trainees and volunteers, to the Trust Board each quarter. In addition the FTSUG submits the quarterly data to the National Guardian Office, who publically publish an annual overview for each Trust.

Below shows graphs 1, 2, 3 and 4 summarising the Q1 data.




Graph 2: Individual contacts to FTSUG since 2017/2018 to 2023/2024
CONTACTS
100
90
80
70
60
50
40
30
20
10
0
2017/2018
2018/2019
2019/2020
2020/2021
2021/2022
2022/2023
2023/2024 Q1
17
23
29
24
71
100
25


Graph 3: Q1 themes of concerns raised
Concerned about role
Poor working relationships
General support
Inappropriate behaviour
Patient safety
Bullying and/or harassment
Concerns about service delivery
HR process involving person
0
1
2
3
4
5
6


Graph 4: Q1 concerns raised by professional group
Administrative and Clerical
Nursing and Midwifery registered
Healthcare Scientists
Additional clinical services
Medical and Dental
Not known
0
1
2
3
4
5
6
7
8
9
10
11
12

Comments and observations:

- During Q1 25 individual contacts were received by the FTSUG; this represented 20 standalone concerns. NB – the national guidance requires Trusts to report on numbers of *individuals* approaching the Guardian. This is in increase on compassion to Q1 in previous years – 2020/2021 (5 cases) and 2021/2022 (22 cases).
- 1 out of 25 concerns was reported to the FTSUG anonymously, and the FTSUG did not know the identity of the individual. Support was provided where possible in this case.
- The highest number of reasons for staff approaching the FTSUG were concerns related to staff member's roles and poor working relationships – both types of concerns have increased compared to previous quarters. The number of concerns related to inappropriate behaviours has reduced.
- During Q1 the number of Administrative and Clerical and Nursing and Midwifery staff approaching the FTSUG has increased since Q4 (2022/2023).

4. FTSUG Activities during Q1

4.1 A high level summary of the activities of the FTSUG during Q1 are detailed below:

- Worked in partnership with the FTSUG from York and Scarborough Teaching Hospitals NHS Trust to offer speak up drop in sessions for staff working within the Scarborough, Hull and York Pathology service. Staff were able to attend at both Hull Royal Infirmary and Castle Hill Hospital to discuss concerns with both FTSUGs.
- Attended and provided a market stall to raise awareness of the FTSUG at the LGBTQ+ Staff Network conference.
- Introductory meetings with the new Counter Fraud Plus (CFP) Team and the new Senior Site Chaplain to discuss partnership working and referrals for staff members.
- Attended the HR Advisory and HR Manager Team meeting to present the 2022/2023 annual figures and feedback specific learning from concerns related to HR matters.
- Initial involvement in the scoping work for the new 'zero tolerance to' frameworks.
- Participated in the stakeholder event as part of the recruitment to the new Group CEO of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLAG).
- Commenced partnership working with FTSUG at Humber Teaching NHS Foundation Trust and continued partnership working with the NLAG FTSUG.
- Continued to progress the remaining open low level actions from the December 2022 internal audit of speaking up at HUTH (overall rating 'substantial assurance'). Proposed the amendments to the Raising Concerns at Work (whistleblowing) policy (CP169) in line with the audit action and currently awaiting confirmation that the policy has been ratified.

4.2 NHS England and Improvement national requirements update

NHS England and Improvement (NHSEI) have published a new national Freedom to Speak Up policy and in conjunction with the National Guardian Office, a revised self-reflection and planning tool for Boards.

NHSEI 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.

4.2.1. Board self-reflection and planning tool update

The Board development session on 8th February 2023 discussed the self-reflection and planning tool and the resulting improvement plan and identification of strengths. The second update to this action plan is detailed in Appendix 1 of this report.

4.2.2. New national speak up policy update

The FTSUG has converted the new national policy into the Trust template and personalised to HUTH, and has consulted with key stakeholders. The policy could not be ratified due to the cancellation of the Workforce Transformation Committee on 20th July 2023 and instead approval will be sought via email as an alternative.

5. Conclusions

The Trust continues to support the FTSUG role and it is positive that the number of individuals approaching the FTSUG continues at similar levels to 2022/2023. The FTSUG continues to work to build networking and relationships with key individuals and teams across the Trust and with external FTSUGs, to strengthen partnership working and sharing good practice.

6. Recommendations

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.

Freedom to Speak Up Guardian
September 2023

Appendix 1:
Summarise of high-level development actions:

Development areas to address in the next 6–12 months	Target date	Action owner	Progress update
1. Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead	**Action completed** • Repeat self-assessment of the Board self-reflection will be scheduled no longer than two years from the previous assessment (February 2023). Executive Lead committed to ensuring this has been completed.
2. Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG	**Action in progress** • 6 further Speak Up Champions recruited and trained during March, April, May, June and July 2023. • List of local Speak Up Champions continually updated on staff intranet Pattie and bimonthly network meetings for all Champions providing peer support and development are in place. • Private workspace on Pattie set up for Champions to provide a central resource for key updates and resources.
3. Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/03/24	FTSUG	**Action in progress** • Bimonthly training dates booked until end of 2023.
4. Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.	**Action in progress** • New national speak up policy has been personalised and circulated to stakeholders. The Workforce Transformation Committee on 20th July 2023 was cancelled – currently seeking ratification through email approval to progress the policy. • Joint drop in session with the York and Scarborough NHS Teaching Hospitals NHS Trust held for SHYPS staff took place 27th July 2023. Further dates will be scheduled to provide further opportunities to speaking up. • The new Group CEO circulated communications in reflection of the recent national media coverage into the conviction of a neonatal nurse and the importance of speaking up in the NHS. • Joint drop in session with the FTSUG and Chief

			Nurse scheduled for 31st August 2023. • Attendance planned to provide a market stall to raise awareness of speaking up at the Staff Disability Network conference in October 2023.
5. Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances. • A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.	31/03/23	FTSUG	**Action in progress** • Question about whether the individual had experienced positive behaviours when speaking up considered and included in the feedback survey. • Question about referral route and awareness of the FTSUG role included in the feedback survey. • Free text box included in the survey to include permission to share stories of speaking up.
6. Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	31/03/24	Head of Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss incorporating existing Health Education England e-learning into line manager development.
7. Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an “internal consultant” to bring expertise into bespoke work design.	31/03/24	Head of Organisational Development	**Action in progress** • The Maternity reporting tool is now live and Cardiology is currently in progress. • FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised.
8. Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	31/03/24	Head of Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss what indicators and data could be appropriately used for a Trust wide group.
9. Development of a Trust wide Professionalism and Kindness	31/03/24	Head of	**Action in progress**

programme that supports just and speaking up culture.		Organisational Development	• PACT "Professionalism and Civility Training" launched from late August 2023 onwards, alongside a marketing campaign to allow us to reflect on how "Bad Behaviour Doesn't Work – Time to Change".
10. Implementation of the new NHS England speaking up policy. To include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.	31/12/23	FTSUG	**Action in progress** • National policy transferred into HUTH template and personalised. • Policy could not be ratified due to Workforce Transformation Committee on 20th July 2023 being cancelled. Approval sought via email approval.
11. Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG	**Action completed** • Draft policy sent to internal stakeholders for information/comment. Including Executive Lead, Director of Workforce, Head of Workforce, Head of HR, Disability Staff Network Chair, BAME Staff Network Chair, LGBTQ+ Staff Network Chair, JNCC Chair, LNC Chair, Equality Diversity & Inclusion Trust Lead.
12. Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.	31/05/23	FTSUG	**Action completed** • Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training.
13. Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8 above.	31/03/24	FTSUG	**Action in progress** • FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports.
14. Review the self-reflection and planning tool outputs from at least two other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.	31/12/23	FTSUG	**Action in progress** • Self-reflection and planning tool reviewed and shared with NLAG FTSUG. • HUTH FTSUG has contacted other FTSUGs working in similar sized acute Trust's across the region to discuss sharing. • Documentation created by the FTSUG in the development of the Speak Up Champion Network

			has been shared regionally on request with all FTSUGs across Yorkshire and Humber.
15. Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.	31/03/23	FTSUG	**Action completed** • Ongoing feedback requested as appropriate
16. Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/03/24	FTSUG	**Action in progress** • Initial work underway to develop a draft strategy; including reviewing other Trust's strategies.

Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner	Progress update
1. Share speak up arrangements with other Trusts. To include: recruitment and ring fenced time for the role, locally agreed absence arrangements, creation of the speak up champions network, involvement with other services across the Trust and being an ally of each staff network.	30/09/23	FTSUG	**Action completed** • Self-reflection and planning tool reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • FTSUGs at three other Trust's across the region have requested observing the training the HUTH FTSUG provides to Speak Up Champions to gather best practice ideas. • HUTH FTSUG to present training videos produced at the Trust by the FTSUG at the next regional FTSUG meeting due to interest from other Trusts.

USE OF THE TRUST SEAL

REFERENCES

Only PDFs are attached

11.1 - Use of the Trust Seal August 2023.pdf

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
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 July 2023 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:
The Trust Board is requested to: • Authorise the use of the Trust's seal

Hull University Teaching Hospitals NHS Trust

Trust Board

Use of the Trust Seal August 2023

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 June 2023.

SEAL	DESCRIPTION OF DOCUMENTS SEALED	DATE	DIRECTORS
2023/06	Hull University Teaching Hospitals NHS Trust and Connexin Limited – Lease relating to the land on the corner of Argle Street and Anlaby Road situate at HRI Anlaby Road, Hull	22/08/23	Jonathan Lofthouse – CEO and Suzanne Rostron, Director of Quality Governance

3 Recommendation

The Trust Board is requested to:

- Authorise the use of the Trust's seal

Rebecca Thompson
Head of Corporate Affairs
September 2023

PROTECTING AND EXPANDING ELECTIVE ACTIVITY

REFERENCES

Only PDFs are attached

- 11.2 - PRN00673_Protecting and expanding elective capacity letter_040823.pdf
- 11.2.1 - Paper on Protecting Elective Capacity JMz 31082023 V3 FINAL.pdf
- 11.2.2 - APPENDIX 2 Board Self Certification - Protecting and expanding Elective capacity August 2023 JMz 31082023 V3.xlsx

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month**.**

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

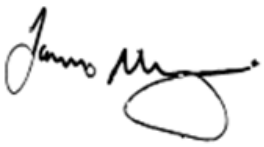
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Agenda Item		**Meeting**	**Trust Board**	**Meeting Date**	12 September 2023
Title	Protecting and Expanding Elective Capacity – Self-Certification Sign-off				
Lead Director	Ellen Ryabov – Chief Operating Officer				
Author	Julia Mizon Deputy Chief Operating Officer (Elective Recovery and Cancer)				
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 Board is asked to consider the attached Self-Certification assessment and approve sign-off by the Chair and Group Chief Executive for submission to the ICB and NHSE.

Protecting and Expanding Elective Capacity

Self Certification Sign-off

1. Purpose

On the 4 August 2023, Jim Mackey and Tim Briggs wrote to NHS Acute Trust Chief Executives – Protecting and Expanding Elective Capacity, requesting the completion and sign-off by the Trust Board against a number of requirements in regards to the delivery elective and cancer recovery ambitions. A copy of the letter is attached at Appendix 1.

The purpose of this paper is to provide assurance that the Trust is taking appropriate measures to protect and expand elective capacity to support elective recovery – the self-certification requirements and HUTH position statement, which is RAG rated, is provided at Appendix 2.

Following approval by the Trust Board, the completed checklist should be signed by the Chair and Group Chief Executive and submitted to our NHS England Regional Team and the Humber and North Yorkshire Integrated Care Board.

2. Requirements

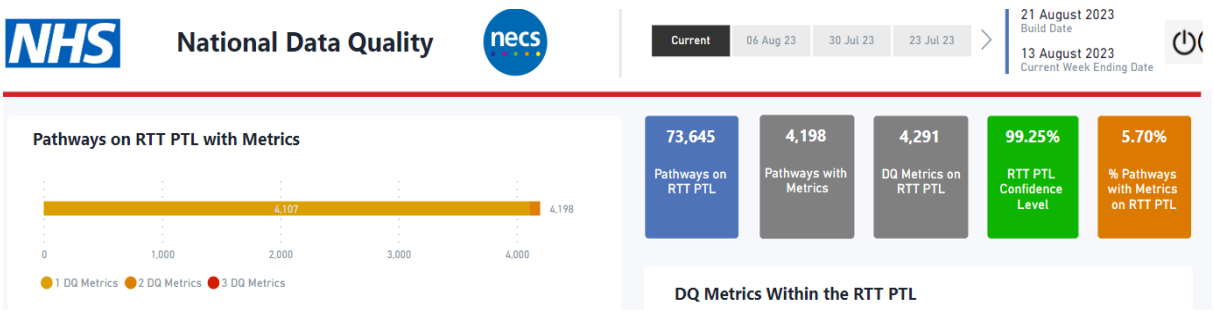
To provide assurance on Validation, First Appointments, Outpatient follow ups, and confirmation if any additional support is required.

2.1 Validation.

The Trust has oversight with systems and process in place to support timely validation.

Assurance was provided by Source Group in June 2022 following a full PTL validation and 7.2% removal rate that the Trust has a tight grip on the PTL with necessary tools to identify and amend any data quality (DQ) issues.

These are monitored by RTT BI data quality reports in conjunction with the LUNA system, with associated monitoring and escalation processes established. LUNA is currently reporting that the Trust has a 99.25% confidence level for RTT PTL data quality.



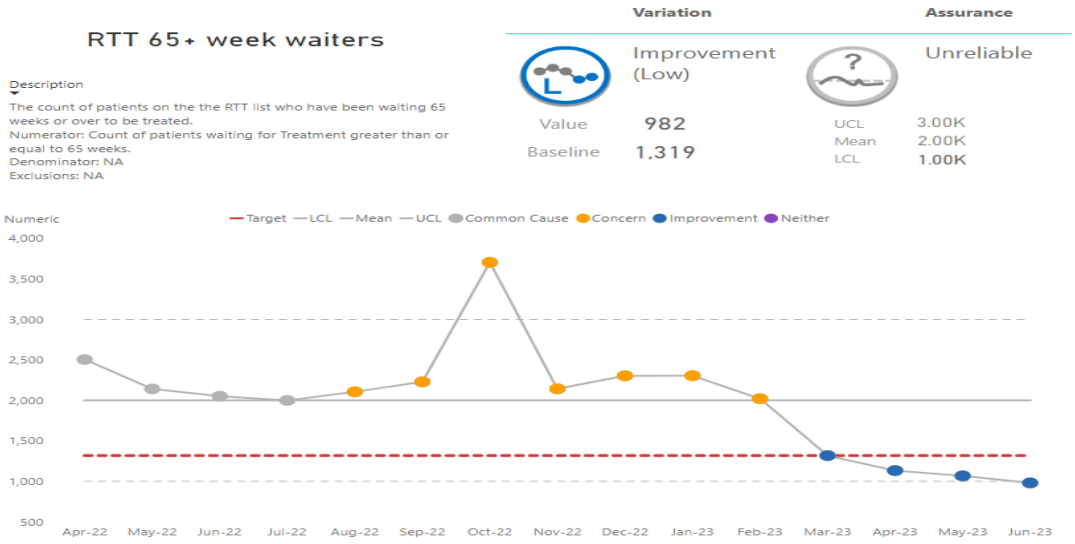
For those patients who are waiting over 12 weeks the Trust is able to maintain a 90% validation rate and does not require any digital support currently. BI data quality reports are used to monitor weekly and escalation processes are in place. The Trust current position is 92% of all RTT pathways >12 weeks have an up-to-date validation comment.

Robust RTT/Access Policy training and support with feedback and escalation processes around errors are in place and the Trust Access Policy guidelines clearly set out the 'non-treatment' clock stop rules.

Process are in place to monitor non RTT patients waiting planned procedures. For those that become overdue, the pathways are updated to elective and RTT active. This is monitored using BI reports with escalation processes in place. There is also a successful text validation process in place with an average removal rate of 6%.

2.2 First appointments

The Trust's position from the start of 2023/24 was a 65-week breach risk PTL of 36,912 patients to treat by the end of March 2024. As at 21 August 2023, the 65-week risk PTL is 11,525, which has seen a reduction of 8,323 in the last 10 weeks (58% reduction).



Internal plans and milestones are all on track to continue good progress and ensure that all patients who are a 65 week risk for the end of March 2024, and are awaiting a first outpatient appointment (1,451 patients) will have received an appointment by the 31st October 2023, in all specialities with the exception of Gynaecology.

A plan is being developed to ensure that all gynaecology 1st outpatient appointments, for patients who will breach 65-weeks by 31 March 2024, will be seen by 31 December 2023. This plan will be submitted to the Performance and Finance Committee in October 2023.

In order to support recovery plans the Trust is maximising the use of the Independent Sector provision where available; funding has been agreed for 2023/24 Q2 & Q3. Capacity is currently being utilised at Spire, St Hughs, DMC and Modality with insourcing being provided by HEYAS. We have received offers of support for mutual id by York and DMAS opportunities continue to be explored for gynaecology. We continue to offer mutual to York for ENT and paediatric urology.

2.3. Outpatient follow-ups

The Trust has become one of 25 volunteer Trusts to take on the challenge of the GIRFT Further Faster Programme – the HUTH focus will be on improving outpatient follow ups through the support of the GIRFT resources, taking learning from other sites and applying that locally across the 15 specialities. We will share our good practice and improvements too.

Improvement programmes are monitored via Elective Recovery Group and well supported by monitoring improvement and data quality via BI reports. Work is ongoing to deliver personalised outpatient care and extend the use of PIFU.

A number of strategies have been implemented to reduce DNA rates which includes the use of partial booking whereby the patient contacts the hospital to agree the appointment date; text reminders using a mobile first strategy with text reminders and the use of Patient Knows Best (PKB) mobile app. Monitoring processes are in place to capture multiple instances of DNA and patient cancellations via a BI DQ report.

The Trust is currently achieving Advice and Guidance of 33 requests per 100 referrals, against a national requirement of 16; with focus in expanding to specific specialties with higher rates of discharge at first attendance.

3. Summary

The attached self-assessment has been RAG rated across 12 domains:

- Green – 9 domains
- Amber – 2 domains
- Red – 1 domain

Amber

- Gynaecology will not achieve the requirement for all patients awaiting a 1st outpatient appointment by 31 October 2023; a plan will be developed to achieve this by 31 December 2023

- Patients moved to PIFU delivery at 5% by 31 March 2024 is currently at 1.9%; the Trust submitted an operational plan to achieve 2%. There is on-going work through the GIRFT Further Faster programme and associated in-house improvement programmes to increase the movement to PIFU. A further update will be provided to the Performance and Finance Committee in October 2023

- Specific speciality updates are included in the self-certification, there are 2 specialities who are being supported to improve PIFU rates:
    - Urology/Prostate: Urology are a priority for improvement, and in-sourced support will assist in the development of a clinical SOP to increase PIFU rates by December 2023. Of the OP FU waiting list, 33.7% (3,757) are overdue. The moved to PIFU rate is currently 0.5%.

    - Gynae-oncology: This speciality is a priority for improvement, and in-sourced support will assist in the development of a clinical SOP to increase PIFU rates by December 2023. Of the OP FU waiting list, 37% (444) are overdue, this includes colposcopy. The moved to PIFU rate is currently 0.2%.

Red

- The Trust submitted a plan to achieve 96% of follow up outpatient activity by comparison to the 2019/20 counterfactual baseline, excluding procedures undertaken in an outpatient setting. A revised delivery plan, based on the GIRFT Further Faster Programme and in-house improvement projects will be provided to the Performance and Finance Committee in October 2023.

4. Next Steps

ICBs are expected to have had sight of the self-certifications and to discuss and agree any support required where a Trust is unable to provide a positive certification, in advance of the certifications being submitted.

ICBs are asked to submit the self-certifications collected from their organisations and for these to be submitted to region by close of play on 28th September 2023. Any ICB submitting a self-certification, on behalf of their organisations, which does not provide assurance against all the activities then the ICB is required to provide narrative (in addition to any Trust narrative) to present an update on the system discussions and any further work being undertaken to try and resolve the outstanding certifications with those providers.

5. Recommendation

The Board is asked to consider the attached Self-Certification assessment and approve sign-off by the Chair and Group Chief Executive for submission to the ICB and NHSE.

MODERN SLAVERY REPORT

REFERENCES

Only PDFs are attached

11.3 - Modern Slavery Statement for Trust Board 170723.pdf

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement
Trust Submission 2022/23

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12/09/23
Title	Modern Slavery Statement				
Lead Director	Simon Nearney, Director of Workforce and OD				
Author(s)	Sarah Dolby, Senior HR Advisor, Employment Policy and Resourcing				
Report previously considered by (date)	This report was due to be tabled at the Workforce Education and Culture Committee on 24 July 2023, however the meeting was cancelled. This report has therefore not been considered by any other 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	✓	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 are asked to approve the attached Trust's Modern Slavery Statement 2022/23. This will then be published on the Trust's website. Once approved by the Board, the statement will be published on the Trust internet in line with statutory requirements (by 30 September 2023).

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement
Trust Submission 2022/23

1 Purpose

The purpose of this paper is to share the Trust's 2022/23 Modern Slavery Statement with the Trust Board for approval. Once approved, the statement will be published on the Trust's website as soon as possible, and by the very latest, the 30 September 2023 to meet statutory requirements.

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.

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 it's homepage within six months of the end of the financial year.

3 The Trust's Proposed Statement for 2022/23

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: Nicola Cockerill
- Safeguarding: Jayne Wilson / Paula Peacock / Andy Lockwood

4 Mandatory Changes to Modern Slavery Statements

As reported in the Trust's previous statement, in the Queen's speech in May 2022, the Government proposed to implement changes to the Modern Slavery Act 2015 by introducing a Modern Slavery Bill. The Bill has not yet proceeded through parliament, but is likely to impose tougher measures for organisations who do not comply with the requirements of the Modern Slavery Act 2015. The Bill is also likely to require organisations to publish their statements on the Government registry as well as imposing a statutory reporting deadline. However, in the interim period, until the Bill is published, organisations must continue to report in line with current expectations.

5 Recommendation

The Trust Board are asked to:

- Note, approve and sign off the content of the Trust's 2022/23 Modern Slavery Statement.
- Consider whether the Modern Slavery Working Group would benefit from senior support to influence and support changes to practices (in relation to modern slavery and human trafficking) across the Trust.

Simon Nearney, Director of Workforce and Organisational Development
July 2023

Appendix 1

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement
1 April 2022 to 31 March 2023

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 reports[1] of modern slavery victims increasing year on year and an estimate of more than 130,000 people being trapped in modern slavery, costing the UK £33 billion per year, it is imperative that the Trust continues to be committed to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking.

This statement sets out the steps that the Trust has taken over the financial year 1 April 2022 to 31 March 2023 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains and 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

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 8,500 whole-time equivalent staff, has an annual income of circa £846m 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 2022/23, 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 publishes a broad range of safeguarding policies and factsheets, for both service users and staff, which include:

- Modern slavery resources including Ukrainian Refugees and the risk from Human Trafficking.
- Home Office-Modern Slavery: Statutory Guidance for England and Wales Jan 2023.
- Eyes Open Campaign to stop child criminal exploitation.

Any new campaigns/policies in relation to modern slavery are published on the Trust intranet.

[1] https://www.antislavery.org/slavery-today/slavery-uk/

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:

- Exploring the option of establishing Safeguarding Champion roles within Health Groups 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 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 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 4 queries were received, compared to 6 in the previous reporting period). One safeguarding adults' referral was made to the Local Authority with consent. Where applicable, information sharing to the Police in the public interest is undertaken by both staff and the Trust Safeguarding Teams.
- The Trust continues to refer all safeguarding children concerns, including those related to modern slavery, to the Local Authority Children's Social Care Services. During the last financial year there were 13 children's safeguarding referrals made to the Local Authority in regards to potential modern slavery. The majority of these were in regards to pregnancy and the unborn baby, although 2 of these referrals were in relation to 16 year old and under children.

4.2 *Due Diligence in Supply Chains*

The Trust's Procurement and Supplies Department is responsible for spending £185m non-pay (based on data from 2022/2023) includes:

- £35m through the NHS Supply Chain.
- £150m direct spend.

NB: It must be noted that these figures are approximate and will fluctuate year on year.

The Trust currently has 1106 active contracts (compared to 1004 in the previous reporting period), covered by 478 individual suppliers (compared to 455 individual suppliers in the previous reporting period). Of the 478 individual suppliers, 379 (79.3%) have provided information in relation to the Modern Slavery Act (compared to 80% in the previous reporting period), as follows:

- 265 suppliers have provided assurance that they are compliant with the requirements of the Modern Slavery Act.
- 114 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). However, the Trust still expects that they conduct their business with due regard to the Modern Slavery Act.

The Trust will continue to update records on the remaining suppliers as and when contracts are renewed.

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:

- Use NHS Terms and Conditions for Goods and Services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions.
- 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.
  - When requesting information for values lower than the £10k referenced in the Standing Financial Instructions, suppliers are requested to complete the Trust's formal quotation form, which includes reference to modern slavery.

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 2023, in excess of 85% of Trust staff are compliant with the required training, which is consistent with previous years.

NB: The Trust's key performance indicators for mandatory training are set to 85% to take into account staff who are temporarily out the workforce due to for example, being on maternity leave.

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 modern 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	Signed
Chairman	Chief Executive
Dated:	Dated:

WDES/WRES

REFERENCES

Only PDFs are attached

11.4 - WDES 2023 Report.pdf

11.4.1 - WRES Analysis Report.pdf

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
Title	Workforce Disability Equality Standard (WDES) Trust Submission 2023				
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 Disability Staff Network Workforce & OD Colleagues				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2022/23**	
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 asked to approve the WDES return and action plan

Hull University Teaching Hospitals NHS Trust

Workforce Disability Equality Standard (WDES)
Trust Submission 2023

1 Purpose

The purpose of this paper is to share the findings of the Trust's Workforce Disability Equality Standard (WDES) submission for 2023 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 2023

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 2023. The return provides the technical data that will be used by NHS England to benchmark the Trust against other NHS organisations. The Trust was required to submit the Data Template by 31 May 2023 and this was achieved.
- 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 325 staff self-reported with a disability whereas when completing the Staff Survey (December 2022) a higher number of staff reported themselves as disabled or having a Long Term Condition.

Both the Reporting Template and the Action plan must be published on the Trust's external website by 31 October 2023.

4 Achievements throughout 2022/23

There have been a number of achievements in the past year, which are detailed below:

4.1 Work with Capital Development Team

The Capital Team have provided a PQQ which can be adapted to incorporate EDI,

Currently input into new capital happens and amendments are made to access & changing facilities eg NCTR ward, Capital Dev Manager core member of EDI steering group. Following joint review of accessibility the surfacing of paths are now accessible at CHH

4.2 Zero Tolerance to Ableism

Work has commenced on what was Zero Tolerance to Disability Discrimination but has now been rebadged. This is expected to be delivered for launch in September 2023, the Task & Finish group have mapped out the process and are delivering the work.

4.3 Recruitment

A process mapping group has been established to break down all elements of the recruitment process and establish ways that we can make the process more inclusive and improve representation.
The recruitment team have ensured that the number of people shortlisted utilising the disability confident preferred interview option has increased significantly.
The widening participation team have provided a careers opportunity day for SEN school children and Ann Burdis is established as a Careers enterprise ambassador.

4.4 ESR Declaration

Bridging Gap sessions launched 12 sessions run 6 made up of management and an attendance of 40 people, there has been as declaration Increase from 2.98% to 3.43%

4.5 Strengthening Network

This action was completed and Leadership Structure of the network is now in place: 2 deputies were appointed one with expertise in Long Term Conditions developing into a disability, the other with Sight Impairment, in addition a Mental Health Lead was appointed. The network took the decision to rebrand from Enabled staff network to Disability staff network which led to an immediate uptick in membership.

4.6 Disability Leadership programme

Incorporated into the work being coordinated through the Inclusivity Academy Task & Finish group. The Disability Leadership Programme run in collaboration with Disability Rights UK is now established and scheduled to be delivered online via zoom over four months from September to March 2024 - 4 full day sessions
The programme will also run alongside a bespoke version of the 90 days challenge and a pre course Discovery Insights session. The initial cohort is to be a maximum of 12.

5 Key Findings for 2023

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 2023.
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 2023.

The key findings from the technical data for 2023 are:

- The Trust employed 9,505 staff at 31 March 2023.
- Of the 9,505 staff, 24.25% (2,305) had not declared being disabled or non-disabled and are recorded as 'unknown or null'. This metric has improved from 28.29% (2022).
- 325 staff have reported as Disabled on ESR; an increase from 272 staff (2022).

- The metric with the highest disparity between Non-disabled staff and Disabled staff Percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. (Staff Survey December 2022 data). This metric has deteriorated for Disabled staff from 31.3% (2021) to 35.8% (2022).

- 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 2022 data). This metric has improved for Disabled staff from 43.0% (2021) to 47.6% (2022), whilst a positive that more reporting is happening it coincides with a worrying trend of more incidents occurring.

The data for 4 to 9 B) above is from the Staff Survey and inherently more staff report themselves as disabled or having a Long Term Condition 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.

6 WDES Action Plan

The draft WDES Action Plan for 2023/2024 is available in Appendix 3.

7 Recommendation

The Trust Board is asked to approve the WDES return and action plan.

Simon Nearney
Director of Workforce and Organisational Development
September 2023

Workforce Disability Equality Standard

Name of organisation:	Hull University Teaching Hospital NHS Trust
Date of report:	March 2023
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 24.25% of the workforce have not declared as disabled or non-disabled, which represents 2,305 of the total workforce.

2. Total Numbers of Staff

Total number of staff employed within the Trust at the date of the report: 9,505

Proportion of disabled staff employed within the Trust at the date of the report: 3.42% 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: 72.33%

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 and we have run a number of “bridging the gap” sessions.

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 will reinforce the “bridging the gap initiative to encourage declaration as well as raising the profile of disabled staff by the introduction of the Zero Tolerance to Ableism framework.

4. Workforce Data

What period does the organisation’s workforce data refer to: Staff in post at 31 March 2023 and activity during the financial year 2022/23.

5. Workforce Disability Equality Indicators

	Indicator	Data for reporting year 2022/23		Data for previous year 2021/22		Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 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.	See Appendix 2 for breakdown by pay banding (From ESR). Where disability is known for 31 March 2023:				In total 72.33% 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 EDS2022 goals and the Trust Equality Objectives.
		Non-clinical workforce (Non-disabled) =	16.66%	Non-clinical workforce (Non-disabled) =	15.70%		
		Non-clinical workforce (Disabled) =	0.86%	Non-clinical workforce (Disabled) =	0.74%		
		Clinical workforce (non-medical Non-disabled) =	44.47%	Clinical workforce (non-medical Non-disabled) =	41.53%		
		Clinical workforce (non-medical Disabled) =	2.22%	Clinical workforce (non-medical Disabled) =	1.96%		
		Clinical workforce (medical and dental non-disabled) =	11.19%	Clinical workforce (medical and dental Non-disabled) =	11.50%		
		Clinical workforce (medical and dental Disabled) =	0.34%	Clinical workforce (medical and dental Disabled) =	0.27%		
2	Relative likelihood of Non-disabled staff being appointed compared to disabled applicants from shortlisting across all posts.	Non-disabled: 0.26 Disabled: 0.16 Relative likelihood: 1.56		Non-disabled: 0.24 Disabled: 0.21 Relative likelihood: 1.14		The data shows that Non-disabled staff are more likely than Disabled staff to be appointed from shortlisting. However we are shortlisting more disabled staff through the activity of the recruitment	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.

	Indicator	Data for reporting year 2022/23	Data for previous year 2021/22	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
				team ensuring Managers adhere to the preferential interview offer under the Employer Confident Scheme	
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: N/A Non-disabled: N/A Relative likelihood: N/A	Disabled: 0.0001 Non-disabled: 0.0002 Relative likelihood: 11.56	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 EDS2022 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: 27.5% Disabled: 34.5% (From Staff Survey December 2022)	Non-disabled: 24.6% Disabled: 30.3% (From Staff Survey December 2021)	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 EDS2022 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:12.3% Disabled: 20.6% (From Staff Survey December 2022)	Non-disabled:12.6% Disabled: 17.9% (From Staff Survey December 2021)	The percentage of Disabled and Non-disabled staff experiencing harassment, bullying or abuse from managers has increased.	Please see action plan. Actions link to EDS2022 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: 20.7% Disabled: 29.0% (From Staff Survey December 2022)	Non-disabled: 18.5% Disabled: 27.9% (From Staff Survey December 2021)	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 EDS2022 goals and the Trust Equality Objectives.
4b	Percentage of staff that the last time they	Non-disabled: 43.2% Disabled: 47.6%	Non-disabled: 41.5% Disabled: 43.0%	The percentage of Disabled staff reporting harassment,	Please see action plan.

	Indicator	Data for reporting year 2022/23	Data for previous year 2021/22	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
	experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	(From Staff Survey December 2022)	(From Staff Survey December 2021)	bullying or abuse at work has increased.	Actions link to EDS2022 goals and the Trust Equality Objectives.
5	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.	Non-disabled: 58.9% Disabled: 49.2% (From Staff Survey December 2022)	Non-disabled: 58.4% Disabled: 52.2% (From Staff Survey December 2021)	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 EDS2022 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: 22.9% Disabled: 35.8% (From Staff Survey December 2022)	Non-disabled: 25.9% Disabled: 31.3% (From Staff Survey December 2021)	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 EDS2022 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: 38.6% Disabled: 28.6% (From Staff Survey December 2022)	Non-disabled: 41.3% Disabled: 31.6% (From Staff Survey December 2021)	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 EDS2022 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.	71.4% (From Staff Survey December 2022)	69.8% (From Staff Survey December 2021)	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 EDS2022 goals and the Trust Equality Objectives.
9a	Staff engagement score for Disabled staff, compared to Non-disabled staff and the	Non-disabled staff: 6.5 Disabled: 6.0 Organisation: 6.4 (From Staff Survey	Non-disabled staff: 6.9 Disabled: 6.4 Organisation: 6.7 (From Staff Survey	The staff engagement score for Disabled staff continues to be lower than for Non-disabled staff.	Please see action plan. Actions link to EDS2022 goals and the Trust

	Indicator	Data for reporting year 2022/23	Data for previous year 2021/22	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2022 evidence and/or a corporate Equality Objective
	overall score for the organisation.	December 2022)	December 2021)		Equality Objectives.
9b	Has the Trust taken action to facilitate the voices of Disabled staff in the organisation to be heard?	Yes	Yes	The Trust has an Enabled Staff Support Network and held a Network Conference.	Please see action plan. Actions link to EDS2022 goals and the Trust Equality Objectives.
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.	2.0%	4.0%	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%, whilst within HUTH the declaration is 3.43%.	Please see action plan. Actions link to EDS2022 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 EDS2022. 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 2023						
				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%	7	87.5%	1	12.5%	8
		Bands 1	Headcount	1	5.6%	8	44.4%	9	50.0%	18
		Bands 2	Headcount	30	3.1%	682	69.6%	268	27.3%	980
		Bands 3	Headcount	22	4.5%	348	71.8%	115	23.7%	485
		Bands 4	Headcount	11	5.1%	153	71.2%	51	23.7%	215
		Bands 5	Headcount	4	2.4%	126	75.9%	36	21.7%	166
		Bands 6	Headcount	5	3.8%	94	70.7%	34	25.6%	133
		Bands 7	Headcount	3	3.1%	64	65.3%	31	31.6%	98
		Bands 8a	Headcount	2	2.9%	43	62.3%	24	34.8%	69
		Bands 8b	Headcount	1	2.1%	27	57.4%	19	40.4%	47
		Bands 8c	Headcount	2	10.5%	7	36.8%	10	52.6%	19
		Bands 8d	Headcount	0	0.0%	5	55.6%	4	44.4%	9
		Bands 9	Headcount	0	0.0%	2	50.0%	2	50.0%	4
		VSM	Headcount	1	3.7%	18	66.7%	8	29.6%	27
		Other (e.g. Bank or Agency) Please specify in notes.	Headcount	0		0		0		0
		Cluster 1: AfC Bands <1 to 4	Auto-Calculated	64	3.8%	1198	70.2%	444	26.0%	1706
		Cluster 2: AfC bands 5 to 7	Auto-Calculated	12	3.0%	284	71.5%	101	25.4%	397
		Cluster 3: AfC bands 8a and 8b	Auto-Calculated	3	2.6%	70	60.3%	43	37.1%	116
		Cluster 4: AfC bands 8c to VSM	Auto-Calculated	3	5.1%	32	54.2%	24	40.7%	59
		Total Non-Clinical	Auto-Calculated	82	3.6%	1584	69.5%	612	26.9%	2278
		1b) Clinical Staff								
		Under Band 1	Headcount	5	7.81%	59	92.19%	0	0.00%	64
		Bands 1	Headcount	0	0.00%	1	100.00%	0	0.00%	1
		Bands 2	Headcount	32	2.80%	890	78.00%	219	19.19%	1141
		Bands 3	Headcount	20	3.92%	332	65.10%	158	30.98%	510
		Bands 4	Headcount	6	2.76%	146	67.28%	65	29.95%	217
		Bands 5	Headcount	80	4.12%	1523	78.42%	339	17.46%	1942
		Bands 6	Headcount	39	3.76%	734	70.78%	264	25.46%	1037
		Bands 7	Headcount	20	3.07%	386	59.20%	246	37.73%	652
		Bands 8a	Headcount	8	4.32%	110	59.46%	67	36.22%	185
		Bands 8b	Headcount	1	1.92%	26	50.00%	25	48.08%	52
		Bands 8c	Headcount	0	0.00%	10	47.62%	11	52.38%	21
		Bands 8d	Headcount	0	0.00%	2	66.67%	1	33.33%	3
		Bands 9	Headcount	0	0.00%	1	50.00%	1	50.00%	2
		VSM	Headcount	0	0.00%	7	43.75%	9	56.25%	16
		Other (e.g. Bank or Agency) Please specify in notes.	Headcount	0		0		0		0
		Cluster 1: AfC Bands <1 to 4	Auto-Calculated	63	3.3%	1428	73.9%	442	22.9%	1933
		Cluster 2: AfC bands 5 to 7	Auto-Calculated	139	3.8%	2643	72.8%	849	23.4%	3631
		Cluster 3: AfC bands 8a and 8b	Auto-Calculated	9	3.8%	136	57.4%	92	38.8%	237
		Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	20	47.6%	22	52.4%	42
		Total Clinical	Auto-Calculated	211	3.6%	4227	72.3%	1405	24.0%	5843
		Medical & Dental Staff, Consultants	Headcount	3	0.59%	354	69.14%	155	30.27%	512
		Medical & Dental Staff, Non-Consultants career grade	Headcount	1	1.61%	46	74.19%	15	24.19%	62
		Medical & Dental Staff, Medical and dental trainee grades	Headcount	28	3.46%	664	81.98%	118	14.57%	810
		Total Medical and Dental	Auto-Calculated	32	2.31%	1064	76.88%	288	20.81%	1384
		Number of staff in workforce	Auto-Calculated	325	3.42%	6875	72.33%	2305	24.25%	9505
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**	Total Board members	Headcount	1	5.88%	9	52.94%	7	41.18%	17
		of which: Voting Board members	Headcount	1	7.69%	8	61.54%	4	30.77%	13
		: Non Voting Board members	Auto-Calculated	0	0.00%	1	25.00%	3	75.00%	4
		of which: Exec Board members	Headcount	1	11.11%	4	44.44%	4	44.44%	9
		: Non Executive Board members	Auto-Calculated	0	0.00%	5	62.50%	3	37.50%	8
		Difference (Total Board - Overall workforce)	Auto-Calculated		2%		-19%		17%	

WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLAN 2023/2024

The Action Plan has been developed, based on the 22/23 WDES technical data results, to help close the gaps in workplace experience between Disabled & Non-disabled staff.

Action	Metric	Delivery Timescale	Lead Responsibility
1. Continue to work closely with Capital Development to work with them to ensure that contractors deliver Equality Impact Assessed Projects • Specific question developed to be used in the Pre Qualifying Questionnaire (PQQ) to be used for all new and existing contractors. • Ensure EF&D colleagues actively ensure that the PQQ is used and only fully approved contractors are used by the Trust for capital and estate development projects.	**8, 9a** **EDS 2022** **2D, 3C**	**September 2023/Ongoing**	**EDI Manager, Head of Capital Projects**
2. Launch a Zero Tolerance to Ableism framework • Set up a distinct QR code and Database to report and record incidents of Ableism. • Establish a Circle group to have overview of specific incidents, heat map areas and to triage to eliminate disability discrimination. • Ensure that the term Ableism is communicated and fully understood throughout the Trust	**3, 4a, 4b, 8, 9a, 9b** **EDS 2022** **2B**	**September 2023**	**EDI Manager & OD**

Action	Metric	Delivery Timescale	Lead Responsibility
3. Review existing recruitment process through an EDI lens and overhaul as appropriate • Conduct a full review of our Disability Confident status with aim to achieve Disability Leader status • Design specific roles for individuals with Learning Disabilities, utilising the Anchor Network status of the Trust to continue our Widening Participation work to increase adequate and appropriate opportunities.	**2, 5** **EDS 2022 2D**	**October 2023/Ongoing**	**EDI Manager**
4. Continue to encourage staff to complete/update personal information details relating to disability on ESR, through increasing disability confidence • "Bridging the Gap" will continue with a specific aim to encourage people with Long Term Conditions to identify with disability declaration to engage with support at an early stage. Also aim to reduce the % of people not declaring either way. • Embed into Trust Heath & Wellbeing Strategy	**All** **EDS 2022 2A, 2C**	**December 2023/Ongoing**	**EDI Manager, Staff Network**
5. Raise the profile of enabling Reasonable Adjustments in the Trust. • Establish a group to explore options to make the process of reasonable adjustments feel fully supportive for staff making applications whatever the adjustment requested and the process followed • Raise the profile of Access to Work and support staff to apply and make the application for adjustments via Access to Work simpler and explore the feasibility of introducing a centralised process • Enable and promote Line Managers to introduce simple adjustments quickly. • Explore with HR how adjustments in relation to disability related leave and absence can be incorporated into HR processes • Explore Passport options for introduction in Trust	**6, 7, 8, 9a** **EDS 2022 2A**	**October 23/Ongoing**	**EDI Manager, HR Advisory Team**
6. Develop a leadership programme to support leaders at all levels to develop their understanding and gain practical skills in relation to EDI • Launch the Disability leadership Programme for staff with a disability in conjunction with Disability UK • Initial cohort of 12 staff to be a 4 month online programme concluding with a 90 day challenge.	**5, 7, 9a** **EDS 2022 3C**	**September 2023 – March 2024**	**OD Team**
7. Tailor the Learning and Development Policy to support needs of staff with			

EDS 2022 Domains

Domain 2; Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source

2D: Staff recommend the organisation as a place to work and receive treatment

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed

3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

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	Delivery Timescale	Lead Responsibility	Achievements/Outcomes
1. Embed the Structure for disabled staff having an input into infrastructure and estate development and projects • 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.	**March 2023**	**Workforce & OD EDI Team**	**The Capital Team have a Pre Qualifying Questionnaire that contractors complete which has been adapted to incorporate EDI, Currently input into new capital happens and amendments are made to access & changing facilities eg NCTR ward**
2 Launch a Zero Tolerance to Disability Discrimination framework • 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.	**January 2023**	**Workforce & OD EDI Team**	**Work has commenced on this and is expected to be delivered to launch in September 23, Task & Finish group have mapped out process and are delivering the work.**
3 Review existing recruitment process through an EDI lens and overhaul as appropriate • 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.	**March 2023**	**Workforce & OD EDI Team**	**A process mapping group has been established to break down all elements of the recruitment process and establish ways that we can make the process more inclusive and improve representation. Carry over to next year**

Action	Delivery Timescale	Lead Responsibility	Achievements/Outcomes
4 **Continue to encourage staff to complete/update personal information details relating to disability on ESR, through increasing disability confidence** • 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.	**September 2022**	**Workforce & OD EDI Team**	**Bridging Gap sessions launched 12 sessions run 6 made up of management and an attendance of 40 people, there has been as declaration increase from 2.98% to 3.43%**
5 **Continue promotion of the Enabled Staff Support Network through disability confidence campaigns.** • Strengthen the Staff Network leadership by establishing 2 new roles of Deputy Chairs of the Network and a Mental Health lead role.	**July 2022**	**Workforce & OD EDI Team**	**Completed and Leadership Structure now in place: 2 deputies one with expertise in Long Term Conditions developing into a disability, the other with Sight Impairment, in addition a Mental Health Lead was appointed**
6 **Develop a leadership programme to support leaders at all levels to develop their understanding and gain practical skills in relation to EDI** • 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.	**March 2023**	**Workforce & OD EDI Team**	**This is being incorporated into the work being coordinated through the Inclusivity Academy Task & Finish group. The Disability Leadership Programme run in collaboration with Disability Rights UK is now scheduled to be delivered online via zoom over four months from September to December 2023 - 4 full day sessions** **The programme will also run alongside a bespoke version of the 90 days challenge and a pre course Discovery**

Hull University Teaching Hospitals NHS Trust

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
Title	**Workforce Race Equality Standard (WRES) - Trust Submission 2022/23**				
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 Workforce & OD Colleagues				

Purpose of the Report		**Reason for submission to the Trust Board private session**		**Link to CQC Domain**		**Link to Trust Strategic Objectives 2022/23**	
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 asked to approve the WRES return and action plan.

Hull University Teaching Hospitals NHS Trust

Workforce Race Equality Standard (WRES)
Trust Submission 2022/23

1 Purpose

The purpose of this paper is to present the findings of the Trust's Workforce Race Equality Standard (WRES) submission for 2022/23 and proposed Action Plan for 2023/24. The 2022/23 WRES is based on data as at 31st March 2023.

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 2023, the Trust employed 9,505 staff, of which:

- 7,541 (79.34%) identify as White;
- 1,777 (18.70%) identify as BAME; and
- 187 (1.96%) did not declare their ethnicity.

It should be noted that 1,244 bank staff are excluded from this number as last year and a separate Bank WRES (BRWES) report will be made for 2022/23 details of which have now been confirmed.

3 WRES Submission 2022/23

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 2023. 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 by 31 May 2023 was achieved.

- 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 31 October 2023.
- WRES Action Plan 2023/24 (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 31 October 2023.

4 Achievements throughout 2022/23

There have been a number of achievements in the past year, which are detailed below:

4.1 Zero Tolerance to Racism Framework

On 10 June 2022 the Trust announced it's Anti-Racist stance at the BAME staff Conference, the Zero Tolerance to Racism reporting tool along with the framework was launched on the 1st August 2022.

A Circle group was established that meets on a fortnightly basis, it's members are EDI Manager, Head of Workforce, Freedom to Speak Up Guardian, Senior Organisation Development Manager, Security Manager & BAME staff network chair. Support is given to and issues addressed directly with Staff, systemic interventions are sought. Examples are infrastructural support for nursing students working with Higher Education providers to provide clear guidance for student nurses over recourse to fair processes, Recommendation to HUTH inequalities steering group for project team to be established to engage with the Gypsy Roma Traveller community, exploring options for greater support for International Medical Graduates that join the Trust recommendation to EDI steering group.

A significant percentage (40%) of reports considered by the Circle group relate to patient behaviours which we challenge, working with operational management. The poster campaign to publish the launch of the framework and publicity in the local press raised the profile of issue in the community.

4.2 Recruitment

A process mapping group has been established to break down all elements of the recruitment process and establish ways that we can make the process more inclusive and improve representation. I all cases where AAC panels constituents would not include a BAME member, the Chief Executive and Chief Medical Officer have mandated that an additional panel member who is BAME shall be included as a full member of the panel, and to have an equality representative on the panel guidance has been produced.

The process mapping group is also reviewing our use of Values Based Recruitment and how it can be made more inclusive

4.3 Career Enhancing Programme

It wasn't believed that the shadow board concept would be a practical solution to the issue of BAME representation in the Trust, instead an alternative programme is being developed in conjunction with the BAME staff network that will offer BAME staff opportunities at career enhancement, involving a blend of development, secondments and mentoring.

4.4 BAME Conference

A very successful and well attended hybrid conference on the theme of "Achieving equity in our diverse workforce" was held during the year. It featured the adoption of an Anti-Racist statement by the Trust underscored by the Zero Tolerance to Racism Framework and a talk about how BAME staff can progress their careers.

4.5 BAME Network Chair

During the year Dumbor Ngaage completed his 2 year term as network chair and after a selection process he was replaced by Yoghini Nagandran a Consultant Geriatrician. Dawda Jatta also completed his term as Deputy Chair, the Network thanked Dumbor & Dawda for all their efforts on behalf of BAME staff in the Trust in particular for the leadership that Dumbor provided in supporting the Trust and colleagues through the Covid pandemic.

4.6 Working on Anti-Racism

The Trust ran a number of sessions in association with BRAP, the aim of which was to develop participants understanding of race and anti-racism. To discuss the challenges and opportunities they have as leaders, managers or general staff who want to transform the workplace culture.

4.7 Mandatory EDI Training

Has been reviewed and updated during the year and is more inclusive in particular it highlights the challenges that BAME staff encounter in the NHS & highlights areas of support and how white colleagues can act as Upstanders.

5 Overview of Key Findings from the 2022/23 Data

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 219 (from 1558 to 1777) which is a positive. 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 are now equally as likely to enter into the formal disciplinary process compared to White staff which provides parity but is a relative increase in BAME staff entering disciplinary processes a trend that needs to be monitored, though the overall picture is in the context of a significant reduction in the total number of disciplinaries by 39.
- BAME staff are marginally more likely to access non-mandatory training and CPD compared to White staff, this number ostensibly equal which would be the objective the data collection methodology is now significantly improved with guidance on how individuals input of training onto HEY247 now readily available.

Further improvements need to be made across the following indicators:

- The percentage of BAME people being appointed from shortlisting increased marginally in the last 12 months, but the relative likelihood of White staff being appointed from shortlisting compared to BAME staff has remained relatively static, but is ahead of the national average.
- Whilst further work to improve the experiences of BAME staff in relation to bullying and harassment and career progression/promotion needs to continue it is yet to be seen how positively the Zero to Racism Framework can impact upon this however we will be able to assess this when the 2023 staff survey results are available.
- Work to improve the diversity of the Trust Board and particularly 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 2023/24 (see Appendix 2).

The outcomes from the Trust's 2022/23 WRES return have been shared with the Trust's BAME Leadership Network.

6 Next Steps

The WRES Action Plan 2023/24 (in Appendix 2) details the Trust's next steps, which represents significant and ambitious plans.

7 Conclusion

The Trust's 2022/23 WRES data, shown in the WRES 2022/23 Report (see Appendix 1), continues to highlight that the lived experiences of BAME colleagues within the Trust is different to other groups.

The Trust continues to be committed to addressing this and has an ambitious action plan developed in conjunction with the BAME Leadership Network 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 2023/24 (see Appendix 2).

8 Recommendation

The Trust Board is asked to approve the WRES return and action plan.

Simon Nearney
Director of Workforce and Organisational Development

September 2023

Appendix 1 - Workforce Race Equality Standard (WRES) 2022/23 Report

1. Background

This report details the Trust's 2022/23 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 31 October 2023.

2. Introduction

The Trust employed 9,505 staff at 31 March 2023. This is an increase of 367 staff in total compared to the previous reporting period (9,138 staff as at 31 March 2022).

The number and percentage of staff by ethnicity is as follows:

Ethnicity	31 March 2022	31 March 2023
White	7433 (81.34%)	7541 (79.34%)
BAME	1558 (17.05%) (+130)	1777 (18.70%) (+219)
Not Stated	147 (1.61%)	187 (1.96%)
Grand Total	**9,138**	**9,505**

NB: The number colour coded in brackets shows where the change is positive/negative for BAME colleagues

3 WRES 2022/23 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 increase of 175 staff across all ethnicities (from 2105 to 2278). Of this there has been an increase of BAME staff by 27 (from 76 to 103).

Table 1: The number and percentage of ***NON-CLINICAL*** staff at 31 March 2023

	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Under B1	8	100.00	0	**0.00**	0	0.00
B1	17	94.44	1	**5.56**	0	0.00
B2	911	92.96	58	**5.92**	11	1.12
B3	464	95.67	18	**3.71**	3	0.62
B4	207	96.28	6	**2.79**	2	0.93
B5	159	95.78	7	**4.22**	0	0.00
B6	130	97.74	3	**2.26**	0	0.00
B7	89	90.82	4	**4.08**	5	5.10
B8a	65	94.20	2	**2.90**	2	2.90
B8b	44	93.62	2	**4.26**	1	2.13
B8c	19	100.00	0	**4.17**	0	0.00
B8d	8	88.89	0	**0.00**	1	11.11
B9	4	100.00	0	**0.00**	0	0.00
VSM	25	92.59	2	**7.41**	0	0.00
Total	**2150**		**103**		**25**	

Clinical Non-Medical Staff

In the clinical non-medical category, there has been a total increase of 215 staff across all ethnicities (from 5628 to 5843). Which includes there has been an increase of BAME staff by 164 (from 731 to 895).

The most significant contributor to the increase in BAME staff headcount is due to the Trust's continued sourcing of internationally educated nurses who will account for the majority of the increase in Band 5 BAME nurses.

Table 2: The number/percentage of ***CLINICAL NON-MEDICAL*** staff at 31 March 2023

	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Under B1	61	95.31	3	**4.69**	0	0.00
B1	1	100.00	0	**0.00**	0	0.00
B2	1061	92.99	69	**6.05**	11	0.96
B3	487	95.49	17	**3.33**	6	1.18
B4	209	96.31	7	**3.23**	1	0.46
B5	1287	66.27	621	**31.98**	34	1.75
B6	911	87.85	115	**1109**	11	1.06
B7	605	92.79	41	**6.29**	6	0.92
B8a	163	88.81	19	**10.27**	3	1.62
B8b	51	98.08	1	**1.92**	0	0.00
B8c	20	95.24	1	**4.76**	0	0.00
B8d	3	100.00	0	**0.00**	0	0.00
B9	2	100.00	0	**0.00**	0	0.00
VSM	14	87.50	1	**6.25**	1	6.25
Total	**4875**		**895**		**73**	

Medical and Dental Staff

There has been a total increase of medical and dental staff across all ethnicities by 88 (from 1304 to 1392) included in this is an increase of BAME staff by 31 (from 751 to 782).

Table 3: The number/percentage of ***MEDICAL AND DENTAL*** staff at 31 March 2022

2021/22	White		BAME		Unknown	
	Headcount	%	Headcount	%	Headcount	%
Consultants	234	44.73	271	**52.34**	15	2.93
Non-Consultant Career Grade	14	22.58	46	**74.19**	2	3.23
Trainee Grades	273	33.70	465	**57.41**	72	8.89
Other	0	0.00	0	**0.00**	0	0.00
Total	**521**		**782**		**89**	

Table 4: The number and percentage of ***NON-CLINICAL*** staff in each band over 2 years

	2021/22		2022/23		2021/22		2022/23		2021/22		2022/23	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	5	100.00	**8**	100.00	**0**	**0.00**	0	**0.00**	0	0.00	0	0.00
B1	29	93.55	**17**	94.44	**2**	**6.45**	1	**5.56**	0	0.00	0	0.00
B2	898	94.83	911	92.96	**39**	**4.12**	58	**5.92**	10	1.06	11	1.12
B3	440	96.70	464	95.67	**11**	**2.42**	18	**3.71**	4	0.88	3	0.62
B4	197	96.57	207	96.28	**6**	**2.94**	6	**2.79**	1	0.49	2	0.93
B5	185	97.88	159	95.78	**4**	**2.12**	7	**4.22**	0	0.00	0	0.00
B6	100	96.15	130	97.74	**4**	**3.85**	3	**2.26**	0	0.00	0	0.00
B7	86	91.49	89	90.82	**3**	**3.19**	4	**4.08**	5	5.32	5	5.10
B8a	67	90.54	65	94.20	**4**	**5.41**	2	**2.90**	3	4.05	2	2.90
B8b	41	95.35	44	93.62	**1**	**2.33**	2	**4.26**	1	2.33	1	2.13
B8c	23	95.83	19	100.00	**1**	**4.17**	0	**4.17**	0	0.00	0	0.00
B8d	6	85.71	8	88.89	**0**	**0.00**	0	**0.00**	1	14.29	1	11.11
B9	1	100.00	4	100.00	**0**	**0.00**	0	**0.00**	0	0.00	0	0.00
VSM	27	96.43	25	92.59	**1**	**3.57**	2	**7.41**	0	0.00	0	0.00
Total	**2105**		**2150**		**76**		**103**		**25**		**25**	

Table 5: The number and percentage of ***CLINICAL NON-MEDICAL*** staff in each band over 2 years

	2021/22		2022/23		2021/22		2022/23		2021/22		2022/23	
	White Headcount	White %	White Headcount	White %	BAME Headcount	BAME %	BAME Headcount	BAME %	Unknown Headcount	Unknown %	Unknown Headcount	Unknown %
Under B1	67	95.71	61	95.31	**3**	**4.29**	3	**4.69**	0	0.00	0	0.00
B1	4	100.00	1	100.00	**0**	**0.00**	0	**0.00**	0	0.00	0	0.00
B2	1016	95.85	1061	92.99	**34**	**3.21**	69	**6.05**	10	0.94	11	0.96
B3	497	96.13	487	95.49	**14**	**2.71**	17	**3.33**	6	1.16	6	1.18
B4	194	94.63	209	96.31	**11**	**5.37**	7	**3.23**	0	0.00	1	0.46
B5	1344	70.81	1287	66.27	**528**	**27.82**	621	**31.98**	26	1.37	34	1.75
B6	906	89.53	911	87.85	**92**	**9.09**	115	**1109**	14	1.38	11	1.06
B7	582	93.57	605	92.79	**32**	**5.14**	41	**6.29**	8	1.29	6	0.92
B8a	140	89.17	163	88.81	**14**	**8.92**	19	**10.27**	3	1.91	3	1.62

B8b	48	96.00	51	98.08	**2**	**4.00**	1	**1.92**	0	0.00	0	0.00
B8c	16	94.12	20	95.24	**0**	**0.00**	1	**4.76**	1	5.88	0	0.00
B8d	2	100.00	3	100.00	**0**	**0.00**	0	**0.00**	0	0.00	0	0.00
B9	2	100.00	2	100.00	**0**	**0.00**	0	**0.00**	0	0.00	0	0.00
VSM	11	91.67	14	87.50	**1**	**8.33**	1	**6.25**	0	0%	1	6.25
Total	**4829**		**4875**		**731**		**895**		**68**		**73**	

Table 6: The number and percentage of ***MEDICAL AND DENTAL*** staff in each band over 2 years

	2021/22		**2022/23**		**2021/22**		**2022/23**		**2021/22**		**2022/23**	
	White Headcount	**White %**	**White Headcount**	**White %**	**BAME Headcount**	**BAME %**	**BAME Headcount**	**BAME %**	**Unknown Headcount**	**Unknown %**	**Unknown Headcount**	**Unknown %**
Consultants	223	46.36	234	44.73	**245**	**50.94**	271	**52.34**	13	2.70	15	2.93
Non-Consultant Career Grade	16	27.12	14	22.58	**40**	**67.80**	46	**74.19**	3	5.08	2	3.23
Trainee Grades	260	34.03	273	33.70	**466**	**60.99**	465	**57.41**	38	4.97	72	8.89
Other	0	0.00	0	0.00	**0**	**0.00**	0	**0.00**	0	0.00	0	0.00
Total	**499**		**521**		**751**		**782**		**54**		**89**	

3.2 Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts

In comparison to the 2021/22 WRES data, this year's data shows:

- 1606 BAME applicants were shortlisted and 322 appointed compared to last year (which showed 1083 BAME applicants were shortlisted and 204 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 1.30 times more likely to be appointed from shortlisting compared to BAME colleagues.

Table 7: The percentage of staff ***SHORTLISTED*** and ***APPOINTED*** over 2 years

Ethnicity	2021/22	**2022/23**
White	25.17%	26.00%
BAME	18.84%	20.05%
Not Stated	45.83%	31.67%
Relative likelihood	1.34	**1.30**

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.

In comparison to the 2021/22 WRES data, the 2022/23 data shows:

- BAME staff are more likely to enter into the disciplinary process than White staff.
- The number of disciplinaries in total across all ethnicities from 1 April 2022 to 31 March 2023 has decreased by 49 (from 125 to 76).
- However, the number of BAME staff entering the formal disciplinary process has increased by 5 (from 10 to 15 in total over the last year).

Table 8: Percentage of staff who entered into a ***FORMAL DISCIPLINARY PROCESS***

Ethnicity	2021/22	**2022/23**
White	1.52%	0.80%
BAME	0.64%	0.84%
Not Stated	1.36%	0.53%
Relative likelihood	0.42	**1.06**

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 2022/23 WRES data, this year's data shows:

- The number of BAME staff accessing training has increased marginally by 21 employees (from 1340 to 1361).
- Within the Trust, the relative likelihood shows that BAME staff are more likely to access non-mandatory training and CPD than White staff, though in effect there is equality of access.

Table 9: Percentage of staff who accessed ***NON-MANDATORY TRAINING*** and ***CPD***

Ethnicity	2021/22	**2022/23**
White	88.04%	74.69%
BAME	86.01%	76.59%
Not Stated	88.44%	74.33%
Relative likelihood	1.02	**0.98**

NB: Colour coded to show where the change is positive/negative for BAME colleagues

3.5 Indicator 5-8 Staff Survey Results

The 2022/23 Staff Survey results show in comparison to the 2021/22 data:

- Bullying & Harassment by patients and service users towards BAME staff and White staff has risen significantly.
- Bullying and harassment from staff has increased for both White and BAME staff, however it has increased more for BAME staff.
- The number of staff who feel that the Trust provides equal opportunities for career progression or promotion has increased by nearly 2% for BAME staff, whilst slightly falling for White staff.
- The number of BAME staff who stated that they personally experienced discrimination at work from a manager/team leader or other colleagues has decreased by nearly 2%.

To complement the Staff Conflict Resolution Policy introduced in May 2021 the Trust launched the Zero Tolerance to Racism framework during August 2022, this has encouraged employees that are the recipients of harassment at work to make a formal report to the organisation for interventions to be made, these relate to behaviour by colleagues, managers and patients the impact of this will be measurable when the 2023 staff survey results are available.

Table 10: Data for Indicators 5 to 8

Staff Survey Indicators	**White %**		**BAME %**	
	2021/22	**2022/23**	**2021/22**	**2022/23**
Indicator 5: KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	25.5%	28.8%	28.8%	33.0%
Indicator 6: KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	19.7%	21.5%	26.1%	31.3%
Indicator 7: KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	58.7%	58.1%	44.8%	46.6%
Indicator 8: Q17. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues	7.3%	6.6%	18.2%	16.4%

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 2023, the Trust has 17 Board members in total, of which:

- 15 (88.2%) are of White ethnicity compared to 16 in the previous year.
- 2 (11.8%) are BAME staff members which is the same as the previous year.

Table 11: Percentage difference between the BOARD MEMBERSHIP VS. OVERALL WORKFORCE

Ethnicity	2021/22	2022/23
Difference (total Board – overall workforce)	-5.9%	-6.9%

4 Achievements throughout 2022/23

There have been a number of achievements in the past year, which are detailed below:

4.1 Zero Tolerance to Racism

On 10 June 2022 the Trust announced it's Anti-Racist stance at the BAME staff Conference, the Zero Tolerance to Racism reporting tool along with the framework was launched on the 1st August 2022.

A Circle group was established that meets on a fortnightly basis, it's members are EDI Manager, Head of Workforce, Freedom to Speak Up Guardian, Senior Organisation Development Manager, Security Manager & BAME staff network chair. Support is given to and issues addressed directly with Staff, systemic interventions are sought. Examples are infrastructural support for nursing students working with Higher Education providers to provide clear guidance for student nurses over recourse to fair processes, Recommendation to HUTH inequalities steering group for project team to be established to engage with the Gypsy Roma Traveller community, exploring options for greater support for International Medical Graduates that join the Trust recommendation to EDI steering group.

A significant percentage (40%) of reports considered by the Circle group relate to patient behaviours which we challenge, working with operational management. The poster campaign to publish the launch of the framework and publicity in the local press raised the profile of issue in the community.

4.2 Recruitment

A process mapping group has been established to break down all elements of the recruitment process and establish ways that we can make the process more inclusive and improve representation. I all cases where AAC panels constituents would not include a BAME member, the Chief Executive and Chief Medical Officer have mandated that an additional panel member who is BAME shall be included as a full member of the panel, and to have an equality representative on the panel guidance has been produced.

The process mapping group is also reviewing our use of Values Based Recruitment and how it can be made more inclusive

4.3 Career Enhancing Programme

It wasn't believed that the shadow board concept would be a practical solution to the issue of BAME representation in the Trust, instead an alternative programme is being developed in conjunction with the BAME staff network that will offer BAME staff opportunities at career enhancement, involving a blend of development, secondments and mentoring.

4.4 BAME Conference

A very successful and well attended hybrid conference on the theme of "Achieving equity in our diverse workforce" was held during the year. It featured the adoption of an Anti-Racist statement by the Trust underscored by the Zero Tolerance to Racism Framework4.6 and a talk about how BAME staff can progress their careers.

4.5 BAME Network Chair

During the year Dumbor Ngaage completed his 2 year term as network chair and after a selection process he was replaced by Yoghini Nagandran a Consultant Geriatrician. Dawda Jatta also completed his term as Deputy Chair, the Network thanked Dumbor & Dawda for all their efforts on behalf of BAME staff in the Trust in particular for the leadership that Dumbor provided in supporting the Trust and colleagues through the Covid pandemic.

4.6 Working on Anti-Racism

The Trust ran a number of sessions in association with BRAP, the aim of which was to develop participants understanding of race and anti-racism. To discuss the challenges and opportunities they have as leaders, managers or general staff who want to transform the workplace culture.

4.7 Mandatory EDI Training

Has been reviewed and updated during the year and is more inclusive in particular it highlights the challenges that BAME staff encounter in the NHS & highlights areas of support and how white colleagues can act as Upstanders.

5 Summary

Improvements have been made across the following indicators:

- The total number of BAME staff has increased across the staff groups by 162 (from 1266 to 1428) 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 are now slightly more likely to enter into the formal disciplinary process compared to White staff.
- BAME staff are marginally more likely to access non-mandatory training and CPD compared 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, the relative likelihood of White staff being appointed from shortlisting compared to BAME staff only decreased 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 needs to continue.

The Trust continues to be committed to closing the gap between White and BAME worklife experience as detailed within the Action Plan 2023/24 (see Appendix 2).

Appendix 2 - Workforce Race Equality Standard Action Plan 2023/24

The Action Plan 2023/24 has been developed, based on the 2022/23 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
Continue the work to promote & refine the Zero Tolerance to Racism Framework and Reporting tool that will enable the Trust to embed it's Anti-Racist stance	Indicators 5, 6, 8	Ongoing	EDI Manager
Explore ways that the Trusts EDI strategies can strengthen the addressing of Race Inequalities specifically taking into consideration the Group Structure of the organisation.	All	January 24/Ongoing	Workforce & OD EDI Team
Charge the project group working on improving the appraisal process to consider ways that specific inclusion objectives can be incorporated into the appraisal process	Indicators 6, 7, 8	December 23/Ongoing	EDI Manager & OD Team
Continue the work of the Project Group reviewing recruitment processes through the lens of EDI, introducing initiatives that will enable BAME staff to progress their careers on an equal basis, specifically Band 6+ nursing appointments	Indicators 1, 2, 7	October 23/Ongoing	EDI Manager
Review the use of Value Based Recruitment in the Trust from an EDI perspective and assess the inclusivity of the process and if there are issues recommend options to change VBR that will offer equality of opportunity irrespective of cultural background.	Indicator 2, 7	February 24/Ongoing	OD & EDI Manager
Introduce our internally designed Career Enhancing Programme that will be designed to expedite career opportunities for BAME staff through a blended mix of Mentoring, Development & Secondments	Indicator 1, 9	November 23/Ongoing	OD Team
Introduce a Pilot for having a number of EDI Champions in Pharmacy, following evaluation consider expanding throughout the Trust	Indicator 5, 6, 7, 8	December 23/Ongoing	EDI & Chief Pharmacist

Strengthen our support for staff by: Participating in the national programme Introducing Cultural Intelligence programmes for nursing managers of Internationally Educated Nurses	Indicator 6	November 23/Ongoing	EDI Manager & Nursing Director
Run another Withstand Development Programme to bolster our offer to Band 4-6 Clinical BAME staff It is an innovative programme designed to bridge the gap between where participants are and where they would like their future career to be.	Indicator 1, 7	November 23	OD Team
Staff Network Chair to participate in the North East & Yorkshire regional Development programme and feedback via EDI steering Group	All	December 23	Staff Network Chair

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

WORKFORCE RACE 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 BAME & WHITE staff.

Action	Delivery Timescale	Lead Responsibility	Achievements/ Outcomes
1. Develop and Launch a Zero Tolerance to Racism Framework and Reporting tool that will enable the Trust to adopt an Anti-Racist stance	August 2022	Workforce & OD EDI Team	June 2022 Trust announced it's Anti-Racist stance at BAME staff Conference, Zero Tolerance to Racism reporting tool along with framework launched 1st August
2. Establish a "Circle Group" to analyse heat maps and individual reports of Racism and Triage for meaningful interventions agreed with reporters	August 2022	Workforce & OD EDI Team	The Circle group meets on a fortnightly basis, it's members are EDI lead, Senior HR Rep, FTSUG, OD rep, Security Manager & BAME staff network chair. Support is given, issues addressed with Staff Systemic interventions are sought. Eg Support for Nursing Students Recommendation to inequalities steering group for project team to engage with Gypsy Roma Traveller community Exploring greater support for International Medical Graduates that join the Trust
3. 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	August 2022	Workforce & OD EDI Team	A significant percentage of (40%) reports relate to patient behaviours which we challenge, a slight issue has been the withdrawal of Patient Experience from the process and finding alternative support operationally

Action	Delivery Timescale	Lead Responsibility	Achievements/ Outcomes
Action	**Delivery Timescale**	**Lead Responsibility**	**Achievements/Outcomes**
1. 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	March 2023	Workforce & OD EDI Team	A process mapping group has been established to break down all elements of the recruitment process and establish ways that we can make the process more inclusive and improve representation. Recommendation made to not have white only AAC panels, with equality representative guidance, will carry over to next year
2. 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.	March 2023	Workforce & OD EDI Team	A process mapping group will review our use of VBR and how it can be made more inclusive, will also be carried across to next year
3. 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	March 2023	Workforce & OD EDI Team	This has been assessed and at present a shadow board isn't felt to be the correct solution for us, instead an alternative programme is in the process of being developed that will offer BAME staff opportunities at career enhancement, involving a blend of development, secondments and mentoring. A finalised design of programme to be completed

HUTH RESPONSIBLE OFFICER STATEMENT OF COMPLIANCE

REFERENCES

Only PDFs are attached

11.5 - HUTH RO Board Report & Statement of Compliance 2022-23.pdf

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
Title	Responsible Officer Report 2022/23				
Lead Director	Makani Purva, Chief Medical Officer				
Author	Oliver Miskin, Senior e-Medical Workforce Officer				
Report previously considered by (date)	This report has not been considered by 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:

Recommendation:
The Trust Board is asked to review the content of the report and approve that the organisation is compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

A framework of quality assurance for responsible officers and revalidation

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

RESPONSIBLE OFFICER REPORT 2022/23

Annex D – annual board report and statement of compliance

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of **Hull University Teaching Hospitals NHS Trust** can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes – Mr Peter Sedman is the Trust's appropriately trained and appointed Responsible Officer for Hull University Teaching Hospitals NHS Trust and Dove House Hospice.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes. This is held and maintained by the HUTH Revalidation Team.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes – the Revalidation & Appraisal policy for medical staff was recently reviewed in July 2023 and the Medical Appraisal Escalation Policy was reviewed in January 2023.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

A peer review has not yet taken place and it is anticipated this will be undertaken in future. The HUTH Revalidation Team will explore the peer review process.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Yes

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Yes

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes – this is ratified via the Trust's Local Negotiating Committee and The Workforce Transformation Committee.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes - Recruitment of new appraisers remains ongoing to ensure the increase in doctors whom the Trust is the Designated Body for have access to an appraiser who can conduct their annual appraisal.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes – the Senior Appraiser Team and HUTH Revalidation Team ensures the training of the Appraiser team is up-to-date, deliver training to new Appraisers

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

and perform Quality Assurance (QA) of appraisals. There is an annual Appraiser Network meeting which provides the opportunity for the Trust's Appraisers to share best practice and receive updates on local and national processes surrounding revalidation and appraisal. The last network meeting occurred in June 2023.

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes - All appraisal inputs and outputs of those Doctors due for revalidation are reviewed by the Senior Appraiser Team and HUTH Revalidation Team prior to the monthly Revalidation Panel chaired by the RO. The Senior Appraiser Team undertook a QA exercise on a 10% sample of appraisal output forms for 2022/23. The QA was completed using a locally designed QA template called HUTH Appraisal Summary & PDP Audit Tool (HASPAT). Results showed that 88% of outputs reviewed were scored as satisfactory to excellent, with constructive feedback provided to those appraisers whose output forms were scored less than satisfactory. Constructive feedback provided to Appraisers by the Senior Appraiser Team is also used in the ongoing Appraiser training programme.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of Doctors with a prescribed connection as at 31 March 2023	**738**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	665
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	61
Total number of agreed exceptions	12

The Trust's medical appraisal figures are discussed monthly at every Health Group performance meeting, as well as at the monthly Revalidation and Appraisal Committee chaired by the Responsible Officer. Those doctors with an appraisal date that is categorised as an '*unapproved missed appraisal*' are managed under the Trust's Medical Escalation Policy.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes – the Trust made 81 revalidation recommendations in 2022/23; 79 positive and 2 deferrals. The 2 deferrals were submitted due to the doctors having an interruption to practice; maternity leave and career break. In summary, 98% of recommendations submitted by the RO in 2022/23 were for a positive recommendation.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes - Where there is concern about a Doctor's conduct or capability this is managed under the Trust's Maintaining High Professional Standards Policy. In all cases involving capability, and where appropriate in cases of possible misconduct, the investigation process would be conducted in consultation with NHS Resolution (formerly the National Clinical Assessment Service, NCAS). If misconduct is substantiated a range of disciplinary sanctions, ranging from reflective learning to dismissal are available. If concerns regarding capability are substantiated, an appropriate course of action developed in conjunction with NHS Resolution may be put in place. In the majority of capability cases the first option is to consider remediation and support.

In addition to local Trust investigations Doctors may also be subject to investigation by the GMC. Where appropriate. this is as a result of the Trust reporting the result of a local investigation to the GMC, but more commonly the Doctor has been referred to the GMC by someone else (patient, relative, previous employer, etc.). The Trust cooperates fully with any GMC investigation into employees.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Yes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes – the RO Transfer Form continues to be used by the HUTH Revalidation Team to be completed by the RO from the prospective employee's previous organisation: this includes revalidation date, date of last appraisal and any concerns arising from appraisal, details of ongoing or previous GMC/NHS Resolution investigations (formerly NCAS), local conditions or undertakings,

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

and any unresolved performance concerns. The prospective RO is informed accordingly.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes:

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes - The Trust's Employee Service Centre (HR department) has in place a system for checking identity, current and previous GMC conditions or undertakings, appropriate recent references, details of last (or current) Responsible Officer, qualification check, and police clearance.

Section 6 – Summary of comments, and overall conclusion

- The Trust has an appointed Responsible Officer, who is trained and supported to perform the role
- The Trust has complied with its obligations as a Designated Body, and has appropriate procedures in place to make recommendations to the General Medical Council on revalidation
- The Trust has appropriate governance structures, policies, and procedures in place to ensure as far as possible that its medical workforce is fit to practise and complies with GMC Good Medical Practice

- There is a robust appraisal system in place, which is developmental and formative in nature.

- The Trust has a Medical Appraisal Escalation Policy to ensure that those Doctors whose appraisal is not undertaken within the required timescales are given the appropriate steps to follow. This policy was reviewed and updated in January 2023 and has been ratified by the Local Negotiating Committee (LNC)

- The Trust continues to achieve the 90% NHS England appraisal target

- Maintaining a high level of appraisal rate is reliant on the continued implementation of an electronic platform, continuing essential administrative support and the Trust having sufficient numbers of trained medical Appraisers to deliver a successful appraisal programme

Section 7 – Statement of Compliance:

The Board of Hull University Teaching Hospitals NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: **Hull University Teaching Hospitals NHS Trust**

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

ANY OTHER BUSINESS

DATE AND TIME OF THE NEXT MEETING:

Tuesday 14 November 2023, 9am - 1pm
The Boardroom, Alderson House

SUPPORTING DOCUMENTS

Quality Report
Maternity Report
Safeguarding Annual Reports (Adults and Children)
Mortality - Learning from Deaths update
End of Life Care Annual Report
Performance Report
Finance Report
Workforce Report
Under Graduate Education Report

REFERENCES

Only PDFs are attached

- 1 - Quality Report - Quality Committee - August 23 draft v2.pdf
- 2 - Maternity Presentation Quality 2023.pptx
- 2.1 - ATAIN Quarter 1 2023FINAL.pdf
- 2.2 - GAP quater 1 2023 FINAL.pdf
- 2.3 - PQSAG Q1 April - June 2023.pdf
- 2.4 - Trust board PMRT report Q1 2023FINAL.pdf
- 2.5 - Trust Board staffing paper July 2023FINAL.pdf
- 3 - Safeguarding Adults Annual Report 2022-23 KR.pdf
- 3 - Safeguarding Children and Young People Annual Report 2022-23 - KR.pdf
- 4 - Learning From Morbidity and Mortality - Q1 23-24.pdf
- 5 - NACEL Outcome form 2023 KS comments.pdf
- 6 - PerformanceReport_Jul23.pdf
- 7 - Finance Report Month 4.pptx
- 8 - Trust Board - Our People 12.09.23 (003).pdf
- 8 - Medical Undergraduate Progress Report June 2023.pdf

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Agenda Item		**Meeting**	Trust board	**Meeting Date**	12 September 2023
Title	Quality Report				
Lead Director	Suzanne Rostron, Director of Quality Governance, Jo Ledger, Chief Nurse and Prof Makani Purva, Chief Medical Officer				
Author	Associate Director of Quality Head of Patient Safety and Improvement, Head of Quality Compliance and Patient Experience Head of Continuous Quality Improvement				
Report previously considered by (date)	This report has not previously been considered elsewhere				

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	x	Honest Caring and Accountable Future	x
Committee Agreement		Patient Confidentiality		Effective	x	Valued, Skilled and Sufficient Staff	x
Assurance	x	Staff Confidentiality		Caring	x	High Quality Care	x
Information Only		Other Exceptional Circumstance		Responsive	x	Great Clinical Services	x
				Well-led	x	Partnerships and Integrated Services	
						Research and Innovation	
						Financial Sustainability	

Key Recommendations:
The Trust Board is recommended to review the executive summary of the key indicators and decide if sufficient assurance has been received with the actions taken to address the concern areas. In addition to confirm if any further action is required.

Quality Report

July 2023 Performance Data

Produced for the September Board Meeting 2023

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1. EXECUTIVE SUMMARY

1.1 ESCALATION OF KEY INDICATORS

Safe Domain	Patient Safety Incident Reporting	The WPSS meets weekly to discuss patient safety incidents for learning; the format is in line with PSIRP, different investigation and learning responses are discussed and plans for reviews agreed. The Patient Safety Team facilitate AARs use and support new PSIRF review tools.	• There were 5 patient deaths reported in July, 1 in EMHG, and 4 in SHG. • 4 deaths are being investigated as PSIIs • A Never Event was reported and investigated in July. This was a wrong site root nerve block in Radiology; this was a repeat event. • Proportion of harm may appear higher as the number of incident being reported is lower, further incident reporting work will take place to address this. • Maternity have established a daily incident review process to ensure the correct grading of incidents.	• Quality Improvement Projects underway to increase the number of patient safety events being reported and this will incorporate work to integrate the transition from the NRLS to Learn from Patient Safety Events service (LFPSE) from April 2023. • QI work streams aligned to Quality Strategy strategic ambitions for harm free care • Incidents resulting in death where care is identified as a contributory factor are discussed at Weekly Patient Safety Summit (WPSS) ongoing investigating as PSIIs. • Thematic reviews of both Radiology and the Emergency Department have begun.
	Inpatient falls resulting in harm	• Training – nurses –Trust is currently over 60%. An electronic booking system is now available on PATTIE. • A new training room has been located at HUTH, the training will commence here September 2023 • Compliance with both Myassure and Fundamental standard audits	• Development of an MDT approach to fall prevention. • Aging and increase in a deconditioned population (Public health England Aug 21). • Funding for essential equipment.	• Plan to enhance training for Non clinical Staff and other HCPs. • Continue to evaluate Quality Improvement Programmes and identify practices that have demonstrated improvement to disseminate across the trust. • Create an established Falls Prevention team due to be established in September.

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
	Deep Tissue Injury pressure ulcers	• Tissue Viability matron involved in all AARs for pressure ulcers. • Critical Care had zero device related pressure ulcers in July following targeted improvement work. • Training is ongoing with 66% of staff completing the bedside assessment training, 67% non-registered and 72% of registered having completed the tissue viability training	• In July,31 Category 2 pressure ulcers reported 6 of which were device related; 0 Category 3 pressure ulcers, 15 Deep Tissue Injuries (DTI) 3 of which were device and 4 unstageable pressure injuries 2 of which were device.	• New skincare product range to be launched to care for moisture associated skin damage. • Monitoring to continue to ensure all Registered Nurses are completing all skin inspections for every patient at least once per shift.

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Effectiveness Domain	HSMR	• The rolling HSMR is 116.80 and the monthly (latest info relates to May 2023) HSMR is 113.01, which has decreased compared to the previous month. • The rolling HSMR is showing a steady rate and displays no sudden elevations	The Trust continues to demonstrate a HSMR with “higher than expected” deaths and is therefore an outlier in HSMR.	The Sepsis and Pneumonia steering groups continue to provide insight data, with detailed action plans being delivered in order to further improve outcomes for these patient cohorts.
	SHMI	Latest data available - • The Trust SHMI continues to remain within the “as expected” levels of death, with the latest SHMI figure (March 2023) of 1.06, a very marginal increase from the previous month. • Pneumonia SHMI continues to remain “as expected” and has very marginally increased to 0.95 as of March 2023. • Sepsis SHMI continues to demonstrate higher than expected’ performance is demonstrating an improving	Sepsis, stroke and pneumonia are the Trusts 3 most prevalent clinical condition diagnoses at the time of patient death.	The Trust continues to monitor HSMR data via regular reporting and committee meetings, whilst streaming into bespoke and overarching quality improvement work plans.

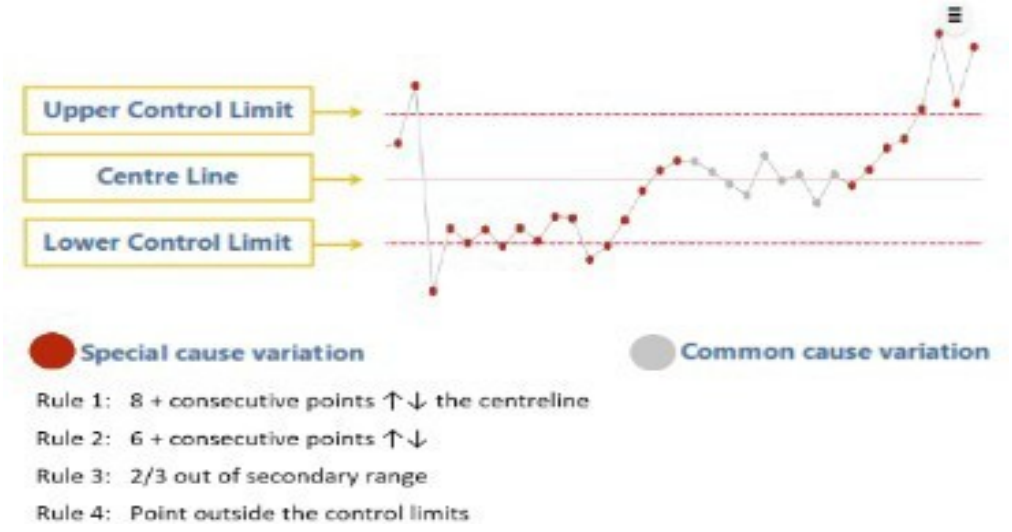
	Indicator	Successes	Risks / Challenges	Actions / Future Plans
		journey from its highest point of 1.47 in August 2021 to 1.26 in March 2023.		
	Stroke	Stroke SHMI is higher than the National Level of 1.0 at 1.28 as of March 2023. The SHMI for stroke has increased between December 22 and March 23. There was an excess of 40 deaths in March 23.	HUTH is one of the middle performing Trusts when compared to its peers against stroke.	Ongoing updates in relation to Stroke mortality given to the Trust Mortality and Morbidity Committee.
	Structured Judgement Reviews	20% of deaths have had a Structure Judgement Review, which has continued to improve following increased engagement from clinicians since late 2022. There are now approx. 500 SJR reviewers in the Trust.	Development of feedback mechanisms, identified by RSM Auditors, minor action for improvement following the Mortality and Learning from Death internal audit.	Action identified by a recent audit of the Learning from Deaths framework, undertaken by RMS, a quality control to check the quality of the SJR against the expectations set out by Trust policy, as well as the National Quality Board. From April 2023 quarterly audit undertaken on a sample of SJR's

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
Responsive Domain	PALS and Complaints	The model complaints steering group approved the updated complaint investigation timescales as the Trust continues to adopt the PHSO NHS Complaint Standards. The Trust will keep the 40 working day target and will continue to aim to investigate complaints as soon as possible within that timeframe. The group also agreed a 60 and a 90 working day target for those complaints which are more complex and across a number of Health Groups or agencies. All complaints received were logged within 3 working days of receipt, no complaints in the backlog for logging	• Maintain improvements against the planned outcomes • The target of 80% of complaints closed within 40 days not yet achieved • There are a number of ongoing complex cases across the Health Groups	• Continue weekly challenge meetings with Medicine, Surgery and Family and Women's. • Continue to gather feedback from complaints on their experience of the complaints process and use the intelligence to inform improvements to the way we manage our complaints as we continue to adopt the PHSO NHS Complaint Standards • Continue to adopt the PHSO NHS Complaint Standards via the Steering Group • Review a selection of complaints closed at the Complaints Reflective Practice Group in August 2023 • Health Groups to focus on addressing the backlog of complaints open over 40 day and to ensure the new complaints are investigated and closed within the target. To also encourage

	Indicator	Successes	Risks / Challenges	Actions / Future Plans
		Continue to implement the early resolution process with the aim of addressing concerns in a quicker timeframe with a reduction in the number of concerns that are escalated to a formal complaint. 42 compliments received via the PALS team in July 2023 with 18 of them reported for Family Women's. The main theme detailed within the compliments continue to be care and comfort (including privacy and dignity) provided to our patients by staff. This shines through in all Health Groups.		early resolution where possible. • Undertake a deep dive into the complaint re-opened and the reasons why to identify areas for improvement in the responses provided to complainants and the quality. • Improve triangulation of data to inform more focussed learning from patient experience, this also links to the patient experience work stream in the Quality Strategy.
Well-led Domain	Continuous Quality Improvement	• Development of the 2024/25 QSIR training programme continuing. • 90 QIPs have been shared and registered with the CQI team. The majority of projects being completed are from Junior Doctors who are required to undertake improvement projects a part of their career progression. • Sepsis QI project, Emergency Department implementation of a High Acuity Bay (HAB) was launched in June 2023, supporting deteriorating patients in being treated more efficiently.		• CQI continuing to work with the Falls team to map improvements and ensure these are sustained. • Review current training programme and revamp for 24/25 to support increasing improvement capability across the Trust. • Patient Safety team and the Patient Experience team, are organising an Improvement Week in the run up to the Patient Safety Day Conference which is scheduled to take place on Friday 29 September 2023.
Care Quality Commission (CQC) updates are shown in detail at the end of this report on the following areas Maternity, Emergency Department, Surgery, Medicine and Trust wide with the CQC action plans monitoring and evidence outlined.				

1.2 EXECUTIVE SUMMARY SCORECARD

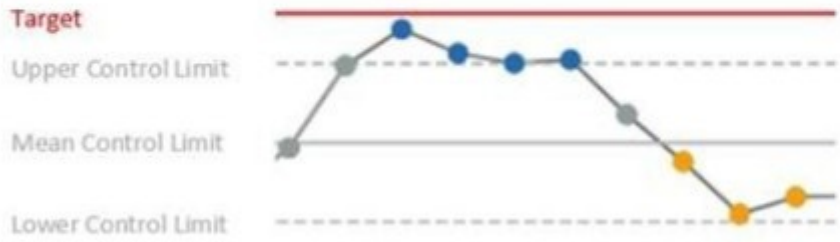
The following provides a high level executive summary of the number of Quality Indicators which are achieving, those which are displaying variance between achieving and failing and those that are consistently failing as detailed on the Integrated Performance Report April 2023.



Statistical Process Control (SPC) is an established analytical technique that plots data over a period of time to help us understand variation and assurance and as a result directing us to the correct area of improvement for the appropriate action to be taken to make a difference. The charts also allow us to monitor the relevant KPIs and determine if they are improving.

A minimum of 15 data points are required for an SPC to be meaningful and inform decision making, improvements and change. This is completed in line with NHS Improvement 'Making Data Count'

Variation			Assurance		
	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target



Common Cause
- No significant change
- Inside control limits

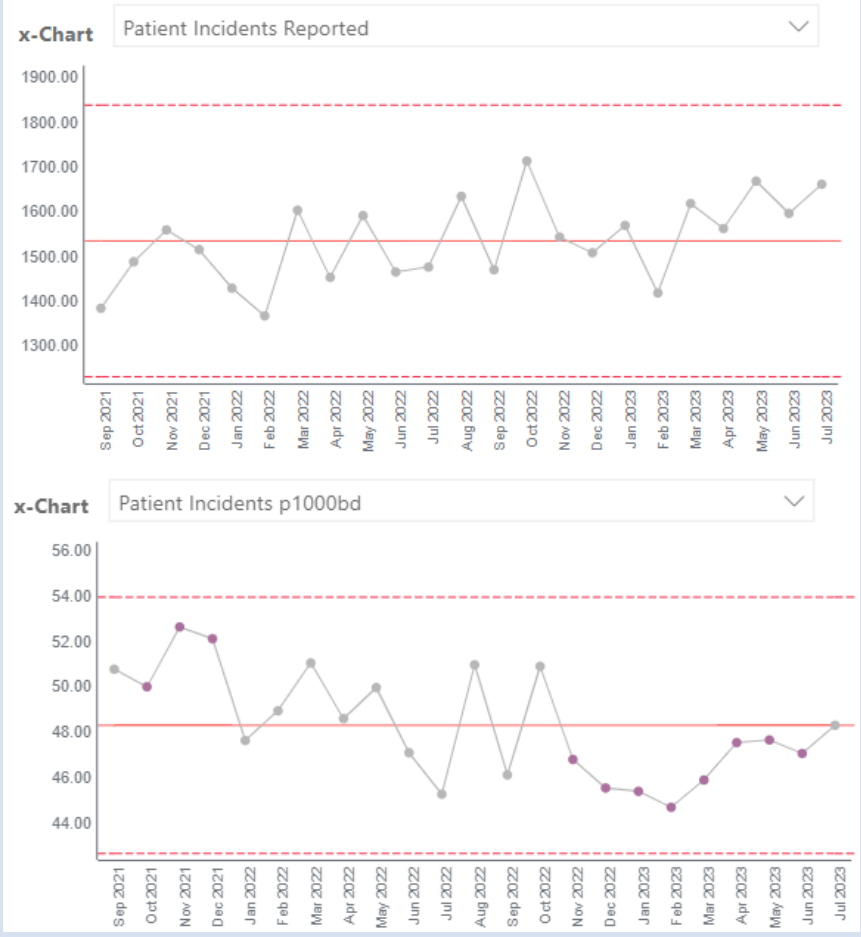
Improvement
- Consecutive Increase
- Above mean
- Above UCL (as appropriate)

Concern
- Consecutive decrease
- Below mean
- Below LCL (as appropriate)

2. SAFE DOMAIN

2.1 PATIENT SAFETY INCIDENT REPORT AND INCIDENTS CAUSING HARM

Patient Safety Incidents reported per 1000 bed days Patient Safety Incidents causing harm per 1000 bed days



Aim: To promote a safe learning culture by reporting patient safety incidents

Target: To see a reduction in the number of incidents resulting in harm

What is the charts are telling us:

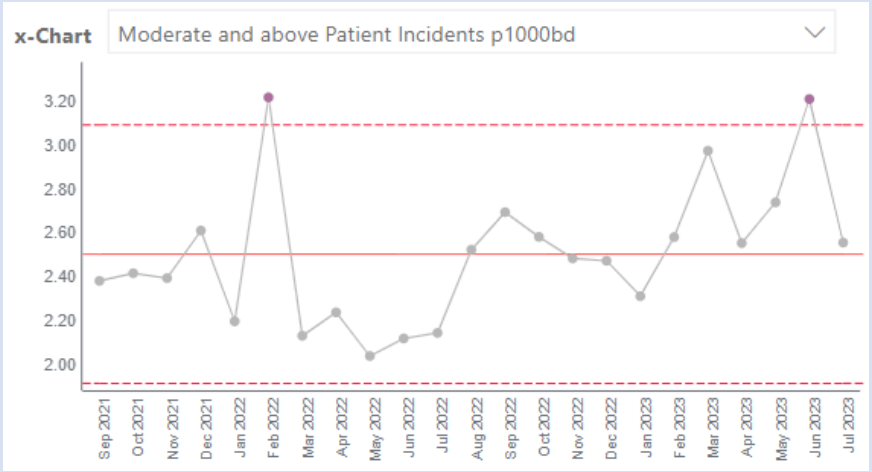
- There were 48 patient safety incidents per 1000 bed days recorded in July 2023 (n=1662); 3.2 (per 1000 bed days) incidents resulted in moderate, severe or catastrophic harm to the patient.
- The number of incidents being reported against all severities per 1000 bed days has been below the mean for nine months.
- The number of incidents causing harm to patients (per 1000 bed days) is showing an upward trend overall with the number reported in July returning to the mean.

Successes:

- The Trust has a positive patient safety reporting culture (high volume, low harm).
- The Trust continues to sustain incident-reporting levels above the national average of 45 with a mean of ~48 per 1000 bed days.
- The WPSS continues to meet to discuss patient safety incidents for learning; with different incident response methods available in line with PSIRP; the different incident and learning responses are discussed positively.
- The Patient Safety Team continued to facilitate After Action Reviews (AARs) in July.

Key Risks and Challenges:

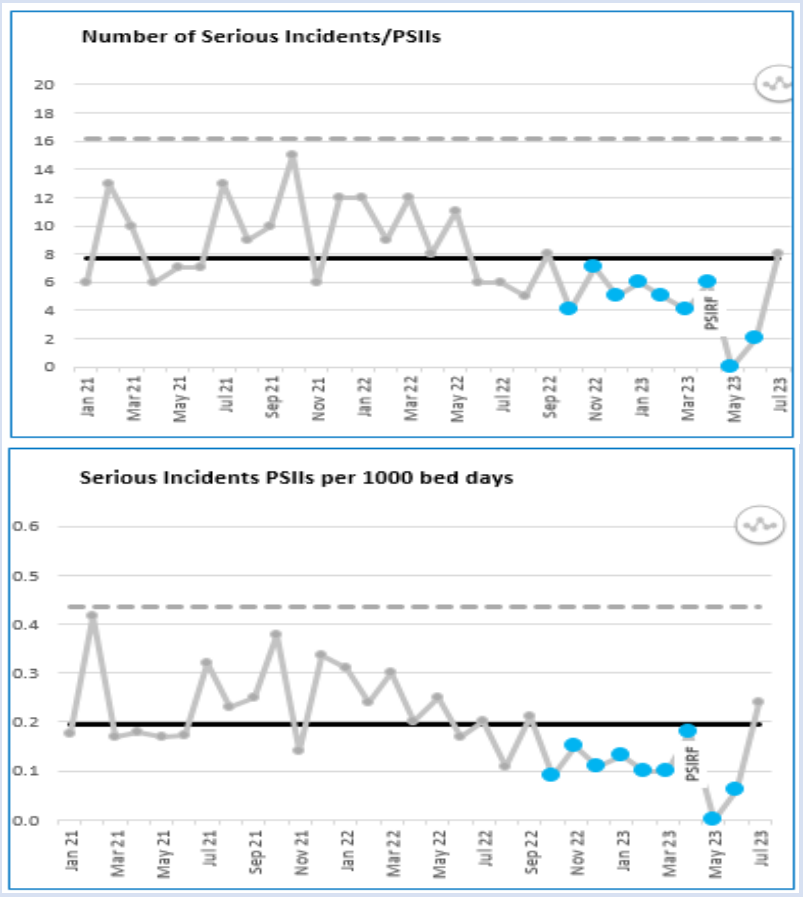
- The highest reported harms to patients was hospital acquired pressure ulcers (48) and administration of care incidents (6).
- There were 5 incidents causing harm reported for hospital acquired skin damage incidents.
- There was a reduction in the number of inpatient falls reported where a patient came to harm; 5 incidents were reported.
- Medicine HG had the highest number of incidents overall, surgical SHG the most that resulted in harm.
- There were 5 patient deaths reported in July, 1 in Emergency Medicine HG, and 4 in Surgical HG.
- The death in the Emergency MHG was a patient who had a delay in treatment

Patient Safety Incidents reported per 1000 bed days Patient Safety Incidents causing harm per 1000 bed days	**Aim:** To promote a safe learning culture by reporting patient safety incidents **Target:** To see a reduction in the number of incidents resulting in harm
	following a stroke; a PSII is being undertaken • One death in the Surgical HG is not being investigated as a PSII; On review of the care of the patient who had Acute Kidney Injury (AKI), there were no omissions in care • 3 deaths in Surgical HG are being investigated as PSIIs • A major trauma patient died; an AAR was undertaken which initially found no omissions in care however the post-mortem report advised cause of death as peritonitis; this had not been diagnosed. • The patient admitted with infected colitis died following a subtotal colectomy; there were delays in the patient being seen by the surgical team whilst in AMU • The patient admitted with gastroenteritis died following a subtotal colectomy; there were delays in the patient being seen by the surgical team whilst in AMU • The last 2 incidents were part of a thematic review looking at 4 incidents in total • A Never Event was reported in July. This was a wrong site root nerve block in Radiology; this was a repeat event. • Proportion of harm may appear higher as the number of incident being reported is lower, further incident reporting work will take place to address this. • Maternity have established a daily incident review process to ensure the correct grading of incidents.
	Actions / Future Plans for Improvement: • Quality Improvement Project underway to increase the number of patient safety events being reported and this will incorporate work to integrate the transition. from the NRLS to Learn from Patient Safety Events service (LFPSE) from April 2023. • QI work streams aligned to Quality Strategy strategic ambitions for harm free care • Incidents resulting in death where care is identified as a contributory factor are discussed at Weekly Patient Safety Summit (WPSS) for investigating as PSIIs focussing on system errors. • A thematic review of Radiology incidents has begun, once completed the learning will be shared at an LfPSE meeting. • A thematic review of Emergency Department care is planned to be presented at Septembers Quality Committee.

2.2 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSIIs) DECLARED

Number of Serious Incidents and PSIIs reported

Serious Incidents/PSIIs per 1000 bed days



Aim: To investigate PSIIs with the aim of learning how to reduce risk and associated harm and ensure supportive systems and process are in place through continuous improvement

What is the chart telling us:

- The Trust declared 8 PSIIs in July 2023; 4 of the incidents were reported onto DATIX in the month and 4 were declared retrospectively following initial investigations.
- The graphs show a shift change in the number of SIs reported over the last year.

Successes:

- The WPSS reviews patient harms and allows for discussion on emerging themes and immediate learning, improvement opportunities and differing approaches to investigation methods e.g. AAR, Safety Huddles, and Thematic Reviews required.
- The WPSS allows for timely identification of serious incidents and sharing information across the HGs.
- The WPSS has been used as a forum to discuss and escalate externally reported incidents through multidisciplinary discussion.
- The Trust began transition from the SI Framework (2015) to PSIRF from 1st April 2023.
- PSIRF information and the investigations toolkit is available on Pattie.

Key Risks and Challenges:

- The Trust had another Never Event as outlined above. As part of the Theatre work stream and wider Never Event Learning a paper will be submitted to Quality Committee.

Actions / Future Plans for Improvement:

- To develop further processes to engage with patients, families by expanding on

Number of Serious Incidents and PSIIs reported Serious Incidents/PSIIs per 1000 bed days	**Aim:** To investigate PSIIs with the aim of learning how to reduce risk and associated harm and ensure supportive systems and process are in place through continuous improvement
	DOC and moving to Human Factors. • New approach has started to work with staff affected by the incident to contribute to learning responses an examples is MDT reviews including national team. • A trajectory has been set for all historic serious incidents declared prior to the transition to PSIRF to be investigated by the end of September 2023; open SI investigations at the end of July was 12 (open over 100 days 4). • Continued work on the investigations open over 100 days and to ensure families are kept updated. • To roll out the use of additional tools in the investigations tool kit e.g. observational and walkthrough analyses • To learn from thematic reviews in no harm and near miss incidents (Safety II). • To grow the Patient Safety Champion network and number of Learning Response Leads for strengthened ward to board learning.

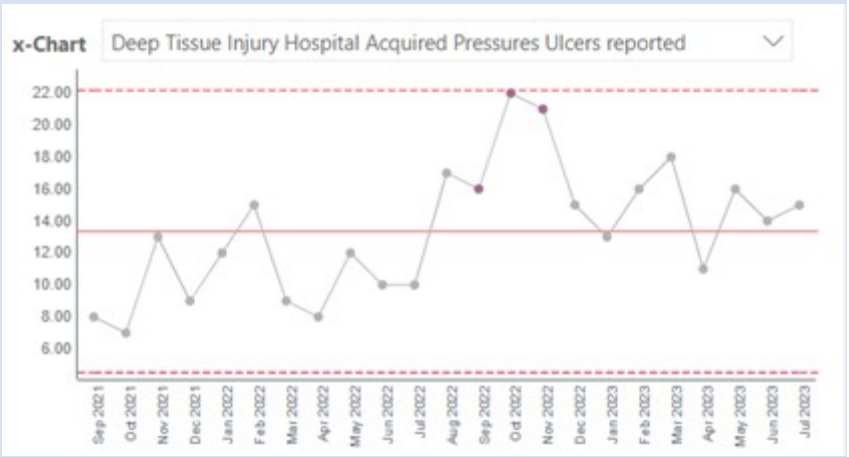
2.4 HOSPITAL ACQUIRED PRESSURE ULCERS CAUSING HARM

Hospital acquired pressure ulcers

Deep Tissue Injury pressure ulcers Category 2 pressure ulcers

Aim: To have a zero tolerance approach to hospital acquired pressure ulcers

Target: To reduce the number of hospital acquired pressure ulcers to below the mean



What is the chart telling us:

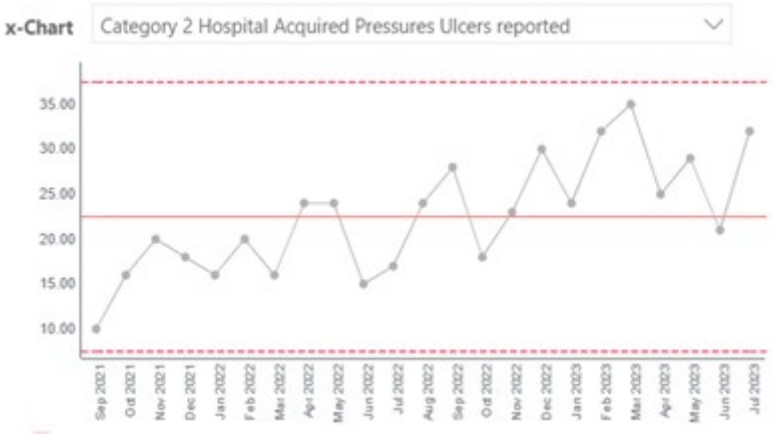
- There were 1.42 pressure ulcers per 1,000 bed days resulting in moderate and above harm in July (n=48 including device related damage).
- Category 2 pressure ulcers for July were 37; this is a slight increase.
  - Deep Tissue Injuries (DTIs) have increased in July to 18; these remain within the control limits.
  - Unstageable pressure ulcers have reduced to 4 incidents, this is within control limits.
  - All incidents have been validated and the chart documents a true number
  - It is to be noted that after validating the July incidents there is an increase in pressure damage incidents from the figures previously reported.

NB the SPC charts do not include device related pressure damage still indicating a downward trend

Successes:

- 372 Registered Nurses have viewed the Tissue Viability Improvement video – this continues to be monitored through HG reports submitted to the Safer Skin Committee.
- Trust wide mattress audit taking place week commencing 17th July.
- The maternity specific study day has taken place with positive feedback.
- Tissue Viability matron involved in all AARs for pressure ulcers.
- AAR/SIs presented at Safer Skin Committee for challenge and sign off.
- Critical Care had zero device related pressure ulcers in July following targeted improvement work.
- Training is ongoing with 66% of staff completing the bedside assessment training, 67% non-registered and 72% of registered having completed the tissue viability training

Hospital acquired pressure ulcers Deep Tissue Injury pressure ulcers Category 2 pressure ulcers	**Aim:** To have a zero tolerance approach to hospital acquired pressure ulcers **Target:** To reduce the number of hospital acquired pressure ulcers to below the mean



Key Risks and Challenges:

- In July there were 31 Category 2 pressure ulcers reported 6 of which were device related; 0 Category 3 pressure ulcers, 15 Deep Tissue Injuries (DTI) 3 of which were device and 4 unstageable pressure injuries 2 of which were device.
- CQUIN number 12 Assessment and documentation of pressure ulcer risk -Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks- This may not be achieved as individualised care plans do not have patient preference questions.

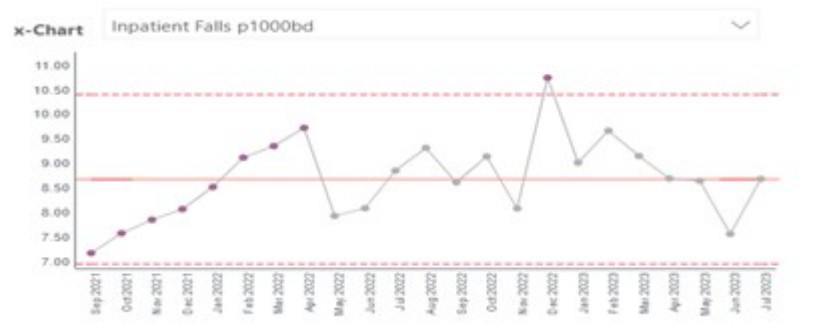
Actions / Future Plans for Improvement:

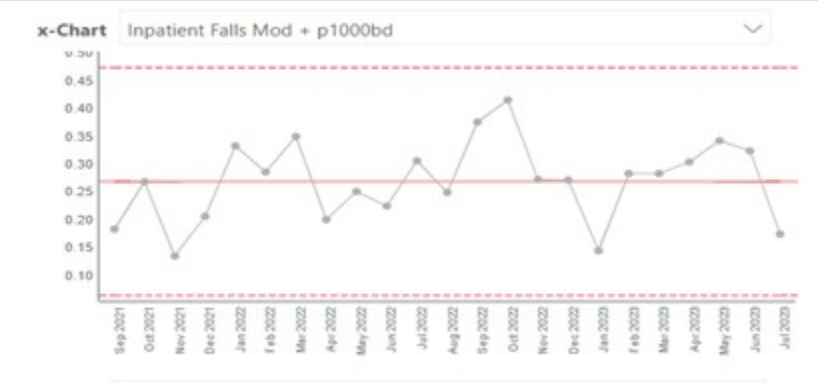
- QR codes for Arjo and Medstrom beds have been attached to beds
- Paediatric study day date still to be confirmed
- CQUIN steering group to work with TV matron to achieve CQUINN 12.
- New skincare product range to be launched to care for moisture associated skin damage.
- Monitoring to continue to ensure all Registered Nurses are completing all skin inspections for every patient at least once per shift.
- Monitoring to continue that the Nurse in Charge is checking all high risk patients and reviewing documentation to ensure that the correct care plan is in place

2.5 INPATIENT FALLS CAUSING HARM

Inpatient falls per 1000 bed days

Inpatient falls resulting in harm per 1000 bed days





Aim: To reduce the number of inpatient falls resulting in harm

Target: To reduce the number of inpatient falls to below the mean

What is the chart telling us:

- There were 9.3 inpatient falls per 1000 bed days in July 2023 (n= 313).
- 0.09 (per1000 bed days) inpatient falls resulted in moderate or severe harm and 0.03 (per 1000 bed days) resulting in catastrophic harm to the patient.
- The number of falls being reported over the last 6 months, is within control limit. The total number of falls is seen to have increased slightly, however the level of harm sustained has decreased.

Successes:

- Training – nurses –still elements to be captured such as staffing groups and types of learning. Trust is currently over 60%. An electronic booking system is now available on PATTIE.
- Training – doctors –there has been a lot of work encouraging doctors to undertake training, it is now mandatory for all doctors.
- A new training room has been located at HUTH, the training will commence here September 2023
- Compliance with both Myassure and Fundamental standard audits
- Development of the virtual ward, with new staff to commence supporting the falls team in September 2023.
- The falls team are successfully working with the Governance team to ensure compliance with PSIRF.
- A new SWARM document is being trialled to be used post falls.
- Falls week –Falls week 18-23 September.

Specific Ward Quality Improvement Programmes

Ward	Project	Start date	Review date

Key Risks and Challenges:

- Development of an MDT approach to fall prevention.
- Aging and increase in a deconditioned population (Public health England Aug 21).

31, H8, H12 & H120	Introduction of yellow wrist bands for patients an increased risk of falls	Dec 2023	Monthly
39	Yellow sticker to prompt Medication reviews		Monthly
FAB	Lying and standing blood pressure (LSBP)	12 June 23	Monthly
H9	Extended visiting and bedside staff assessment	5 June 23	Monthly
H90	Bay tagging and cohorting, to	5 June 23	Monthly

- Funding for essential equipment.
- Poor attendance at training sessions.
- Accuracy of DATIX information.
- Coroners scrutiny.
- Potential CQC inspection.
- Electronic location for non-registered staff to document the observations and care provided following a patient fall.

Actions / Future Plans for improvement:

- Plan to enhance training for Non clinical Staff and other HCPs.
- Continue to evaluate Quality Improvement Programmes and identify practices that have demonstrated improvement to disseminate across the trust.
- Create an established Falls Prevention team due to be established in September.
- Aging and increase in a deconditioned population (Public health England Aug 21) using this information to support NCTR patients with therapist.
- Improve process for record keeping in relation to training numbers.
- Maintain Fall information on Pattie
- Prepare for National Falls Prevention Week 18th – 23rd September
- To review Non inpatient falls on site via Falls Committee
- Implementation on Ward 90 AFLOAT (Avoiding Falls Level of Observation Assessment Tool)

3. EFFECTIVENESS DOMAIN

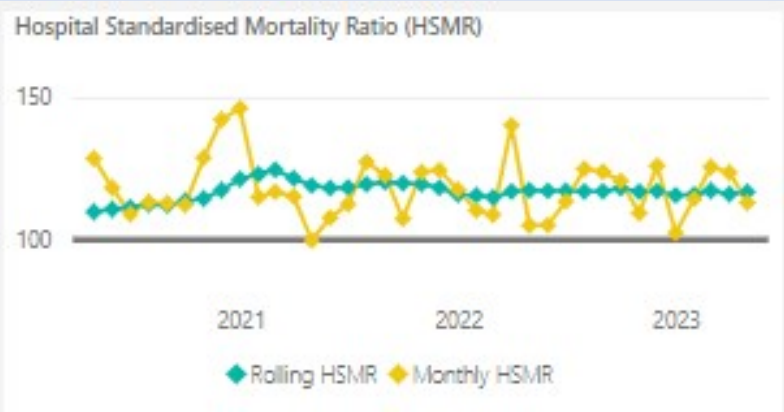
3.1 MORTALITY

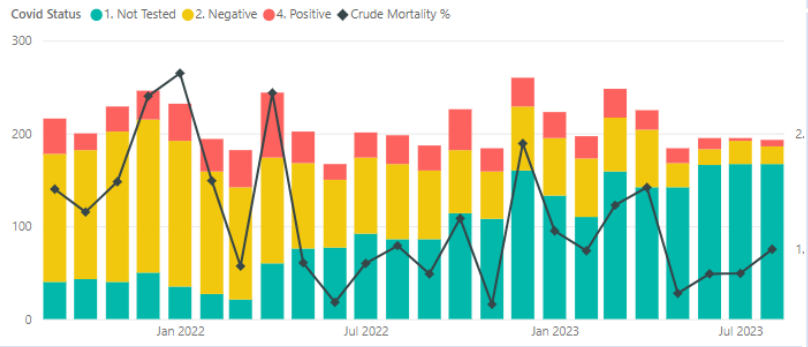
Hospital Standardised Mortality Ratio (HSMR)

This is the previous data set for information, this was in the previous report. The next data set will be available in the September report.

Aim: To reduce the HSMR to below the national average of 100 and improve patient outcomes

Target: Below 100





What is the chart telling us:

- HSMR currently 113.01 reporting period May 2023.
- HSMR continues to demonstrate 'higher than expected deaths' and is above the national average and target of 100.
- The rolling HSMR is 116.80

Successes:

- The rolling HSMR is showing a steady rate and displays no sudden elevations.

Key Risks and Challenges:

- The Trust continues to demonstrate a HSMR with "higher than expected" deaths and is therefore an outlier in HSMR.

Actions / Future Plans for Improvement:

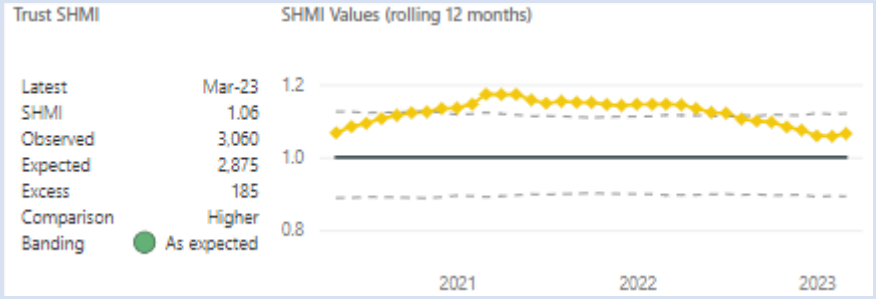
- Continual improvement work streams are formed and monitored via the Trust Mortality and Morbidity Committee, with careful and continuous monitoring taking place on a regular basis.
- The Sepsis and Pneumonia steering groups continue to provide better insight data, along with detailed action plans being delivered in order to further improve outcomes for these patient cohorts.

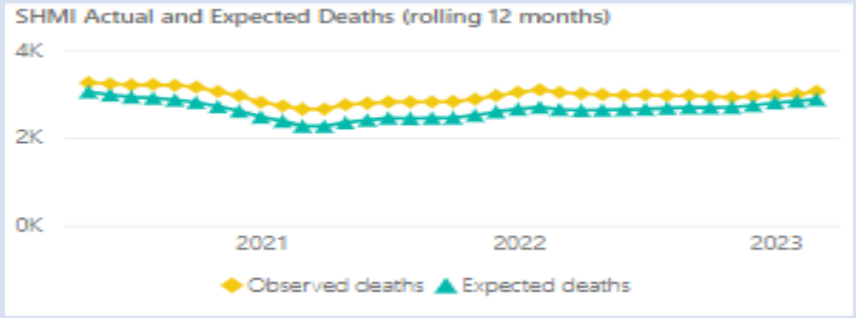
Summary Hospital-level Mortality Indicator (SHMI)

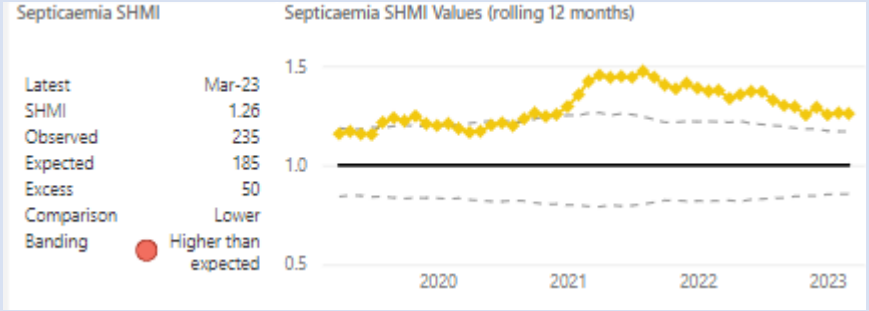
This is the previous data set for information, this was in the previous report. The next data set will be available in the September report.

Aim: To reduce the SHMI to below the national average of 1.0 and improve patient outcomes

Target: Below 1.0







What is the chart telling us:

- Charts are displaying performance for a rolling 12-month period. Latest data is March 2023
- Trust SHMI has continued a downwards trend since the end of 2021 and in March 2023 (latest available data) has increased very slightly to 1.06.
- The out of hospital deaths remain consistent against the SHMI.
- Pneumonia SHMI continues to remain “as expected” and has increased very marginally to 0.95 in March 2023, compared to the previous month.
- Sepsis SHMI continues to demonstrate ‘higher than expected deaths’ with an excess of 50 deaths in March 2023. Although it remains ‘higher than expected’, performance is demonstrating an improving journey from its highest point of 1.47 in August 2021 to 1.26 in March 2023.
- Stroke SHMI has increased to 1.28 in March 2023. An excess of 40 deaths occurred in March 2023

Successes:

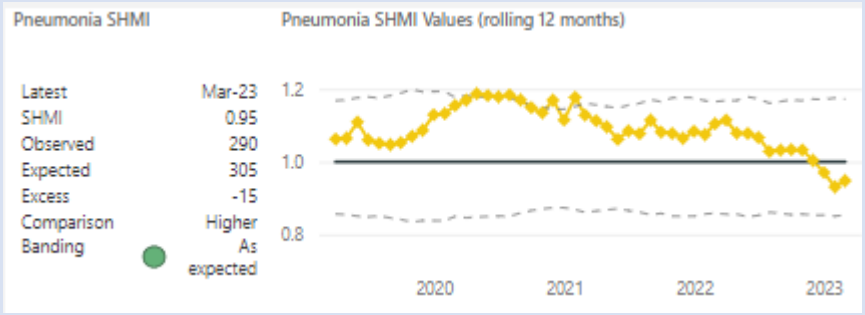
- The overall Trust SHMI has very marginally increased compared to the previous month and is now 1.06 and within expected range.
- Pneumonia SHMI has dropped below the national average of 1.0, to 0.95.
- Sepsis SHMI has appeared to level out, showing an overall improvement since 2021, currently 1.26.

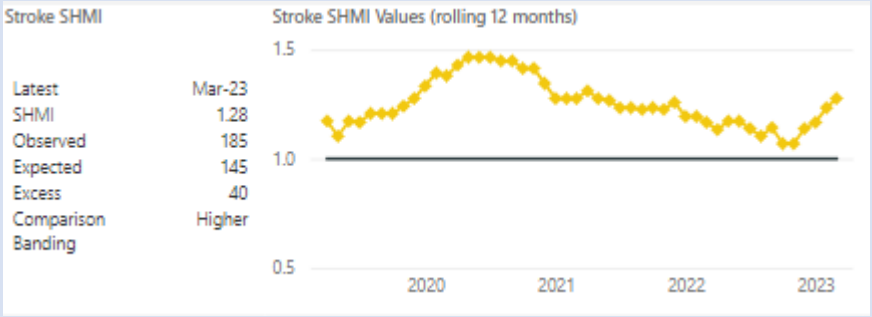
Key Risks and Challenges:

- The top 3 common clinical conditions remain Sepsis, Pneumonia and Stroke

Actions / Future Plans for Improvement:

- The Trust continues to monitor HSMR data via regular reporting and committee meetings, whilst streaming into bespoke and overarching quality improvement work plans.





- Continual delivery of the Stroke improvement plan, improving service and outcomes for stroke patients.
- Continual review of stroke deaths, including discussions at Stroke M&M meetings.
- Regular updates in relation to Stroke mortality given to the Trust Mortality and Morbidity Committee.

April to June 2023

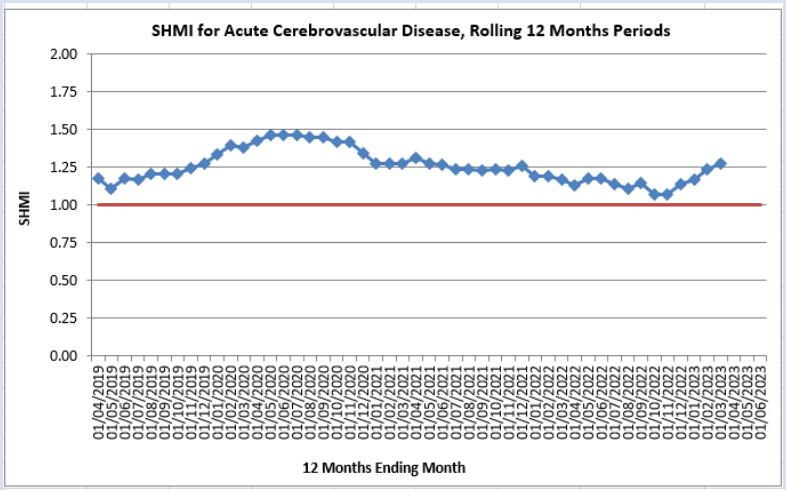
The data for April to June 2023 is due to be released in September 2023.

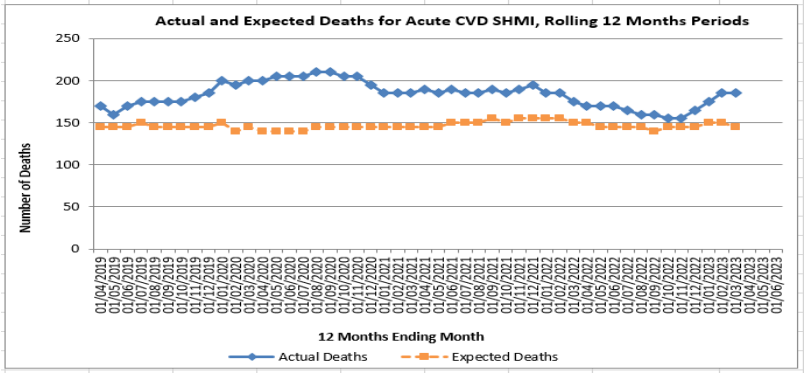
Summary of Stroke 30-day mortality

This is the previous data set for information, this was in the previous report

Aim: To reduce the HSMR to below the national average of 100 and improve patient outcomes

Target: Below 100





What is the chart telling us:

- The SHMI for Stroke is higher than the National Level of 1.0. Latest statistics from March 2023 shows the SHMI for Stroke at 1.28.

Successes:

- The Stroke service continues to deliver structured judgement reviews on all of its deceased patients. The SHMI has dropped significantly overall, however, the data points may suggest an upward negative trend.

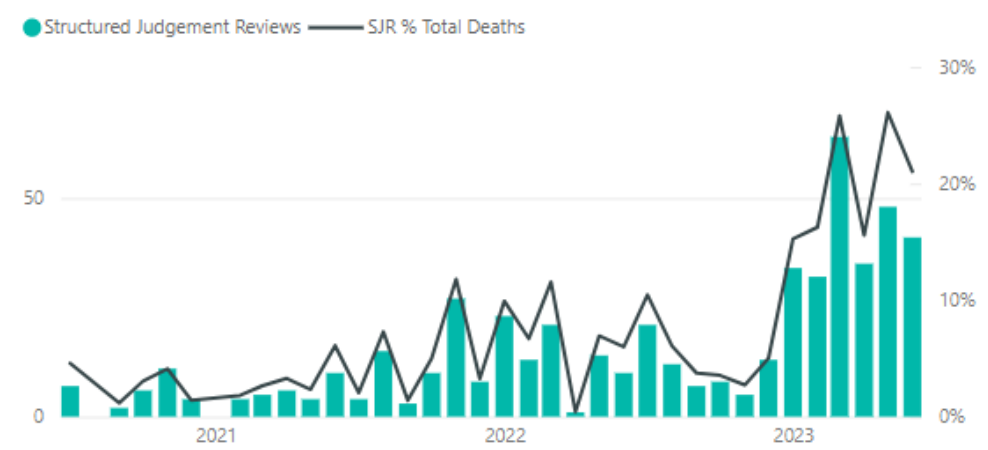
Key Risks and Challenges:

- The SHMI for Stroke continues to be higher than the national average.
- The last four consecutive months for which data is available shows an increase in SHMI (December 22 to March 2023).

Actions / Future Plans for Improvement:

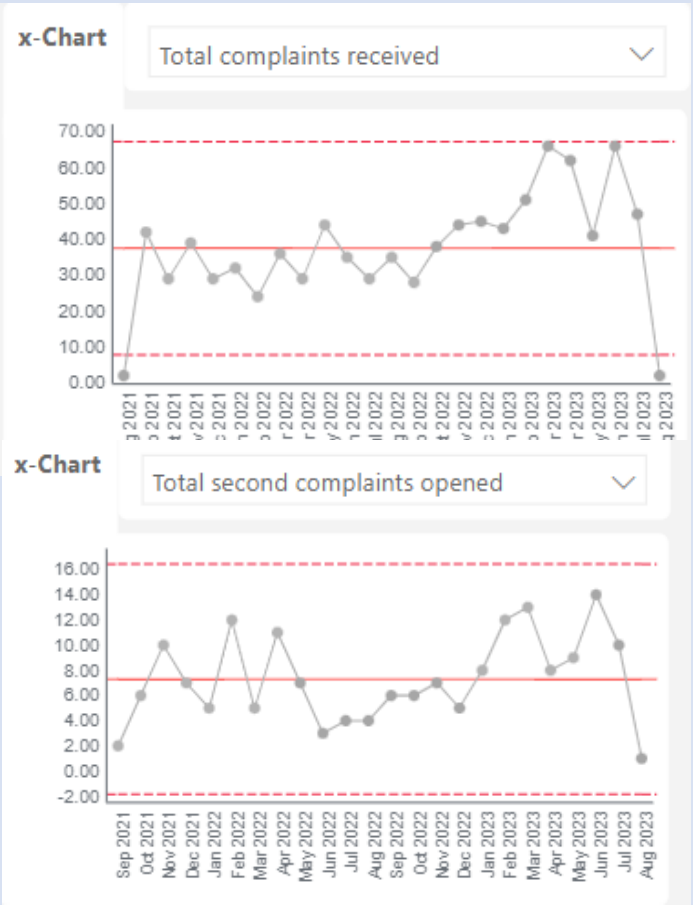
- Assessing the key learning that took place during the SJR's, in addition to the recurring themes and decide the best plan of action. This could be in the form of quality improvement projects / amending any current quality improvement projects.
- Stroke SJR's that require a Tier 2 review (those scoring poorly) will be reviewed by Consultants from outside of the Stroke Service, allowing an MDT approach to review and eliminating any possible bias.

3.4 STRUCTURED JUDGEMENT REVIEWS (SJR)

Structured Judgement Reviews Completed and Staff Trained	**Aim:** To increase the number of SJR completed to inform learning from deaths Target: 10%
	**What is the chart telling us:** • The chart shows a positive uptake in the number of Structured Judgement Reviews being completed, as an overall monthly percent against the total number of in-hospital deaths. The Trust aims to review at least 10% of deaths per month, via the SJR methodology, in addition to the M&M approach led by each Specialty. •
	Successes: • An average of 20% of deaths receive a Structured Judgement Review per month, which has continued to improve following increased engagement from clinicians since late 2022 • 500 members of staff have undertook the online (HEY247) SJR training module since January 2022. The training is directed at ST5 and above grade clinicians, in addition to Specialist nurses and Matrons. This has had a positive impact on the number of SJR's being completed to a high level of quality. •
	Key Risks and Challenges: • Ensuring feedback is provided to Clinicians, in addition to the shop floor, in terms of outcomes from SJR, including learning and actions.
	Actions / Future Plans for Improvement: • After a review of End of Life preferences / personalised end of life care (in particular within the ED – CQC action) it was identified that the Lorenzo based SJR form should be amended to prompt the SJR reviewer to comment on personalised end of life care. This will allow for further analysis and identification of potential learning that will be beneficial for improvement for personalised end of life care.

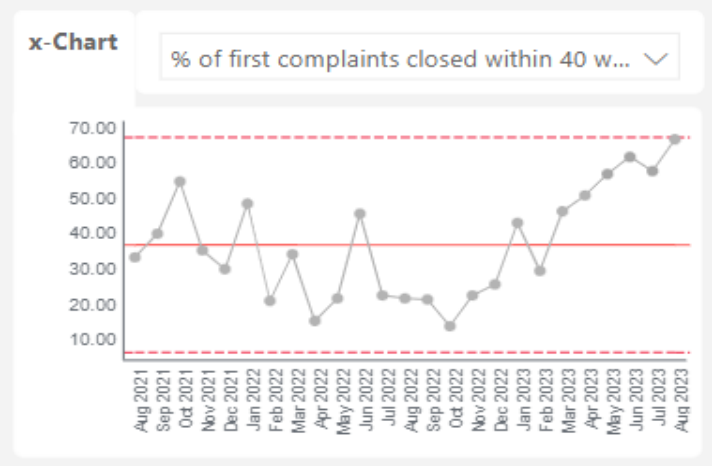
4. RESPONSIVE DOMAIN

4.1 COMPLAINTS RECEIVED

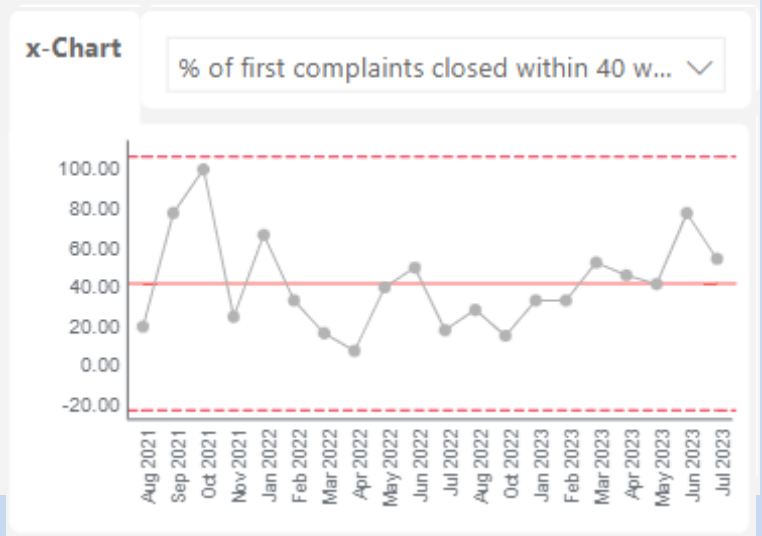
Complaints Received	**Aim:** To improve the management of the complaints to ensure the effective and responsive management of complaints received **Target:** Improve the management of complaints
	**What is the chart telling us:** • 35 initial complaints and 10 re-opened complaints were received in July 2023 At the end of July 2023 there were 101 complaints open. A breakdown of open complaints is as follows: • 80 complaints were initial (new) complaints and 21 were re-opened as a second complaint • 68 complaints were under investigation within the 40 working day target • 33 complaints were under investigation but were overdue the 40 working day target, with the longest one open from May 2022 (at the end of July 2023); however, this has since been closed and at the time of writing this report, the oldest one open is from March 2023. • 4 cases were active with the PHSO **Successes:** • All complaints received were logged within 3 working days of receipt, no complaints in the backlog for logging • Continue to implement the early resolution process with the aim of addressing concerns in a quicker timeframe with a reduction in the number of concerns that are escalated to a formal complaint. **Key Risks and Challenges:** • There are a number of ongoing complex cases across all Health Groups. **Actions / Future Plans for Improvement:**

Complaints Received	**Aim:** To improve the management of the complaints to ensure the effective and responsive management of complaints received **Target:** Improve the management of complaints
	• Continue to drive improvements through the weekly backlog meetings with leadership from the Nurse Directors and support from the Patient Experience Team • Health Groups to focus on addressing the backlog of complaints open over 40 day but to also ensure the new complaints are investigated and closed within the target. To also encourage early resolution where possible. • Undertake a deep dive into the complaint re-opened and the reasons why to identify areas for improvement in the responses provided to complainants and the quality • Continue to deliver the NHS Model Complaint Standards via the Steering Group • Improve triangulation of data to inform more focussed learning from patient experience, this also links to the patient experience work stream in the Quality Strategy.

% of complaints closed within 40 days



Family and Women's



Aim: Increase % of complaints closed within 40 day target

Target: 80%

What is the chart telling us:

- The charts demonstrates continued improvements against the closing of complaints within 40 days. Although the target of 80% has not yet been achieved 57% of complaints were closed within 40 days in July 2023.
- Surgery, Medicine and Family and Women demonstrating an improvement in the % if complaints closed within 40 days.
- Surgery had 11 complaints overdue, this was a very slight increase from 8 in June 2023 but a reduction from 57 in December 2023.
- Medicine had 10 complaints overdue, which is an increase from 3 in June 2023 but a reduction from 41 in December 2022.
- Maternity had 2 overdue complaints, which is a reduction from 3 in June 2023 and 12 in December 2022.
- Family and Women's (excluding Maternity) had 9 overdue complaints, which is a slight reduction from 10 in June 2023 and 19 in December 2022.

Successes:

- The model complaints steering group approved the updated complaint investigation timescales as the Trust continues to adopt the PHSO NHS Complaint Standards. The Trust will keep the 40 working day target and will continue to aim to investigate complaints as soon as possible within that timeframe. The group also agreed a 60 and a 90 working day target for those complaints which are more complex and across a number of Health Groups or agencies.

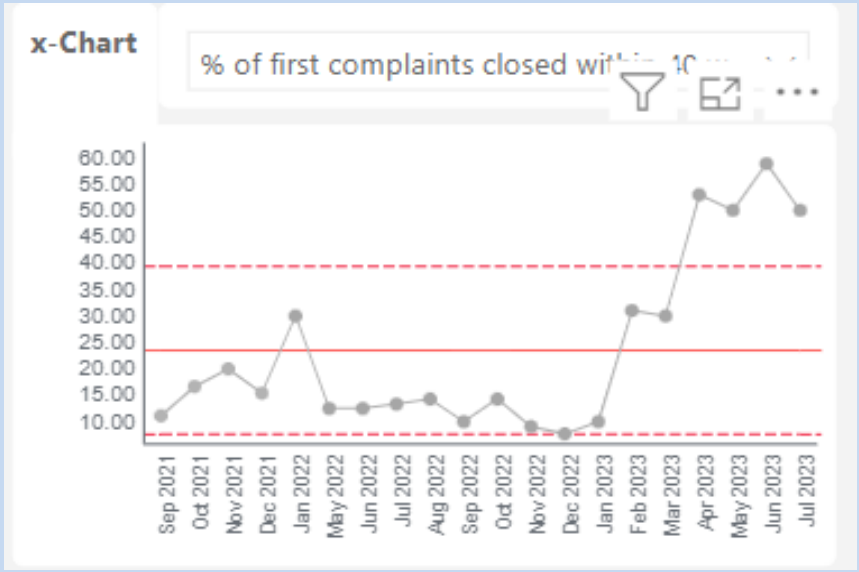
Key Risks and Challenges:

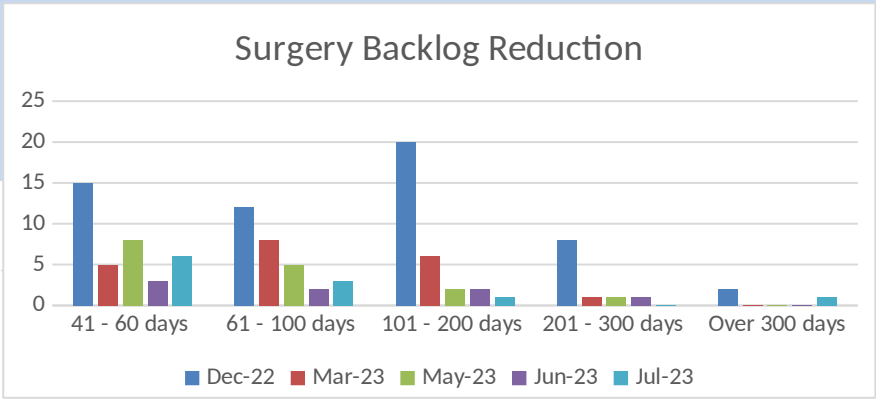
- Maintain improvements against the planned outcomes
- The target of 80% of complaints closed within 40 days not yet achieved

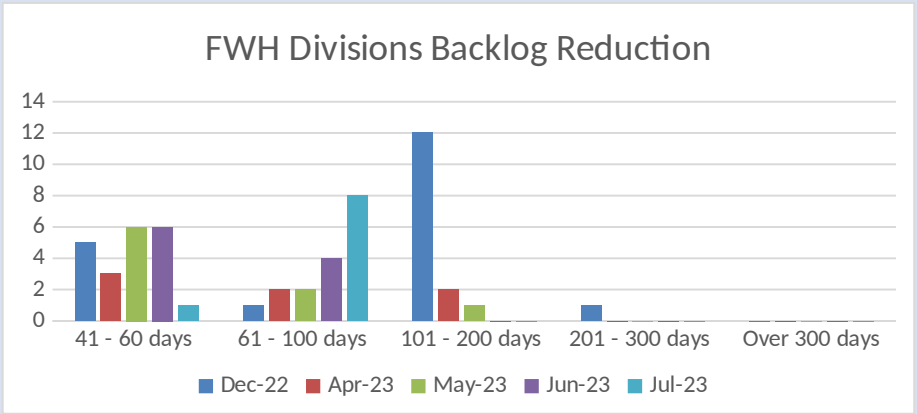
Actions / Future Plans for Improvement:

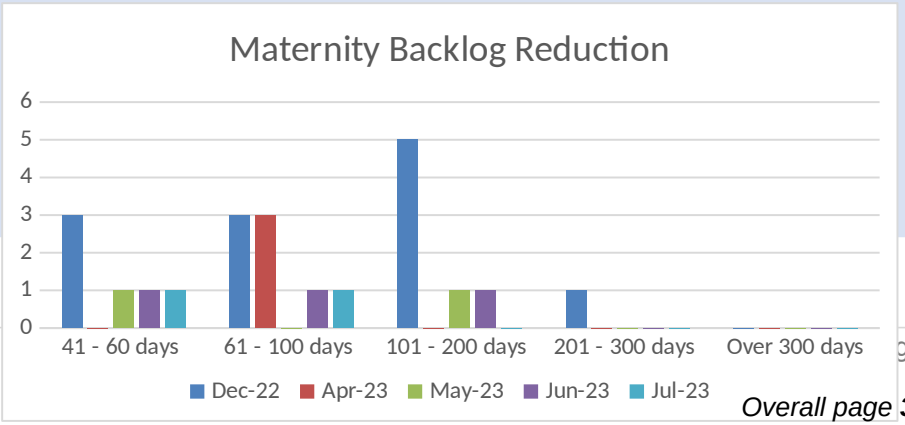
- Continue weekly challenge meetings with Medicine, Surgery and Family and Women's.
- Continue to gather feedback from complaints on their experience of the complaints process and use the intelligence to inform improvements to the way we manage our complaints as we continue to adopt the PHSO NHS Complaint Standards.
- Continue to adopt the PHSO NHS Complaint Standards via the Steering Group.
- Review a selection of complaints closed at the Complaints Reflective Practice Group in August 2023.

Surgery

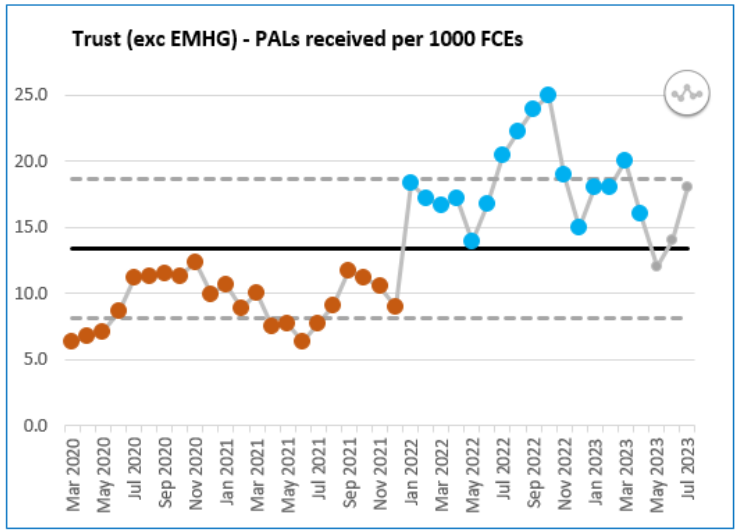








PALS Received



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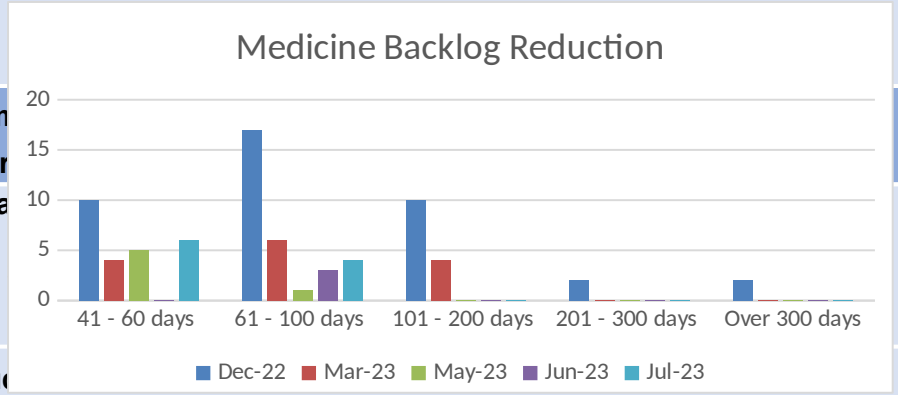
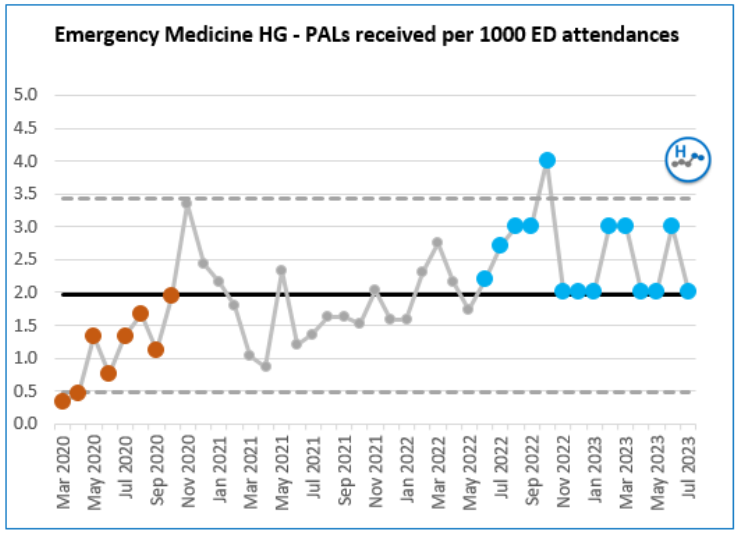


Su

- New PALS information/awareness posters, leaflets and information cards available and being distributed across the organisation in line with the PHSO NHS Complaint Standards and to ensure staff, patients, relatives/carers and visitors know how to raise their concerns.

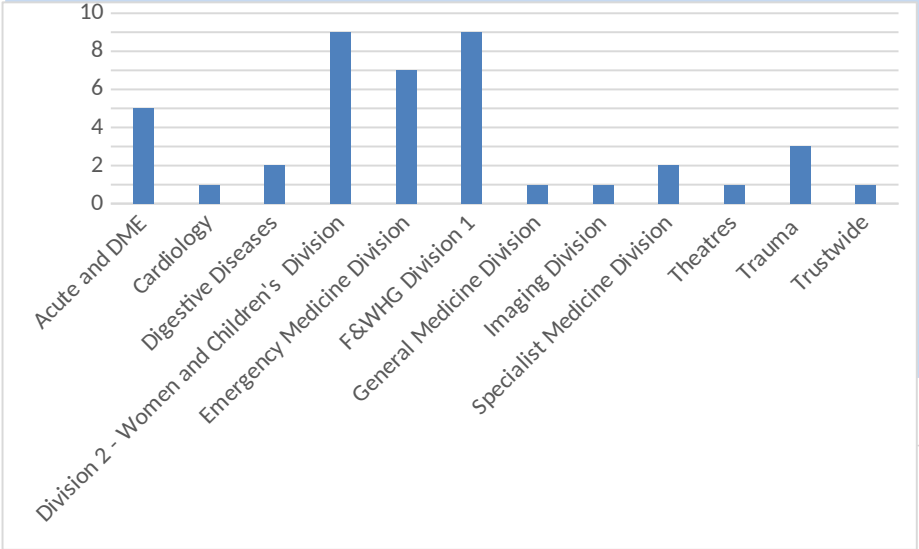


Key Risks and Challenges:

- Main theme continues to be cancellations, delays and waiting times – no changes to the main themes

Compliments Received

Aim: To record and share the compliments received via the PALS team



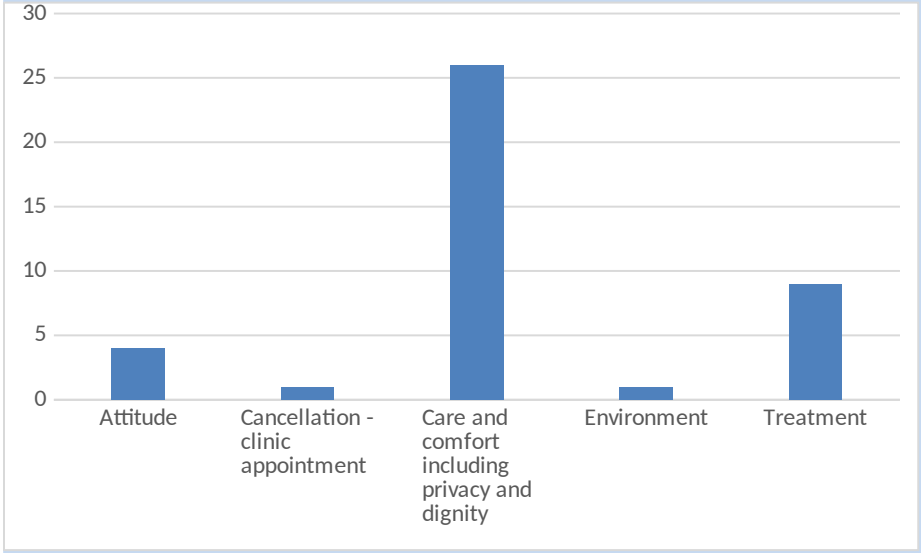
What is the chart telling us:

- 42 compliments received via the PALS team in July 2023 with 18 of them reported for Family Women's.

Successes:

- The main theme detailed within the compliments continue to be care and comfort (including privacy and dignity) provided to our patients by staff. This shines through in all Health Groups.

Key Risks and Challenges:



- None

Actions / Future Plans for Improvement:

- Continue to share all compliments received to the relevant areas for good practice to be acknowledged and staff/teams thanked as required.

CONTINUOUS QUALITY IMPROVEMENT

5.1 TRAINING

The first collaborative QSIR Virtual session with the North West and North East System Improvement Team and other QSIR Faculties within the region including the CQI team at HUTH concluded on the 29th June 2023.

The initial feedback received was incredibly positive and when asked to use one word to describe the programme, words included: '*discovering'*, *'enlightening'*, *'stimulating'*, *'interesting'*, *'innovating' and 'motivating'*.

A second collaborative cohort will be taking place in November 2023. The CQI team will be supporting with QSIR Virtual training at this session and staff from HUTH will be invited to join the training sessions available.

Development of the 2024/25 QSIR training programme continues. The development of the training programme will include:

- A rebrand of the training packages in place - training will still utilise the QSIR teaching and resources but in a way that will support staff to choose the level of training that best suits their needs.
- How we can build and strengthen our training capability across the Trust.
- How we can support senior staff to lead on improvement and support staff to undertake improvements – this supports a board to ward and ward to board approach where improvement becomes business as usual.
- How we support a return on investment following training and demonstrate where improvements have made an impact on including patient safety, cost savings and improved staff experience/satisfaction.

The final training programme will be shared with the Quality Committee by September 2023 for consideration.

5.2 QUALITY IMPROVEMENT

Registered projects

90 QIPs have been shared and registered with the CQI team. The majority of projects being completed are from Junior Doctors who are required to undertake improvement projects a part of their career progression. It is expected that engagement with QIPs will increase following their induction in August. Regular communications are sent out inviting staff to share their projects and success stories.

Sepsis

Following the QI Kick Start Improvement workshop for the Emergency Department in April 2023, the implementation of a High Acuity Bay (HAB) was launched on 26 June 2023. This is intended to support deteriorating patients in being treated more efficiently. An additional Sepsis nurse was employed on 24th April 2023. Further, the Sepsis nurses are spending an increased amount of time in the Emergency Department to provide specialist infection and sepsis knowledge, as well as embedding use of the NerveCentre Sepsis management tool.

The below charts demonstrate the percentage of patients receiving antibiotics within an hour of arrival with a high news score and the average time of prescriptions being administered to those patients. Both charts are beginning to indicate some improvement.

Figure 1: SPC chart depicting the percentage of patients with high NEWS who received antibiotics within 1 hour of arrival. Input from Sepsis nurses in the Emergency Department began on the week commencing 24th April 2023.

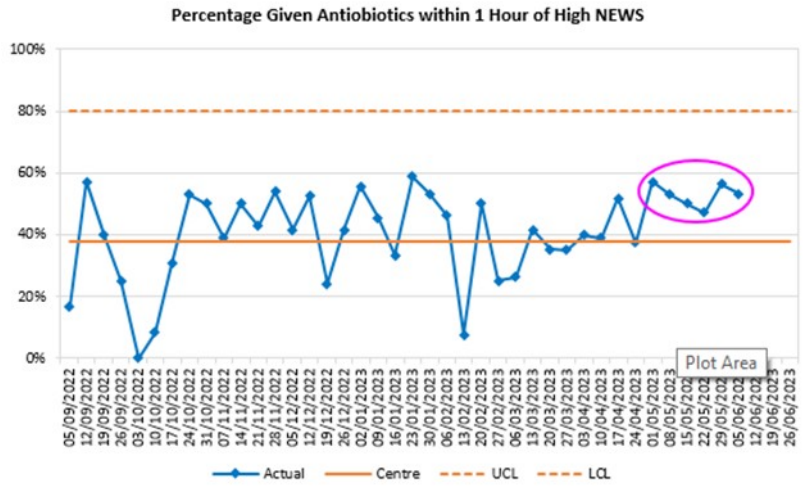
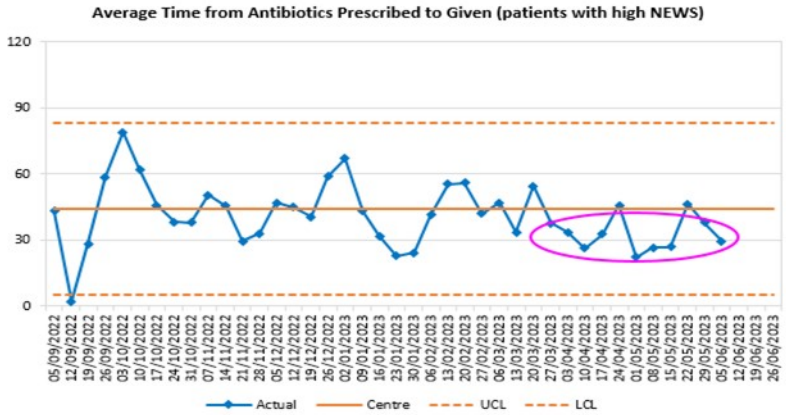


Figure 2: SPC chart depicting the percentage of patients with high NEWS who received antibiotics within 1 hour of arrival. Input from Sepsis nurses in the Emergency Department began on the week commencing 24th April 2023.



Data continues to be collected over time to see if improvements have been made and ultimately sustained over time.

Falls

The CQI team are providing support to the Fall's team to map out all the improvements that are currently being undertaken, understand the measures used and best ways to plot the data to see if improvements are being made and again sustained. Further work is required to understand what interventions already taking place that have had the most impact and what interventions can be implemented and spread to other areas.

5.3 THINK TANK

One submission has been received regarding introducing an automatic door to the entrance of a clinic, due to patients with disabilities struggling to open a heavy door.

The frequency of the Think Tank Group meetings have been reduced from monthly to bi-monthly to support members of the group to progress and provide updates against progress when the meetings take place. The next meeting is due to take place on 11 October 2023. A process is in place to review and allocate all new think tank submission as and when they are submitted.

5.4 GETTING IT RIGHT FIRST TIME (GIRFT)

The GIRFT team have agreed the format of the Working Group meetings moving forward to include: monthly meetings to review action plans with specialities following deep dive visits and quarterly Quality Assurance Group to discuss matters involving the wider GIRFT portfolio.

The Trust has taken part in four Deep Dive visits in 2023 for the following services:

- Respiratory – 1 February 2023
- Rheumatology – 23 March 2023
- Acute and General Medicine Deep Dive – 24 April 2023
- Gynaecology Gateway Review – 10 May 2023

A further deep dive visit is currently being organised for Geriatrics.

The first GIRFT Quarterly Quality Assurance Group has been scheduled for 11th September 2023.

The Trust is one of twenty-five trusts in the UK that have volunteered to participate in the Further Faster pilot initiative. The aim of the Further Faster initiative is to go beyond the current target of reducing **65** week waiters to zero, to eradicate all **52** week waiters by April 2024 instead across 16 specialities. Initial meetings are currently underway.

5.5 IMPROVEMENT WEEK

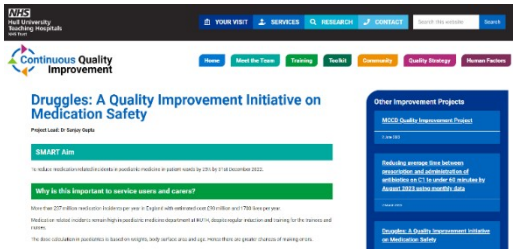
The CQI Team, in collaboration with the Patient Safety team and the Patient Experience team, are organising an Improvement Week in the run up to the Patient Safety Day Conference which is scheduled to take place on Friday 29 September 2023. The theme for this year's Patient Safety Day and Improvement week is 'Engaging patients for patient safety'. The event is accessible on Eventbrite at World Patient Safety Day: 'Engaging Patients for Patient Safety' Tickets.

5.6 WEBSITE

The CQI website, found at https://www.hull.nhs.uk/improvement/, is entering phase 2. The website provides staff with a 'QI toolkit' of resources and information needed to support and undertake improvement projects. Anecdotally, we refer members of staff to the website if they enquire about using QI tools and they have given positive feedback about the resources available.

Following the launch of the website, the second phase for development of the website will include:

- Review the interaction with the website and feedback from users.
- Inclusion of Clinical Audit and GIRFT as part of the Continuous Quality Improvement portfolio.
- Development bite size videos with key improvement tools.
- Development of the improvement community which will link back to the internal website to support with improvement discussions and recruitment of staff to be involved and take part.
- Information about co-production events and ways for patients to get involved with improvements across the Trust.



CARE QUALITY COMMISSION (CQC)

5.7 MATERNITY SECTION 31 RESPONSE FOR AUGUST 2023

CONTEXT
On receipt of the full and final CQC report for maternity, the Trust is taking the opportunity to reflect on its work and learning thus far to address the concerns, and is making some changes to these going forward. As a result, the Trust is revising the structure and contents of the action plan to include all required actions from the report, and the multi-disciplinary clinical and operational teams in maternity are leading on this, supported by the Trust's executive directors and others. This will include changes to the ways in which the action plan is measured and assessed, using what is termed the 'Reverse RAG©' approach. Additional changes will be made to the expected time frames for the delivery of actions, which will extend the completion dates for some of them and their supporting narrative. This is to ensure they can be delivered fully and sustainably, supported by robust evidence of delivery. Furthermore, changes are being made to the ways in which the action plan is to be governed and assured. This information was provided to the August 2023 Quality Improvement Group meeting.

When the revised action plan and governance and assurance arrangements are in place, these will be shared and explained more fully through the respective governance and assurance mechanisms, including to the Trust's Quality Committee, the Trust Board, the Care Quality Commission, the Quality Improvement Group, and this report. To strengthen the governance and assurance of the action plan, the Integrated Care Board's Director of Midwifery has agreed to become a member of the weekly check and challenge meeting, as has the Chief Medical Officer for Northern Lincolnshire and Goole NHS Foundation Trust. This will help to provide further independent assurance to this process and supports Group transition.

The Maternity Service has also been accepted onto the Maternity Safety Support Programme and a Maternity Improvement Advisor has been appointed.
The Interim Chief Nurse has briefed the new Group Chief Executive on these matters, and he endorses this revised approach.

AN UPDATE COPY OF THE ACTION PLAN THAT COVERS ALL CONDITIONS THAT ARE CONTAINED WITHIN THE SECTION 31 NOTICE
Delivery of the Maternity Services Section 31 action plan is monitored on a weekly basis at the Maternity Check and Challenge meeting that is chaired by the Interim Chief Nurse, which last met on 18 August 2023. The first draft of the revised action plan will be presented to the committee at its meeting on Friday 1st September 2023. Until the revised action plan is in place, reporting will continue against the original action plan and until the transition to the new ways of working is completed.

There are a range of governance and assurance meetings in place to monitor the delivery of the action plan and test the evidence. These include:

- The Weekly Maternity Check and Challenge Meeting, which is chaired by the Interim Chief Nurse/Board Safety Champion. This meeting focuses

on the delivery of the actions and their supporting evidence. Action notes are taken at this meeting.

- The monthly Maternity Safety Champions Meeting, which is chaired by the Interim Chief Nurse/Board Safety Champion, and has attendance from the Non-Executive Director (NED) Maternity Board Safety Champion. This meeting covers the expected range of safety issues for the service, including the S31 action plan. Full minutes and papers are available if required.
- The Trust's Quality Committee, which meets monthly and is chaired by the (NED) for Quality. The papers for this meeting are shared with all Board members, for information.
- Every Trust Board meeting (bi-monthly). The full Board of Directors receives a summary report for all CQC actions (not limited to the S31 action plan) and detailed appendices in addition to any 'deep dive' presentations.

A breakdown against progress of the actions so far is summarised in the table below:

Status of actions	Number
Actions completed with evidence of completion provided	21
Actions implemented with ongoing monitoring	1
Actions not yet due but on track	1
Overdue	9

Whilst the amount of work undertaken since March 2023 is acknowledged, concerns were raised at the last Maternity Check and Challenge Meeting (held 18 August 2023) regarding the impact of some of the actions on the waiting times for women triaged in the Antenatal Day Unit (ADU), along with progress against some of the outstanding actions. The actions that are overdue currently are, as follows:

- MAT2.1 – Capacity and demand work continues. An update against this work was presented to the July 2023 Quality Committee and August 2023 HUTH Quality Improvement Group meeting; however, this work is not yet completed. Further analysis is being undertaken to map attendances to the unit out of hours, and attendance volumes and trends. This work is ongoing and will inform the model for the new ADU triage unit.
- MAT2.3 – Royal College of Obstetricians and Gynaecologists (RCOG) approval of the four additional consultant obstetrician posts. RCOG has approved three of the four posts, and the fourth is awaiting approval, which the Trust has been advised will likely be during September 2023. The three approved posts are out for recruitment, and the advert closes on 14 September 2023. An Advisory Appointments Committee (AAC) is scheduled for October 2023.
- MAT2.9 – Development of a revised escalation framework. The draft escalation framework has been circulated for consultation; however, this was not approved at the Obstetrics and Gynaecology Governance Meeting on the 11 August 2023 due to the meeting not being quorate. Separate arrangements are being made to approve the framework; however, escalation arrangements to senior clinicians and the Trust's Site Team are in place already.

- MAT3.6 – Development of a revised Maternity Training Needs Assessment (TNA). This was initially delayed due to the release of the Clinical Negligence Scheme for Trust (CNST) Year 5 standards and the need to incorporate these, but has now been updated and circulated for consultation. This is awaiting formal approval at the next Obstetrics and Gynaecology Governance Meeting. Support has been requested from the Local Maternity and Neonatal System (LMNS) regarding the challenges associated with the delivery of the new CNST training needs, and this was also escalated to the HUTH Quality Improvement Group meeting.
- MAT4.5 – Digital work. An electronic Clinical Data Capture (CDC) telephone triage form has been introduced into the Antenatal Day Unit (ADU), which is working well. A Maternity Business Intelligence Dashboard has also been developed and is now displayed in the unit to allow clinical oversight of the women in ADU in real time. There are still some teething issues remain with this system refreshing its dataset, these are being worked on by the Trust's Digital Team.
- MAT7.1 – Undertake a governance review. The Trust has secured the support of an external management consultant to assist with the review of the maternity governance and assurance arrangements. Revised arrangements for this will be implemented alongside the refresh of the action plan during September 2023.
- MAT8.1 – Review current Perinatal Mortality Review (PMRT) arrangements. The review of PMRT is underway, and is being supported by the external management consultant. This work will include a review of best practice guidance in this area. This work is linked to MAT7.1.
- MAT5.2 – Handover arrangements. Work continues with implementing a consistent approach across the unit for handover arrangements. Handovers have been observed, standardised documentation has been developed, and training has been provided to the staff. In addition, the Trust's digital team is developing an electronic form to support the handovers and the evidence of completion. However, this is still in its early phase and will require time for embedding and review.

Action MAT8.2 is due to be completed by the end of August 2023, but will not meet this deadline. This action is to develop the delivery plan to merge the Neonatal and Maternity Services in line with recently published national recommendations. Dr Uma Rajesh has been appointed as the new Clinical Director of Obstetrics and Neonates. It was agreed that this action should be addressed outside of the CQC action plan, as these arrangements are in their early stages.

As part of the ongoing discussions with regulators and commissioners, the risks identified and escalated previously remain the same. These include:

- The delays with implementing the BadgerNet maternity system. This is affecting the implementation of Birmingham Symptom Specific Obstetrics triage System (BSOTS).
- Incident categorisation – this is ongoing work and actions have been identified to improve this further.
- Non-compliance with the moderate scanning pathway from 32-weeks' gestation for all women that smoke (Saving Babies Lives 2)
- Ongoing maternity leave and midwifery vacancies impacting on service delivery issues, which include:
- Delays to Induction of Labour, resulting in the need to transfer women to neighbouring units.
- A fragile home birth service.
- Delays to antenatal bookings which, in turn, is having an impact on the number of women being booked before ten weeks' gestation. Delays to

bookings has an impact on antenatal screening options for Thalassemia and Sickle Cell for those women in an at risk group. The service has implemented a risk assessment process, which is implemented by the community midwifery sister identifying those women in an 'at risk' category for Thalassemia and Sickle Cell Disease. This is to ensure these women are not cancelled.
- Cancellation of mandatory training to cover clinical duties, which will impact on the delivery of training and meeting the year 5 CNST Maternity Improvement Scheme standards.

These risks continue to be reviewed daily and are mitigated, where possible. More information will be provided about these risks, and their mitigation, in the next update. This report also provides a summary midwifery workforce update.

ALL REPORTS WRITTEN TO DEMONSTRATE COMPLIANCE WITH CONDITIONS
Since the last submission to the CQC, a presentation was made to the HUTH Quality Improvement Group meeting on 4th August 2023. The report and appendix references are, as follows:

- Maternity Presentation to the HUTH QIG held 4 August 2023

UPDATE ON TRAINIGNG FIGURES INCLUDING THE COMPLIANCE
The report attached at Appendix D shows each required competency within maternity services, by area, including progress against the monthly targets set. A summary of these follows.

The data is taken from the 'HEY247' training database, with most recent data as at 21 August 2023. A Trust target of 85% compliance is in place for each competency, except for Information Governance, which has a target of 95% in line with national requirements.

Progress since the 20 July 2023 has been static with some deterioration in compliance rates for several competencies. There is particular concern regarding a further drop in Fetal Monitoring and Newborn Life support training.

Over the previous month there has been focus on Perinatal Growth Assessment Protocol (GAP) e-learning and Safeguarding Adults, both of which have had an increase in compliance rates. Perinatal Gap E-learning compliance has improved by 11% since the end of May 2023 and Safeguarding Adults Level 3 by 13%.

Slow progress over the last month is attributed to staffing levels, where it has been difficult to release staff to undertake the required training, particularly for the longer training days such as Fetal Monitoring. There have also been changes to the staff headcount numbers in some areas, such as an increase on the Midwifery Led Unit from 34 staff to 41, which has impacted on compliance rates and progress against trajectory. There has also been some impact on doctors' training rates in month, but this was due to the August junior doctor changeover. The Medical Education Centre and health group will continue to support the junior doctors to complete their statutory, mandatory and role specific training.
Progress to date is summarised, as follows:

Competency	w/c 31.5.23	w/c 21.6.23	w/c 20.7.23	w/c 21.8.23
Information Governance	88.51%	91.9%	91.9%	90.8%
Resuscitation	82.67%	86.6%	88.4%	87.7%
Health, Safety and Wellbeing	89.34	92.2	93.1%	91.7%
Moving and Handling	80.29	83.2	84.4%	84.9%
Fire Safety (clinical)	79.59	84.7	85.6	84.9
Mental Capacity Act	79.24	84.1	84.1%	82.2%
Deprivation of Liberty	85.84	89.7	89.4%	88.0%
Infection Control	89.02	90.0	89.4%	88.3%
Equality, Diversity and Human Rights	91.9	94.4	94.7%	92.6%
Safeguarding Children Level 2	80.61	83.7	85.6%	84.6%
Safeguarding Children Level 3	85.27	87.9	89.2%	87.3%
Safeguarding Adults Level 2	87.33	90.4	83.3%	82.0%
Safeguarding Adults Level 3	69.12	76.3	79.0%	82.3%
Conflict Resolution	91.89	94.1	92.2%	90.2%
Perinatal Gap E-learning	52.74	54.6	59.6%	63.7%
Fetal Monitoring	81.39	86.0	80.8%	70.2%
Fundal Height Measurement	67.5	77.3	78.0%	76.6%

Newborn Life Support	67.38	77.8	77.7%	74.5%
PROMPT	80.24	83.8	83.8%	83.1%
Mandatory Training Day 2	75.38	80.2	79.1%	75.5%
K2	71.42	84.7	90.5%	89.3%

The key areas of focus over the next four weeks, are:

- Information Governance
- Safeguarding Adults Level 2
- Perinatal Gap E-learning
- Fetal Monitoring
- Fundal Height Measurement
- Newborn Life Support

Actions to be/being undertaken to support improvement in training compliance rates:

- The August training compliance report is to be shared with all midwifery and medical line managers
- Monthly reports are being generated that detail each individual staff member's compliance rates, including when training is due to expire. This information is being sent to all respective managers.
- The Human Resources Business Partner and the new Head of Midwifery are to meet monthly with individual managers, from September, to go through training compliance rates and support with actions required to improve where required. Managers will be required to address these matters with their staff, and assurance checks will take place.
- Reminders will also be sent out to staff, by the HR team, to advice of any areas of non-compliance
- Staff will be offered the option to undertake in their own time, but which will be reimbursed either through payment or time off in lieu, subject to their preferred requirements.
- Once completed, the revised Training Needs Analysis will include the escalation process for any staff that repeatedly fail to meet their training requirements and the action that will be taken. This will be communicated to all staff.
- A review of when training days are taking place is being undertaken to help maximise staff attendance.

MATERNITY DASHBOARD

The following provides a summary of the latest Maternity Dashboard for this month's submission.

National Averages - Maternity Index:

	National Averages	May 2023	June 2023	July 2023
Spontaneous Birth	57%	52.1%	55.2%	51.5%
Elective Caesarean Section	13.2%	16.9%	19.8%	18.3%
Emergency Caesarean Section	16.9%	21%	19.6%	24.5%
Instrumental	12.4%	8.2%	5.6%	5.4%
Ventouse Birth	5.2%	1.7%	2.0%	2.1%
Forceps birth	7.3%	6.9%	3.6%	2.9%
Inductions	32.8%	27%	34%	25.2%
Booking before 10 weeks	95%	86%	89%	70%

WORKFORCE UPDATE

Since the CQC inspection, the following working improvements have and continue to be made.

The service has appointed a new Head of Midwifery on a secondment from Bradford Teaching Hospitals NHS Foundation Trust for one year.

HUTH has appointed four international midwives, supported by funding from NHS England. The international midwives arrived in the England on the 4th of August 2023, and are currently in York undertaking their Objective Structured Clinical Examination (OSCE) training. The service plans to shortlist a further six international midwives on 31 August 2023, with a planned arrival date into the UK during early November 2023.

The service has recently appointed 18 newly qualified midwives (15.8 Whole Time Equivalents) that will commence on 25 September 2023.

The midwives will undertake a four-week induction programme followed by a further two week supernumerary period before being included on the rosters. To support the newly qualified midwives, the service has appointed a full time Practice Learning Facilitator (PLF).

The service identified that midwives were undertaking historical surgical scrub roles in theatre, a clinical duty that could be performed by a registered theatre nurse. The service has been working with the Interim Chief Nurse to release adult registered nurses to undertake this role. Currently, there are three scrub nurses in post that have undertaken bespoke training for obstetric theatres, with a further three to commence on the 11 September 2023, which equates to and additional 5WTE.

From information provided in the most recent Birthrate Plus report, the service acknowledged the need to upskill the Band 2 Maternity Support Worker to B3 following a programme of education and development. Working with the University of Hull and the Local Maternity and Neonatal system (LMNS), a twelve week university module has been developed. HUTH has five B2 Maternity Support Workers that commence the programme on 28 September 2023, to support the long-term workforce plan for the service.

5.8 EMERGENCY DEPARTMENT

The ED regulatory action plan includes 27 actions against the 15 'Must do' actions. A brief breakdown against the progress of the actions so far is provided in the table below:

ED Must Do Actions – Total of 27 actions to address to address 15 'must do actions'	Number
Actions completed with evidence of completion provided	13
Actions implemented with ongoing monitoring	6
Actions not yet due but on track	5
Overdue	1

An update against the overdue action is as follows:

- Action ED6.2 - To agree a trajectory for all Trust employed Security Staff to receive risk reduction training. This action is not yet complete as feedback received is that training dates to be confirmed as an external provider is providing the training and security will be booked on this training – likely to be October 2023.

A variation to the 'must do' plan has also been recorded for the following actions;

- Action 5.2 Establishment of a Trust-wide MCA/DOLS/Safeguarding Work-stream, a separate work-stream has not been established but the work has been addressed in the Safeguarding Steering Group.
- Action 8.3 - Review of the completed nursing assessment for the vulnerable / sickest of patient's food and balance charts and identify the level of compliance and required improvements. This review is being undertaken within the matron's handbook and will be shared from July onwards and reported in the next quarterly report.

5.9 SURGERY

The Surgery regulatory action plan includes 98 actions against the 25 'Must do' actions. A brief breakdown against the progress of the actions so far is provided in the table below.

Surgery Must Do Actions – Total of 98 actions to address 25 'must do actions'	Number
Actions completed with evidence of completion provided	42
Actions implemented with ongoing monitoring	36
Actions not yet due but on track	9
Overdue	13

An update against the Theatres work stream was presented to the Quality Committee in August 2023; however due to the pace of progress, the committee was not assured. The Theatres work stream will be presented to the October 2023 HUTH QIG meeting

Martha has also commenced the supportive work to the Surgery Health Group in relation to Governance arrangements

The overdue actions in Surgery are as follows:

- SHG2.5 – Completion baseline review of the matron handbook audits and delivery of actions – this is underway by the Nurse Director
- SHG3.4 – Theatres to migrate onto electronic observations, nursing records and medications – some of the digital improvement work relating to observation are delayed due to changes required following pilots in ED
- SHG4.1 – Nerve centre roll out including escalation – delays due to changes required following pilots in ED
- SHG8.5 – Focussed work on resuscitation training – Trajectory for compliance with training capacity being developed to support Health Groups achieve compliance
- SHG9.3 – Development of a medicine management plan – To be completed in conjunction with Pharmacy Team
- SHG10.4 – Quarterly MCA audit – To be undertaken by the Safeguarding Adults Team
- SHG12.2 – Implementation of a specialty level policy tracker for monitoring – Compliance Team to support
- SHG12.3 – NICE Guidance to be a standing agenda on Speciality Governance meetings – to be addressed through the Governance improvement work been supported by Martha
- SHG12.4 – Implementation of a Surgery specific Patient Information Group – To be arranged and supported by the Compliance Team.
- SHG14.1 and SHG14.3 – Referrals to the Chaplaincy Team – Chaplaincy Team to provide quarterly reports on referrals rates

5.10 MEDICINE

The Medicine regulatory action plan includes 39 actions against the 7 ‘Must do’ actions. A brief breakdown against the progress of the actions so far is provided in the table below:

The must do actions overdue are linked to conducting an audit to review OOH medical cover across MHG and identify shortfalls. It is worth noting that the health group have reduced junior doctor vacancies but the audit has not been completed as per the plan.

Medicine Must Do Actions – Total of 39 actions	Number
Actions completed with evidence of completion provided	6
Actions implemented with ongoing monitoring	26
Actions not yet due but on track	6
Overdue	1

The must do actions overdue are linked to conducting an audit to review OOH medical cover across MHG and identify shortfalls. It is worth noting that the health group have reduced junior doctor vacancies but the audit has not been completed as per the plan.

At the August 2023 Medicine Check and Challenge meeting assurance and evidence was received regarding the Nurse Led actions. An additional meeting has been arranged to seek assurance on the medical and operational related actions.

5.11 TRUSTWIDE

The Trust-wide regulatory action plan includes 10 actions against the 4 ‘Must do’ actions. A brief breakdown against the progress of the actions so far is provided in the table below.

Trust-wide Must Do Actions – Total of 10 actions	Number
Actions completed with evidence of completion provided	4
Actions implemented with ongoing monitoring	6
Actions not yet due but on track	0
Overdue	0

- TW2.2 Training Compliance for the overall Trust is now 90.1% and will continue to be monitored
- TW2.3 Training compliance for Safeguarding, Deprivation of Liberty and Mental Capacity Act is all over the Trust 85% Trust Target and will continue to be monitored.
- TW2.4 Resuscitation training compliance has improved but compliance is still below target at 78.3%. Trajectory for compliance with training capacity being developed to support health groups achieve compliance.

Agenda Item		Meeting	Quality Committee and Trust Board	Meeting Date	2023
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** **Quarter 1 data April – June 2023**				
Lead Director	Interim Chief Nurse				
Author	Clinical Governance Midwife Neonatal Consultant (ATAIN program lead) Director of Midwifery				
Report previously considered by (date)	Quality Committee and 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	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 • Decide if any further information and/or assurance are required.

Hull University Teaching Hospital NHS Trust
FAMILY AND WOMENS HEALTH GROUP
Avoiding Term Admissions into Neonatal Units (ATAIN):
Learning from Term Admissions Quarter 1

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 NHS 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 designed 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 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 demonstrated by table 1 there has been a decrease in the number of Term Admissions to NNU since 2016. **Table 1** highlights the number of admissions to the NNU during the commencement of the ATAIN programme.

Table 2 shows the current position for the year 2023 in **Quarter 1** (01/04/23- 30/06/23)

Table 1

Year	Total Term Admissions to NNU	% 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%
2022	186	41%	2.3%
2023			

Table 2

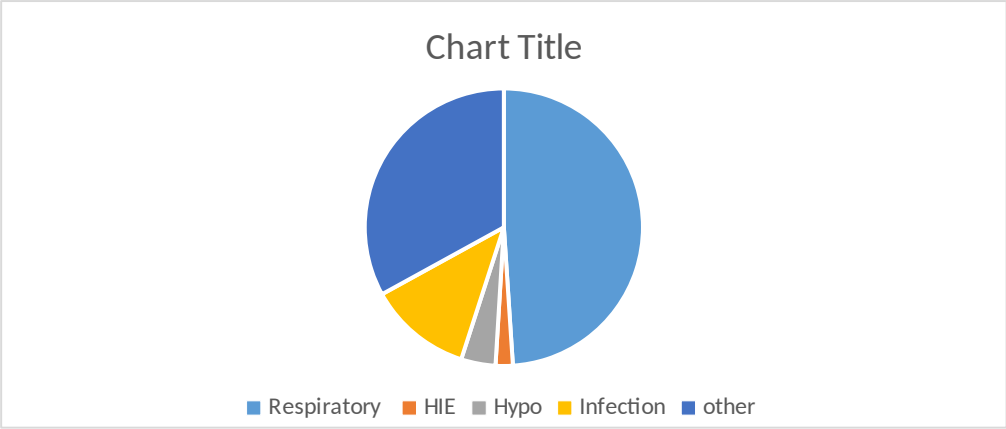
Duration	Total Babies Born	% of total NNU admissions	% of term admissions to NNU
Quarter 1 2023	1236	36.4%	3.9%
Quarter 2 2023			
Quarter 3 2023			
Quarter 4 2023			

All unexpected term admissions to NNU 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.

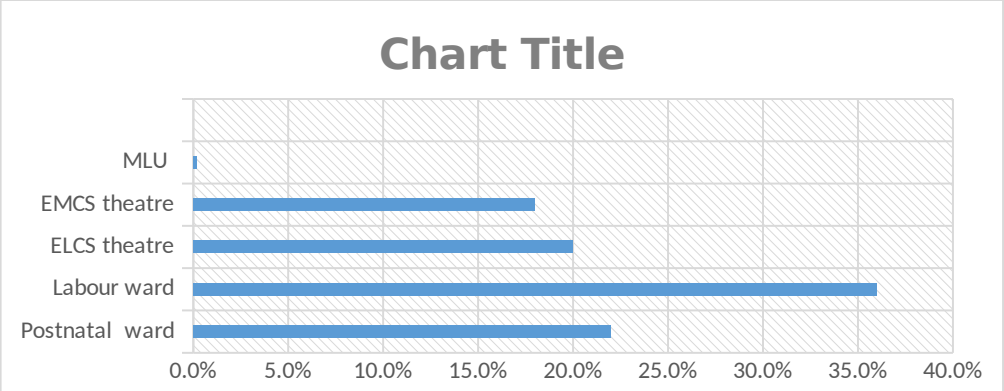
A high-level review was completed of the primary reasons for all admissions, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. Firstly the focus was on gestation as demonstrated below 38% of the cohort of babies are 37+0 – 37+6 weeks gestation. 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 focused on area of admission.

Gestation
Unexpected Term Admissions to NICU cases, reviewed through Maternity case review equated to 20 cases in quarter 1. Themes identified are presented below. The average gestation at admission to NICU was 39+0 -39+6 weeks.

The primary reason for admission to NNU was for respiratory support requiring Continuous positive airway pressure (CPAP).



Admission Location
Babies were most commonly admitted to NICU from the Labour & delivery Suite and The Postnatal Ward. 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 has been trialling a new quality improvement initiative starting in June 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.



As stated in CNST year 4 all reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet

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 Emergency Caesarean Sections. 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 with this mode of delivery within a theatre situation therefore this has been added as a quality improvement within the action plan.

Birth Weight
The most common birth weight range at admission to NICU was 3.0 – 4.0kg.

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 2.

Suitability for transitional care
The number of babies admitted to the NNU that would have met current Transitional Care admission criteria but were admitted to the NNU is 7 compared to 8 in quarter 3 and the number of babies that were admitted to, remained on NNU because of their need for nasogastric tube feeding is 0 as the transitional care support at Hull University teaching Hospital supports NG feeding.

The themes as identified above were reviewed and the following action plan agreed through multidisciplinary discussion. Compliance with the below 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

Clinical Governance Midwife
Neonatal Consultant (ATAIN program lead)
Director of Midwifery
July 2023

Action	Lead	Status

Review of 'Respiratory management of the infant' guideline to ensure high standard of practice standardised	Consultant Neonatologist	Completed
Consideration for development of a criteria for admission to NICU to avoid unnecessary admissions	Consultant Neonatologist	Completed
Development of a Robust system in order to collect data on all Avoidable Term admissions to NNU	Neonatal consultant and Clinical Governance Midwife Local Maternity System	Completed
Respiratory management platform to be trialled for respiratory support (CPAP) at the bed side on labour ward	Neonatal consultant	In progress
To embed practice of skin to skin at EMCS/ELCS	Labour ward coordinators Infant feeding co coordinators	In progress

Agenda Item		Meeting	Quality Committee and Trust Board Meeting	Meeting Date	Q1 2023
Title	**Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5:** **Safety Action 6 – Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three** **Element 2 – Outcome Indicators I and II**				
Lead Director	Interim Chief Nurse				
Author	Midwifery Sister – GAP Lead Director 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
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 Trust Board is requested to: • Receive the report and decide if any further information and/or assurance are required.

MATERNITY SERVICES
Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5:
Safety Action 6 – Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three Element 2 – Outcome Indicators I and II

1. Purpose of the Report

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: Outcome Indicators I and II & with Saving Babies Lives Care Bundle Version 3 (SBLCB3) Element 2 Outcome Indicators 2d & 2e, with additional data provided for Point 2.22.

2. Introduction

Saving Babies' Lives Care Bundle Version 3 (SBLCBv3) is a care bundle for reducing perinatal mortality across England published in July 2023. This third version of the care bundle includes a refresh of all existing elements, drawing on national guidance such as from NICE or RCOG Green Top Guidelines, and frontline learning to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. It also includes a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. There are now 6 elements of care, incorporating learning from the CNST MIS.

Element 2 covers Fetal Growth: Risk assessment, surveillance, and management. Data required for Element 2 Point 2.22:

a) Percentage of babies born <3rd birthweight centile >37+6 weeks' gestation (Outcome indicator 2d)
b) Ongoing case-note audit of <3rd birthweight centile babies not detected antenatally and born after 38+0 weeks, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur)
c) Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies
d) Percentage of babies >3rd birthweight centile born <39+0 weeks gestation (Outcome indicator 2e)

For the purposes of this report, point a) & b) link to CNST Safety Action 6, Element 2:

Outcome Indicator I – percentage of live births and still births <3rd birthweight centile born >37+6 gestation
Outcome Indicator II – percentage of live births and still births >3rd birthweight centile born <39+0 weeks gestation

NHS Resolution is operating a fifth 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 to the CNST

maternity incentive fund. The scheme incentivises 10 maternity safety actions. Trusts demonstrating they have achieved **all** of the ten safety actions will recover their contribution and will also receive a share of any unallocated funds. Information about Year five was published on 31 May 2023.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by 12 noon on 1 February 2024.

3. CNST Safety Action 6, Element 2 – Outcome Indicator I & SBLV3 Element 2 – Point 2d)

Percentage of live births and still births <3rd birthweight centile born >37+6 gestation:

April, May, June 2023 (Quarter 1):

Number of babies born at HUTH = **1227**

Number of babies born at HUTH < 3rd centile & >37+6 = **38**

Percentage = 3.10 %

CNST Safety Action 6, Element 2 – Outcome Indicator II & SBLV3 Element 2 Point 2e)

Percentage of live births and still births >3rd birthweight centile born <39+ weeks gestation:

April, May, June 2023 (Quarter 1):

Number of babies born at HUTH = **1227**

Number of babies born at HUTH > 3rd centile & <39+0 = **342**

Percentage = 27.87 %

SBLV3 Element 2 - 2.22 Point b)

Ongoing case-note audit generated from the Trust DATIX reporting and reported through the Perinatal Institute Growth Assessment Protocol (GAP) Score system of <3rd birthweight centile babies >38 weeks not detected antenatally

For Quarter 1 (April, May & June 2023), there were 13 cases identified and some of these were also analysed through a year-long DATIX deep dive (May 2022 – May 2023) and using a simple approved calculation to identify if the case is a missed diagnosis of SGA:
Some cases fell into two categories:

7 cases fell within the accepted difference between birthweight and estimated fetal weight at the last growth ultrasound prior to birth (using the recently approved calculation) i.e. not a missed diagnosis of SGA (53.85%)

4 missed cases were identified which ultrasound of fetal growth had undertaken (30.77%)

2 missed cases were identified that only had fundal height measurements undertaken: one of these had a missed referral for serial scans due to maternal smoking status and one had incorrect demographics on the growth (15.38%)

Emails were sent to the relevant practitioners to inform them that they had missed an opportunity for a growth scan and incorrect geographical details on the growth chart. Details of the 4 missed cases who had fetal growth ultrasound scans were sent to the obstetric sonographers for discussion at their multi-disciplinary meeting(s

From the GAP score report produced during early during this quarter, a GAP newsletter was distributed to all maternity staff in April 2023. This covered GAP data involving detection rates of babies born under 10th centile, reminders to all staff to refer for growth scans if indicated, commence GAP protocol, highlighted the recent Trust GAP guideline changes and focused on consideration of risk at every contacts with birthing people. The next GAP newsletter should be due to be produced in August 2023. In the future, the introduction of the BadgerNet IT maternity system and its links with the Perinatal Institute GAP software for inputting scans and fundal height measurements should further improve data collection and care.

SBLV3 Element 2 – 2.22 - Point c)

Percentage of babies born >39+6 and <10th birthweight centile to provide an indication of detection rates and management of SGA babies

Quarter 1 data (April, May, June 2023)

Number of babies born at HUTH <10th birthweight centile & >39+6 = **53**

= 4.3% of babies born at HUTH in Quarter 1 (2023)

5. Summary

i) CNST Safety Action 6, Element 2 – Outcome Indicator I & SBLV3 Element 2 Outcome Indicator 2d:
Percentage of live births and still births <3rd birthweight centile born >37+6 gestation has been documented

ii) CNST Safety Action 6, Element 2 – Outcome Indicator II & SBLV3 Element 2 Outcome Indicator 2e:

Percentage of live births and still births >3rd birthweight centile born <39+0 weeks Gestation has been documented

iii) Data has been provided to evidence SBLV3 Element 2 Point 2.22

6. Recommendations

The Trust Board is requested to:

- Receive the above report and 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

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	
Title	**Perinatal Quality Surveillance Tool**				
Lead Director	Interim Chief Nurse				
Author	Lead Midwife Director of Midwifery				
Report previously considered by (date)	Quality Committee Q1 2023 report				

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 Trust Board is requested to: • Receive the report and decide if any further information and/or assurance are required.

PERINATAL QUALITY SURVEILLANCE TOOL

April - June 2023

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

An inspection for Maternity Services Safe and Well Led domains was undertaken on 15th March 2023. CQC inspectors visited all areas of the maternity services based at the Hull Women & Children's Hospital. They spoke to staff and women attending the service as well as conducting more formalised interviews with managers and clinicians.

Following the inspection a Letter of Intent was received on 17th March 2023 and an immediate action plan put in to place for 18th – 21st March 2023 to support systems and processes in the Antenatal Day Unit. This was followed up with a further, longer-term action plan and submitted to the CQC on Tuesday 21st March 2023.

Following a further unplanned visit from the CQC we received a Section 31 notice on the 28th April 2023.

Full feedback from the CQC and updated ratings for the visit have not yet been received.

3.0 HSIB REFERRALS

The following provides numbers of HSIB referrals made:

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
1	1	1	1	1	0						

April 2023 MI025959 G1P0 Shoulder Dystocia, Unexpected admission to NICU

May 2023 MI026851 G1P0 41+1 IOL, Intrapartum Stillbirth

4.0 DATIX INCIDENTS

The following provides the number of incidents reported:

Severity	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
Moderate	2	2	2	1	2	4						
Major	0	0	0	0	0	0						
Catastrophic	0	0	0	0	2	0						

Moderate

PS11/2023/12947 G1P0 Shoulder Dystocia, Unexpected admission to NICU
W282333 Ruptured Uterus, 4.1L PPH
W280849 Failure to recognise AKI 1
W283696 Drug error – IV haemabate given instead of IV oxytocin
W283570 Failure to escalate care appropriately
W283499 Laceration to baby's head during EM LSCS
W283480 Uterine rupture, PPH 2.5 L

Catastrophic
PSII/2023/12941 Intrapartum Stillbirth
SUI/2023/11014 PMRT escalation due to Obstetric care graded C

Themes & Actions
No themes identified at present

5.0 PATIENT SAFETY INCIDENT INVESTIGATIONS

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
1	2	0	0	0	1						

SUI/2023/11014 PMRT escalation due to Obstetric care graded C

6.0 TRAINING COMPLIANCE

Family and Womens Health Group
Overall Summary Report - Training

Date Period - As at 21st June 2023
Data Source - HEY247

Mandatory Training Onvly	current % Compliance Mandatory Training
Obstetric Specialist Nurses	97.2%
Maple & Rowan Wards	78.6%
Community Midwifery	93.3%
Labour Ward and Delivery	93.4%
ANC/ADU	88.0%
Midwifery Led Unit	88.1%
Obs & Gynae Medical Staff	85.2%
Required Training Modules	**current % Compliance Mandatory Training**
Information Governance	91.9%
Resuscitation (part of Prompt annual training)	86.6%
Health, Safety and Welfare	92.2%
Moving and Handling (Clinical)	83.2%
Fire Safety (Clinical)	84.7%
Mental Capacity Act	84.1%
Deprivation of Liberty	89.7%
Infection Control (Clinical)	90.0%
Equality, Diversity and Human Rights	94.4%
Safeguarding Children & Young People - Level 2	83.7%
Safeguarding Children & Young People - Level 3	87.9%
Safeguarding Adults - Level 2	86.8%
Safeguarding Adults - Level 3	76.3%
Conflict Resolution	94.1%
Perinatal institute GAP e-learning	54.6%
Fetal Monitoring (6 hours face to face)	86.0%
Newborn Life Support (Neonatal Resus) (part of Mandatory training day 2)	77.8%
PROMPT (22/23)	83.8%
Mandatory training day 2 (22/23)	80.2%
K2 - 20.6.23 data	84.7%

7.0 MINIMUM SAFE STAFFING LEVELS

Midwifery Staffing – See Bi annual Midwifery Staffing Paper

8.0 SERVICE USER VOICE FEEDBACK

Feedback received via the PALS team

Good evening

I would like to start by saying how lovely the staff were both in the labour ward and rowan ward. I gave birth on the 12/5/23 and there was a band 6 midwife called Ashley who looked after me from the start of my labour. She was extremely kind and understanding. I have ASD and her care towards me was exemplary, she took special care in making sure the lighting wasn't too harsh and any machines used were turned down. These little changes really helped me focus on my labour and made me feel relaxed and comfortable. She spoke to me in a way that was calm but informative, and included my partner in the discussions which meant a lot to both of us. Her understanding of ASD made the experience much easier, she was able to see how to help me best. Ashley handed over to Olivia explaining how she'd been helping me, and Olivia continued to do this. She was also extremely kind and supportive. Olivia acted very professionally when my labour took a direction which ended in a emergency forceps delivery in the delivery room. I don't remember much of this as I haemorrhaged, the experience was traumatic but I remember her talking me through what was happening and why it was happening. All staff involved acted quickly and in the best interest of me and the baby, I cannot fault their actions.

When taken to rowan ward I was cared for by Hannah Band 6 midwife and a midwife assistant who I know worked part time but I cannot remember her name (she was short in stature and had blonde hair, in her 20's and had mentioned her birth experience which had been a c section). Hannah was met with me in an emotional state I was demanding to go home, on reflection I was most definitely in shock from the birth. She stands out to me because she knew exactly how to calm me down and was kind but direct with me. She listened to my distress and made sure I was assessed for better pain relief by the doctor. She comforted me and educated me on why my baby who was being sick after every feed due to the type of birth I'd had and reassured me that this was normal. She explained how it was helping my baby to clear the mucus from her lungs. She also helped me harvest colostrum which gave me confidence in feeding. The midwife assistant who I described continued to help me through the night, she was very compassionate and kind.

9.0 STAFF FEEDBACK

Feedback received from a Community Midwife:

I feel impelled to put a few lines together on behalf of myself and my colleague's in Wyke Community Team to highlight to you both just how fabulous your leadership team are.

I have examples, merely days apart of not only compassionate leadership, leading by example, but examples of true, woman centred care.
On Friday; Anna and Hannah themselves attended a homebirth for my team as there was no one else available. This woman had previously had a difficult experience in the hospital and very much wanted to birth at home.

Instead of telling her she would have to transfer in, Anna put out immediately for help and Hannah who was actually annual leave attended this beautiful birth with her. Both the woman and my team were thrilled that they did this.

Today, my second woman who was booked for a homebirth went into labour. Again; faced with the challenges of staffing levels, Hannah and Anna sprang into action again to put this woman's wishes first and managed to get workload covered to release my colleague Donna and Kay to attend her. Again, resulting in a beautiful homebirth and what was special today was this woman was part of a Student Midwife's caseload. Laura has attended almost all of this woman's care and was then able to be present and experience her homebirth.

Well, I have had a few tears of joy today.
I just wanted to share with you the positivity and the happiness we are feeling right now.
Times may be hard but we have the best team ever

10.0 CORONERS

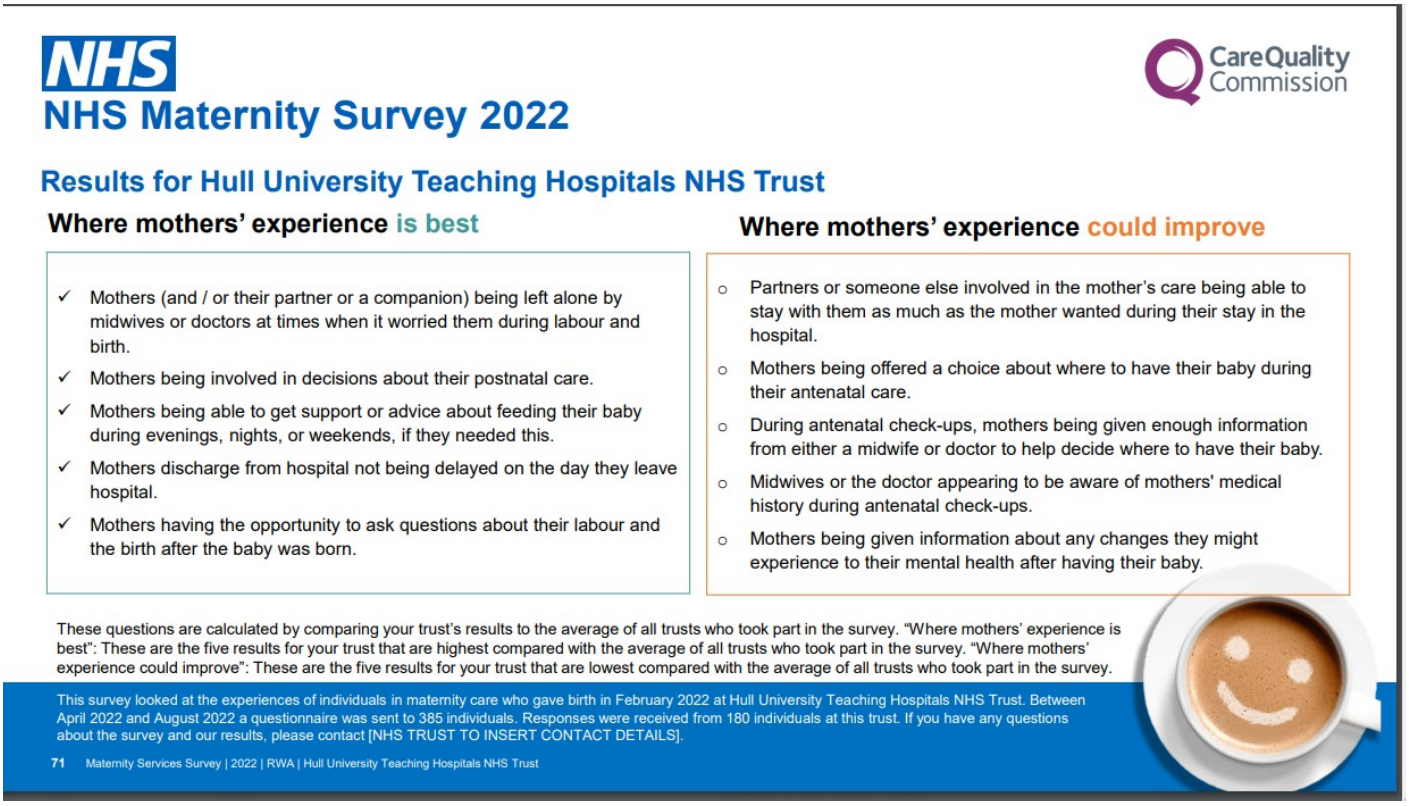
The Trust was issued with no Coroners Regulation 28 in relation to maternity:

Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
0	0	0	0	0	0						

A Coroner's Inquest was held on the 29th/30th June 2023 regarding a spinal cord injury and sad death of a baby following a Keilland's forceps.

Inquest concluded re Keillands forceps

- Conclusion: FAM was born 16/02/2021 having been delivered by use of Kiellands rotational forceps. He was floppy, bradycardic, blue, at the time of delivery; and underwent resuscitation according to the NLS algorithm. Treated as a case of HIE but clinical picture at variance with this condition, so he was investigated for other disorders. An MRI scan showed presence of high cervical spinal cord injury which was caused by the use of Kiellands rotational forceps. FAM died at Hull Royal Infirmary on 16/3/21 as a result of spinal cord injury.
- Regulation 28 PFD Report issued to the RCOG. Also mentioned during the hearing my concerns re use of Kiellands forceps on one hand, on other, vacuum into which some Mothers may find themselves where hospitals do not use them having been discarded by obstetric teams for valid reasons. I propose to exercise my statutory powers under Reg28 to write to the president of RCOG in London, also at liberty to send report to whomsoever may wish, which may include others who wish to see report, e.g. NHSE, etc, and family will get this, as well as IPs, also sent to Chief Coroner, HHJ Teague KC.



NHS

NHS Maternity Survey 2022

CareQuality Commission

Results for Hull University Teaching Hospitals NHS Trust

Where mothers' experience is best

- ✓ Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
- ✓ Mothers being involved in decisions about their postnatal care.
- ✓ Mothers being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Mothers discharge from hospital not being delayed on the day they leave hospital.
- ✓ Mothers having the opportunity to ask questions about their labour and the birth after the baby was born.

Where mothers' experience could improve

- o Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- o Mothers being offered a choice about where to have their baby during their antenatal care.
- o During antenatal check-ups, mothers being given enough information from either a midwife or doctor to help decide where to have their baby.
- o Midwives or the doctor appearing to be aware of mothers' medical history during antenatal check-ups.
- o Mothers being given information about any changes they might experience to their mental health after having their baby.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where mothers' experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where mothers' experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

This survey looked at the experiences of individuals in maternity care who gave birth in February 2022 at Hull University Teaching Hospitals NHS Trust. Between April 2022 and August 2022 a questionnaire was sent to 385 individuals. Responses were received from 180 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

71 Maternity Services Survey | 2022 | RWA | Hull University Teaching Hospitals NHS Trust

APPENDIX – Abbreviations

- ATAIN – Avoiding Term Admissions to Neonatal Unit
- 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

Agenda Item		Meeting	Quality Committee and Trust Board	Meeting Date	July 2023
Title	**Safety Action 1 – MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) Perinatal Mortality Review Tool** **Quarter 1 data April to June (2023)**				
Lead Director	Interim Chief Nurse				
Author	Bereavement Midwife/Director 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
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 • 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 5 - 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 5.

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 fifth 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 2023 and will included eligible cases between the **30th May and 7th December 2023**. 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 **1st February 2024**. 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), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD), and HSIB for the number of qualifying incidents reportable (safety action 10, standard a). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross reference to the maternity incentive scheme via the key lines of enquiry.

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) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from **30th May 2023**, MRBRRACE-UK surveillance information should be completed within one calendar month of the death.

b) For 95% of all deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30th May 2023**

c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30th May 2023**. 95% of reviews should be started within 2 months of the death, and a minimum of 60% of multidisciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.

d) Quarterly reports should be submitted to the Trust Executive Board from **30th May 2023**

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 Q1 April to June 2023, the reporting period of the CNST year 5 incentive scheme commenced at the end May 2023

a) There were 2 eligible baby deaths in the Trust, in 100% of the cases the MBRRACE-UK perinatal surveillance was commenced within 7 days and completed within one calendar month

b) The parent's perspective was sought in all 2 cases occurring in Q1, achieving 100% compliance with the standard.

c) 100% of the cases in Q1 when babies were born and died in the Trust, have been commenced within the standard of 2 months. Both remain under review. 5 cases in which the babies deaths occurred within Q4 (January –March 2023) the reviews have been completed 100% compliance. 4 cases the reports have been published, 1 case, the report is being written demonstrating 80% compliance which is within the standard. All remaining cases under PMRT review the babies were born at another Trust and the death occurred in HUTH, and are not subject to the standard.

d) Quarterly report submitted as per standard and discussed with the Trust safety champion

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

Director of Midwifery

July 2023

MATERNITY PMRT ACTION TRACKER FOR Q1 2023/2024

MBRRACE ID	ACTIONS	Lead	Due date	RAG
83553	Review guideline to ensure woman prescribed Aspirin when GDM diagnosed following booking HbA1c	AW	28/02/23	
	To ensure that women are appropriately seen in the pre-term birth clinic The capacity issues are recorded on the HUTH risk register	UR	31/07/23	
84712	Obstetric lead to give individual feedback and raise at senior staff meeting	KS	30/06/23	
	Develop a documentation aid to improve recording discussions with families regarding preterm mode of birth	KS	30/06/23	
86507	To highlight to staff via PMRT newsletter and on MDT2 the need for Keilhauer bloods for all bereaved women	AB/ SC	30/06/23	
85655	Highlight to staff in the PMRT newsletter and on MTD2 the requirement to monitor progress following a stillbirth on a partogram	SC	31/05/23	
	Highlight to staff in the PMRT newsletter and on MTD2 the requirement to ensure maternal observations are recorded consummate with risk	SC	31/05/23	
	Highlight to staff in the PMRT newsletter and on MTD2 the requirement to ensure women receive pre-existing prescribed medication	SC	31/05/23	
86709	Publish in PMRT newsletter requirement to repeat a BP reading when scores on the MEOWS- share with Managers to highlight in department newsletters/handovers	SC	28/07/23	
	Publish in PMRT newsletter requirement to record a recent weight when prescribing Fragmin - share with Managers to highlight in department newsletters/handovers			
	Publish in PMRT newsletter requirement to order and report electronically confirmation IUD scans performed in ultrasound scan department. Email ultrasound department to share learning			
Actions now completed (to be received at the PMRT meeting then removed from this tracker)				

Hull University Teaching Hospitals NHS Trust
Trust Board and Quality Committee

Agenda Item		**Meeting**	Trust Board Meeting	**Meeting Date**	July 2023
Title	Bi – Annual Midwifery Staffing Report				
Lead Director	Interim Chief Nurse				
Author	Director 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
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 Trust Board is requested to:

- Receive the report outlining a 6 month review of maternity staffing
- Decide if any further information and/or assurance are required.

Background
This report provides a review of the maternity workforce in relation to the quality and safety of care provided. It will incorporate an overview of national maternity transformation, monitoring of maternity workforce, safe staffing reviews, Midwife: Birth ratio, ward review, escalation and reporting. The report will encompass HR data extracted from April 2022 – June 2023 and e-roster data from January 2023 – May 2023.

1. Monitoring of Maternity Workforce
There is a maternity escalation policy in place at HUTH; this supports midwifery leaders to take appropriate actions/escalation when staffing levels fall below acceptable standards in line with local Birthrate plus recommendations. There is also a Trust wide Safe Care meeting that occurs three times a day, maternity staffing is discussed along with the wider organisation and if any unsafe staffing issues are identified they are escalated to the Director of Midwifery (DoM) for appropriate actions to be taken, such as diverting services if required. The service is experiencing very high level of maternity leave at the moment this is presenting daily staffing challenges and midwifery leaders meet daily to ensure safe staffing was maintained in maternity.

The available workforce has been reviewed and strategies to redeploy staff across the service has been enacted as required. This has predominantly involved non-clinical staff/specialist midwives/managers moving to clinical areas to provide direct care. This has been carried out following individual review of training needs and ensuring that individuals were moved to a clinical area that met with their skill set.

Absence Rates Registered Midwives April 2022 – June 2023

Absence Rates Non - Registered support workers April 2022– June 2023

Sickness and absence within maternity services is an ongoing issue, all midwifery managers have initiated the Trust 'Supporting and Managing Attendance Policy CP251' were appropriate and meet regularly with

HR managers. The maternity service has acknowledge it has an ageing workforce with some staff having longstanding health issues.

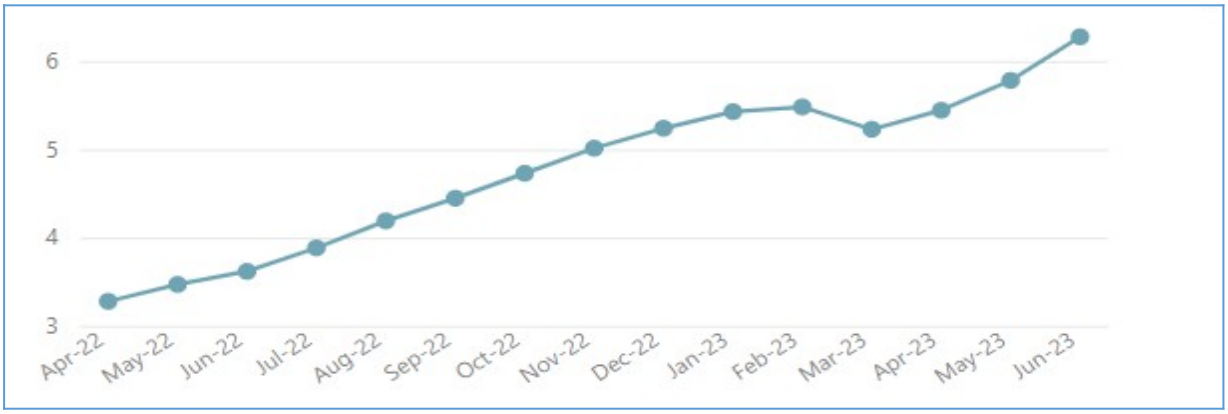
Individual sickness is reviewed with line managers and there are multiple personal reasons why staff are absent from work. In response to your concern there have been three midwifery managers absent from work but not as a direct response to work related stress.

In addition and in response to the Ockenden Report all Trust were asked to 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 four 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 maintain safe staffing and continue to provide high quality, safe maternity care.

Finally the service has had a double pay initiative that was in place since June 2022.

Maternity Leave April 2022 – June 2023



The maternity service is experiencing a high number of registered midwives who are on maternity leave the table below demonstrates the number of WTE midwives on maternity leave over time.

WTE	July 22	Aug	Sep	Oct	Nov	Dec	Jan 23	Feb	March	April	May	June	July	August	Sept	October	Nov	Dec	Jan 24	Feb	March	April	May	June	July
0.96																									
1.00																									
0.85																									
1.00																									
0.75																									
0.64																									
1.00																									
1.00																									
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1.00																									
0.64																									
17.24																									

Leavers Registered Midwives April 2022 – June 2023

The pandemic has made professionals review whether they want to continue to work within the NHS, including the midwifery profession.

A recent 2022 RCM survey highlighted that only 5.9% of midwives said that there are enough staff at their organisation for them to do their job properly. This is a fall of 12.5 compared to 2020, where 18.4% of midwives said there was enough staff at their organisation.

This is a significant concern and we know that newly qualified midwives are at a higher risk of leaving within the first two years then the rest of the workforce. This is why HUTH have invested in the Retention, Recruitment and Pastoral Midwife (RRPM) to support ongoing work with existing staff and new starters.

All leavers receive an exit interview to understand in more detail the reasons for leaving. The reasons staff have given for leaving are as follows:

- Career progression (promotion)
- Undertake further training such as Health Visiting University programmes
- For a more happier work life balance
- Return to Nursing
- Some midwives have feedback negative behaviour from peers as a reason for leaving
- Flexible retirement

The rate at which midwives are leaving the profession is slowing, however feedback from staff is that they are feeling extremely fatigued following the pandemic.

2. Vacancies June 2023
Number of Registered midwives currently in post is 168.23 WTE against a budget of 187WTE = (18.77 WTE) vacancy coupled with:

- maternity leave 17.42WTE if we recruit to 60% = (10.45WTE)

- Total vacancy of = 29.22WTE registered midwifery posts

3. Recruitment
HUTH maternity service works in close partnership with the University of Hull to support workforce planning. In the current climate there is an annual intake of students every September that feeds into HUTH.

Newly Qualified Midwives – we have offered jobs to 22 student midwives due to qualify in September 2023. 15 have accepted posts equating to 12.57 WTE. There are two awaiting final response.

Triage Midwives – 2 recruited (1 external), 1 further internal to interview. Advert has gone back out.

We have listened to feedback from core labour ward staff and wider teams to understand what clinical tasks midwives are undertaking that are non-midwifery. The staff voiced concern that undertaking historical surgical scrubbing in theatre is a task that could be undertaken by a theatre nurse.

As a direct result of this feedback the service has appointed nurses, who are currently undertaking a bespoke training package to facilitate the release of midwives from this non midwifery role. Work is ongoing with the Trust theatre matron and Chief Nurse to ensure the new model is delivering releasing clinical midwifery hours back into the system.

International recruitment (IR)

On the 11 July 2022 HUTH received a letter from NHS England informing the Trust that they have expanded the offer to join the NHSE Maternity IR Programme to all maternity services. This offer is to support improvements in maternity services and to help with the ongoing workforce gap identified in midwifery. The service have 5 international midwives that will be starting in 4th August 2023, there is an advert out to recruit another 5 international midwives.

4. Safe Staffing Reviews

In January 2023 all midwifery establishments within the inpatient services were reviewed collaboratively between the senior management team, Interim Chief Nurse and Director of Midwifery to understand the workforce requirements needed to effectively manage all clinical areas safely in line with the most recent Birthrate Plus Report.

Maternity staffing and acuity continue to be reported three times a day in line with HUTH Safe Care reporting mechanisms. The labour ward complete a 4hrly Birth Rate Plus acuity tool and any 'red flags' are reported via the Perinatal Quality Surveillance Tool and the monthly Nurse Directors staffing report. Senior leaders escalate any staffing concerns to the Director of Midwifery or deputy on a daily basis. The Birthrate Plus workforce acuity tool monitors staff versus acuity and is embedded within the maternity services at HUTH.

5. Clinical Area Reviews and Red Flags

Quality indicators and staffing continue to be reviewed as part of the weekly managers meeting. This meeting is chaired by the Director of Midwifery or Deputy Matron and facilitates senior oversight of safe staffing levels. Sickness levels are monitored via the senior managers with support from Human Resource department.

Birth Rate plus Red Flags

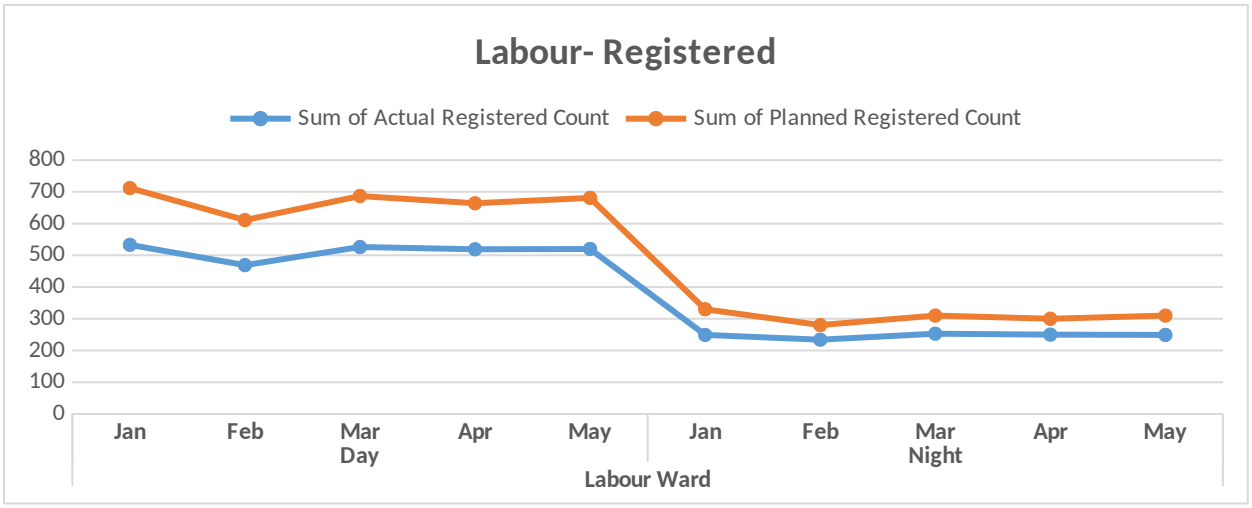
January – March 2023 Labour ward – 14 red flags reported

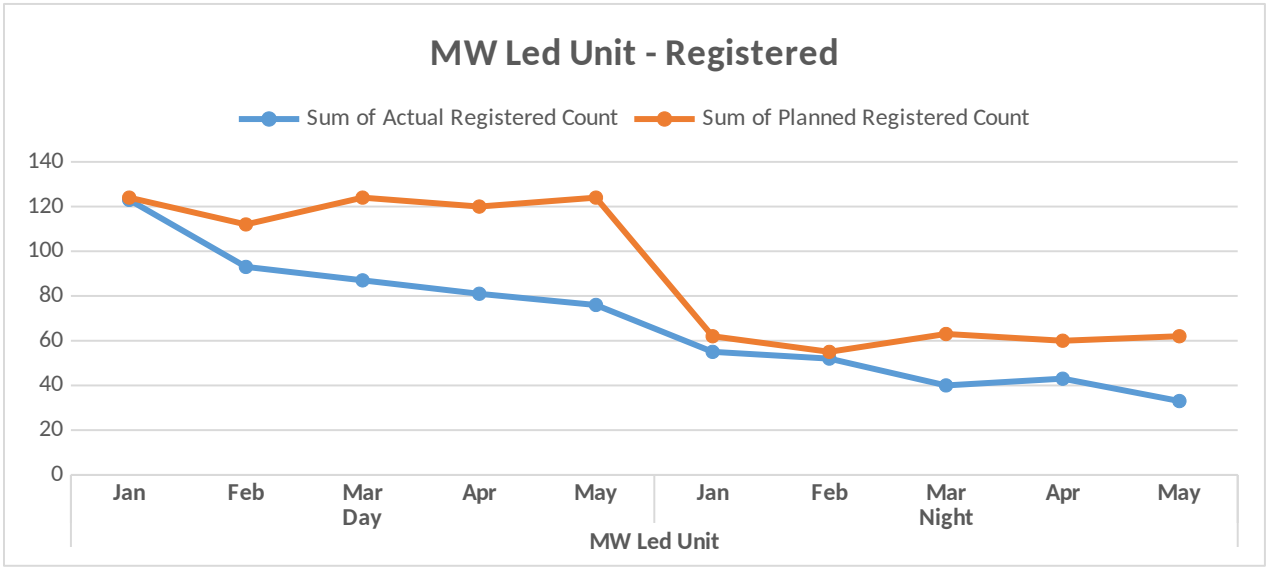
- 2 delayed or cancelled time critical activity
- 1 delay between presentation and triage
- 1 of these were delay between admission for induction and beginning of process
- 8 were missed or delayed care

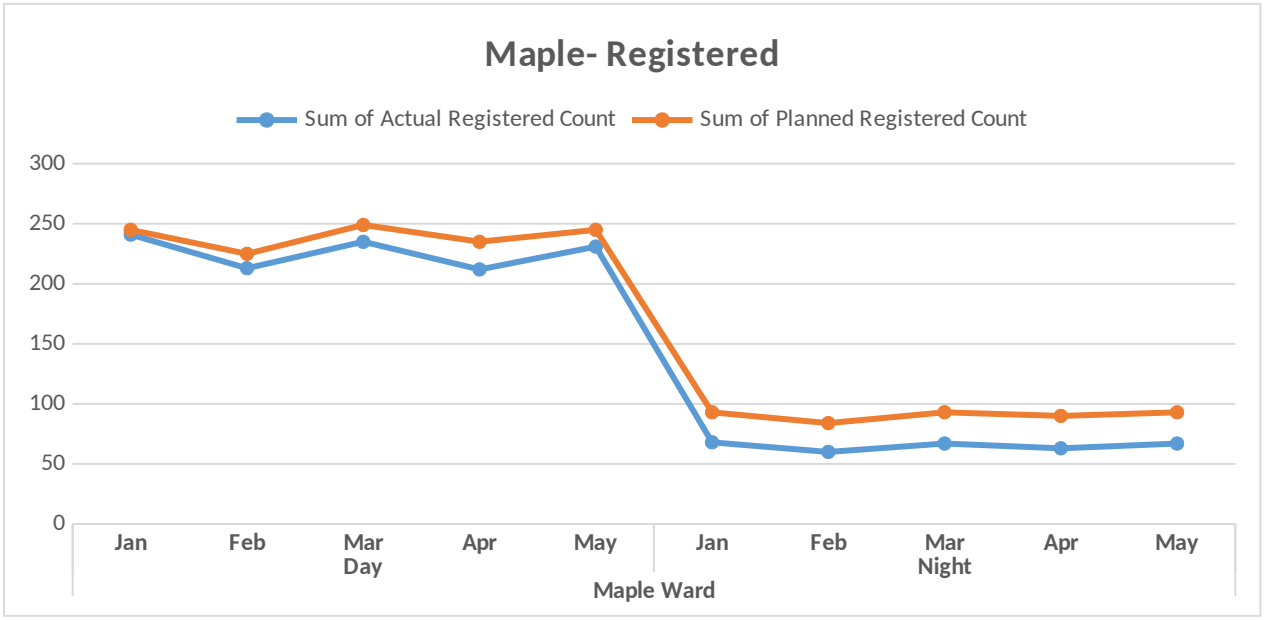
April – June 2023 Labour ward - 18 red flags reported

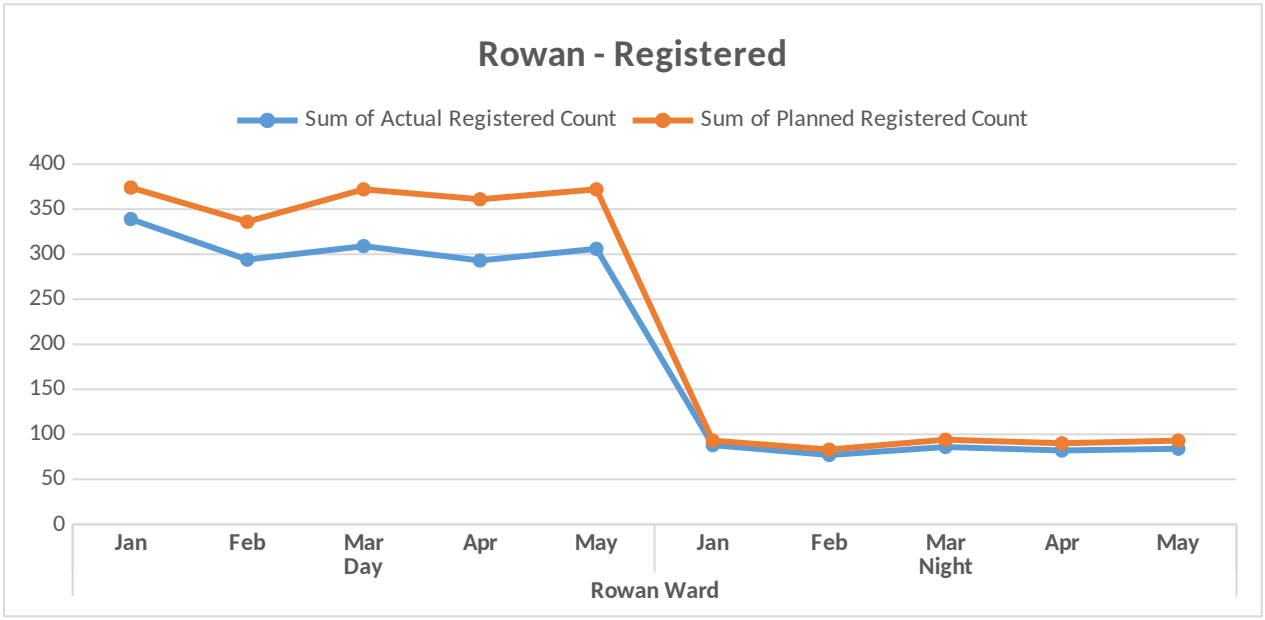
- 1 delayed or cancelled time critical activity
- 2 of these were delay between admission for induction and beginning of process
- 13 were missed or delayed care
- 2 unable to provide 1:1 care in labour

6. Planned versus actual Jan – May 2023 (Inpatient areas)

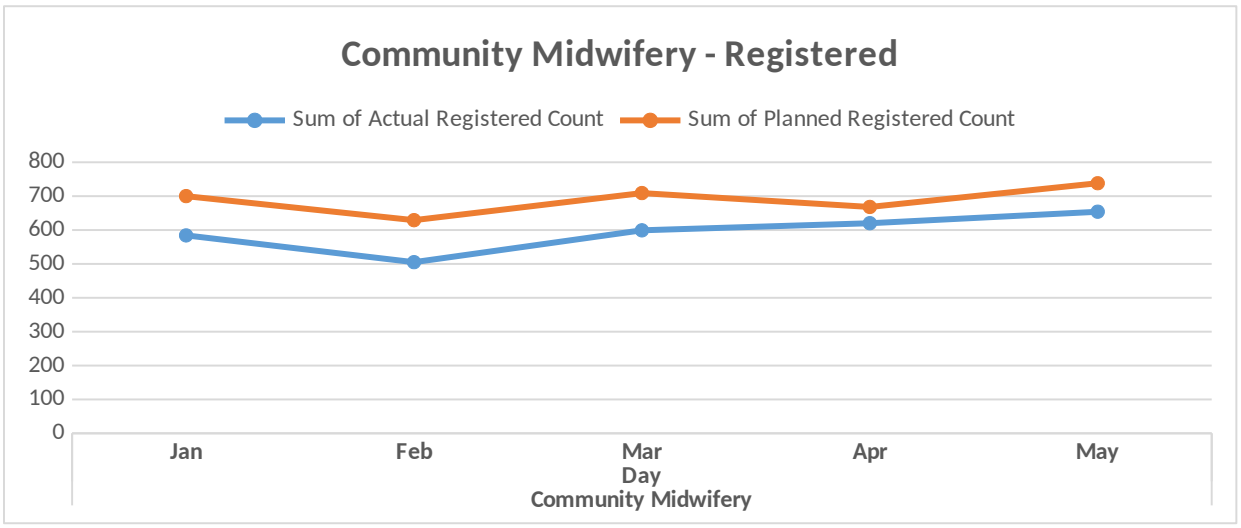




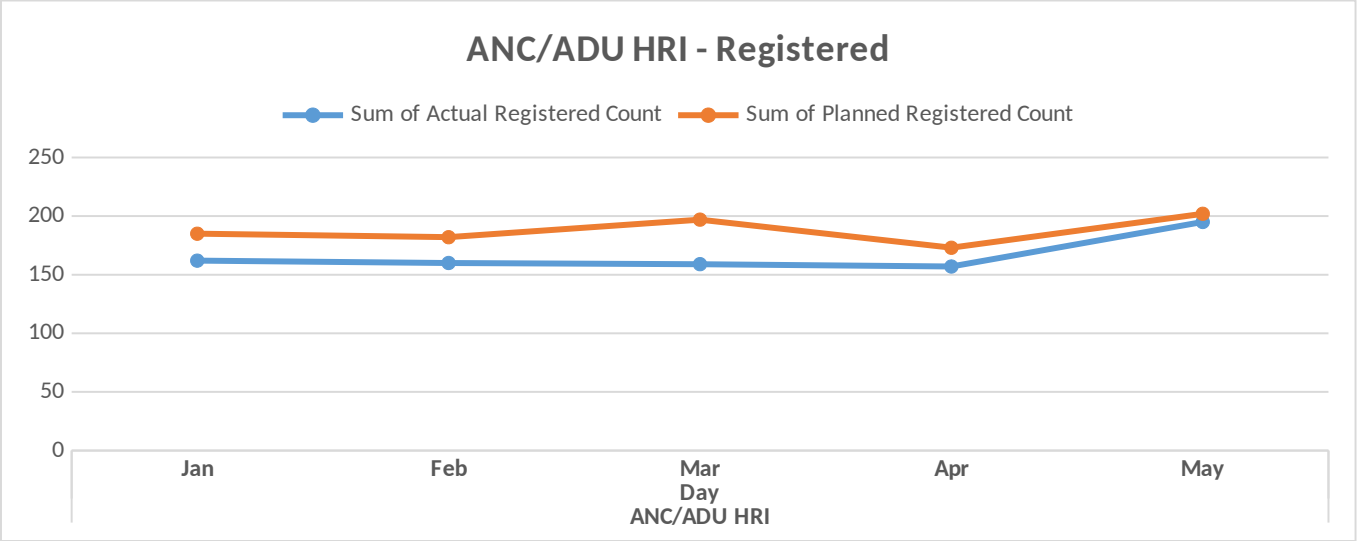




Community Midwifery planned versus actual



ANC/ADU planned versus actual



7. Birthrate Plus Report 2021

HUTH in line with national guidance has undertaken a Birthrate plus assessment using three months casemix data for the months of April to June 2021. The Birthrate plus Workforce Planning system provides each maternity service 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 report identified that compared to data collated in 2018 the overall health needs of the local population have significantly increased than previously reported. This in turn has a direct correlation to the number of midwives required to deliver safe and affective care to women throughout their maternity journey.

The report recommended that the clinical midwifery budget to be set at 187.89WTE midwives, compared to the previous funded establishment of 179wte. The report also identified the need to uplift midwifery establishment by a further 9.29WTE for additional specialist and management roles to support the delivery of key national drivers rather than deliver direct clinical care.

The report was shared with the Trust Board and in collaboration with senior leaders including finance and Chief Nurse the midwifery Budget has been uplifted 187WTE to reflect the midwives required to deliver direct clinical care.

Following the Ockenden publication and in line with the Royal College of Midwives (RCM) 'Strengthening midwifery leadership: a manifesto for better maternity care', HUTH has uplifted is current Head of Midwifery (HoM) to Director of Midwifery (DoM). The Director of Midwifery presents all maternity reports to the Trust Board with support from the Chief Nurse, which enables the DoM to provide assurance to the Board that key national drivers are being delivered and that services are safe.

The on-going workforce plan and next steps are to strengthen the midwifery leadership team by exploring other roles such as Head of Midwifery, Consultant Midwives, Advanced Midwifery Practitioners (ACP), and research midwives. The key priority for the service was to ensure the immediate uplift and recruitment of clinical midwives delivering direct patient care in line with Birthrate plus recommendations. However since the Birthrate plus report was received HUTH have introduced the following specialist roles which include:

- Practice learning Facilitator (PLF)1WTE
- 5 theatre nurses
- Maternity Safety Specialist Role B8a 1WTE
- Business support manager B8b 1WTE to support with Ockenden and CNST
- Extra Midwifery Sister in Community 1WTE
- Extra midwifery sister on Rowan and Maple Ward
- 2 8a Operational Matron roles
- Head of Midwifery – secondment for 1 year

Ongoing workforce reviews are being undertaken to support a 24/7 triage service within HUTH, the building work is planned to be completed by the end of August 2023.

8. Recommendations

The Trust Board is requested to:

- Agree that the review of the position of the midwifery staffing report is a true representation of the midwifery staffing position
- Decide if any further information and/or assurance is required.

Director of Midwifery
Interim Chief Nurse
July 2023

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

SAFEGUARDING ADULTS

ANNUAL REPORT

2022 - 2023

Contents:

ANNUAL REPORT FOR SAFEGUARDING ADULTS – 2022/23

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 2022/23, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2023/24.

2. EXECUTIVE SUMMARY

The Trust has statutory responsibilities to safeguard adults at risk of harm, abuse and neglect that access it 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 2022/23:

- 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 Place ICB about the governance and progression of Safeguarding Adults agenda items.
- The Learning Disabilities Liaison Nurse post holder commenced on secondment in May 2021 and the post was substantiated in April 2022. The post holder commenced maternity leave in early May 2022 and Humber Teaching Foundation Trust (HTFT) have supported to provide a secondment for maternity cover from 16th May 2022. The seconded post holder has progressed well, continuing to provide support to patients, families and staff. The substantive post holder returned in March 2023 four days and the seconded post holder is now substantive 1 day each week, providing a 5 day service. The current post is commissioned by Hull Place, Humber and North Yorkshire Integrated Care Board.
- The Dementia Care Team, consisting of a named Consultant and Lead Matron, have published a dementia and delirium strategy 2022 – 2025 with the support of the Executive Team. Collaborative working continues with the Safeguarding Team, Mental Capacity Lead and Enhanced Care Team (ECT) Matron to improve the quality of care and safe environment for this group of vulnerable adults.
- 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.
- Routine / Selective Enquiry has continued to be rolled out across the organisation with 1668 staff now completing the Level 1, 1562 at Level 2 Domestic Abuse Training. Routine enquiry is included as part of Domestic Abuse Level 3 training package developed, which is mandatory for an identified cohort of staff.
- The Trust continues to work towards full implementation of the Hull Strategic Domestic Minimum Standards.
- The Trust continues to have access to two Independent Domestic Abuse Advocates (IDVA's) as an in-reach service provided by the Hull Community Safety Partnership. The

IDVA service is provided within the Trust three days each week but will support any patient or staff member on request.

- 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 are no longer being 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.
- Continue to review how to improve feedback to referrers on the quality of the safeguarding referrals raised.
- Continued 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 continues to identify a rise in domestic abuse calls from staff about patient and staff 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.
- Continue to lead 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. 100% compliance for audits to be undertaken for the clinical areas identified has been achieved and 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.
- A high level Safeguarding report has been developed and is sent to all Nurse Directors twice weekly. The report provides information to identify vulnerable adults who are inpatient in relation to high level safeguarding, mental health detention, learning disabilities, enhanced care supervision, detention under DoLS.
- One member of the safeguarding team has undertaken training in Forensic Aspects of Adult Safeguarding. This initiative is 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 Place ICB. The concept has been championed and supported by the NHSI/E North safeguarding England team with the delivery of regional training. 2021. The Humber pilot initiative has commenced, which will only include the Humberside health providers. Supervision and support is provided via the FFLM Adult safeguarding forum held quarterly.
- 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.
- Continue to identify 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 detainments. In collaboration with our partner HTFT

Mental Health Legislation Team, interactive training sessions been made available to all staff for 'Use of Section 5(2) holding power of the Mental Health Act within an Acute Hospital', with ad hoc sessions provided on request of individual clinical areas.

- The format of the electronic discharge summary to health providers for patients discharged from HUTH's emergency department ED) in custody, is under review. Sharing relevant information with services via the Yorkshire Humber Care Records with services is being pursued. Digitalisation for other areas within the Trust outside of ED is also currently being pursued to inform the Yorkshire Humber Care Records process.
- Supported clinical teams to access the Court of Protection for Serious medical Treatment decision and restrictive measures
- Piloted De-escalation and Management intervention training in line with CQC requirements
- Delivered 26 face to face MCA/DOLs training session via HEY247

There have been a number of challenges during 2022/23 for safeguarding but overall, the Trust is in a strong position for 2023/24. 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 2021/22 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
Domestic Abuse	
Continue roll out plan for Routine/Selective enquiry in identified areas of the Trust, including staff training.	This work has continued as per the project plan and now includes ground floor fracture clinic, NICU, SDEC and some ward areas. There have been areas targeted for training due to incidences or staff requests following domestic abuse queries. Routine/Selective enquiry training is part of Domestic Abuse Level 3 training developed and implemented 2022/23, mandatory for identified cohort of staff as part of phase 2 SG adult's level 3 training.
To gain White Ribbon UK Accreditation to support ending men's violence against women.	This has not been achieved in this annual report timeframe. This is an action identified for 2023/24.
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.	Staff have been sought to champion domestic abuse. A Training package is being developed in collaboration with the Domestic Abuse Strategic Domestic Abuse Commissioning Manager.
Training and Development	
Ensure the continuation of implementation of Intercollegiate Level 3 safeguarding adults	The plan for implementation of Level 3 training is ongoing, as agreed at the Trust Safeguarding

Statement	Update
training, phases two and three, and across professional groups in the trust is embedded within the organisation in line with the Training Needs Analysis.	Steering Group. Phase 2 training includes development of Domestic abuse and MCA training at level 3. PREVENT training is a mandatory requirement as part of phase 2 SG adults L3 training. Implementation of phase 1 and 2 is now complete. The development of phase 3 is in progress.
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	Compliance of 55.4% achieved for Safeguarding Adults Level 3 training for phase 1 and 2 (phase 2 implemented September 2022). Escalation of compliance to health group leads via Safeguarding Steering Group.
Review of the Prevent Health Wrap Training Plan and in line with the changing national requirements and guidance	This was completed and now aligned to Level 3 SG Training, with an increase in headcount required.
Enhanced Care Team	
To review service model in light of audits, service requirements and business intelligence. .	Organisational Change plan in draft format. In collaboration with CAMHs in reach service a dual model has been developed to increase the support for vulnerable under 18 year olds while maintaining an advice and support service for adult in patient services
Review 1 year seconded band 6 post with a view to permanency.	The seconded post will end in June 2023. As part of the organisational change plan there is an intention to substantiate this post
Improve quantitative and qualitative data collection to inform service development	Quarterly Enhanced Care Audits have continued throughout the year
Audit delivery of new model. Repeat audits of ECT documentation and continue to improve in light of findings.	The service has been undergoing a review in light of changing needs in HUTH. Organisation plan in review with Chief and Assistant Chief Nurse
Support the Digital Team in rolling out ECT Nerve Centre assessment tool in HRI.	Nerve centre assessment tool is now embedded in practice on both HUTH sites. It is currently undergoing a review with an aim to deliver the new tool June 2023
Learning Disabilities	
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	The Mental Health and Learning Disability (Trust) Strategy April 2022 – March 2027 developed with an associated implementation plan. The strategy is available on the Trust Intranet site.

Statement	Update
To undertake the fifth LD and Autism benchmarking audit when it is available in 2022	The fifth audit was opened online by NHSE/I in November 2022 and data collection was submitted by HUTH within the deadline for January 2023.
To continue to host and support the LD Liaison Nurse role.	The LD Liaison Nurse post has continued and is progressing well, providing support to patients, families and staff.
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.	Activity profiles for patient interventions (LD and Autism) have commenced and are reported to the MH, LD and Autism Steering 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 patients and families in need of are identified and supported whilst in the Trust.	The activity of the LD liaison nurse post holders continues to increase and raised the need for further support for patients, families and staff for East Riding patients. Assistant Chief Nurse has raised this issue with the provider (Humber FT) and is continuing discussions with regards to workforce planning and resilience
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.	The MH, LD and Autism Steering Group continue to make progress in the actions outlined in the work plan.
To continue to support the LeDeR process and continue to support the local and regional multiagency teams in this programme.	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 ensure the Learned Lessons from local and national LeDeR reviews are regularly shared, discussed and actioned with HUTH staff.	The Assistant Chief Nurse and Named Nurse Safeguarding Adults attend Humber Collaborative Learning Disabilities Mortality Review (LeDeR) Programme and Humber LeDeR Steering Group to ensure learned lessons are shared and actioned within HUTH.
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.	Required Oliver McGowan learning live on HEY247 with plan to launch Autumn/Winter 2023
Mental Health	
To enable the Mental Health Liaison Team and AMHPS (Approved Mental Health Professionals) to have full access to the trusts	The staff cohort (Registered) in Humber were identified for requiring full access to HUTH's system and training was offered and accepted to

Statement	Update
Lorenzo electronic medical records system.	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.
Scope and develop a business case for Mental Health Practitioner to enhance the safeguarding team and support patients who have mental health needs	This action has not been achieved this year, however this is included within the MH and LD, Autism strategy and delivery framework.
Identify 'Champions' for MH from the Medical teams in key health groups to support patients and staff with complex issues.	This has not been achieved in this annual report timeframe. This is an action identified for 2023/24. There is funding from NHSE/I for mental health champion in paediatrics and this is expected to be fulfilled for 1 x PA per week by Autumn 2023.
To launch the MH, LD and Autism Strategy in the Trust and finalise the delivery framework/action plan.	The MH, LD and Autism Strategy in the Trust was published in July 2022 and finalisation of the delivery framework/action plan is almost complete.
Electronic Solutions	
The safeguarding team to work with the Lorenzo team to progress the development of electronic recording of safeguarding and MCA/DOLS referrals and applications	Collaboration has taken place but not achieved within the time frame of this report. It has been escalated to the Board
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.	The Enhanced care assessment tool was launched Trust wife June 22 and a review of the tool is in progress. Alerts for DOLs and Learning disability are active and information used for service provision and support processed
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. Feedback from local areas in the Trust have provided positive feedback on the Trust SG service and these have been filed as evidence.
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	This has not been achieved in this annual report timeframe. This is an action identified for 2023/24.Feedback is provided to the services on individual referrals.

Statement	Update
actions agreed dependent on the results, and disseminated within the health groups for implementation.	
Mental capacity	
Develop and implement a tool for monthly auditing of Deprivation of Liberty applications, to review quality and compliance to the Code of Practice.	Audit commenced and feedback via Safeguarding Steering Group. Findings informed learning outcomes to continue to improve practice.
MCA lead to establish a HUTH Liberty Protection Safeguards working group to support the transition from DoLS to LPS.	The group was established but due to the delay in LPS implementation, it did not progress. LPS has been postponed indefinitely at the time of reporting.
MCA lead to establish a Restrictive Practice Working group to work towards CQC compliance with Restraint Reduction Network (RRN) standards	This has not been achieved. However the MCA lead is actively involved in appropriate groups • Violence Reduction Working Group • ED Mental Health QIP
The MCA lead to design and implement an audit to evaluate the use of the Act in emergency and elective admissions	This has not been achieved in the timeframe of the report due to operational pressures in ED. To be prioritised for the coming year.
Other	
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 Steering Group and Governance Committees.
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.	Revision completed and agreed at Safeguarding Steering Group. 100% compliance achieved in December 2022 and maintained in audits being undertaken for clinical areas identified.
Review the capacity and structure of the Safeguarding Adults Team.	The review of the Safeguarding Adults team is underway with plans but these have not been formally approved at date of this report.
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.	The Safeguarding Adults and Children's operational delivery plan has been monitored and updated in 2022/23. This is completed by operational leads.
LADO/SDO – to recruit senior trust staff to undertake the role of SDO, to support managers and staff through this process, liaising with	Four trust staff are trained to undertake the role of SDO. Awareness session provided to senior trust staff via the Nursing Executive meeting.

Statement	Update
external agencies as part of the process.	
Forensic Project for Adults at Risk of Harm	
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	HUTH has supported, contributed and participated in the pilot process of forensic examination of adults at risk of harm who present with suspected non-accidental injuries which commenced after approval for the project outline and funding from NHSE/I in May 2022. An independent evaluation was commissioned by NHSE/I and will be available shortly.
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	Members of the Safeguarding Adults Team have undergone training from the Faculty of Forensic and Legal Medicine and have supported the development of a project plan for the pilot and attend a quarterly peer support group to provide ongoing support for any clinician involved in the work, as well as a quarterly lunch and learn event. .

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 Humber and North Yorkshire Integrated Care Board (ICB)) 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 Health and Care Act 2022 set out plans to put Integrated Care Systems (ICS) on a statutory footing, empowering them to better join up health and care services, improve population health and reduce health inequalities. From 1 July 2022, each ICS will be led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy. . The NHS is a key component of safeguarding and the Humber and North

Yorkshire ICB is a core member of the Humber and North Yorkshire Health and Care Partnership, alongside NHS providers, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations. The ICB 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 Place-based partnerships within the local ICB, 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 2022/23, attendance of the Trust representatives at both was excellent via electronic meeting platforms.

The CQC undertook an unannounced inspection at the Trust in November 2022. The well-led element of the inspection was undertaken in December 2022. The CQC highlighted a number of actions as follows in relation to safeguarding training and the application of Deprivation of Liberty.

Emergency Department:

- The service must ensure that systems and processes are established and operated effectively to safeguard patients
- The service must ensure that care or treatment for service users is not provided in a way that includes acts intended to control or restrain a service user that are not necessary to prevent, or

not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint.
- The service must ensure that a service user is not deprived of their liberty for the purpose of receiving care or treatment without lawful authority

Medicine and Surgery
- Appropriate consent not obtained for people who lack Capacity
- Inconsistent practice and awareness of MCA and DOLS

The Safeguarding Adults Team are supporting the Health Groups with their required improvements and plans are in place to address the actions. The performance, leadership and governance of the safeguarding adult's team gave no areas of concern.

The Trust is required to submit quarterly reports on Safeguarding to the Hull Place, Humber and North Yorkshire ICB as part of the locally set Key Performance Indicators. 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 ICB 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 fourth most deprived local authority in England in 2019 (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 (Public Health England Local Authority Health Profile, 2019). The overall mortality rate for deaths that occurred prior to the age of 75 years was 42% higher in Hull compared to England for 2021 with higher rates of cardiovascular disease, cancer, liver disease, respiratory disease and all age communicable diseases such as influenzas, 58% higher for premature deaths from causes that are considered preventable.

In Hull 54 per cent of the population in Hull is within the 20 per cent most deprived in England. Hull also has a high percentage of children living in absolute and relative poverty, and the percentages differ markedly across Hull's wards. (Hull Director of Public Health Annual Report 2022)

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 established Suicide Prevention Group.

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 2022/2023 was the Chief Nurse, Mrs Joanne Ledger.

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 (0.4 WTE April 2022 – Retired July 2022) - Named Nurse for Safeguarding Adults

- Mrs Jayne Wilson B8a (1.0 WTE) – Named Nurse for Safeguarding Adults (commenced substantive post December 2023)). B8a secondment (1.0 WTE) Named Nurse for Safeguarding Adults (July 2022-December 2022). B7 (0.4 WTE) Safeguarding Adults Specialist Nurse, B8a secondment (0.6 WTE) Named Nurse for Safeguarding Adults (April 2022-July 2022).
- Ms Rachel Hoggarth (1.0 WTE) B8a - Enhanced Care Team Matron and Lead for the Mental Capacity Act
- Mr Andy Lockwood B7 (1.0 WTE) – Safeguarding Adults Specialist Nurse (Commenced substantive post February 2023).
- Miss Amy Carberry B7 secondment (1.0 WTE) -Safeguarding Adults Specialist Nurse (May 2022-January 2023).
- Sophie Oxtoby B6 (1.0 WTE) Enhanced Care Team Specialist Nurse
- Angela Dunnachie B6 Secondment (1.0 WTE)- Clinical Educator for Dementia and Learning Disabilities (April 2022 -March 2023 when funding ceased)

Further roles that support or work within the team are:

- Natalie Wood B7 (0.8 WTE) – Learning Disability Liaison Nurse – Post commissioned by Hull CCG, hosted by Humber Teaching FT.
- Theresa Lambert B7 (0.2 WTE) Learning Disability Liaison Nurse – Post commissioned by Hull CCG, hosted by Humber Teaching FT (commenced substantive post January 2023). Samantha Johnson B7 secondment (1.0 WTE) Learning Disability Liaison Nurse – Post commissioned by Hull CCG, hosted by Humber Teaching FT (May 2022 - November 2023).
- Independent Domestic Abuse Advisor (IDVA) – (16 hours per week – in reach) Two Post holders (8 hours each) seconded into the Trust from the Hull Safety Partnership via Hull DAP (Domestic Abuse Partnership).

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, Mrs Wilson, Mrs Darley (SG Children's Named Nurse) and Mr Lockwood have also undergone the training to become a Designated Officers.

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 to 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 two Learning Disabilities Liaison Nurses, Mrs Natalie Wood and Mrs Theresa Lambert who provide 1.0 WTE support and are employed by Humber Teaching NHS Foundation Trust. The Learning Disabilities Nurses are co-located within HUTH Safeguarding Adults Team. They also regularly meet with the Trust MCA Lead, 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 continues 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 identified for 'Serious Medical Treatment' and referred to the MCA lead for guidance through court of Protection process with positive outcomes in both scenarios.

The Trust Safeguarding Steering Group reports to the Patient Experience Sub Committee. The Safeguarding Steering Group met five times during 2022/23.

The Safeguarding Adult's team is a small team which manages a series of items such as Mental Health, Deprivation of Liberty, Court of Protection 'serious medical treatment' and restraint applications, 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. Further improvement in relation to immediate electronic discharge information to the care provider for Hull police custody suite are almost complete following a review. In collaboration with the safeguarding adult's team, the Emergency Department and the care provider for Hull Custody suite, access to immediate discharge information will be available via the Yorkshire Humber Care Records.
The Safeguarding team also facilitates and chairs meetings with the Learning Disability liaison teams from the community and the Trust LD Liaison Nurse, ICB 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. Jamie Bell, Sarah McDougall, Nikki Harrison, Rachel Boulton and along with Leah Coneyworth, Head of Patient experience and engagement 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 ICB.

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 is now recorded on the new electronic initial assessment record via Nerve Centre which has been rolled out across the Trust at both HRI and CHH.

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 2022/23 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 transfer to Patient Safety Incident Reporting Framework in 2023 will lead to changes in the review of incidents and Safeguarding. The Assistant Chief Nurse is advising on this and ensuring Safeguarding is captured as part of the changes.

The Trust has contributed to three Domestic Homicide Reviews which were commissioned or completed and submitted to the Home Office in 2022/23 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 2023/24.

The Trust continues to be supported by the Independent Domestic Abuse Advocates (IDVAs), who have a presence on the HRI site three times 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. Weekly walk rounds by the Safeguarding Practitioner and IDVA within the Maternity, Neonatal and Gynaecology services were extremely well received by patients and staff until July 2022 and these are now undertaken on request and on an ad hoc basis. The Trust IDVAs 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 Partnership 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 Partnership 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 continues to review the groups supporting underpinning of the governance processes and to perform this scrutiny as part of 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 undertaken in 2022/23, 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 214; the Police, the Humber and Yorkshire Integrated care Board 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 2022/23.

Safeguarding Children, Young People and Adults at Risk in the NHS:
Safeguarding Accountability and Assurance Framework- NHS England – July 2022

This was reviewed from previous version from August 2019 and NHSE published a revised framework last July.

All health providers including provider collaboratives 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 children in care.
- Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead – this role should include the management of adult safeguarding allegations against staff. This could be a named professional from any relevant 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, adults and children in care 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 Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019, Looked After Children: Roles and Competencies of Healthcare Staff 2020 and the Adult Safeguarding: Roles and Competencies for Health Care Staff 2018
- Safeguarding must be included in induction programmes for all staff and volunteers.
- 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.
- Safeguarding must be included in induction programmes for all staff and volunteers.
- 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.

Named professionals
Named professionals have a key leadership 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 supervision and training is in place. Named professionals should also attend regular supervision sessions. They should work closely with their organisation's safeguarding lead, designated professionals in the ICBs and local safeguarding children partnerships, SABs as well as their regional safeguarding forums and networks. Named professionals should have direct access to the head of safeguarding and/or executive lead for safeguarding in their organisation to ensure they have influence in the organisation's strategic plans. This SAAF recognises the critical role that maternity services play with regards to safeguarding and the Think Family agenda. From work with the maternity transformation programme, NHS Safeguarding has a national maternity safeguarding network who will provide system leadership and oversight on maternity through a contextual safeguarding lens.

Mental Capacity Act (MCA) lead
All NHS providers are required to have an MCA lead. This role 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, as per the Deprivation of Liberty Safeguards (DoLS) legislation under the MCA. 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. GP practices are required to have a lead for safeguarding and MCA, who should work closely with named safeguarding GPs and designated professionals for safeguarding adults and 16 and 17 year olds with the advent of liberty protection safeguards (LPS)
.
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 the Designated Professionals for Hull and East Riding Place ICB.

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 ICB adult safeguarding lead.

The MCA lead has instigated a monthly Deprivation of Liberty safeguards audit reviewing the quality of applications, escalated through the Safeguarding Steering Group. Findings are used to inform learning, identify areas of concern and required, Fundamental Standards audits are also 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 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?

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 Steering Group.
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.

Opportunities and training attended by the Safeguarding Adults team in 2022/23 has increased which includes attendance face to face at a courageous conversations domestic abuse event in addition to virtual domestic abuse events and mental health in acute settings. The team continues to keep up to date with the latest research including Modern Day Slavery and Human Trafficking, Liberty Protection Safeguards, County Lines, and Grooming and Sexual Exploitation of vulnerable adults. The Named Nurse for Safeguarding Adults undertook and completed the Mary Seacole Programme in January 2023.

Case Studies

Patient A:

Background
Anne (pseudonym) attended the emergency department (ED) following a significant physical assault by her partner with resulting injuries, including fractures. The police were fully involved. Following assessment in ED, required treatment was provided with a plan for admission for safety reasons and support as Anne stated she wished to flee her current relationship.

What Happened
During Anne's attendance, the Trust's in-reach Independent Domestic Abuse Advocate (IDVA) telephoned the Trust Safeguarding Adults Team to enquire if Anne remained in attendance at ED and if she would consent for IDVA support following being informed by the police of the incident. HUTH Safeguarding Adults team liaised with ED's coordinator to confirm Anne was in ED at that time with a plan for admission, also consent obtained from Anne to accept IDVA support. At the time of enquiry, Anne's treatment in ED was almost complete and arrangements in progress to admit to hospital for safety reasons following disclosure of wishing to flee her relationship. ED were supportive to keep Anne within their department until the IDVA attended due to the potential that emergency support and housing could be sought, avoiding admission to hospital being required. The IDVA attended ED within the hour and supported the patient to develop a safety plan for discharge which included liaison with family members and escort arranged to transport Anne to a place of safety with family. A safeguarding adults concern was submitted with Anne's consent.

Learning
- Partnership collaboration involving police, domestic abuse service and HUTH safeguarding teams to safeguard a vulnerable adult
- Established links in place between HUTH Safeguarding teams and in reach IDVAs/domestic abuse service
- Established links with ED senior nursing team and Trust Safeguarding teams which promote collaborative working to safeguard vulnerable patients
- Safeguarding the patient prioritised with initial plan for admission for safety reasons
- Making Safeguarding Personal ensured as Patient involved fully as decision maker and safeguarding adults concern submitted with consent

Unnecessary admission to hospital was avoided

Patient B:

Background
Lucy (pseudonym) was brought to ED by ambulance from her residential care home following GP review identifying extensive bruising for which there was no explanation provided of how these occurred.

What Happened
Following assessment in ED and no rationale being available to determine the extent of the bruising established, a safeguarding adults concern was submitted with a decision for admission to hospital. Lucy had been assessed as lacking mental capacity for the concerns raised and the safeguarding adults concern was submitted in best interests in the absence of any known family or next of kin. An IMCA referral was submitted. Upon receipt of the safeguarding adults concern to the Trust safeguarding adult's team, this was shared with the Named GP for safeguarding adults in the local authority area as a potential case within the 'Humber Forensic Pilot'. The Humber Forensic Pilot aims to undertake investigation into adult abuse/non accidental injuries for vulnerable adults similar to the process already in place for safeguarding children. Following submission of a safeguarding adults concern, the Trust safeguarding adult's team provided supervision and support to ED to document bruising and injuries forensically to ensure evidence was available if required for further safeguarding or criminal investigation. The police were also informed in the patient's best interests following a lack of mental capacity being evidenced in relation to the safeguarding concern required to be raised.

Learning
- Professional curiosity and appropriate safeguarding of a vulnerable adult
- Collaborative partnership working with the Humber Forensic Pilot/Named GP for Safeguarding Adults
- Safeguarding planning evident with admission to hospital
- Evidence of appropriate use of MCA/best interests decision making

Patient C

Background
A 19-year man with learning disabilities was brought to the attention of the MCA Lead. Three attempts were made to support the patient to have MRI investigation and dental treatment under anaesthetic. All due process MCA processes had been followed for the previous attempts however the patient escalated to such a point that the procedures where abandoned. At the third attempt, it became clear that administering an n anaesthetic would require additional restrictive practices which needed to be agreed through the Court of Protection.

What happened?
The MCA Lead supported HUTH and Community Multidisciplinary teams to understand the previous experiences of the patient and identify changes to the care plan to ensure delivery of the investigations and interventions. As part of the best interest process, complex care and restraint plans were developed over a period weeks in preparation for submission to the Court of Protection.

With the support of the Trust appointed solicitors, a successful application was submitted and the patient attended on the agreed day. The care plan supported a step-by-step approach from leaving his home to the time he left HUTH. The patient was restrained once for negligible a period to enable safe anaesthetisation. The MRI was achieved and further care, dental checks, COVID vaccination, phlebotomy and vascular ultrasounds of legs were undertaken without significant distress to the patient

Learning
- To identify cases at the earliest opportunity to prevent repeat poor experiences

- Successful outcomes provide equity of care for vulnerable adults
- Collaborative working with community partners is imperative to ensure the smooth transfer of the patient to and from HUTH
- The MCA lead and the clinical team was recognised for the support provided with a HUTH Moment of Magic Award

Patient D
Background
A 62 year old lady was admitted to the Trust for a hysterectomy due to endometrial Cancer. The ward sister of the clinical area alerted the MCA lead of her concerns about the patient's capacity to consent to the procedure and the potential need for restraint. It became apparent that the patient had Learning Disabilities. Timing was critical as the patent had waiitng6 months and there were concerns the cancer may have spread

The MCA Lead supported the ward to investigate the patient journey to this point and if the MCA process had been followed to ensure either safe consent or best interest had been followed. The consultant surgeon had documented evidence 6 months previously but the process was incomplete. The consultant confirmed their attempts to follow process, but had failed due to lack of engagement from external partners.

It was greed that a short delay to the surgery would be a reasonable adjustment to allow time to expedite an urgent best interest meeting. A best interest meeting was convened and it was agreed to proceed with surgery in the patient's best interest. The MCA Lead sought legal advice from Trust solicitors about restrictive measures. The proposed sedation and anaesthetic was proportionate to need therefore no application was required to the Court of Protection and the patient had the agreed surgery with only a 3 day delay.

Outcome
Patient was discharged 3 days post operatively to her usual address. A further best interest meeting was held post discharge to discuss potential follow on treatment. The agreed decision was not to proceed further as the level of restraint would be disproportionate

Learning
- The nursing team identified a concern and acted in an appropriate and timely manner to safeguard the patient and their practice
- The MCA lead was able to support to ensure minimal delays to treatment
- With a reasonable adjustments agreement, a delay in treatment was avoided.
- MCA Lead co-ordination and the subsequent Team work was essential to the outcome

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.

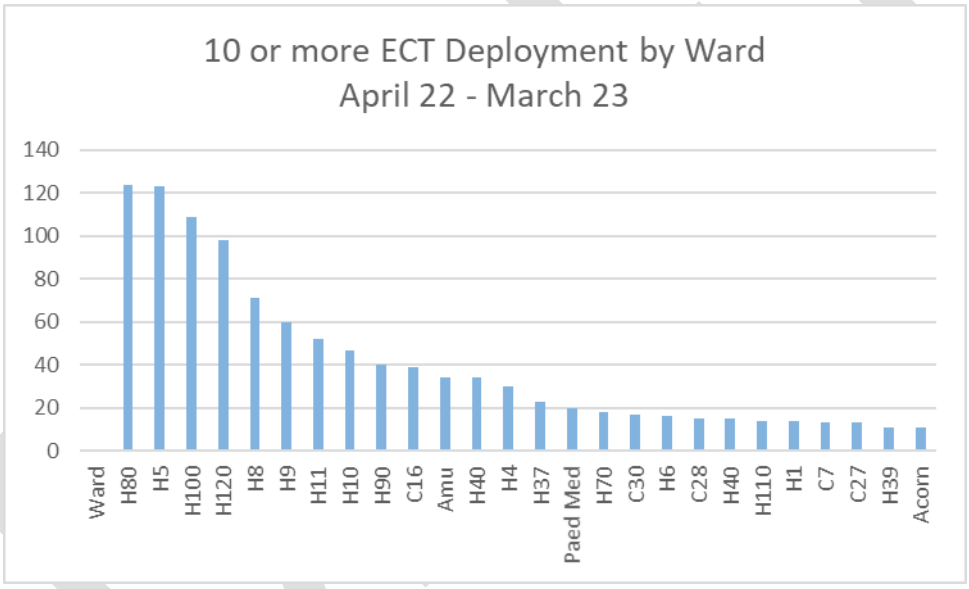
Enhanced Care Team (ECT)

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

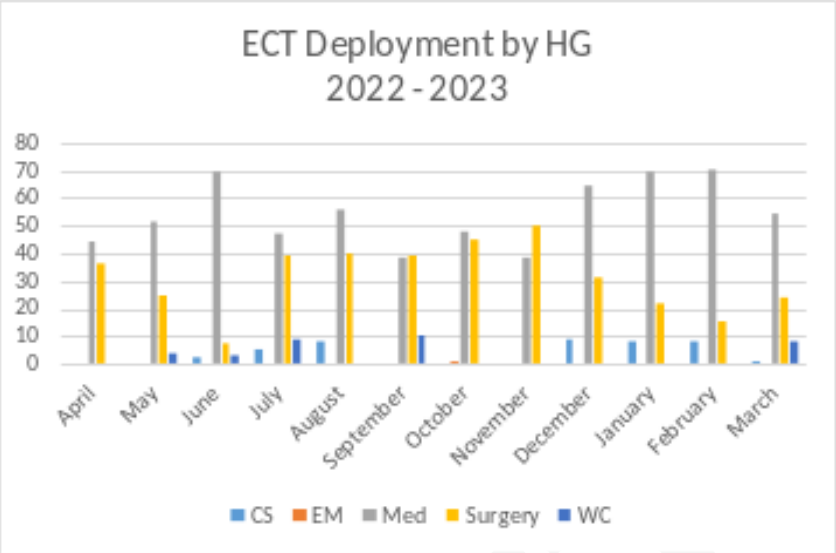
enhanced level of care and supervision (Security are allocated to Level 5 patients who are a risk to others).

The ECT Matron/Specialist Nurse, monitors requests for Level 4 and 5 1:1's, in collaboration with the HUTH Security Team. Information is collated through Heath Roster Safe Care, Nerve centre, ECT assessment and submission of Datix identifying 1:1 restraint. 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, the greatest recipients of the series have been H80, H4, H100 and. This reflects the clinical need of patients in the areas, presenting with Dementia, Brain Injury and altered states of consciousness.

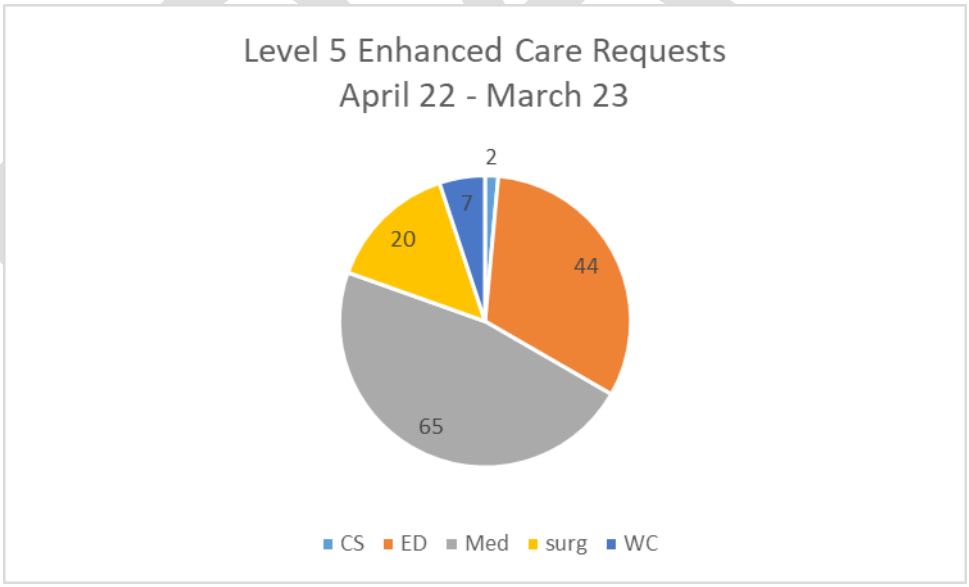


The Health Group with a consistent high use of level 4 support was Medicine HG with an exception for the month of November 22, when Surgery was the highest user (see table below)



Level 5 support

There were 138 requests for level 5 security support. Most requests originate within ED (32%) and Medicine (47%) Health Groups (see table below). Only five requests were uncovered in the reporting period. The longest requirement was 16 days and the mean requirement was 2 days. All level 5 request were reviewed, assessed and stepped down at the earliest opportunity, either because the patient no longer required any additional support or their needs could be met by the enhanced care team more effectively.



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 Lead - Activity

Court of Protection

The MCA Lead has identified and supported five Court of Protection cases, either as the main responder or as a joined responder

- Serious Medical Treatment
- Significant restrictive practices
- Residency orders
- Case reviews

The MCA Lead has supported the liaison between HUTH legal teams and clinical teams and developed bespoke care planning for presentation to the Court of Protection.

Restrictive Practices

Support for patients who may require additional restrictive practices to those laid out in CP354 and CP431 (Restrictive Practices in the Care of Children and Young People) policies, has increased during this reporting period. In particular, the increase need for physical restraint when proportionate to the clinical need.

Restrictive practices span the frameworks of the Mental Capacity Act and the Mental Health Act. The national training standards described in the Restraint Reduction Network document (2019) and required by QCQ, recommend that all staff who may restrain have access to accredited training.

The MCA Lead has led on identifying clinical areas at highest risk of needing to restrain for therapeutic purposes. Paediatric medicine accessed de-escalation Management Intervention (DMI) Training and this has then been used as the proposed model for the Trust. The MCA lead is now working with ED on the Mental Health QIP to identify staff groups who will require training, support the procurement of this. It is anticipated this will then lead to a roll out through the organisation to ensure the Trust is compliant with both the RRN standards and CQC expectations. The MCA lead is also working with Organisational Development to support the delivery of this required learning element

External Support for Restrictive practices

There have been seven patients this year who have required additional support, requiring access to external restraint staff when the measures to deliver vital care was above and beyond current policy agreements and staff training allows. The MCA lead has supported and developed bespoke plans and risk assessments with the clinical areas to safeguard patients and practitioners. Three of these required recourse to the Court of Protection under the Framework of the Mental Capacity Act.

This poses a significant financial risk to the Trust. Within the reporting year the Trust has spent £532,258.56 on external support. Of this, £514,971 was to support one vulnerable patient detained under the Mental Health Act and care delivered using restrictive practices under the framework of the Mental Capacity Act. There is an opportunity to mitigate future cost, with trained staff, however, there may still be a requirement for external support when restrictive measures are over an extended period of time.

The MCA lead continues to be an active member of the Violence Reduction Steering Group. Led by the Security Team, this prides a forum to understand the use of security, themes and trends, and how these relates to the care and treatment of vulnerable patients

DOLs to LPS transition

Through the period of the report the MCA lead has continued to be involved in the transition work. Liaising with local and regional partners on a monthly basis to ensure the Trust has the most up to date information. An LPS transition working group was established, but without national direction was discontinued. National direction has advised all LPS transition work to step down. The Trust and its local partners are now focussed on embedding the fundamental principles and processes of the Mental Capacity Act into every day clinical practice.

MCA Independent Mental Capacity Advocacy (IMCA)

At the start of 2022, East Riding Local Authority established a new advocacy contract with VoiceAbility. With no previous relationship with HUTH, the MCA worked with VoiceAbility to develop a common referral process similar to the Hull Local Authority provider, Cloverleaf. The agreement was finally reached in March 23. During the intervening period the MCA Lead supported an interim process to ensure continued oversight governance of IMCA applications was maintained.

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 was initially (commissioned) funded by the four Humber CCG's and is being led by the Named Doctor for Adult Safeguarding at the East Riding and North Lincolnshire (ICB) HCP. The Assistant Chief Nurse worked with the Named Doctor for Adult Safeguarding in ER and North Lincolnshire ICB HCP who facilitated two regional workshops to explore this area and has supported this piece of work.

Members of the Safeguarding Adults Team have undergone training from the Faculty of Forensic and Legal 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 knowledge based 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 policy which governed the project was approved by East Riding of Yorkshire Safeguarding Adults Board in May 2022 (gained approval for the project outline and following funding from NHSI/E, the pilot) and commenced shortly after. A multi-agency forensic steering group has met monthly to oversee the project. A quarterly peer support group meets to provide ongoing support for any clinician involved in the work, as well as a quarterly lunch and learn event.

An independent evaluation was commissioned by NHSE&I and will be available shortly. .

5.3.1 Mental Health and Learning Disabilities

A Mental Health, Learning Disabilities and Autism Steering Group was established in 2020 and continued to meet bi-monthly during 2022/23. 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 Steering Group in 2022/23. 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 forefront of discussion.

The committee progressed the MH, LD and Autism agenda during 2022/23. Key priorities included:

- Completion and approval of a MH, LD and Autism 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 (Humberside 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 is compliant with a three yearly 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 continued to strengthen. The information related to Mental Health detainments continues to be improved 2022/23 due to regular communications with the safeguarding team, Humber MH Legislation team 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

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 post holder 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. Regular meetings held between the mortality manager and the safeguarding team to ensure LD patients were being identified following their deaths did not occur in 2022/23 due to capacity for both teams, although meetings are planned to recommence in April 2023. The safeguarding adult's team continued to support in undertaking structured judgement reviews for LD patients throughout 2022/23.

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 which is reported to the MH, LD and Autism Steering Group. The process for reviewers has been changed at a national level and the Trust is no longer required to undertake full reviews. However, during 2022/23 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 is shared with local partners through agreed leads from the Trust, ICB and other agency leads.

Main points for this past year around learning from LEDER and also LD links:

- Safeguarding team and LD Liaison Nurse continue to work in collaboration with the mortality lead and Medical Examiners within the Trust, to support the review of records to assist Structured Judgement and LeDeR reviews.
- LD Liaison Nurse post for the Trust recruited to cover for maternity leave in 2022/23. Substantive post holder returned in March 2023 4 days weekly and Humber NHS Foundation Trust supporting with LD liaison nurse (who supported for maternity cover) for a further day to maintain a 5-day service, Monday to Friday.
- Electronic Care Plan developed for patients with LD and including LD and Autism as part of the electronic assessment tool, awaiting approval and implementation via our hDigital team.
- A Virtual ward for learning disability and safeguarding developed within the electronic nursing records. Once recorded, electronic flag for learning disabilities remains in place and pulled through to future episodes of care within HUTH. This mechanism allows the SG team to identify patients quickly following their admission and then contact the wards to provide support and advice on reasonable adjustments and care.
- Daily visits to ED by SG team, Monday to Friday, to provide advice and support for vulnerable patients, including LD and Autism.

- Safeguarding team continue to support family, patient and professionals in complex court of protection case for care, treatment and restraint.
- In collaboration with the Humber Transforming Care Partnership, HUTH participated in the development of a hospital passport to support patients with vulnerabilities or who require reasonable adjustments, including LD, Autism and Dementia. Implementation of the newly developed passport has commenced with Guidance notes for completing the hospital passport also developed.
- Training and development plan for identified cohort of HUTH staff to be competent in restrictive practices commenced.
- All front facing clinical staff are required to complete MCA & DoLS training on appointment and then refresh every three years. This is currently delivered virtually. From January to March 2023 the trust MCA lead has delivered twice weekly face to face ELearning to support staff in a more pragmatic approach. Focussing on mental capacity assessment and how this informs either consenting or best interest decision making. The MCA lead has also delivered face to face training using the content of the eLearning when requested by clinical teams. The MCA lead has recognised the need for a further review of current eLearning modules and will be reviewing and developing a strategy to address gaps in knowledge.
- SG team supporting external assessors to gather information and intelligence that have enabled LeDeR reviews to be completed for patients who have been in receipt of care from HUTH.
- The SG team have continued to be active and supportive members of the operational and strategic LeDeR network groups. This has included continuing to raise the concerns around RESPECT forms being completed in a timely manner in the community setting, so that when patients attend the Trust this documentation is available for review as part of the episode of care.
- Trust Intranet Page on LD updated for staff guidance and LEDER uploaded as received as well as presented at the MH, LD and Autism Steering Group.
- Internal MH, LD and Autism steering group terms of reference reviewed and incorporates LeDeR.
- MH, LD and Autism Strategy April 2022 – March 2027 developed with an associated implementation plan. The purpose of this Strategy is to describe how and to ensure that people with mental ill health, learning disabilities and or autism and their carers are able to access high quality health care with positive outcomes when using services within HUTH, and that services continue to evolve in line with recognised requirements. The strategy also acknowledges that people with LD will need to have access to reasonably adjusted pathways to meet individual needs and requirements. The strategy is available on the Trust Intranet site.
- Secured funding from Health Education England for dedicated Clinical Educator for combined post LD and Dementia. Post holder commenced and focused on training to incorporate areas of care and treatment for this cohort of patients. Learning from when things have not gone well was included within the training. Post and funding ended March 2023 and there are plans to review the educational roles in the Trust
- Serious Incident Checklist to incorporate LEDER and other investigations to run alongside incident investigation.
- Representation from the SG team within the Accessible Information Group within HUTH.

6. SAFEGUARDING ADULTS TRAINING 2022/23

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 10th April 2023)	% Compliance Target 85%
Safeguarding Adults Level 1	86.6
Safeguarding Adults Level 2	84.4
Safeguarding Adults Level 3	55.4
Mental Capacity Act	77.9
Deprivation of Liberty Safeguards	79

The Trust is complaint with mandatory training for Level 1 training only. 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 65.2% and the training was revised in January 2023 increasing the headcount to 1147 from 351.

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, H100, and H11. Subjects have included Safeguarding Adults, Deprivation of Liberty Standards, restraint, supporting patients with complex needs and the Mental Capacity Act. The safeguarding adult's team has also provided face to face training as part of the Let's Get Started Programme for New starters covering Safeguarding adults, MCA, learning disabilities, domestic abuse and allegations against staff, capturing approximately 120 registered nurses and 30 nursing associates.

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.

In response to CQC findings, the MCA Lead Delivered twice weekly training between January 23 and March 23 with the objective of improving knowledge addressing gaps in knowledge and practice of mental capacity assessments, detentions using the MCA and MHA and other restrictive practices. Acknowledging operational pressures further five sessions were delivered to requesting clinical areas.

The Safeguarding Adult Team has, for the last three years, supported this obligation with identified Senior Designated Officers. The Assistant Chief Nurse, Named Nurse for Safeguarding Adults, Named Nurse for Safeguarding Children and the Safeguarding Adults Specialist Nurse have undertaken bespoke training to undertake these roles.

7. SAFEGUARDING ADULTS ACTIVITY 2022/23

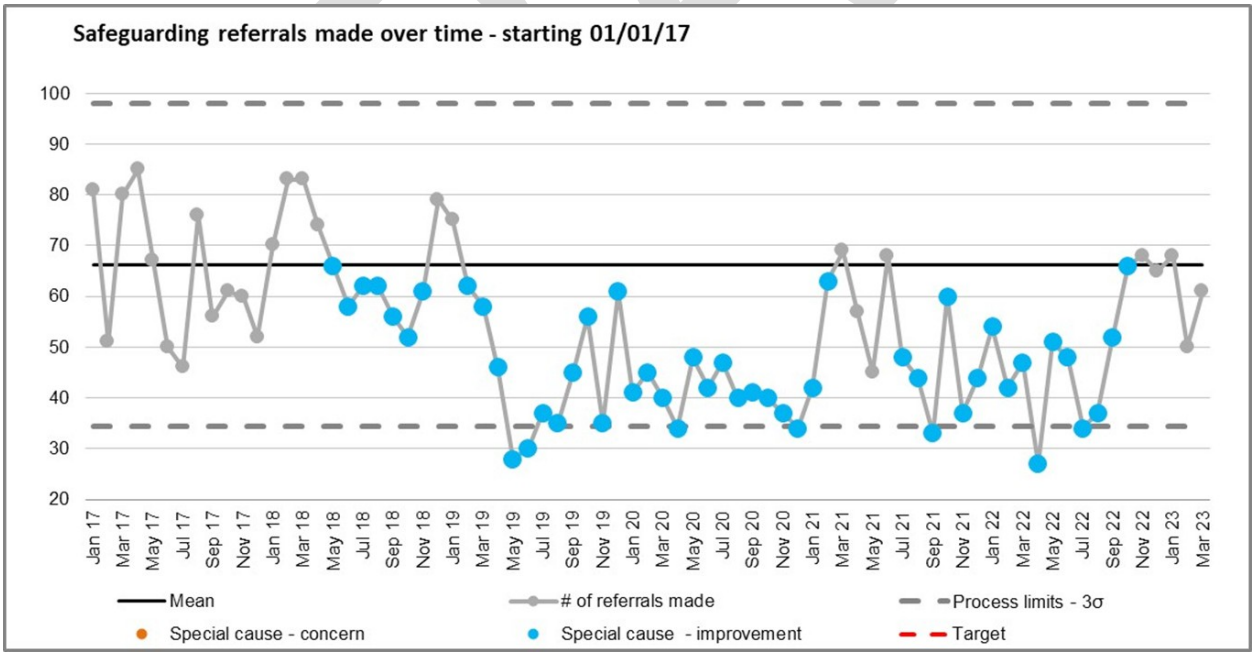
7.1 INTRODUCTION

This section of the annual report 2022/23 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

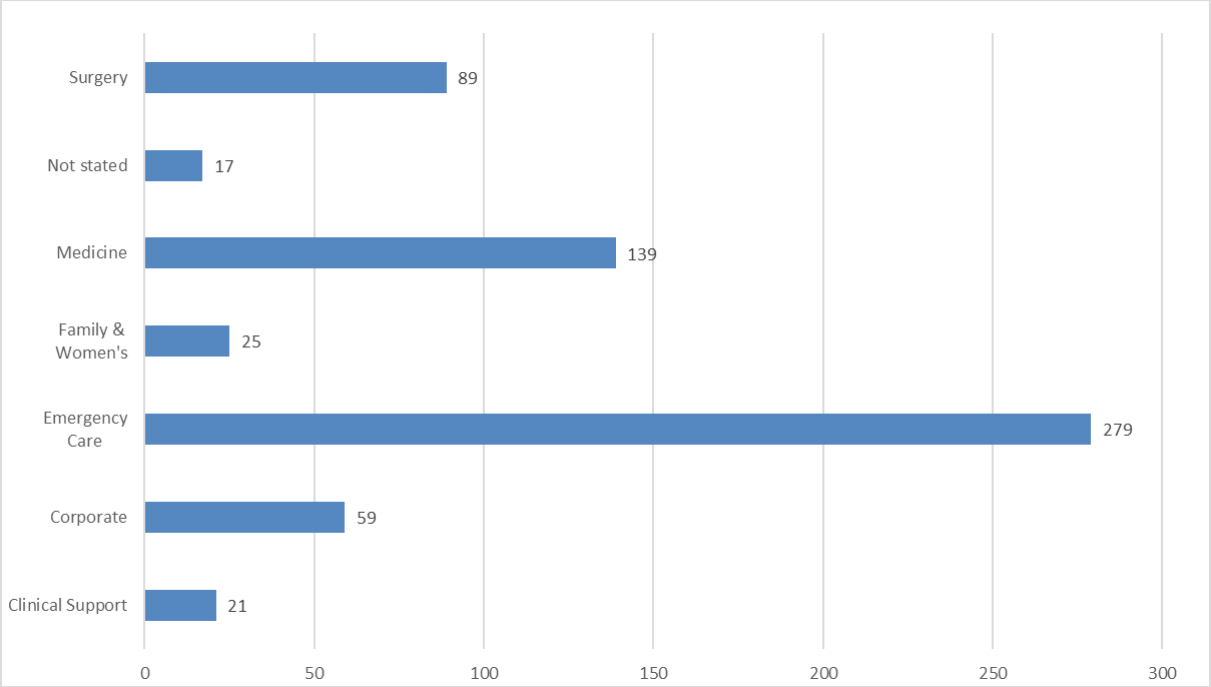
7.2.1 Total reported

During 22/23, there were **629** adult safeguarding concerns made. This is a **6%** increase in the number of concerns made from the same reporting period in 21/22 (**592**). The graph below demonstrates the number of concerns made over time from January 2017 up to March 2023:



7.2.2 Concerns Made by Health Group

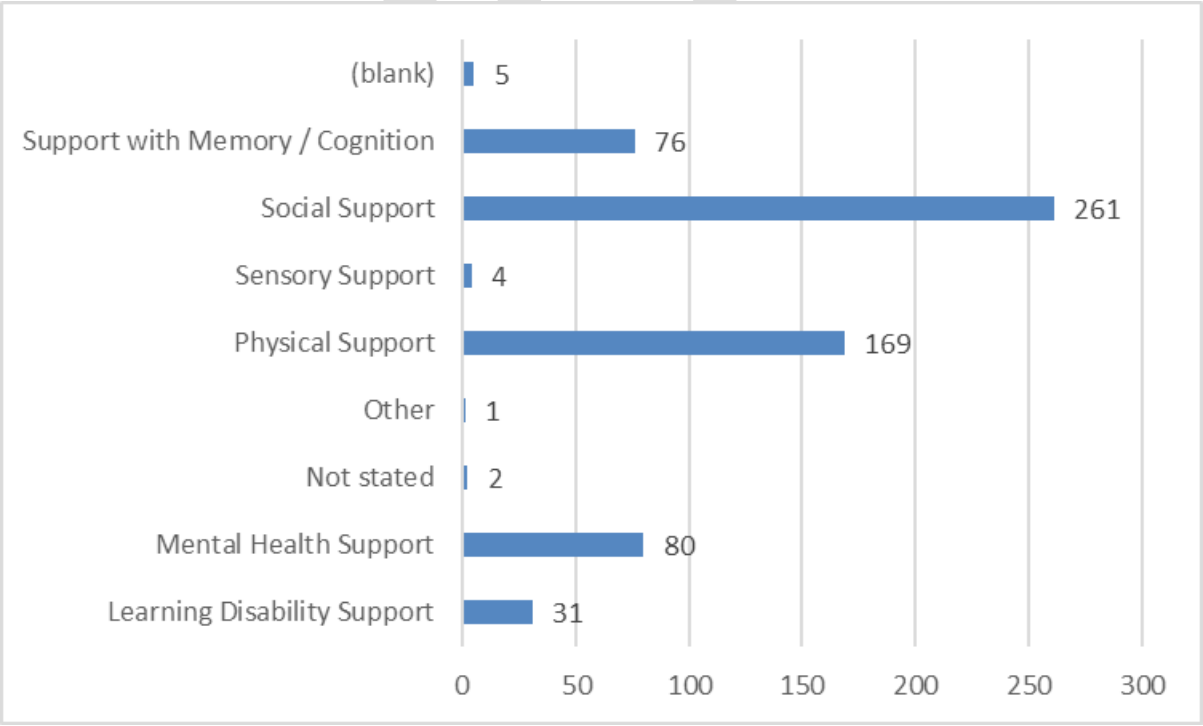
The below graph demonstrates the number of adult safeguarding concerns made by each of the Health Groups during 22/23:



For the year 2022/23, Emergency Services reported the highest number of adult safeguarding concerns accounting for **44%** (**279**) of the concerns. There was an increase of **32%** in comparison to **33%** of the reports recorded from Emergency Medicine in the year 21/22.

7.2.3 Concerns Made by Client Group

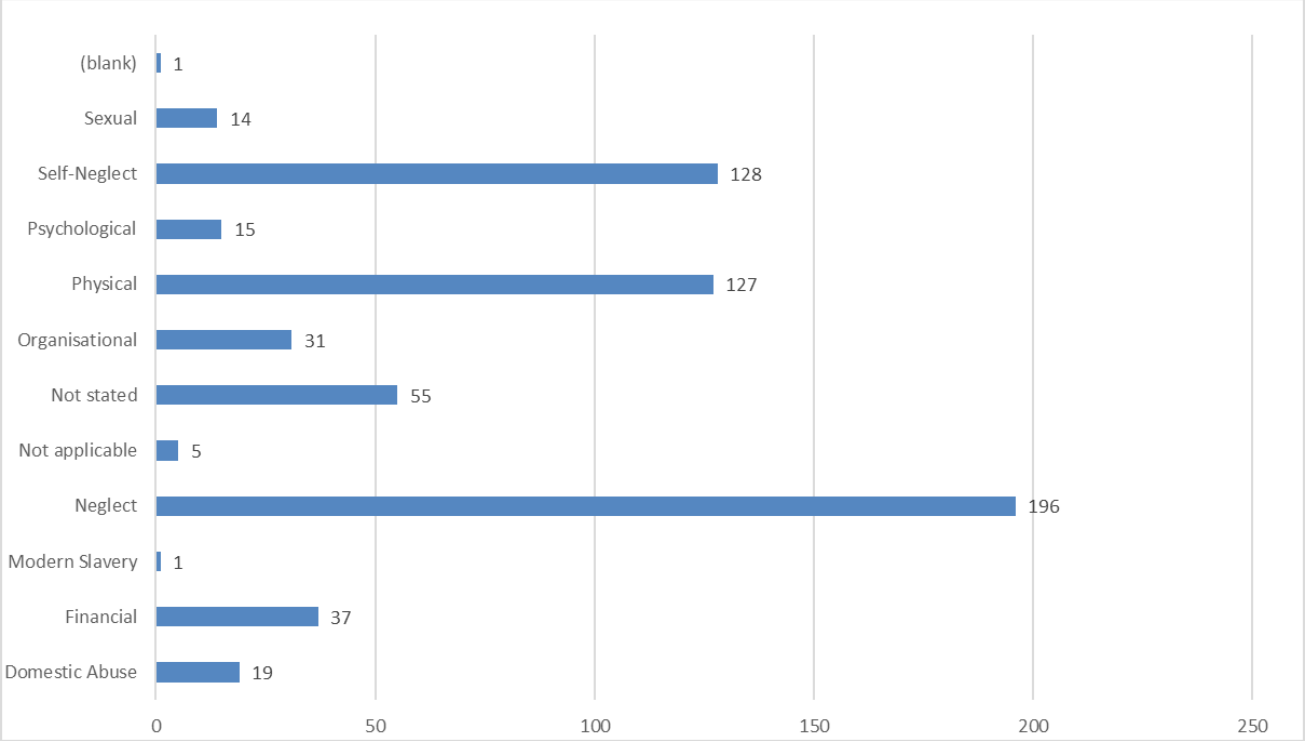
The below graph demonstrates the number of adult safeguarding concerns made during 22/23 by Client Group:



Adult safeguarding concerns around social support was the highest reported client group accounting for **41%** (**261**) of the **629** concerns reported during 22/23 with slight decrease of **3%** from 21/22 (**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 Type[1]:



Adult safeguarding concerns around neglect was the highest reported type of abuse accounting for **31%** (**196**) of the **629** concerns reported during 21/22 with a slight decrease of **3%** from 21/22 (**202**).

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 22/23 and whether there has been an increase/decrease from the previous year:

[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.

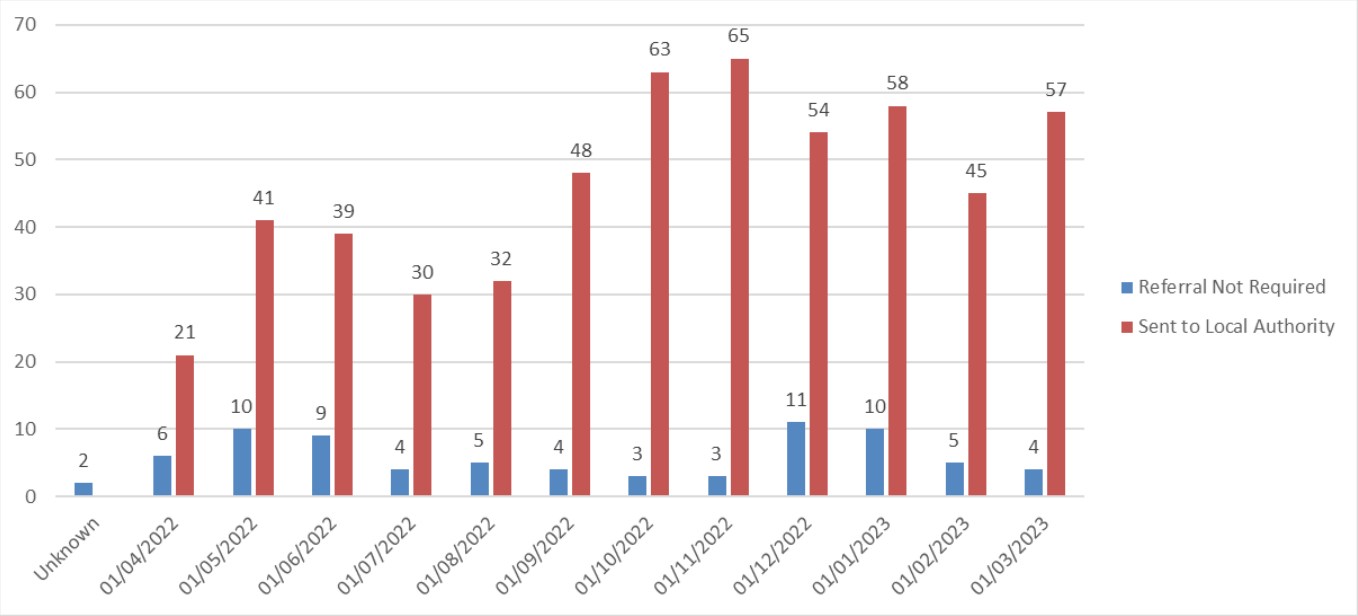
Topic	21/22	22/23	Up / Down from previous year
Accidental overdose	1	4	↑
Alcohol / substance misuse	3	4	↑
Attempted suicide / intentional overdose / self-harm	9	5	↓
Child referral	0	0	↔
Deliberate Neglect - care home / carer	3	0	↓
Deliberate Neglect - family / partner	3	1	↓
Domestic Violence / Abuse	63	70	↑
Failure to follow care plans / escalate	3	0	↓
Failure to follow care plans / escalate - medication	1	1	↔
FGM	0	0	↔
Financial/Self-Neglect/Organisational	0	0	↔
Financial abuse - carer	3	1	↓
Financial abuse - family	15	17	↑
Financial abuse - friend / neighbour	7	2	↓
Financial abuse - partner	2	2	↔
Financial abuse - unknown	4	3	↓
Financial, physical and neglect	0	2	↑
General neglect / lack of personal cares	17	2	↓
General neglect / lack of personal cares / Increase in care / support at home / self-neglect	31	15	↓
General neglect / lack of personal cares / Pressure Damage / Deep Tissue Injury - Care Home Acquired	0	0	↔
General neglect / lack of personal cares / psychology	0	0	↔
General Neglect / Lack of Personal Cares	0	0	↔
Homeless	5	2	↓
Hospital - Failure to follow care plans / escalate or treatment delay	1	0	↓
Hospital - medication error	0	0	↔
Hospital - Other	3	4	↑
Hospital - Patient Absconded	0	0	↔
Hospital - physical abuse from Staff Member	0	0	↔
Hospital acquired pressure damage/ deep tissue injury	2	1	↓
Hospital Fall	3	1	↓
Hospital SI	24	21	↓
Human Trafficking / Modern Slavery Concern	3	0	↓

Topic	21/22	22/23	Up / Down from previous year
Increase in care / support at home / self-neglect	16	1	↓
Mental Health / Vulnerable person	28	32	↑
Missed appointments	1	0	↓
Neglect	66	122	↑
Neglect / missed diagnosis	1	1	↔
Neglect / organisational	50	62	↑
Neglect / substance misuse	0	1	↑
Not enough information	5	0	↓
Other	25	15	↓
Patient Absconded	3	0	↓
Physical - unknown	7	11	↑
Physical abuse / assault - family	11	12	↑
Physical abuse / assault - friend / neighbour	2	6	↑
Physical abuse / assault - Health Professional / Nursing home	9	13	↑
Physical abuse / assault - other resident	1	7	↑
Physical abuse / assault - stranger/unknown	5	5	↔
Physical abuse / domestic abuse	0	3	↑
Pressure Damage / Deep Tissue Injury	26	5	↓
Pressure Damage / Deep Tissue Injury - Care Home Acquired	20	5	↓
Pressure Damage/ DTI/ Care home acquired	0	0	↔
Pressure Ulcer/Neglect	0	0	↔
Psychological / emotional abuse - carer / professional	1	4	↑
Psychological / emotional abuse - family	6	6	↔
Psychological / emotional abuse - other	3	4	↑
Self-neglect	87	142	↑
Sexual	2	3	↑
Sexual / physical abuse	4	3	↓
Sexual abuse / assault - family	0	1	↑
Sexual abuse / assault - friend	2	0	↓
Sexual abuse / assault - stranger/unknown	0	0	↔
Sexual abuse / assault - stranger/unknown/professional	1	6	↑
Unaccompanied for appointment / admission inc. no history/information	0	0	↔
Unexplained bruising / marks	2	0	↓
Unwitnessed fall / multiple falls	0	0	↔

Topic	21/22	22/23	Up / Down from previous year
Un-witnessed fall / multiple falls	0	0	↔
Un-witnessed fall / multiple falls (Hospital)	0	0	↔
(Blank)	2	3	↑
	592	**692**	↑

7.2.6 Total Sent to the Local Authority 22/23

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):

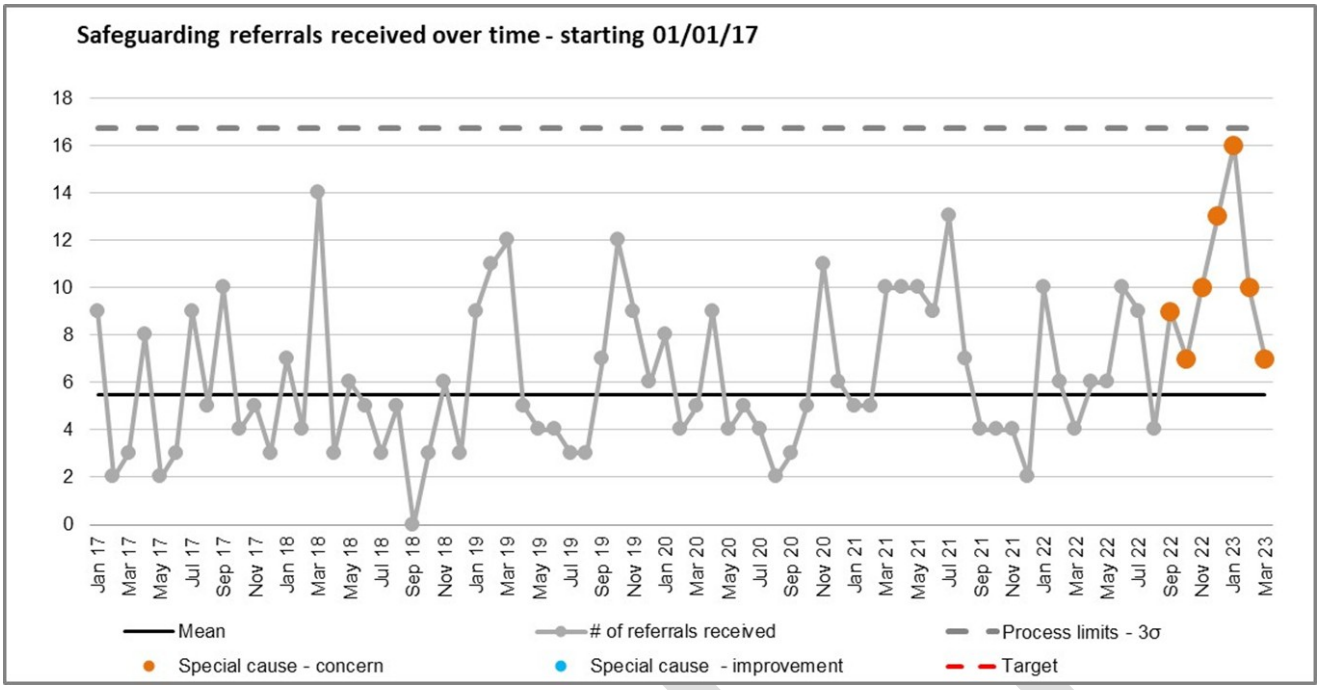


Of the **629** adult safeguarding concerns made during 22/23, **88%** (**553**) were sent to the local authority. The Compliance Team continues to send bi-monthly requests for updates against open concerns to all Local Authorities as a minimum. Following changes to the process for managing open adult 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 **107** formal concerns made to the Safeguarding Adults Team during 22/23. This is an increase of **22%** from the same reporting period in 21/22 (**84**). The below graph demonstrates the number of concerns made over time.

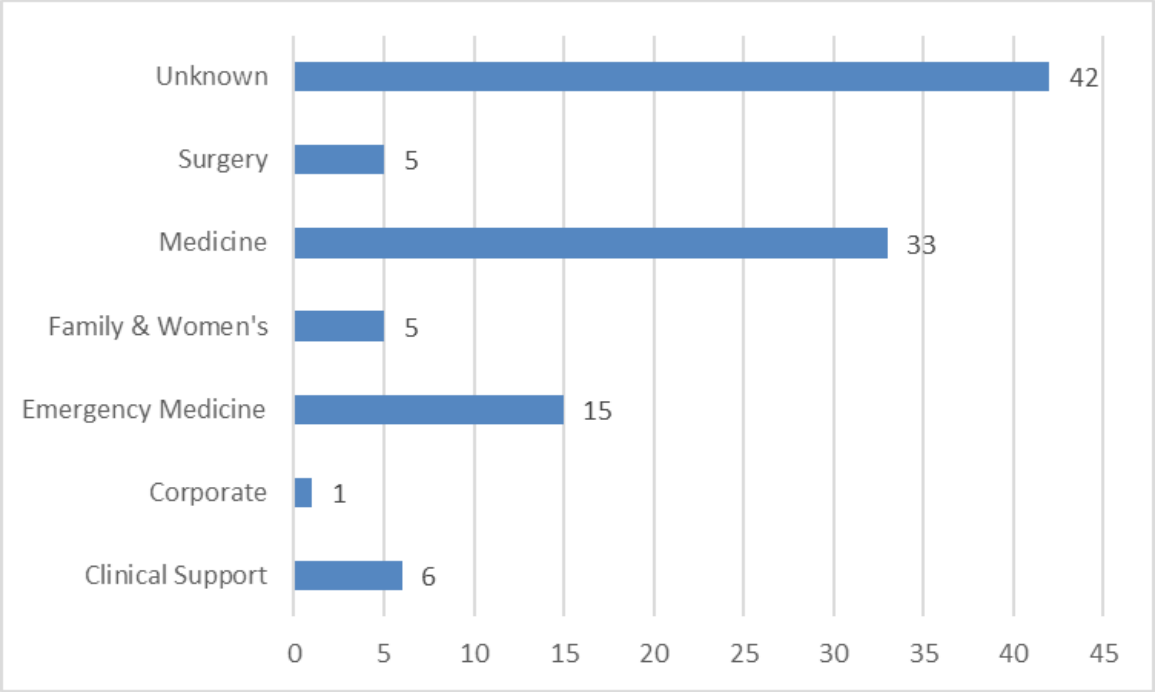


The below table shows of the concerns received and the ratio that required investigation over the last five financial years:

	18/19	19/20	20/21	21/22	22/23
Total Received	66	70	69	84	107
Total met criteria for investigation	51	53	51	53	77
Ratio requiring investigation	77%	77%	74%	63%	72%

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 22/23:



Medicine Health Group received the highest number of adult safeguarding concerns accounting for **31%** (**33**) of the **107** adult safeguarding concerns received during 22/23 with a decrease of **4%** from 21/22.

7.3.3 Referrals Received – Themes and Trends

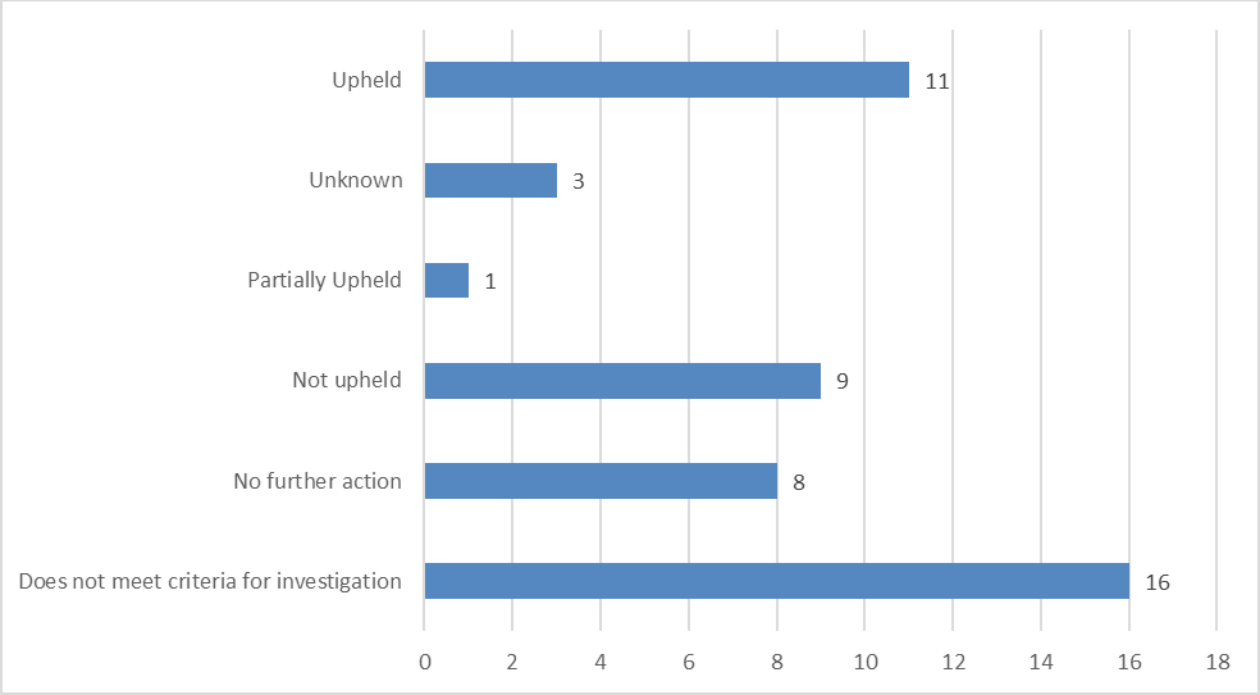
The table below shows the themes and numbers of all concerns received in 20/21 and whether there has been an increase/decrease from the previous year:

Topic	21/22	22/23	Up/ Down from previous year
Attempted suicide / intentional overdose / self-harm	0	0	↔
Care within hospital including neglect	30	71	↑
Communication / Information	3	0	↓
Concerns relating to discharge	15	7	↓
Discrimination / lack of treatment	0	0	↔
Fall	0	2	↑
General neglect / lack of personal cares	6	0	↓
Hospital - Failure to follow care plans / escalate	2	2	↔
Hospital - medication error	5	7	↑
Hospital - treatment delay	7	1	↓
Hospital acquired pressure damage	1	5	↑
Hospital acquired pressure damage / deep tissue injury	2	1	↓
Hospital acquired pressure damage or deterioration in existing pressure damage	2	1	↓
Not enough information	0	0	↔

Topic	21/22	22/23	Up/ Down from previous year
Not for Investigation	4	0	↓
Physical abuse / assault	2	2	↔
Self-neglect / organisational	1	3	↑
Unexplained bruising / marks	1	0	↓
Unknown	3	5	↑
Total	84	107	↑

7.3.4 Outcome of Closed Investigations

There were **48** concerns closed during 22/23. The following graph demonstrates the outcome of the investigations, including how many were upheld[2]:

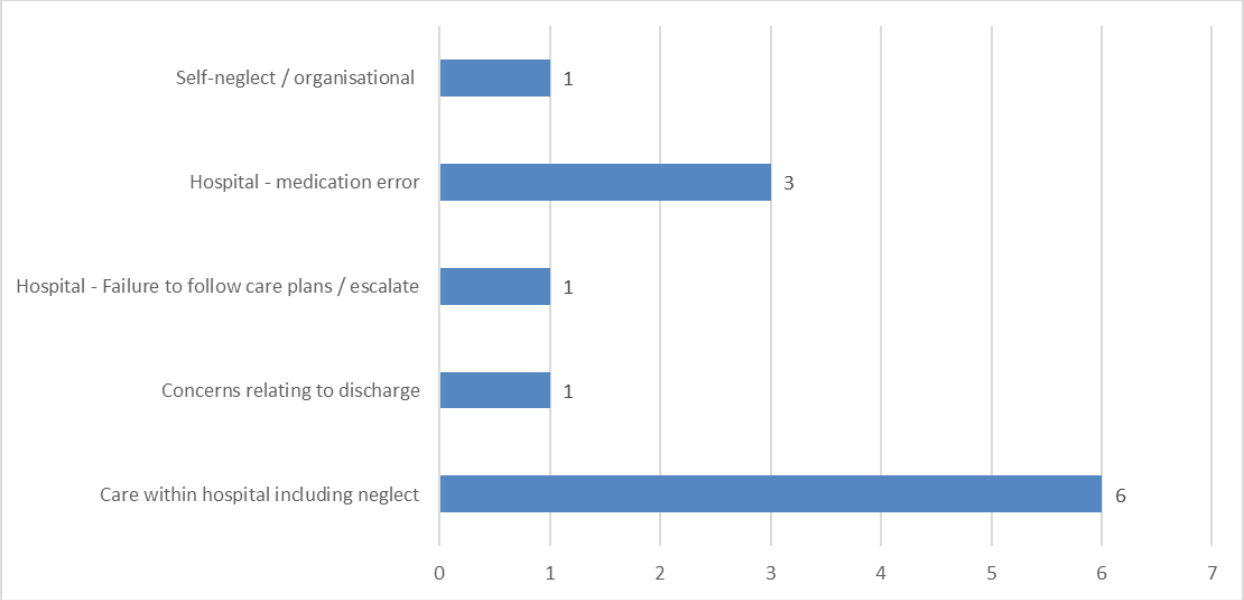


Of the **48** closed concerns received during 22/23, **25%** (**12**) of the investigations undertaken showed the concerns received as upheld or partially upheld.

7.3.5 Themes and Trends – Completed Investigations

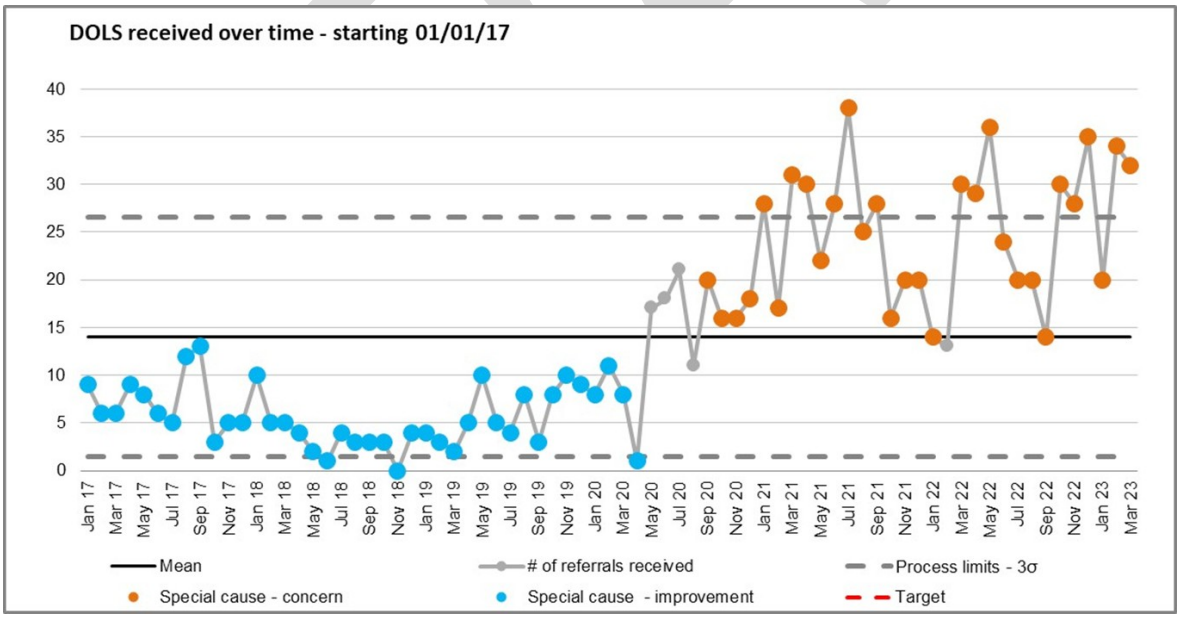
Of the **12** completed investigations that were upheld and partially upheld, **50%** (**6**) involved care within hospital including neglect. The below table shows the themes of the closed investigations that were either upheld or partially upheld:

[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 22/23, the average number of days for completing investigations for those concerns closed in 21/22 was **44** working days. This is a decrease of **26%** from 20/21 (**60**) in average number of working days for completing an investigation.

7.4 DEPRIVATION OF LIBERTY (DOLS) APPLICATIONS



Of the **322** DOLS received during 22/23, **48%** (**154**) were approved for submission to the relevant local authority. Of the **322** DOLS received during 22/23, **52%** (**153**) did not require or meet the threshold for an application to the local authority. Reasons 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 Mental Capacity policy and associated restraint process was sufficient to safely support the process
- The patient has been discharged or regained capacity
- The patient had died before the application was approved

Cancellation of the application before completion is a risk to the organisation as some patients could be illegally detained without the correct framework in place.

Cancellation Thresholds for DoLs

The MCA lead monitors the closure of DOLs on discharge, regaining of capacity or death. The MCA lead monitors active DOLs twice weekly to ensure they are still required. This is to ensure no one is detained who does not need to be and to stop the 14 day best interest process for the Local Authorities. DOLS closed within 7 days, may have been more appropriately managed using the restrictive practices process. Further education and support may be required through MCA training to support staff

The 154 DOLs agreed where discontinued within the following time frames:

- Within 7 days of the urgent application - 39
- Within 14 days of the extension - 40
- Post 14 days requiring the Local Authority to Best interest Assess – 75 only 6 were assessed and had Standard Authorisation in place

7.5 INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) CONCERNS

There were **24** IMCA applications made during 22/23, this is a decrease of **33%** from 21/22 (**35**). All **24** applications were processed as per the agreed process. HUTH is now working with two regional providers, one provides quarterly feedback and the MCA Lead is engaging with the other to employ this feedback model.

7.6 MULTI-AGENCY PUBLIC PROTECTION ARRANGEMENTS ALERTS

There were **16** alerts received during 22/23, this is an increase of **19%** from the same reporting period in 22/23 (**13**). The alerts were logged and escalated to the Named Nurse for Safeguarding Adults for action and dissemination.

7.7 INFORMATION REQUESTS

There were **110** formal information requests made during 22/23, this is an increase of **37%** from 21/22 (**69**). All information requests were dealt with and responded to.

7.8 HUMAN TRAFFICKING CONCERNS

There were **1** concerns reported in 22/23 relating to possible human trafficking / modern slavery incidents, this is a decrease of **600%** from the same reporting period in 21/22 (**6**). The **1** concern was investigated and none were deemed to be human trafficking / modern slavery concerns.

7.9 DOMESTIC ABUSE AND DOMESTIC HOMICIDE REVIEWS

There were **101** concerns reported relating to Domestic Abuse (DA) during 22/23, this is an increase of **5%** from 21/22 (**96**).

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 22/23			Q2 22/23			Q3 22/23			Q4 22/23		
	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Total received	4	6	6	7	7	12	10	13	7	12	7	10
Sent to the LA	3	4	5	7	7	12	9	12	6	8	6	9
Not sent to the LA	1	2	1	-	-	-	1	1	1	4	1	1
Concerns sent to the IDVA	1	3	2	2	1	7	3	2	2	2	-	-
Consent: Yes	1	4	4	7	3	7	9	6	6	7	2	7
Consent: No	3	2	2	-	4	4	1	7	1	4	2	3
Consent: Not stated	-	-	-	-	-	1	-	-	-	1	3	-

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 22/23, there were **53** concerns made without a corresponding Datix incident recorded accounting for **8%** of the safeguarding concerns submitted.

7.10.2 Datix Incidents Recorded Without a Corresponding Safeguarding Concern

In 22/23, there were **159** 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 2022/23 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 2022/23

A list of key operational and strategic achievements is stated as follows:

- Positive feedback from NHS Hull and East Riding Place ICB Designated Safeguarding Lead about the governance and progression of Safeguarding Adults agenda items.
- Seconded appointment for post - Learning Disability Liaison Nurse, substantive and seconded post holder now providing five-day cover in substantive role.
- ECT Digital assessment embedded in practice across the Trust within Castle Hill site.
- 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 rollout of Routine / Selective Enquiry across the organisation continues following the 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 continues to work 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 two Independent Domestic Abuse Advisors (IDVAs), an in-reach service provided by the Hull Community Safety Partnership.
- Supported the Learning Disabilities Mortality Review (LeDeR) programme The trust safeguarding team supported external reviewers in providing access to information, including medical records (within the GDPR arrangements), Structured Judgement Reviews and other LeDeR related information.
- Continue to review, revise and enhance the processes and governance of the LeDeR programme with partner agencies and commissioners.
- A fifth-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 continues to identify a rise in domestic abuse calls from staff about patient and staff victims that did not always result in a formal concern being raised.

- 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.
- Process established 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.
- 100% compliance achieved and maintained in undertaking Fundamental Standards audits for safeguarding.
- 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. There have 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.
- Members of the safeguarding team have undertaken training in Forensic Aspects of Adult Safeguarding and have supported and contributed to the Forensic Pilot Project commenced. 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.
- Continued work with the Lorenzo development team to provide an integrated reporting system for safeguarding adults concern and MCA/DoLS forms.
- 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 detainments.
- The format of the electronic discharge summary to health providers for patients discharged from HUTH's emergency department ED) in custody has been reviewed further for improvement. Sharing relevant information with services via the Yorkshire Humber Care Records with services has been pursued and access for health care custody suites is expected shortly. Digitalisation for other areas within the Trust outside of ED is also currently being pursued to inform the Yorkshire Humber Care Records process.
- Development of a twice weekly high-level report to the senior nursing director team.

10. KEY ACTIONS FOR 2023/24

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 2023//24 is as follows:

Domestic Abuse	• 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 develop a training package in collaboration with the Domestic Abuse Strategic Domestic Abuse Commissioning Manager to staff identified for championing the subject of domestic abuse within the Trust.
Training and Development	• Ensure the continuation of implementation of Intercollegiate Level 3 safeguarding adults training, phase three and refresher training (3 yearly) across professional groups in the trust is embedded within the organisation in line with the Training Needs Analysis. • Aim to reach 85% within three years (2021/23) of introduction of the training package for level 3 safeguarding adults training comprising of • Roll out Oliver McGowan training • Be an active member of the Required Learning Working group to support the SG training agenda • Review MCA required learning and implement changes with Organisational Development
Enhanced Care Team	• Finalise organisational change and implement new model in collaboration with CAMHs and Paediatric Medicine • Develop an audit tool to review the use and quality outcomes of new ECT model • Substantiate the current band 6, 1.0 WT and increase Band 6 support in line with Organisational change • Implement reviewed Nervecentre ECT assessment tool and make a required assessment in adult in-patient services
Learning Disabilities	• Include the Learning Disabilities and Autism NHSI/NHSE national standards results into the Mental Health and Learning Disability (Trust) Strategy delivery plan, to enable compliance with actions identified from the 2018, 2019, 2020, 2021 and 2022 benchmarking exercises, where possible and to produce justifications where compliance is not achievable • To undertake the sixth LD and Autism benchmarking audit when it is available in 2023 • To continue to host and support the LD Liaison Nurse potholders in the role. • To continue providing 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 patients and families in need of are identified and supported whilst in the Trust. • Maintain the Mental Health and LD Steering Group and deliver on the agreed programme as described in the Mental Health, LD and Autism Strategy 2022-2027and delivery plan. • 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. • Scope the opportunities and develop a business plan for the LD ACP with NHS England funding
Restrictive Practices	• MCA Lead will support embedding De-escalation and Management Intervention training as required • Develop a standalone restrictive practices policy in collaboration with the children's safeguarding Team, reflecting changes in the organisation and compliance requirements • Develop resources to support clinical teams develop bespoke care plans when restraint is delivered using either the MCA/MHA framework
Mental Health	• 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. Implement MH Champion in paediatrics. • As part of the MH, LD and Autism Strategy implemented in the Trust, to finalise the delivery framework/action plan. • Continue to identify 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 detainments.
Electronic Solutions	• The safeguarding team to continue working with the Lorenzo team to progress the development of electronic recording of safeguarding and MCA records and referral system • Continue working 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. • Complete review of Enhanced Care Behavioural assessment tool and implement for all patients
Mental Capacity Act	• The MCA lead to design and implement an audit to evaluate the use of the Act in emergency and elective admissions • Quarterly quality updates on MCA application in HUTH • Support and influence Health Group MCA agendas in relation to the Consent process for vulnerable patients • Develop and implement guidelines to support clinical areas to identify

	court of Protection applications • Identify and collaborate with future Advocacy providers to ensure a common referral process and negotiate quarterly reporting. • The MCA lead to design and implement an audit to evaluate the use of the Act in emergency and elective admissions • MCA lead to support and develop pathways to improve integration of MCA processes into the Trust consent processes
Deprivation of Liberty Safeguards	• MCA lead to review compliance recording process to ensure reliable information is documented for auditing purposes • MCA to continue monthly Quality audits to inform learning and development
Other	• 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 two more 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 the pilot project, once developed, for vulnerable patients who 'was not brought' and to seek implementation and operationalisation of the 'Was not brought policy' for the client group identified. • Develop a process to monitor safeguarding supervision for safeguarding adults to meet the Trust's safeguarding obligations. • Review and update policies as required
Forensic Project for Adults at Risk of Harm	• To continue support, contribute and participate in the Pilot Process of Forensic Examination of Adults at Risk of Harm who present with suspected non-accidental injuries • Following an independent evaluation of the Forensic Pilot Project, as commissioned by NHSE/I, to 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.

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 nine years.

6. REPORT END

Report Authors:

- Kate Rudston, Assistant Chief Nurse and Trust Safeguarding Lead
- Jayne Wilson, Named Nurse Safeguarding Adults
- Rachel Hoggarth ECT Matron and MCA lead

With thanks to report contributors:

- Karen Harrison, Dementia Lead Matron
- Leah Coneyworth, Head of Patient Experience and Engagement
- Nikki Harrison, Compliance Officer
- Ben Greenwood, Education and Development.

Date: July 2023

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

SAFEGUARDING CHILDREN & YOUNG PEOPLE

ANNUAL REPORT

2022 – 2023

Index	Page Number

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 2022/2023, raise awareness of key issues affecting practice and service delivery, and identify key priorities for 2023/2024.

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. 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.

Over the past 12 months, the Safeguarding Children Team has worked hard under the leadership of the Named Professionals and Assistant Chief Nurse to promote and drive both Safeguarding and Child Protection service provision across the organisation and in the wider community. This annual report demonstrates the further progress which has been made during the year with a particular focus on being responsive and building strong relationships in the Trust and with partner agencies. Both of which have been essential to the support the development and expansion of the service we offer.

Safeguarding children referrals by Trust staff are made to a range Local Authority Children's Services in the locality of the child's home address. Safeguarding referrals are undertaken utilising the Threshold of Need framework. This framework helps staff to identify the correct level of support a family needs and which service can best meet the needs. In order to improve the quality and appropriateness of referrals, Thresholds training has been promoted and delivered across the organisation with over 80% compliance achieved at the end of the financial year. The positive effects of this training, and increased knowledge, has been evidenced in the number and direction of referrals. Early help referrals now account for between 30-40% of all social care referrals for the unborn and children, whilst the total numbers of referrals remains constant. This data provides clear evidence that staff are using the framework to help identify the correct level of service a family needs. In addition, improved pathways for communication with Children's Social Care and targeted audit activity have also been positive drivers for quality improvement and understanding where we need to focus safeguarding training and supervision.

The Named Midwife has continued to work closely with both Maternity and Pregnancy Advisory Services (PAS) to lead and drive on national safeguarding and public health initiatives. These include; The SIRs Project, which supports the sharing of information related to fathers of the unborn and the Royal College of Paediatrics and Child Health (RCPCH) safeguarding guidance. This collaborative working has helped to ensure services are provided in the Trust, which are in line with national recommendations and provide systems, which assess risk with associated action planning.

The Assistant Chief Nurse and Named Midwife have continued to lead discussions with the Maternity leadership team, in regards to the context of safeguarding children/unborn at risk, safeguarding supervision systems and attendance at safeguarding meetings. 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.

Service provision for Child Protection medicals/Child Sexual Assault Assessment Service (CSSAS) has gone from strength to strength despite the challenges of reduced medical cover. A team restructure and staff changes provided the opportunity to review processes

and pathways for Child Protection medicals. This included our commissioned CSAAS contract. Significant changes have included, an update of the pathway into the service, improved data collection and reporting mechanisms and the promotion of our specialist service. These changes have led to an expansion of the service, increased requests for Child Protection medicals and requests for specialist advice and guidance. This has meant that children are receiving the holistic care that they need in an environment which is safe and meets both their needs and the requirements our commissioners and the legal system.

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.

The Trust was inspected by the Care Quality Commission in November 2022. There were no issues raised with regards the Safeguarding of Children and Young People arrangements.

SAFEGUARDING CHILDREN AND YOUNG PEOPLE

The safeguarding world has seen many changes in the aftermath of the COVID pandemic which are still affecting children and families to this day. Some of which has been directly associated with isolation and families being invisible to services, such as increased Domestic Abuse and family conflict and others which are indirect such as the continued impact to service provision from home working, staff shortages and the reduction in face to face meetings. This has required safeguarding teams to review their processes, systems and ways of working to see if they are still fit for purpose and meet the needs of the families who access our services.

Safeguarding Children and Young people has always been high on the agenda in the organisation but never more so than this past year, the recovery period, when there was a need to work closer than ever with our safeguarding partners /partnerships to reset our focus on children and families. This has required that we work together with a commitment to coproduce priorities to ensure that multi-agency arrangements are in place to support and protect vulnerable children and families.

Both Maternity and Paediatric services have continued to face challenging times during this period with high levels of staff absence and sickness, in addition to difficulties filling vacant posts. From a Safeguarding Children perspective 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, particularly in Maternity services.

Processes have remained 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 (LA) and Safeguarding Partnerships regarding the difficulties being faced within the organisation and the plans which were in place. The Maternity and Safeguarding group set up over a year ago have continued to meet regularly to review and update the action plan developed to address some of the concerns raised and minimise risk. This remains an active risk on the Family and Women's Health Group risk register.

Remote working and training has continued in some areas, which has caused some challenges. This has been more so within community services where office working has never fully been reinstated. In the organisation the Safeguarding Children team have 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, 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.

Business Intelligence (BI) reports are utilised daily to support the Safeguarding Children team to gather information regarding Safeguarding Children activity in the Trust. These include the attendances of children in the Emergency Department (ED), children who are inpatients on adult wards and those children who had remain inpatients for over 90 days. This information is utilised by the Safeguarding Children team to provide timely safeguarding support and supervision to staff and the medical team.

Both East Riding and Hull Children's Social Care (CSC) have undergone significant improvement plans following their Ofsted inspections in 2019. East Riding local authority has had a recent Inspection (ILACS) in January 2023 with overall grade of Good reported for impact, leadership experience and effectiveness. Hull LA's last inspection was November 2022 again with improvements noted in all areas from the previous inspection. 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 age groups including adults at risk.

The Trust continues to meet its statutory obligations in terms of having the required Named Nurse, 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 key 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 a full team restructure with the Named Nurse Safeguarding Children taking on the role of CSAAS Manager. Pathways and processes have been updated which have included the specialist team at the Anlaby Suite being involved with all strategy meetings where there was an allegation of sexual abuse /assault. These changes have been shared with partners as part of a Humberside wide training plan led by the team education lead. This extensive work undertaken to promote the service has had a positive impact on increasing awareness of our service with a subsequent increase in demand for specialist advice, consultation and requests for a Child Protection Medicals.

In addition, a multi–agency Operational (CSAAS) group, led by the team at the Anlaby suite, has been instrumental in supporting the wider promotion and understanding of the service and its development.

A RAG rated action plan with short and long-term goals remains in place for 2023/2024 with an associated communication strategy, which includes new and improved patient leaflets and improved web content including a promotional film of the Anlaby Suite. All of which will ensure the ongoing success of the service.

Following on from last year's annual report progress against the key actions for 2022/2023 are:

2.1 KEY ACHEIVEMENTS AND OUTCOMES:

- There has been a review and restructure of the Safeguarding Children team and leadership of the CSAAS. This has provided a robust structure for both Safeguarding and CP medical activity. The commissioners have confidence in the leadership of both services and evidence and assurance have been provided regarding the future direction and expansion of the service.
- The team have worked closely with the Trust Organisational Development team to develop a Communication strategy /mission statement with associated branding. This will be utilised as part of the wider communication strategy for the Anlaby Suite to improve access and knowledge of the service to families, children and professionals.
- The CSAAS Operational Group is now a well-established multi agency forum in the Humberside region. The Team at the Anlaby Suite leads this. There has been significant positive impact in terms of improved information and data sharing, communication pathways and increased access and knowledge of the service.
- We have reviewed the pathways and processes for the Child Sexual Assault Assessment Service (CSAAS). This has included the development of robust operating procedures, data collection and reporting systems.
- We have provided specialist training for over 450 professionals across the Humberside region related to the CSAAS. This has included involvement with multi-agency strategy meeting training across the Humberside region.
- We now participate in all strategy discussion where there is reported sexual abuse. The demand is increasing with 164 meetings attended in 2022/23. The benefits have been significant with staff being able to share their skills and knowledge and contribute to the outcome of the cases. Staff have contributed to decision making to safeguard and promote the welfare of children and young people.
- The team have raised concerns to NHSE and Humberside Police regarding disparity in the service delivery for 16/17 year old children who require the CSAAS. An exception plan has been developed by the service to ensure that young people receive a service in the most appropriate environment based on need.
- We have reviewed and refreshed Safeguarding Supervision arrangements within Paediatric and Maternity services which are reflected in the updated Safeguarding Supervision policy and promoted within training.
- We have implemented the use of the FGM Risk Assessment Tool in Maternity services. This is now completed directly in the Electronic Patient Record (EPR) and provides evidence of assessment by the Midwifery team.
- We have worked with Hull and East Riding Safeguarding Partnership's to develop multi-agency guidance regarding Section 85, the Pre-birth and FGM pathways. This multi-agency working ensures that HUTH have a voice in the partnership and our pathways into the service are clearly reflected.
- The Adult and Children Safeguarding teams have continued to support the roll out programme of Domestic Abuse (DA) training, i.e. e-learning Routine Enquiry and DA.

The training data and increase in referrals for DA supports the success of this training plan. 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.

- The Named Doctor for Safeguarding Children was appointed to post in October 2022. This has increased resilience and meets the requirements of Accountability and Assurance Framework (2022)
- 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 requiring 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 are continuing the review the safeguarding referral process within the Trust. This has required close partnership with the Hdigital and Change Management team. This includes bench marching and developing a plan for the 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. It is anticipated that this will occur in 2023/2024
- Safeguarding children policies and procedures are up to date.
- 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.
- We have completed a review of processes with the Enhanced Care Matron related to restrictive practices in the care of Children and Young people. This included the development of a new policy (CP431) a training needs analysis and training plan for the Paediatric and Safeguarding Children team.
- Work has been undertaken with the Pregnancy Advisory Service to review and benchmark RCPCH National Safeguarding Guidance for under 18s accessing early medical abortion. All actions have now been completed including an updated risk assessment tool, trained safeguarding supervisors and consideration and support around emotional wellbeing.
- The Named Midwife has offered support and safeguarding advice to help progress the Sharing Information Regarding Safeguarding ('SIRs') project within Maternity services. This has included a review of how this can be delivered trust wide.
- Meetings have taken place with the National Working Group (NWG) for Child Exploitation and Trafficking with the aim of developing an assessment tool which is user friending in an acute organisation and/or primary care. This work will continue in 2023/24
- We have continued work to strengthen the communication process between Child and Adolescent Mental Health services (CAMHS) and the Trust. This has helped 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.
- The CAMHS Paediatric in reach service is now established in the Trust. This role provides senior clinical support for Children and Young people in the Trust with identified mental health needs. Positive and effective working relationships have been established with the Named Nurse Safeguarding children, Safeguarding teams, and Enhanced Care Matron and Paediatric leadership/Teams. This has assisted in improving information gathering and sharing, support and escalation pathways

- We have made links with our safeguarding counterparts in NLAG with visits to the teams. This has been undertaken with the function of sharing good practice, processes and systems of working.
- We have provided support and guidance to establish the Named Nurse for Children Looked After (CLA) post in the Organisation. This has included initial discussions regarding the role and functions, supporting in developing the Job description and on-going support for the post holder. New pathways and systems are being developed with appropriate links to safeguarding.

1. BACKGROUND

Working Together to Safeguard Children 2018[1] 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 1989[2] 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 2004[3] 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 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 Hull and East Riding Place (formally the Clinical Commissioning Groups). These come under the new statutory Integrated Care System (ICS) and Board (ICB) – NHS Humber and North Yorkshire. 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 Health (Integrated Care Board -ICB), 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

[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 Childrens Act 1989 – Government Legislation, Parliament of the United Kingdom

[3] The Childrens Act 2004 – Government Legislation, Parliament of the United Kingdom

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. Dr Lesley Clarkson who was appointed in October 2022 fulfils the Named Doctor role. Dr Clarkson, is a Forensic Medical Examiner who is FMERSA trained and works within the Anlaby Suite as part of her work plan. Patricia Darley is the Named Nurse for Safeguarding Children and manages the team. Following a restructure of the team the Named Nurse has taken on the additional responsibilities of managing the Child Sexual Assault Assessment Service (CSSAS). Paula Peacock continues to provide strategic and operational guidance and support in the role of Named Midwife.

The Safeguarding Children 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 Joanne Ledger.

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 Local Learning Lessons Reviews (LLR's) and Line of Sight Reviews (LoS) , Safeguarding Practice Reviews (SPR's) Care Quality Commission (CQC) and Ofsted Inspections. In addition we also support and contribute to all Local Child Death Review (CDR) meetings where there has been contact with a child and/or their family. Recommendations and actions from these reviews are monitored through the Trust Safeguarding Steering Group.

The Child Sexual Assault Assessment Service (CSAAS) has been delivered within service specification but has continued to see a decline in numbers. This decline began in 2021/22 in the aftermath of the COVID pandemic but the recent decline is attributed to reduced medical cover following the retirement of Dr Chris Wood. The impact of reduced medical cover has had a profound impact on the ability to undertake acute forensic medicals which require a Paediatric Consultant with specialist FMERSA training. This equated to 14 Children and having to be seen out of area during our Core working hours and 12 during weekends and bank holidays. On a positive note, an extensive programme of training and service promotion by the team has led to a steady increase in Child Protection medicals for non-recent sexual abuse. The team have also extended the offer of specialist advice and guidance through involvement at Strategy discussions which has been positive in terms of ensuring that appropriate thresholds are met for those who are referred to the service.

During the reporting period 2022/2023 there has been one-reported concern through the Trust Patient Advisory and Liaison Service (PALS) about the safeguarding children's service/ Anlaby suite. This was related to the attendance and outcome of a case where a child attended for a Child Protection medical. This was reviewed with a comprehensive response from the Consultant Paediatrician involved in the case.

The Integrated Care Board, Hull and East Riding Place remain 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.

2. 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 11,000 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 Hull and East Riding of Yorkshire. In addition, Tertiary and Secondary services are delivered to over 1,200,000 people in the wider Humber Coast and Vale region.

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 266,000 people, approximately 52,000 of which are children aged 0-15 years. It was identified as the fourth 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 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).

3. 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 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 Video Recorded 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. The Anlaby Suite provides this cover during core working hours where they have availability of both a medical room and suitably qualified medical professional. 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. In addition, children attending the Emergency Department with unexplained injuries may be referred directly to the inpatient service where the CP medical would be completed by a Paediatric Consultant.

The Sexual Assault Assessment Service (CSAAS) is separately commissioned by NHS England and NHS Improvement to provide a Child Protection Medical Service (CSAAS) for children under 16 years of age and for 16 to 17 year olds with vulnerabilities (see section 5.4) who live in the Humberside region.

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 2022/2023 with both monthly and quarterly reporting of key performance activity. The service have also been instrumental in supporting the redesign of a new Provider report which is now utilised across the region at paediatric SARC facilities. 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 Named Doctor for Safeguarding Children.

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, 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 Children, Young People and Adults at Risk People in the NHS Accountability and Assurance Framework 2022.*

The Trust for 2022/2023 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
- Safeguarding Educator/Practitioner (1.0 WTE)
- Safeguarding Children Practitioners x 2 (2.19 WTE)
- Administrator for S47 Child Protection Medicals (1.0 WTE)
- Management Assistant (1.0 WTE)
- Administrative Assistant (0.53 WTE)
- Child Death Review Co-ordinator Hull – HullCC - Honorary contract (1.0WTE)

The team structure was reviewed and updated in 2022 following the resignation of the CSAAS Lead Nurse/Safeguarding Supervision Coordinator. Although the CSAAS service had seen progression year on year it was felt that the management of the service would be better under the remit of the Named Nurse Safeguarding Children with increased support from the Child Protection administrator.
This changed model provided an opportunity to review and benchmark our service against national standards and other SARC services with significant changes in our data collection, pathways and reporting undertaken. This has had a positive impact on the service with our stakeholders and commissioners reporting increased confidence and satisfaction with how the service is managed and delivered.

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 Adult 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. Supporting and leading, where required, the development of new or updated Safeguarding Partnership guidance.
8. Compliance or working towards compliance of Commissioner contracts as per annum.
9. Participation in Safeguarding Practice Reviews, Line of Sight and Learning Lesson Reviews, Serious Incident investigations. This includes ensuring the actions from these reviews are implemented and embedded.
10. Review of all Safeguarding Children's referrals and incidents involving children and young people occurring in the Trust.
11. Providing a monthly quality report detailing Safeguarding Children and Child Protection activity.
12. Identification of themes, reporting on activity and items for escalation to the Trust Safeguarding Steering Group.
13. Providing leadership on the Safeguarding Children and Young People's agenda.
14. 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.
15. Escalation within both 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. The Assistant Chief Nurse/Safeguarding Lead holds and 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, a team of senior leaders who have completed the managing allegations workshop cover the SDO role. 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)

Background

NHS England and NHS Improvement, with a range of partners in the health system (such as The Integrated Care Board (ICB), Local Authorities and the Criminal Justice System (such as Police, Police and Crime Commissioners (PCCs)) is jointly responsible for the commissioning of a cost-effective, integrated response to sexual violence and rape in order to meet the needs of local populations.

With the Police and PCCs, NHS England and NHS Improvement co-commissions Sexual Assault Referral Centre (SARC) Services. NHS England and NHS Improvement is specifically responsible for commissioning the public health services, section 7A, elements of SARC services**.** SARC services also provide sexual assault forensic medical examinations, medical care, treatment, and independent sexual violence advocacy support.

SARC services are delivered to both recent and non-recent (historic) victims and can offer them the opportunity to assist in a police investigation of the sexual offence against them, including a forensic medical examination with consent.

The Anlaby Suite delivers a high quality, cost effective Child Sexual Assault Assessment Service (CSAAS) for children and young people aged 0 to 15 years from across the Humberside Police force area. This incorporates Hull, East Riding, North Lincolnshire and North East Lincolnshire local authorities. The service can also accommodate cases for

young people aged 16-17 years (up to their 18th birthday) if they have additional needs are deemed clinically appropriate.

The Anlaby Suite provides medical examinations for acute cases (up to 7 days of the alleged incident), recent cases (7-30 days since the alleged incident) and non-recent cases (after 30 days since the alleged incident).

We accept referrals from Police and Children's Social care. Any decision to refer children and young people to the Anlaby Suite is a joint agency decision and a strategy meeting is necessary along with an agreed Section 47 Investigation.

What we do

The CSAAS 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 provide a dedicated Child Protection service to examine and advise on the medical aspects of suspected or actual child sexual abuse. A Consultant Paediatrician undertakes the medical examinations. The examination includes a comprehensive 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.

General Practitioners also make referrals 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). Registered nurses, and midwives with paediatric experience and/or paediatric qualification, support the doctors.

The service associates 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 when necessary. In addition, there are referrals to Children's Independent Sexual Violence Advisers (ISVAs/the Blue Door) to provide on-going support for child victims as necessary. Contacts have been established with voluntary sector support, such as ReFresh, substance misuse support and Corner house, Child Sexual Exploitation support.

Performance Data

Monthly performance data is shared with representatives from Health, Children's Social Care and Police. The information relates to the number of medical examinations conducted each month by each local authority area. We also include information relating to any cases sent out of area (core hours and weekends/bank holidays) along with strategy meeting data.

A comprehensive CSAAS Provider Report is compiled and submitted each quarter as required by the Health & Justice CSAAS and SARC Quality Schedule for 2022/23. The quality assurance schedule is to support the quality performance assurance and oversight of SARC providers and has been developed by the Health & Justice Quality Leads Group. We are expected to submit a report to the Commissioners as agreed in the reporting schedule. Following submission of this document the CSAAS Manager and members of her Team

meet quarterly with the Commissioners to discuss the information contained within the quarterly report.

Innovation/Improvement

Throughout 2022/23, staff from the Anlaby Suite were instrumental in implementing new processes, ideas and services. Staff made changes to processes, leading to improvements in health outcomes and overall patient experience. Throughout the year, staff focus was on improving the service and processes. There was improved collaboration, communication and knowledge with other partnership organisations.

Some improvements/Innovation throughout 2022/23 are:

- Strategy Meeting Participation and data recording
- Creation of Operational Working Group with regular meetings
- Developed and implemented an improved CSAAS Provider Report
- Created improved databases for performance reporting
- Provide monthly performance reports to health, children's social care and police
- Improved training in respect of the CSAAS
- Supported Police and Social Care with Strategy Meeting Training
- Improved the Waiting Room facilities
- Improved partnership working with the Blue Door/regular performance meetings
- Marketing – improved leaflet, improved website
- Regular attendance at the RASSO (Rape and Serious Sexual Offences) service Improvement Group.

Strategy Meetings

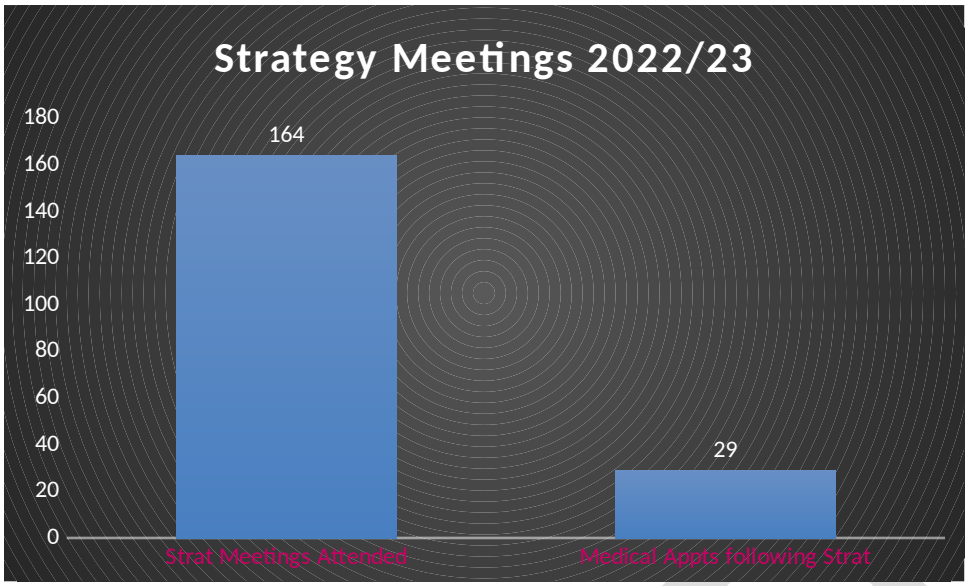
From April 2022 the Anlaby Suite team participated in Strategy meetings. The Health & Justice CSAAS and SARC Quality Schedule for 2022/23, Service Delivery Plan for 2022/23 required the Anlaby Suite to focus on raising awareness of the contribution CSAAS health professionals could make to Safeguarding Strategy Discussions involving children and young people who attend the service following a suspected or actual sexual assault.

This was a significant exercise for the Team and involved raising awareness of our service, putting new processes in place and allocating staff to undertake this new role. Data was collected throughout the year with regular performance data shared with representatives from Police, Health and Children's Social Care. There was also actions from Commissioners to share regular information within the quarterly CSAAS Provider Report.

As part of the CSAAS SDIP 2022/23 the Anlaby Suite were required to provide an Evaluation Report in Q4. This evaluation report demonstrated learning and areas for development for 2023/24.

Strategy Meeting Results

Throughout 2022/2023, staff from the Anlaby Suite participated in 164 strategy meetings**.** All meetings were virtual via Microsoft Team's. The Safeguarding Nurse Practitioners, Named Nurse or Named Midwife participated in the meetings. Staff participated in 164 strategy meetings and medical's appointments were offered in 122 cases. However, in comparison to the number of medical offered, the conversion rate to medical examination was 29 cases. This equates to a conversion rate of 18%.



Strategy Meeting: Observations

Evaluating strategy discussion participation and effectiveness was crucial and determined by analysing conversion rates. Data was collated an analysed throughout the year (2022/23) and evaluated against strategy meeting participation in comparison to the number of child protection medical examinations that ensued.

Strategy Meeting: Low conversion rates

Conversion rates were a key element to measure strategy meeting participation effectiveness. Ultimately, the Anlaby Suite would like to generate as many medical examinations as possible following recommendation at the strategy meeting. Learning has been fundamental throughout the year and we recognised that small changes could potentially improve conversion gains. Low conversion rates were discussed regularly at Operational Group meetings.

Strategy Meeting: Successes

Strategy meeting participation has increased since the introduction of strategy meetings in April 2022. The benefits have been instrumental with staff being able to share their skills and knowledge and contributing to the outcome of the cases. Staff have contributed to in decision making to safeguard and promote the welfare of children and young people.

The Team at the Anlaby Suite feel team collaboration has improved since the introduction of strategy meeting participation. Staff regularly share information and decision making with other members of the team. They often seek advice from other nurse practitioners, the consultants, admin team and other partnership agencies. They recognise the importance of team collaboration and good communication in order for the strategy meeting process to be effective.

CSAAS Medical Examinations (2022/23)

The Anlaby Suite provide quarterly SARCIP (Sexual Assault Referral Centre Indicators of Performance) data to the North of England NHS Commissioning Support Unit (NECS). Data is required as detailed within their Sexual Assault Referral Centre Indicators of Performance

(SARCIP). This provides, across partners, a dataset, which can provide assurance, activity, and outcome data.

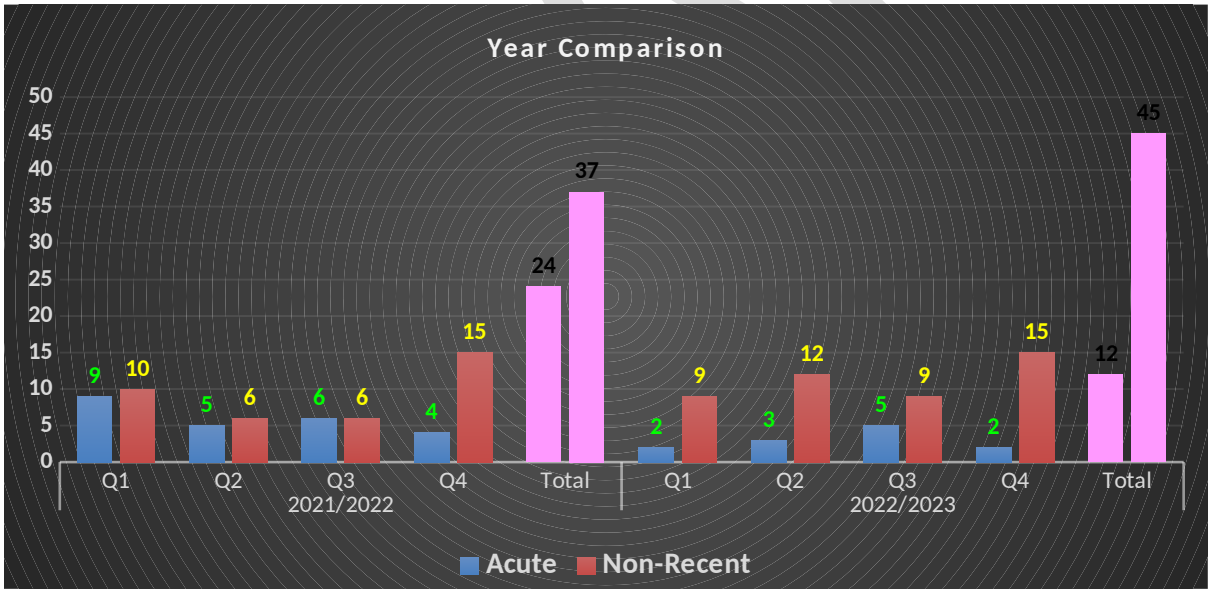
SARCP Data for year 2022/23 is displayed in the table below, identifying the number of Acute Forensic cases along with the number of Non-Recent cases.

22/23	Acute	Non-Recent	Total
Q1	2	9	11
Q2	3	12	15
Q3	5	9	14
Q4	2	15	17
Total	**12**	**45**	**57**

The number of Non-Recent cases increased by an additional 8 compared to the previous year. However, acute cases decreased by 50% compared to the previous year. This is likely due to the partial retirement of the Named Doctor for Safeguarding Children.

Comparison Data

The below graph displays the number of Acute and Non-Recent cases over the last two years (2021/22 and 2022/23). The bars are divided into acute cases and non-recent cases with an annual total for each year.



Graph details the year comparison totals for Acute and Non-Recent cases from 2021/22 – 2022/23.

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. The LSCPs Policies and Procedures underpin all of the documents. 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. This activity has been suspended in the later part of the financial year but assurance is provide though steering group reports.

The Assistant Chief Nurse, Named Nurse and Named Midwife review all reported incidents (DATIX) within the Trust related to children and maternity 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 2022/2023 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. The Assistant Chief Nurse and/or Named Nurse attend these.

In addition, the Named professionals and staff working within the Safeguarding Children Team represent HUTH on LSCP's sub committees. The LSCPs monitor the Trust safeguarding performance through:

Section 11 Self-Assessment Audit of Safeguarding Children arrangement is completed on a yearly basis 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 concerning 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 audit activity and peer review.
- 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 and East Riding Place ICB – 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 2022/23 with agreed indicators carried forward to 2023/2024. There is no financial target attached to the key performance indicators.

5.7 SERVICE USER AND STAKEHOLDER FEEDBACK/INVOLVEMENT

The Anlaby Suite obtain real-time feedback from patients and professionals to improve healthcare services and patient outcomes. In May 2022, the Anlaby Suite purchased a digital "ViewPoint" Survey and Feedback Terminal. The device has been utilised since May 2022 and allows patients/parents/carers and other agencies to share their experiences and provide feedback.

The Real-time Feedback includes capturing the service user's thoughts and feelings by using a touch screen multi-question survey. The Team at the Anlaby Suite developed bespoke questions with a mix of rating, multiple choice and free text questions. The use of Smiley Face Surveys created an instant opportunity for the children/parents and professions to tell us what they thought of the service. This provided the Team with the ability to drill down into the details of the feedback in order to make timely and effective improvements.

The ViewPoint system allows the Suite to track patient/carer satisfaction and overall experience. The automated data collection and live dashboard reporting provides staff from the Suite immediate access to the data they require. The ViewPoint patient surveys are specially designed to ask core questions across the hospital so that all services can be compared, monitored and improved.

Feedback results were extremely positive and the device has been an excellent way to obtain patient feedback in relation to their experience. Patients/parents and professionals are asked to complete the feedback by using our Viewpoint terminal prior to leaving the Suite.

As part of the CSAAS contract, a quarterly feedback report is submitted to NHS England and monitored through the quarterly contract meetings. Feedback results were extremely positive and the device has been an excellent way to obtain patient feedback in relation to their experience. Patients/parents and professionals are asked to complete the feedback by using our Viewpoint terminal prior to leaving the Suite.

Data tells us that service users rate their experience of using the service as positive and children provide comments which indicated that they felt at ease and safe.

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 in safeguarding is 85%. The impact of COVID has continued to effect compliance as there is minimal face-to-face training, higher than average sickness levels and a significant number of posts unfilled in some health groups.

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, in other acute trusts, have reported significant concerns regarding levels of compliance. 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 Designated professionals have remained updated throughout his period regarding compliance with safeguarding training.

In order to continue to address these shortfalls in compliance a review and consideration for re-establishing face to face training will take place in 2023/2024. It may be that a hybrid model is delivered which provides staff with an opportunity to undertake the training in a method most suitable to their department and training style.

Table 1: Compliance Rates as at 31 March 2023

Intercollegiate Level of Training	Current Compliance (%) Target 85%
Level 1 (Basic)	86.9%
Level 2 (Intermediate)	83.8%
Level 3 (Advanced, multi-agency)	75.3%
Level 4/5	75.0%
Threshold	80.9%

Compliance with Threshold training in now in line with the 3-year plan to achieve over 80% compliance.

The Training and Education department, the Named Nurse for Safeguarding Children and the Assistant Chief Nurse, monitors the compliance with Safeguarding Children Training closely. 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 2022/2023. Small group and 1:1 sessions have been delivered face to face with on line training offered where required. Staff shortages have affected compliance with supervision, particularly in Maternity services. In order to address this three additional safeguarding supervision training sessions have been delivered which were well attended with positive feedback. This increasing number of supervisors adds resilience and increased opportunities for Supervision within each health group. This increased offer will continue into 2023/2024.

A review of supervision arrangements, including staff consultation has been undertaken. 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 2023/24.

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 organisation's 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.

In April 2022 an audit was undertaken to review and provide assurance of the effectiveness of the CP-IS across Hull. The outcome of the Audit identified that the multi-agency systems, which were in place, were not working effectively to record in a timely manner those children who were subject of a Child Protection Plan.

Communication took place with HUTH Named Nurse for Safeguarding Children and the Independent Reviewing Service Manager in the Local Authority (IRS). This helped to identify actions which were required to improve the systems which were in place at that time. A plan was made for a further audit to be conducted after six months to determine the impact of the changes to process. This audit took place in February 2023 utilising data provided by the IRS of all children and unborn who became subject of a Child Protection Plan in December 2022.

The outcome of the second Audit clearly evidenced that the CP-IS process was embedded and working effectively. Based on the Audit we have assurance the CP-IS is connecting Children Social Care and Health systems in HUTH in all cases.

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.

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.

The Safeguarding Fundamental standards audit is undertaken in all relevant areas on a yearly rolling programme. Fundamental Standards have been developed to review objectively the quality of care delivered and documentation by our clinical teams, measured against a set of key questions that assesses compliance of the clinical area with local safeguarding policies, to ensure that patients are protected from abuse, or the risk of abuse and their human rights are respected and upheld. Patient experience is also assessed as part of the safeguarding fundamental standard audit. The audits ensure consistency of what

is looked at and creates a credible, comparable rating. The aim is to celebrate areas of excellent practice, identify areas where further improvements and support is required, with a clear time frame for the improvement to be delivered. The findings of the audit are presented at the trust safeguarding Steering 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.

The Safeguarding Children team reviews all referrals which helps to monitor the quality of referrals and ensure that trust policies for safeguarding children and women with vulnerabilities are adhered too. Work is ongoing to support the LA to improve communication and feedback to the referrers, and the outcome of their referrals.

Hull City Council social services utilise a single integrated front door portal for referrals which is different from the East Riding who continue with an electronic emailed referral system.

The Named Nurse and a small working group from HUTH, including an allocated change manager and Hdigital team have continued to review and benchmark processes. This includes how we as an organisation can implement a process for completing safeguarding children referrals directly in the Electronic Patient Record (EPR). This is a complex and challenging review due to the different systems in each LA. There would be advantages for staff at HUTH if there could be integration into the EPR as referrals would be sent off in a timely manner, would be easily accessible in the EPR with an auditable trail. Work will continue to support the integration in 2023/2024

In order to ensure all staff are aware of safeguarding concerns for children all safeguarding children/unborn documentation including referrals are uploaded directly to the child's/mothers (for unborn) EPR by the trust safeguarding children team. This means that the record can be easily viewed by staff who are community and hospital based and have access to the electronic patient record.

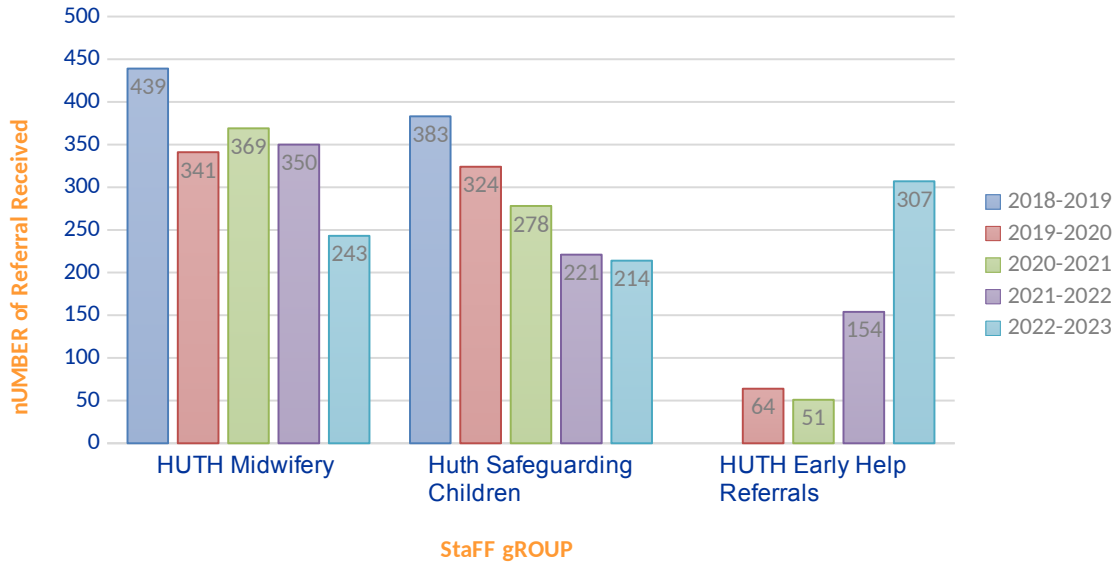
Table 2: Number of Referrals Made to Children's Social Care

Referral Type	2018-19	2019-20	2020-21	2021-22	2022- 23
Midwifery	439	341	369	350	243
Safeguarding Children	383	324	278	221	214
Early Help Referrals	-	64	51	154	307
Total number of Referrals Made	822	729	698	725	764

As Table 2 and Figure 1 (see below) 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 2022/2023. Taking a yearly comparison, there have been double the number of submission made in this reporting period compared to 2021/2022 and six fold when compared to those made in 2020/2021.

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. This changing pattern for the understanding and referral to the LA based on need provides strong evidence of the success of the roll out of Threshold training across the organisation, which is now at 80% compliance. 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.

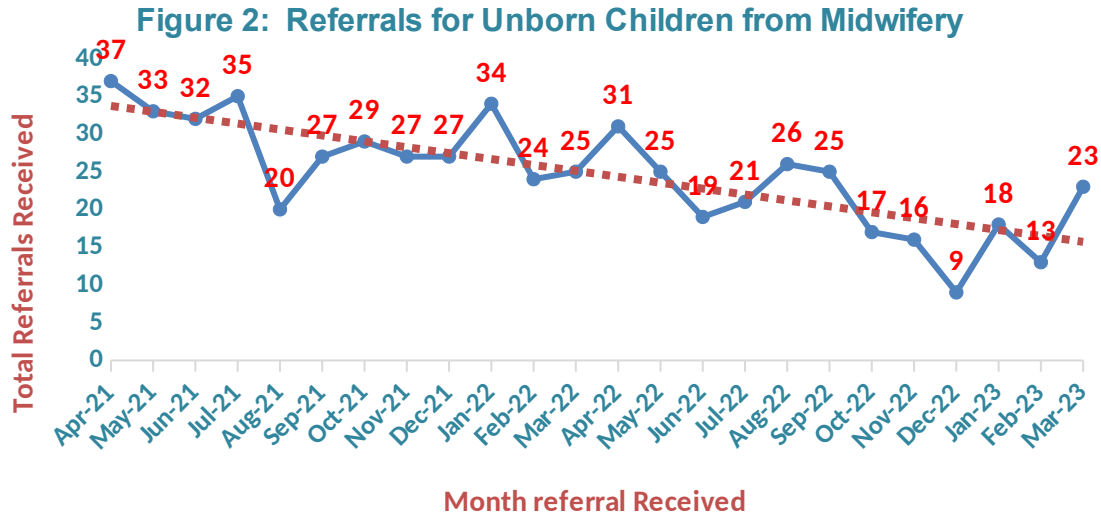
Figure 1: 5 Yearly Comparison of Referrals Received by Staff Group

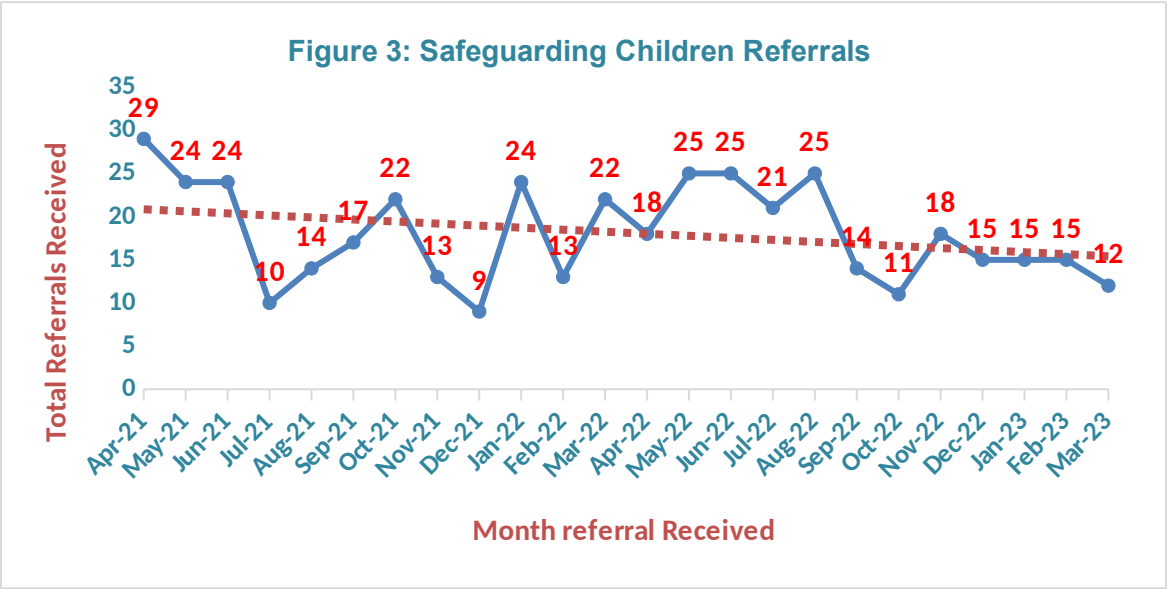


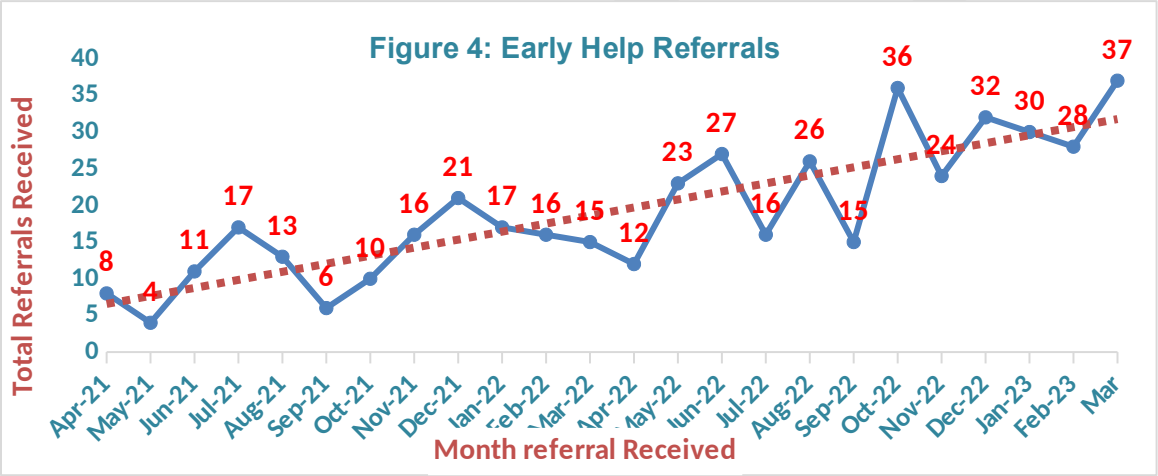
Figures 2 to 4 below provides from April 2021 onwards a monthly comparison of referrals received for midwifery, Safeguarding Children and Early Help respective

Referrals 01/04/2021-31/03/2023 by referral source

Figure 2: Referrals for Unborn Children from Midwifery





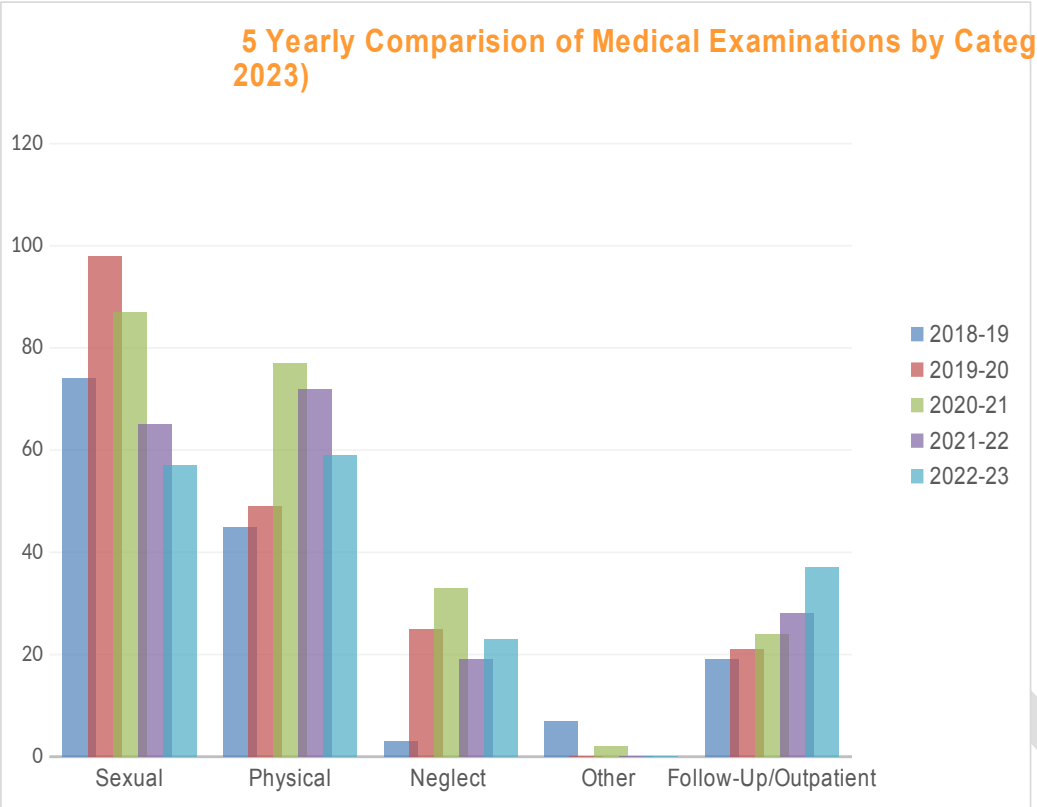


7.3 CHILD PROTECTION MEDICALS

The following table illustrates the number of S47 Child Protection Medicals carried out during core/office hours within the Anlaby Suite over the last 4 years. In total, there were 176 medical examinations carried out 2022-2023.

Table 3: Number of Child Protection Medicals with Reason for Attendance

Type of Examination	2018-19	2019-20	2020-21	2021-22	2022-23
Sexual Abuse	74	98	87	65	57
Physical Abuse	45	49	77	72	59
Neglect	3	25	33	19	23
Other	7	0	2	0	0
Follow-Up/Outpatient	19	21	24	28	37
Total	**148**	**193**	**217**	**184**	**176**



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

The purpose of the Child Death Review (CDR) process is to try to ascertain why children die and put in place interventions to protect other children, prevent future deaths wherever possible as well as improving services to families and carers.

Child Death Overview Panels (CDOP) became statutory in April 2008. CDOP has a statutory responsibility to review the deaths of all children up to the age of 18 years old (excluding babies who are stillborn, late fetal loss and planned terminations of pregnancy (carried out within the law) resident within the Local Authority area. It includes any infant death where a death certificate has been issued, irrespective of gestational age.

The publication of the Child Death Review Statutory and Operational Guidance in 2018 builds on the requirements set out in Chapter 5 of Working Together to Safeguard Children (2018) and details how individual professionals and organisations across all sectors involved in the Child Death Review should contribute to guided standardised practice nationally and enable thematic learning to prevent future child deaths.

As part of the local arrangements professionals at HUTH, including the Designated Doctor for Child Death and Named Nurse Safeguarding Children work closely with Humber and

North Yorkshire Integrated Care Board, Hull Place, Hull City Council and other Child Death Review partners to support the Child Death Review Operational Group. This group was formed to ensure arrangements comply with statutory guidance and are working effectively. The group meet regularly to progress a local delivery plan. A Child Death Review Executive Group provides strategic oversight for the local child death review process. Membership comprises of joint chairs, Director of Public Health, and Interim Director of Nursing and Quality, also CDOP chair, Designated Nurse Safeguarding, Designated Doctor for child deaths, Assistant Chief Nurse and Child Death Review Co-ordinator.

Some changes and updates which have occurred during this period Include:

- Child Death Process has moved 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 Co-ordinator for Hull to HUTH on an honorary contract.
- Continued implementation of a local secure online child death review notification and reporting process via the eCDOP system, which feeds into the National Child Mortality Database.
- Continued review and drive to implement the Specialist Child Death Nurse/Key Worker post.

The Named Doctor, Child Death Co-ordinator and Named Nurse act as the central point within the Trust for the notification and subsequent sharing of information with other agencies concerning child deaths. Access to a Designated Doctor for Child Deaths is a requirement for local child death review arrangements. Dr Mary Barraclough, Consultant Paediatrician at HUTH carries out this role.

Each year the Hull Child Death Overview Panel (CDOP) produces an annual report for partners on local patterns and trends in child deaths, any lessons learnt, and actions taken. This information includes identification of contributory factors in children's deaths and modifiable factors requiring action to prevent future child deaths. HUTH Named professionals contribute to CDOP for Hull and East Riding.

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.

Hull University Teaching Hospitals NHS Trust (HUTH) recognises the importance of Safeguarding Supervision in professional development and that it helps the supervisee develop confidence in decision making. HUTH have in place a range of systems and processes to meet the Trust's safeguarding obligations, both in respect of safeguarding children/unborn and adults. This includes arrangements for Safeguarding Supervision.

Safeguarding Supervision arrangements are led by the Safeguarding Teams in the trust. The Named Midwife and Nurse provide leadership support in conjunction with the Safeguarding Children team to support the development of the policy, pathways, processes and data collection. Assurances that these processes are affective and fit for purpose is via the Safeguarding Steering Group chaired by the Assistant Chief Nurse This provides a framework in keeping with the requirement of The Children Act, (2004) Care Act (2014) and Working Together (2018).

There have been challenges in providing robust data to evidence those professionals who are compliant with the requirement for Safeguarding Supervision as per trust policy CP341. This has required the Named Midwife and Nurse to review the Safeguarding Supervision arrangements in the Trust in order to understand how processes and systems can be updated to aid improved recording and collating of Safeguarding Supervision activity for those staff who have received and/or delivered Safeguarding Supervision.

The changes which have been undertaken include:

1. Updated Safeguarding Supervision policy CP341
2. Updated Safeguarding Supervision documentation
3. Request to HDigital/change manager for support with adding documentation directly to the EPR
4. Proposal produced and presented to safeguarding steering group which evidences the need for safeguarding supervision compliance to become a component of the trust appraisal system.
5. Meeting undertaken with Assistant Learning and Development Manager to review and bench mark implementation into the Appraisal system.
6. Updates to Trust Internet pages (Pattie)

Safeguarding Supervision arrangements and compliance will continue to be a key focus for 2023/2024.

In addition to adhoc Supervision 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
- Community Midwifery teams
- Specialist Midwife for Vulnerable Women
- Paediatric Senior matron
- Pregnancy Advisory Service

8.1 PROVISION OF SAFEGUARDING SUPERVISION

Prior to the COVID 19 pandemic, the Safeguarding Children Team offered planned and adhoc face to face safeguarding supervision across both HUTH sites. This model of supervision had been really well received by staff members. Ongoing restrictions of COVID and lack of face to face contact meant that the Safeguarding Children Team were required to

become more imaginative in the delivery of safeguarding supervision with the use of Big Blue Button platform and Microsoft teams software. While there are some benefits to remote delivery of safeguarding supervision, it was evident from the requests of staff that face to face contact was the preferred model of receiving safeguarding supervision. As COVID restrictions were gradually lifted the Safeguarding Children team were able to recommence both face to face safeguarding supervision and safeguarding supervisor training.

8.2 PLANNED CASELOAD HOLDER SUPERVISION

Caseload holder supervision is for staff who work with a caseload of patients, with paediatric and unborn children involvement. This planned quarterly supervision is delivered on a 1:1 or as a group, in accordance with the type of caseload held. Planned quarterly caseload holder safeguarding supervision is well established in specialist paediatric areas, with excellent engagement from staff and positive feedback received from supervisees. Community midwifery services are also caseload holders.

8.3 PLANNED GROUP SUPERVISION – NONE CASELOAD HOLDERS

Planned group safeguarding supervision is for all staff in clinical areas with paediatric and unborn children involvement. Staff from the neonatal unit have consistently received, and are compliant with safeguarding supervision requirements. There have been some difficulties in safeguarding compliance for staff working on the paediatric wards and paediatric emergency department. At times there have been operational difficulties in regards to staffing levels and workload capacity. Paediatric leadership teams have collaborated well with the Safeguarding leadership team to address these concerns.

It is anticipated that the Safeguarding Children team will deliver safeguarding supervision with the re-establishment of paediatric study days and safeguarding supervision. More recently, collaboration has been evidenced in the uptake of paediatric staff completing the safeguarding supervisor training, alongside maternity staff. This has provided some assurance that maternity and paediatric leaders are providing time and opportunity for staff to access safeguarding supervision. Trained safeguarding supervisors will be able to provide adhoc and planned Safeguarding Supervision sessions on a 1:1 and or group basis within their service area

8.4 MATERNITY SUPERVISION ARRANGEMENTS

Safeguarding supervision arrangements across maternity services has continued to be one of the actions from the Safeguarding in Maternity Steering group meetings. Maternity leadership have positively identified safeguarding supervision compliance as a concern. Throughout 2022 work has been undertaken by both the Safeguarding Children and Maternity leadership teams with plans in place to ensure there are robust systems and processes to manage safeguarding supervision delivery and compliance as per safeguarding supervision policy. This work will continue throughout 2023-2024.

In order to increase the shortfall of midwifery safeguarding supervisors the Safeguarding Children Practice Educator and Named Midwife have provided face to face safeguarding supervisors training days throughout 2022. Training dates were planned with maternity managers to accommodate staffing capacity. Midwifery places and ease of access/venue were specifically prioritised for maternity.

These sessions have been positively received and midwifery staff have been really well engaged in the training.

In addition

The Named Midwife and Safeguarding Children Practice Educator have continued to provide a planned monthly safeguarding supervision session / safeguarding update to all midwifery staff attending their mandatory clinical midwifery training session.

All newly qualified midwives, as part of their induction programme to HUTH, receive a half-day safeguarding training / supervision session. This includes the mandatory 'Threshold of Need Training'

It is anticipated that the Named Midwife and Safeguarding Children team will support the newly appointed Safeguarding Midwife with their supervision processes once in post.

The Named Midwife provides safeguarding supervision to Community Midwifery Sisters and Specialist Midwife for Vulnerable Women. At the request of Head of Midwifery the Named Midwife has been providing group safeguarding supervision to maternity managers on a quarterly basis. These have been really well received by maternity managers.

The Safeguarding Children Team provide daily telephone contact across both maternity and paediatric services. Alongside this, routine ward rounds are carried out three times a week by the Safeguarding Children team to all paediatric wards and the maternity unit
This supports nursing and medical staff with their safeguarding practice and decision making, including thresholds for making a children's safeguarding referrals / signposting to partner agencies and adult services.

8.5 ADHOC SAFEGUARDING SUPERVISION

Both Safeguarding Children and Safeguarding Adult teams are available to provide daily safeguarding supervision support to all adult services across HUTH. These supervision sessions provide staff with immediate advice and support with safeguarding concerns. During 2022 the Safeguarding Children team have noted an increasing awareness of the safeguarding children agenda across adult services. The Safeguarding Children team have been keen to support staff knowledge and understanding delivering bespoke safeguarding supervision sessions to ward managers across adult intensive care unit (HRI) and adult emergency department.

Adult Wards with Children age 18 years

The Safeguarding Children team now provide daily contact to any adult ward where a child aged under 18 years old has been admitted (Mon-Fri). This provides assurances that children are receiving the appropriate parental/carer support for the duration of their admission and supports staff who may not be as familiar with safeguarding children issues and processes. If required the both Safeguarding Children and Safeguarding Adult teams visit the wards to offer additional face to face support and supervision.

Patient Advisory Service (PAS) /Gynaecological Outpatient's Department

In addition to supporting maternity services, the Named Midwife and Safeguarding Children Practitioner have supported PAS team Clinical Nurse Specialists (CNS) with advice and supervision regarding children/unborn and young people. The CNS are correctly identifying and escalating concerns regarding high-risk vulnerable families and girls under 18 years accessing their service. The PAS team have also been accessing support and supervision via Safeguarding Adult team in particular regards to Domestic Abuse. Due to the complexity of the safeguarding risks this was escalated by Named Midwife and formal quarterly face to

face safeguarding supervision has been delivered to all PAS team members by Named Midwife and Safeguarding Children Practice Educator throughout 2022.

The Lead CNS has now completed her Safeguarding Supervisor training. This will enable her to deliver planned safeguarding supervision to PAS team along with ad hoc supervision across gynaecological services.

Remote Safeguarding Supervision Sessions

The Safeguarding Children team have been providing a monthly (one hour) safeguarding supervisor meetings via Big Blue Button for all Safeguarding Supervisors within HUTH to access support / refresher training as required. This offer has not been well attended by services. In view of this from April 2023 these sessions will be opened up to include the opportunity for any staff member / Supervisee / Safeguarding supervisor to attend. These sessions will provide evidence towards their required safeguarding supervision compliance.

9. SAFEGUARDING CHILDREN

The Safeguarding Children team utilise Business Intelligence (BI) reports to support information gathering related to safeguarding children activity across the organisation. These include a safeguarding activity report which provides details of those children admitted via the Emergency Department (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 the 0-19 Public Health team or Child Looked After (CLA) team if required. Other BI reports include a live report of children admitted to adult wards and a report which identifies those children who have been resident in the organisation for over 80 days. The combined review of this data allows the safeguarding team to focus safeguarding activity in the areas of greatest need. Early contact is made with the relevant teams to offer support, advice and ensure that safeguarding processes are followed. The BI report is also utilised to provide anonymised statistics to both Hull and East Riding Local Authorities such as the number of children attending following self-harm.

There are well-established and effective 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, the Safeguarding Children team reviews paediatric documentation during ward rounds if there is a complex case with safeguarding concerns. This provides an opportunity for discussion, supervision and advice regarding good quality documentation. Where concerns are noted these are discussed with the ward manager and utilised within team training days.

During the reporting period, the Safeguarding Children Team have provided a high level of visibility and immediate contact with a member of the team who are available during core working hours. This is unusual with the majority of safeguarding teams now working from home and being contacted by email with a delayed response.

Examples of activity include:

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, Woodlands ward, 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 offer quarterly planned face-to-face supervision to the Specialist Nursing Teams, Community Midwife Managers band 7 Midwives and Vulnerabilities Midwife which supports those who 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 is 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 have continued working through improvement plans and have had further Ofsted inspections in this period.

The Trust Safeguarding Leads/Named professionals work closely with both the senior leadership team and front door and locality teams in the LA. Examples of good practice, which have become well established, include the 'Front door and health liaison meeting' and the Operational CSAAS group. These groups along with other meetings have led to HUTH developing strong and supportive links with our LA partners. These meetings provide an opportunity to constructively challenge practice, undertake specific complex case discussion and commend good practice. The links have been instrumental in supporting escalation and early case discussion where there are complex safeguarding concerns with children in the organisation.

Other examples of joined up working include; Multi-agency audit activity and training, task and finish groups related to the pre-vulnerability pathway, strategy discussions escalation and resolution guidance, and bruising and injury to non-mobile babies guidance.

9.2 MENTAL HEALTH

The number of cases of children presenting with complex mental health concerns has continued to increase during 2022/23. One of the challenges for the organisation has been the lack of appropriate mental health beds and social care placements beds for this group of young people. Nationally Tier 4 mental health beds are in high demand with long waiting lists. This had led to children being admitted to a paediatric ward and/or remaining in an inpatient bed when they are medically fit for discharge. This has put an increasing demand on service provision as the needs of these children can be specialised and has often-required enhanced levels of supervision to ensure the young person remains safe.

Weekly mental health concerns reports are completed where there is a delayed discharge. This 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.

In order to support staff and minimise risks associated with the increasing numbers of children admitted to paediatric wards with mental health concerns a number of service developments have been implemented:

- A training plan has been agreed with the first wave of training delivered for De-escalation Management and Intervention training (DMI). This included a cohort of paediatric staff and safeguarding practitioners undertaking a two-day training programme. The training has been instrumental in supporting safe practice when restraint maybe required.

- Improved and joined up escalation processes. The senior paediatric leadership team work closely with the safeguarding leadership team to escalate concerns across both health and social care. This has not always been effective in preventing a delayed discharge but has ensured that all agencies are clear on the actions they need to take to support the child and family.

- The CAMHS paediatric in reach is now well established in the organisation. This role provides senior clinical support for Children and Young people in the Trust with identified mental health needs. Positive and effective working relationships have been established with the Named Nurse Safeguarding children, Safeguarding teams,

Enhanced Care Matron and Paediatric leadership/Teams. This has assisted in improving information gathering and sharing, support and escalation pathways

- Increased levels of training provided specific to this group. This is delivered by the CAMHS in reach nurse, Enhanced Care Matron and the Safeguarding teams. Specific training has been delivered around the Mental Health Act (1983)

In addition, in a number of these cases the children remain in hospital for a prolonged periods 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 steering group 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 2023/2024.

9.3 CONTEXTURAL SAFEGUARDING AND CHILD EXPLOTATION (including County Lines and Missing Children)

Contextual Safeguarding and Child Sexual Exploitation (CSE) remain 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.

The Safeguarding Children team have been working with the National Working Group (NWG) to review risk assessment tool and consider if a tool can be developed specifically for acute trusts. The challenge with existing tools is that the majority are developed for community caseloads where there are longer contacts with children and young people. This work will continue into 2023/2024.

10. MIDWIFERY

The Named Midwife, supported by the Assistant Chief Nurse has continued to work closely with the maternity leadership team in regards to the context of safeguarding children/unborn at risk and safeguarding supervision systems and processes. Action plans have been put in place to ensure there are robust systems and processes to manage safeguarding activity and any identified risks are appropriately assessed and managed. This has been monitored through the Maternity Safeguarding Steering Group meetings, led by the Assistant Chief Nurse. These meetings provide the 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 throughout 2023- 2024.

The continued effects of the COVID pandemic along with a national and local shortfall in practicing midwives have had a direct impact on maternity services ability, within Hull Women and Children's services, to meet some of their section 11 responsibilities.

Capacity and attendance at safeguarding meetings remains an active risk on the Women and Children Health Group risk register. The consistent high numbers of children's

safeguarding and early help referrals for unborn/newborn demonstrates the high level of safeguarding activity and increasing safeguarding workload across maternity services. This safeguarding activity is also evidenced from the consistent high numbers of high-risk mothers and unborn that are brought for discussion at the weekly Hull multi-agency pre-birth vulnerability panel.

Maternity leadership have positively identified this risk with the appointment of a newly created full time Safeguarding Midwife post. The function of the role is to improve collaboration and information sharing with partner agencies, increase attendance at multi-agency safeguarding meetings and establish processes and systems to aid maternity staff with their safeguarding activity. The Named Midwife will work collaboratively with the Safeguarding Midwife to ensure that safeguarding services across maternity continue to follow national and local recommendations.

The Named Midwife actively contributes to service improvement across HUTH in both strategic and operational forums and at external partnership meetings. This ensures that there is a two-way flow of information with HUTH having a clear voice in contributing to the wider discussion about safeguarding issues within maternity services.

The Named Midwife has liaised closely with the Local Authorities and Safeguarding Children Partnerships regarding safeguarding within maternity services and the plans and assurances that have been put in place.

The Named Midwife is currently working with the Designated Nurses Safeguarding Children across the LMNS (Local Maternity and Neonatal Systems) to consider how health partners can work together to improve engagement and assessment of father of unborn, SIRS project (Sharing information regarding safeguarding). This follows recommendations from the National Safeguarding Practice Review Panel (2021) and recent local safeguarding practice reviews.

The development and introduction of the SIRS project within the LMNS will continue to be a feature throughout 2023-2024.

PAS (Patient Advisory Service) /Gynaecological Outpatient's Department

During 2022 the Government commissioned the Royal College of Paediatrics and Child Health (RCPCH) to lead on the development of new national safeguarding guidance for under 18s accessing Early Medical Abortion (EMA) services.

The Named Midwife has worked with the PAS Clinical Nurse Specialist (CNS) to ensure that processes and services within HUTH are in line with the legal requirements and statutory safeguarding guidance relating to children and young people under 18 accessing EMA services. All actions in regards to recommendations have been completed, this included a revision of an under 18 risk assessment tool and provision to collect regular data through the BI reporting system.

10.1 FEMALE GENITAL MUTILATION (FGM)

HUTH continue to follow mandatory recording and reporting requirements to the FGM enhanced dataset (Health and Social Care Information Centre). FGM notifications are completed by staff when there is disclosure or on examination confirmation that a woman has had FGM. If the woman attends maternity services, a further notification is made when the baby is born irrespective of whether the baby is male or female.

The total number of FGM cases reported through the National Dataset from HUTH has increased throughout 2022.

This is likely due to the lifting of COVID restrictions and more freedom of movement / travel.

A Benefits and Change Manager recommenced work with the Named Midwife and Lorenzo team, in the organisation, to review processes for recording FGM alerts, completing the enhanced dataset and establishing an FGM risk assessment tool within the electronic Lorenzo records. Evidence had previously been obtained, through discussion with other Trusts, regarding the widespread use of the Department of Health (2016) FGM Risk Assessment Tool
This review although initially delayed (due to priorities of the Covid pandemic) has now been completed. The changes in FGM processes went live on Lorenzo electronic system at the end of October 2022. The introduction of a risk assessment tool will support maternity with decision making as to whether the unborn child (and family members) or woman is at risk of harm in relation to FGM and make appropriate agency referrals based on the risk.

Plans and assurances were put in place by the Safeguarding Children Team and Named Midwife, to support and guide the initial roll out of the changes across maternity.

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 (CP342) and new guidance in regards to the use of the FGM risk assessment tool. This is evidenced in the completion of good quality documentation within the patient record and the National Dataset updated.

The priority of making these changes has been further enhanced during recent requests from both Hull and East Riding Safeguarding Children's Partnerships to review current FGM Partnership's guidance/policy with the aim of developing consistent FGM practice. The Named Midwife participated in an East Riding partnership task and finish group and a multi-agency FGM Procedure and Guidance is now in place. Similarly a task and finish group has been established with Hull partnership with the plan to review and revise FGM procedures and guidance during 2023.

FGM-IS (information sharing) 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 is fully implemented within HUTH with the Named Midwife adding family history of FGM alerts to the electronic Summary Care Records of all female babies born who were born during 2022-2023

The Named Midwife has attended quarterly strategic HMSP meetings. Updates and relevant key actions are fed into HUTH Safeguarding Steering group, and cascaded as appropriate via the Trust intranet site and through safeguarding training and supervision processes.

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 organisation now has an Independent Domestic Violence Advisor (IDVA) on site who provides in-reach services 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.

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. They provide links to both Hull and East Riding Domestic Abuse Strategic and Operational groups with active participation at meetings and with related audit activity. 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 for relevant nursing, midwifery and allied professional staff groups training. This has been delivered as part of a three-year roll out program across the trust with good uptake during 2022/23. Domestic Abuse level 3 training has also been developed which will be delivered as part of Adult Level 3 Safeguarding training in 2023/24

10.3 CARING FOR VULNERABLE WOMEN

The Named Midwife has worked closely with multi-agency partners in Hull to update the Unborn Procedures Guidance and Pre-birth Pathway. The Pre-birth Pathway has been designed in order to develop consistent pre-birth assessment practice, which identifies potential vulnerability early in pregnancy and provides a clear pathway for all partner agencies along with appropriate support services. Multi-agency training planned for late 2022 /2023 has been rescheduled to be delivered throughout 2023-2024

The Named Midwife along with Specialist Midwife for Vulnerable Women actively participate in a weekly panel meeting of safeguarding professionals to review those women/unborn who have been referred to Children's Social Care. The multi-agency forum has been effective in ensuring there is appropriate information sharing and has supported the early identification of risk and review of thresholds.

Alongside pre-birth multi-agency guidance, internal pathways within HUTH maternity services support all midwives to assist in the assessment and identification of those women and families who require additional. The Named Midwife has been supporting maternity leadership with the review of the current guidance (451) Supporting Pregnant Women with Complex Social Factors.

The Named Midwife has been actively contributing to meetings with East Riding local partners in regards to the development of an East Riding multi-agency pre-birth pathway. It is anticipated that the pathway and establishment of regular panel meetings will develop throughout 2023 – 2024.

10.4 MODERN SLAVERY

The Named Midwife and Adult Safeguarding Specialist Practitioner are members of the Humber Modern Slavery Partnership (HMSP). This consists of a strategic network of agencies across Humberside local authorities, committed to tackling Modern Slavery and Human Trafficking and attend regular multi agency meetings.

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 steering group bi monthly reports. Cases can be reported as an SI by the Trust or reported on STEISS by a Designated Nurse for Safeguarding Children.

In 2022/2023 there have been no reported SI cases specifically related to Safeguarding Children.

11.2 SAFEGUARDING PRACTICE REVIEWS / LESSONS LEARNED REVIEWS

The Trust has participated in no new Safeguarding Practice (SPR's) in the 2022/2023 reporting period. This is because the cases which have progressed to an SPR have had no or minimal involvement from HUTH. That said the Named Nurse Safeguarding Children is an active member of the Learning from Individual Cases group (HSCP), Safeguarding Assurance Group (ERSCP) and the quality and the Quality Assurance and Performance groups (HSCP). These groups continue to review and update actions related to ongoing SPR and Local Learning reviews such as the Line of Sight reviews. Actions and briefing notes, including 7 minutes briefings are cascaded and shared within the organisation through Safeguarding Steering group, Safeguarding Supervision, training and via the trust intranet.

The trust has contributed to ten 'Line of Sight' reviews with participation from relevant health group and staff member involved in the care of the child and family attending the meetings. The Named Nurse Safeguarding Children sits as a panel member supporting the review process when required.

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 steering group.

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 2023-2024

The Trust has identified a number of actions required to strengthen the Safeguarding Children's arrangements in the Trust and continue from 2022/23. The actions are determined from internal practice and review, regulatory inspections, commissioning requirements, Safeguarding Children's Partnership activities and from Lesson's Learned Reviews, Line of Sight and Serious Care Reviews.

A summary of work planned for 2023/24 is as follows:

- 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 will need to be discussed and reviewed at trust board level and with commissioners of the service.
- Planned appointment of Locum Paediatric Consultant with safeguarding as a component of the contract. This will increase resilience and ensure that the CP Service is able to provide full medical cover in core working hours.
- Complete work on the communication strategy for the CSAAS, which includes new and improved patient leaflets and improved web content including a promotional film of the Anlaby Suite.
- 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. Additional work is underway to add the supervision forms to the electronic patient record and embed safeguarding supervision within the yearly staff Appraisal. This will continue to be a key action for 2022-23 as these 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. A review has taken place of the tools available but most are not suitable for practice in an Acute Trust. Work will continue with the NWG to develop an appropriate tool. Once developed a training package will be put in place for the roll out in the appropriate health groups
- 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.
- 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.
- Continue to support the escalation of concerns in relation to inappropriate admission and delayed discharge of children where there are mental health concerns
- The Named Midwife will continue to offer support and safeguarding advice to help progress the 'SIRs' project within maternity services.
- Named Nurse will continue to support the development of partnership guidance for bruising and injury to Non-mobile babies, and Escalation and Resolution guidance.
- Develop a Children and Young people voices group to better understand the needs of young people who access the Anlaby Suite and the development of the service.
- Work with the ICB to establish the role of Specialist Nurse/Key worker for Child Death within the organisation. Support the development of guidance, polices and SOP's related to the Child Death Review Process.
- Continue to 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.

- In order to continue to address these shortfalls in compliance with safeguarding training a review and consideration for re-establishing face to face training will take place with the education and development team.

REPORT END

Report Authors:

Patricia Darley, Named Nurse for Safeguarding Children

Paula Peacock Named Midwife

Kate Rudston, Assistant Chief Nurse

Date: July 2023

Hull University Teaching Hospitals NHS Trust
Trust Board and Committee Front Sheet

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	22.09.23
Title	Learning from Mortality and Morbidity Report – Q1 2023/24				
Lead Director	Prof Makani Purva – Chief Medical Officer				
Author	Chris Johnson – Effectiveness and Improvement Manager				
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 2023/24**	
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 asked to receive the report as supporting information to the Board papers.

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
MORTALITY - LEARNING FROM DEATHS QUARTER 1 2023/24

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide the Quality Committee with a summary of mortality statistics and learning from deaths in line with the requirements set by NHS Improvement, outlined in the national framework. The data in this report is from Quarter 1, 2023/24, unless otherwise stated (broader timeframes are used in some instances for deeper statistics, for example, HSMR and SHMI.)

The report also aims to outline the plans for the upcoming year, detailing the positive direction taken by the Trust to enable a stronger focus on learning from mortality and morbidity during 2023/24 and beyond.

The content of these reports will now closely follow the proposed work plan and content of the monthly Trust Mortality and Morbidity Committee.
Information relating learning and actions taken are obtained from various sources including the Medical Examiner Office, Speciality M&M meetings and the Trust incident reporting system (Data).

2. MORTALITY STATISTICS

2.1 NATIONAL SHMI TRENDS

Deaths following time in hospital, England, April 2022 – March 2023

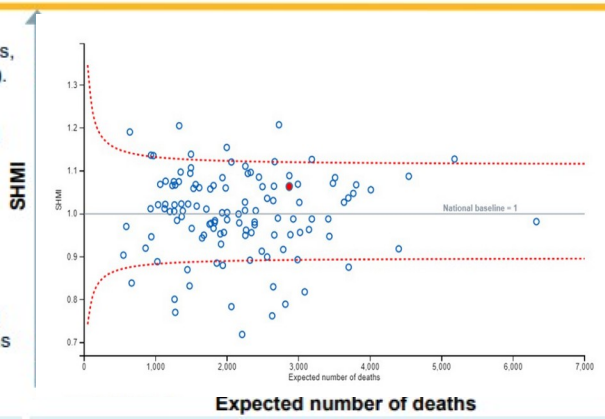
Monthly statistics: Published 10 August 2023

NHS England

This publication compares the actual number of deaths following time in hospital with the expected number of deaths, using the Summary Hospital-level Mortality Indicator (SHMI).

The expected number of deaths is estimated using the characteristics of the patients treated: age, sex, method and month of admission, current and underlying medical condition(s) and birthweight (for babies). It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged. COVID-19 activity is excluded from the SHMI (further information is available in the full release).

Between April 2022 and March 2023, there were around 8.3 million discharges, from which approximately 260,000 deaths were recorded either while in hospital or within 30 days of discharge for the 120 hospital trusts covered.



Expected number of deaths

The **10** trusts with a ***higher than expected*** number of deaths were:

- County Durham and Darlington NHS FT
- **Doncaster and Bassetlaw Teaching Hospitals NHS FT**
- **Dorset County Hospital NHS FT**
- **East Cheshire NHS Trust**
- **Epsom and St Helier University Hospitals NHS Trust ***
- Leeds Teaching Hospitals NHS Trust
- Medway NHS FT
- Mid and South Essex NHS FT
- **Norfolk and Norwich University Hospitals NHS FT ***
- Salisbury NHS FT

The **14** trusts with a ***lower than expected*** number of deaths were:

- Ashford and St Peter's Hospitals NHS FT
- **Chelsea and Westminster Hospital NHS FT**
- Gateshead Health NHS FT
- **Guy's and St Thomas' NHS FT**
- **Homerton Healthcare NHS FT**
- **Imperial College Healthcare NHS Trust ***
- **Kingston Hospital NHS FT**
- **London North West University Healthcare NHS Trust**
- Northampton General Hospital NHS Trust
- **Royal Free London NHS FT**
- **Royal Surrey County Hospital NHS FT**
- **University College London Hospitals NHS FT**
- **University Hospital Southampton NHS FT**
- University Hospitals Dorset NHS FT

There was a fall in the overall number of spells from March 2020 due to COVID-19 impacting on activity for England and the number has not returned to pre-pandemic levels. 'FT' means 'Foundation Trust'. Trusts in bold were also in the same category in the same reporting period last year. * These trusts are involved in a pilot to submit Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS) instead of the Admitted Patient Care (APC) dataset. This may impact the SHMI value: see the Background quality report.

The SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust.

It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.

The SHMI is not a measure of quality of care. A *higher/lower than expected* number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a '**smoke alarm**' which requires further investigation.

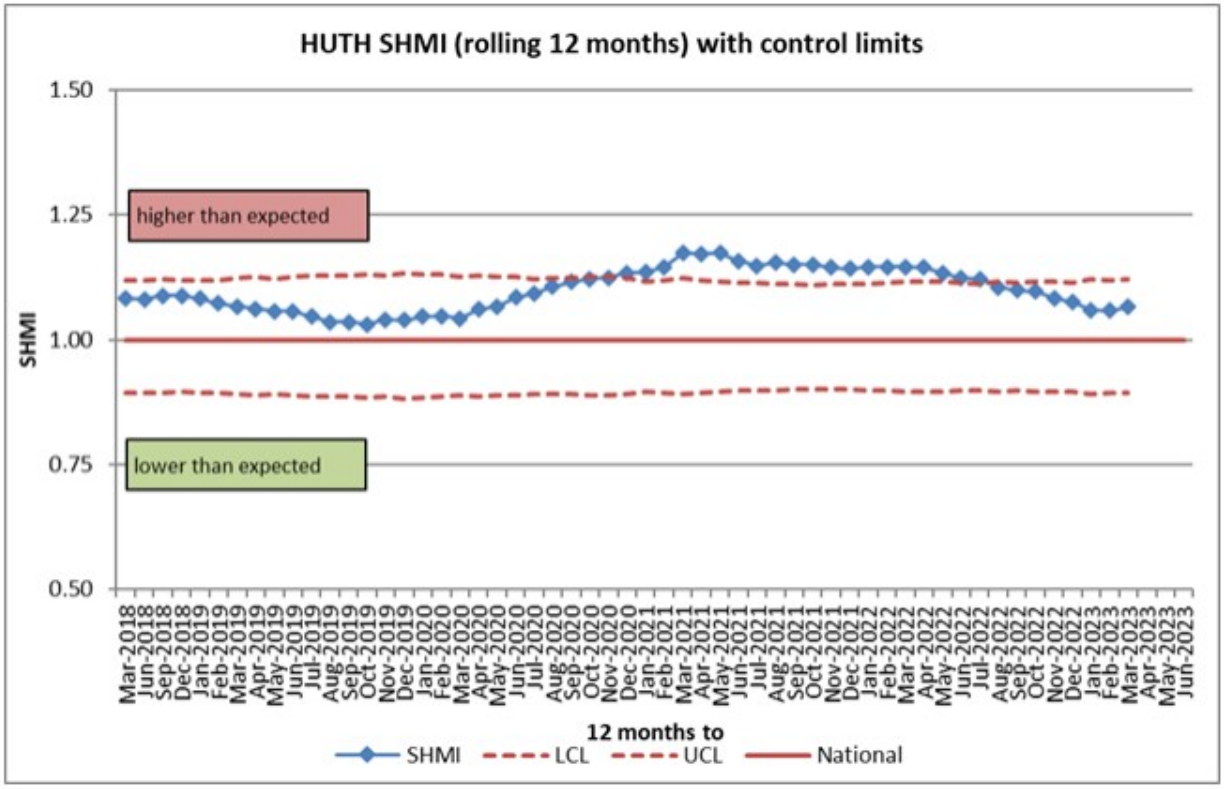
The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts by their SHMI.

See the full release at https://digital.nhs.uk/data-and-information/publications/statistical/shmi
Lead Analyst: Alison Neave

Tel: 0300 303 5678
Email: enquiries@nhsdigital.nhs.uk

2.2 TRUST SHMI TRENDS

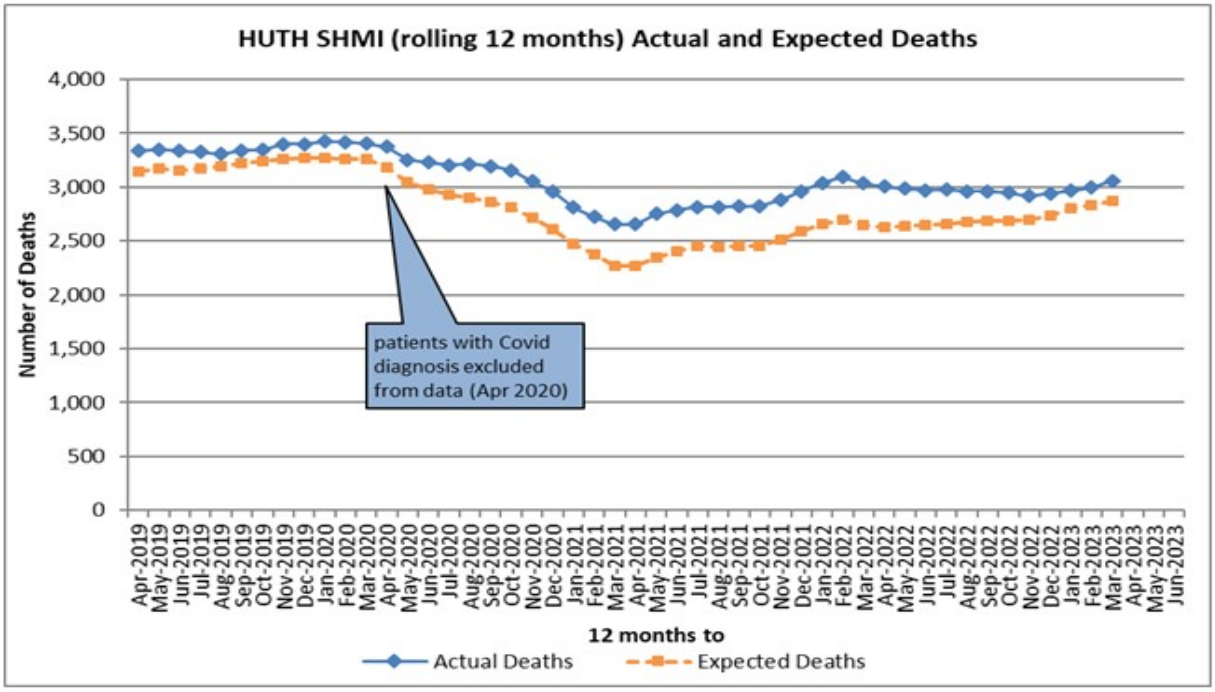
HUTH is identified as having an 'as expected' SHMI, with an overall SHMI of **1.0648**



Of the conditions for which a SHMI is calculated by NHSD, HUTH is identified as being higher than expected for:
- Septicaemia
- Fracture of neck of femur (hip)

(no condition-specific SHMI is calculated by NHSD for some conditions that might be of interest, including acute cerebrovascular disease, in the data that is published)

The following chart shows the number of expected deaths vs. the actual deaths:



2.3 CONDITION SPECIFIC SHMI TRENDS

The following tables show the ten most prevalent conditions present at time of death. **% of Total** shows the deaths per condition, as a proportion of the total number of in-hospital deaths.

Last 36 Months

SHMI CCS Condition	Deaths	% of Total
122 - Pneumonia (except that caused ...	773	10.2%
259 - Residual codes; unclassified	617	8.1%
2 - Septicemia (except in labor)	577	7.6%
109 - Acute cerebrovascular disease	498	6.6%
108 - Congestive heart failure; nonhyp...	295	3.9%
129 - Aspiration pneumonitis; food/vo...	257	3.4%
100 - Acute myocardial infarction	222	2.9%
157 - Acute and unspecified renal failure	208	2.7%
42 - Secondary malignancies	208	2.7%
19 - Cancer of bronchus; lung	190	2.5%

Quarter 1

SHMI CCS Condition	Deaths	% of Total
122 - Pneumonia (except that caused ...	66	10.9%
2 - Septicemia (except in labor)	53	8.8%
109 - Acute cerebrovascular disease	41	6.8%
108 - Congestive heart failure; nonhyp...	32	5.3%
100 - Acute myocardial infarction	24	4.0%
129 - Aspiration pneumonitis; food/vo...	24	4.0%
226 - Fracture of neck of femur (hip)	19	3.1%
127 - Chronic obstructive pulmonary d...	17	2.8%
157 - Acute and unspecified renal failure	13	2.2%
19 - Cancer of bronchus; lung	13	2.2%

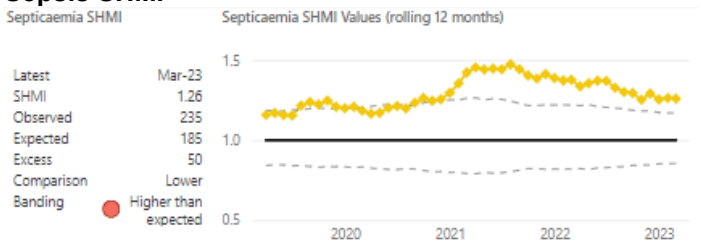
The top 5 most common SHMI diagnosis at death, during the l**ast 36 months** as shown above, are:

- Pneumonia – 773 deaths (10.2% of all deaths)
- Covid-19 – 617 deaths (8.1% of all deaths)
- Septicaemia – 577 deaths (7.6% of all deaths)
- Acute cerebrovascular disease (Stroke) – 498 deaths (6.6% of all deaths)
- Congestive heart failure, non-hypertensive – 295 deaths (3.9% off all deaths)

The top 5 most common SHMI diagnosis at death, during **Quarter 1,** as shown above, are:

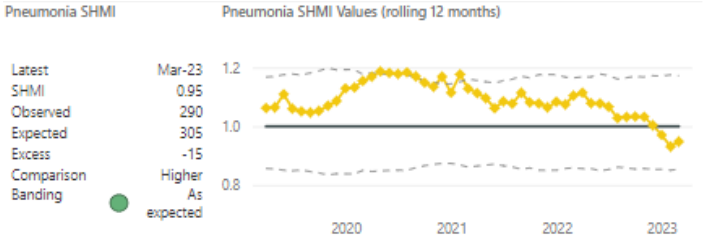
- Pneumonia – 66 deaths (10.9% of all deaths)
- Sepsis – 53 deaths (8.8% of all deaths)
- Acute Cerebrovascular disease (stroke) – 41 deaths (6.8% of all deaths)
- Congestive heart failure, non-hypertensive – 32 deaths (5.3% off all deaths)
- Acute myocardial infarction – 24 deaths (4.0% of all deaths)

Sepsis SHMI



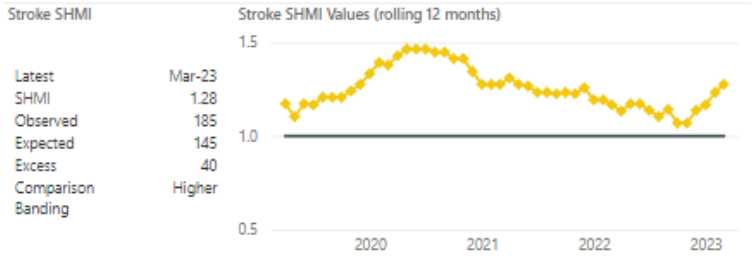
Sepsis SHMI is currently 1.26, higher than expected and showing a very marginal (0.1) increase over the previous month but demonstrating overall improvement.

Pneumonia SHMI



Pneumonia SHMI remains within the “expected” range, at 0.95, with 15 less deaths than expected occuring in March 2023.

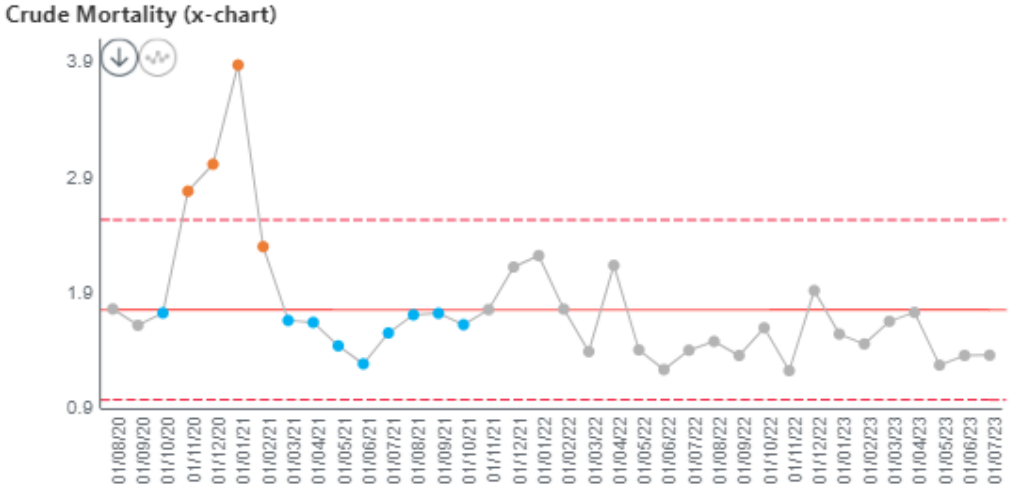
Stroke SHMI



Stroke SHMI remains appears to be increasing since December 2022. This has been raised with the Stroke service and plans are currently underway to assess the best approach to adressing this. The latest SHMI (March 2023) is 1.28, with March 2023 having 40 excess deaths.

2.4 CRUDE MORTALITY TRENDS

The following SPC chart illustrates the deaths that occurred within the Trust over the last 36 months.



Deaths remain within the control limits, showing no cause for concern.

3. MANDATORY MORTALITY REVIEW COMPLIANCE

The National Quality Board determined minimal criteria for undertaking mortality review via a chosen case-note review methodology. The Trust adopted the structured judgement case note review system to undertake such reviews. The criteria are illustrated below, along with the Trusts compliance against these criteria during Q1.

Criteria	Number of cases requiring SJR / M&M / other case-note review	Outcomes / Update
Deaths where a concern was raised about the quality of care provision (including cases raised by ME)	12 SJR M&M referral - 9	These 12 cases were identified via the medical examiner service and are currently progressing through the review stage.
Patients who had Learning Difficulties or Severe Mental Illness	5	The Safeguarding Team, in addition to other trained reviewers, regularly undertake reviews on this cohort of patients.
Deaths where an alarm has been raised with the provider (mortality alert – Dr Foster)	Cases are regularly now reviewed for cohorts of patients from within the outlier diagnoses.	A review into a potential outlier status in relation to Major Trauma patients is underway, with initial findings presented in this report.
Number of deaths that was assessed via PSIRF and completed.	0	Any deaths deemed more likely than not to have been avoidable.
Further sample of deaths where the learning will inform a provider's quality improvement	Target of 5% per cohort	The Trust aims to undertake reviews on further samples of patients

In addition to the Structured Judgement Review, cases receive other reviews outside of the SJR methodology within the M&M setting. The Trust is also enrolled in the LEDER program and has trained reviewers who undertake reviews on patients who die both within the Trust and outside of the Trust, forming part of the wider LEDER network.

4. STRUCTURED JUDGEMENT REVIEW STATISTICS

The following table illustrates the number of SJR's and other case note reviews completed within Q1; including details on how many were escalated to Tier 2 and Triumvirate level.

	Total Number of SJR / other case note reviews completed	Cases escalated to Tier 2 Review	Cases requiring Escalation to Speciality Discussion	SJR cases escalated and declared as a Serious Incident (deaths deemed more likely than not to be avoidable)
Q1	134	14	3	0

The latest figures show that the Trust undertook SJR's on an average of 20% of all monthly deaths towards the end of Quarter 1 22/23, into Quarter 2 23/24. Quarter 1 ended with 25% of all inpatient deaths receiving a Structured Judgement Review, the highest since the SJR methodology began in 2016.
This is a result of improved engagement from Clinicians around the SJR process, in addition to the mandate of SJR training that is easy to access via the online portal.

As of 1st August, 2023, there have been a total of **500** ST5+ Clinicians undertake the online SJR training module. This number will continue to grow throughout Quarter 1 of 2023/24 and will enable more SJR's to be completed, in line with Trust policy.

Quality checks are now being undertaken on a quarterly basis to ensure SJR's are completed in line with National Quality Board and Royal College of Pathologists recommendations, as per response to the audit undertaken by RMS on the Trust's learning from death framework.

4.1 QUALITY ASSURANCE OF MORTALITY REVIEWS- QUARTER 1 RESULTS

Quality control audits are undertaken on a sample of 10 SJR's on a quarterly basis to ensure that they are undertaken in-line with expectations set out in Trust Policy. A summary of results is shown in the table below.

Number of SJR's which commented on good practices/care	Number of SJR's which commented on care that was less than appropriate	Number of SJR's written concisely and in line with expectations set out in the SJR training framework	Number of SJR's where learning was identified and detailed, with any appropriate action plans
9/10	**8/10**	**10/10**	**8 Not Required** **2 Yes**

Feedback was provided to the reviewers to let them know that their efforts are of high quality and that they formed part *of* the Trust Audit to ensure the continued successful delivery of the learning from deaths framework. Where it was felt that there could have been better comments made relating to good practices, this was also communicated with the reviewers.

6. LEARNING FROM MORBIDITY AND MORTALITY REVIEWS

This section of the report aims to collate and expand upon the agreed work plan and topics of discussion that took place in the Trust M&M Committee's that took place during Q1, 2023/24.
Learning is broken down into Health groups and Specialties, as per the M&M Committee work plan.

There are 3 main areas covered in this report, these relate to:

- Surgery Health Group including Trauma (TARN)
- Family & Women's Health Group (MBRRACE-UK Summary)
- Clinical Support Health Group
- Learning from the review of patients with learning disabilities

6.1 Learning from review within the Surgery Health Group (TARN)

The review of TARN patients is on-going, as part of the response to the outlier alert received by the Trust in 2022. Several observations have been made during this review, including:

- Majority of deaths > 65. Unexpected deaths rise with increasing age.
- Older patients less likely to activate a trauma team
- Injury patterns are different
- None of the deaths under 65 were admitted to medicine.

Notably, in the elderly, most were admitted onto medical wards.

We know that a significant number of patients who were classed as "Expected to survive" in the TARN database were quickly put on palliative pathways once they arrived in the Trust, suggesting there may be challenges to the current record keeping practices.

Many patients do not have a ReSPECT form and are unable to recover after a few days, essentially due to frailty. This issue may be compounded by the fact that there are fewer GP's per capita in the region, leading to fewer patient assessments out of hospital, which can then increase the chances of elderly patients being at a higher risk.

A comprehensive presentation of findings and outcomes is due to be presented at the trust M&M Committee in October 2023.

6.2 Summary of Lessons Learned Recommendations from the Confidential Enquiry into Maternal Deaths (MBRACE-UK)

The full report can be viewed here**:** https://www.npeu.ox.ac.uk/mbrrace-uk/reports

Key Messages from the latest Report

Key recommendations for all health professionals:

- Assess women with persistent and severe insomnia carefully for signs of underlying mental illness.
- Access services such as Psychiatric Liaison, Crisis and Street Triage Teams should alert specialist Perinatal Mental Health Teams to any referrals of self-harm in pregnant or postpartum women that they have received to allow triage regarding the need for specialist follow-up.
- Be alert to factors, such as cultural stigma or fear of child removal, which may influence the willingness of a woman or her family to disclose symptoms of mental illness, thoughts of self-harm or substance misuse
- Wheeze can be due to pulmonary oedema. Consider wheeze which does not respond to standard asthma management and exertional syncope as red flag symptoms of cardiovascular disease in addition to orthopnoea and chest pain.
- Be aware of the common risk factors for heart disease and venous thromboembolism, such as extreme obesity, and consider on an individual basis whether women should be made aware of the symptoms and signs of heart disease as well as those of venous thromboembolism.
- Be aware that women using oral anticoagulation with warfarin may be more safely managed without transition to low molecular weight heparin treatment when having an early termination of pregnancy
- Be aware of the added risk of fetal compromise when a woman's pregnancy is complicated by both hypertension and diabetes. It is not only babies predicted to be small for gestational age who may be at risk.
- Involve the critical care team in antenatal multidisciplinary team planning for women with serious morbidity who are anticipated to require admission to intensive care after giving birth

6.3 Learning from review within the Clinical Support Health Group
Mortality and Morbidity review within Oncology and Haematology services has identified a number of lessons to be learned**,** summarised below:

Escalation Planning

- The importance of thorough documentation of treatment plans, family/Nok communication and communication with Primary care. These should all be clearly and thoroughly documented. During Covid-19, this was undertaken to a very high standard, but has unfortunately dropped off.

- Reluctance to address escalation plans during an outpatient clinic setting. This is the ideal, controlled location to undertake decisions of such plans with patients. The patient's family will usually be present, assisted by a number of clinical staff and letters will be sent back to primary care that detail the conversation, thus creating a hard copy evidence. ReSPECT forms can also then be given to the patient for them to take home, in case of out of hours emergency care.

- Reluctance to make plans for any non-malignant reasons (not related to cancer – e.g. COPD).

- Documentation must be in place for patients whom escalation is deemed appropriate (aggressive intervention management).

Recognition of Last Days of Life

- Danger of misplaced optimism – Unrealistic optimism can lead to family members/NoK making poor decisions and potentially denies the family/patient the decision of getting to a hospice/home to die.

- Reluctance to make decisions on other consultants patients.

- Failure to recognise the last days of life can result in unnecessary or inappropriate procedures being performed.

One of the recurring themes emerging from M&M discussion relate to communication. Whether this be communication between staff, or communication with the patient and patients family/NoK.

Other areas of learning include the level of scrutiny drug prescription charts receive, due to them being on EPMA, rather than a physical piece of card that can be held and scrutinized.
Fluid management is also recognised as an area for improvement, where patients with AKI may be disconnected from their line in order to shower, but then not connected straight away and often it can be a number of hours before being reconnected. This probably leads to extended length of stay.

The actions taken to help address these issues revolve around empowering the team to advocate for the patients, to encourage escalation and challenge any decisions made that they feel is not right for the patient. The senior nursing

staff in particular are much more likely to recognise patient deterioration and likely outcome, so this will be a key area of focus in improving outcomes for these patients.

Where there are doubts relating to a patient having suspected sepsis, the Oncology and Haematology services will treat the patient for Sepsis. If in doubt, treat it.

With the advent of new immunotherapies, the Oncology and Haematology services have noticed new toxicities that the service is not used to experiencing. Over the last few years, the service has consolidated expertise and acquired buy-in and support from other Physicians from various specialist areas in order to understand and develop better practices within immunotherapy.

6.4 Learning from the Review of Patients with Learning Disabilities
The Trust continues to undertake mortality reviews on patients who passed away with a diagnosed learning disability, which also provides support to the national LeDeR program by sharing the outcomes of mortality reviews with them. Some of the key learning and actions that have taken place from such reviews include:

- Ensuring that there is a high standard of presentation when families/NoK attend a ward to visit a deceased patient – one case suggested that there was room for improvement in relation to the mindfulness of presenting a deceased family member (proper signage around drawn curtains, for example). This understandably resulted in a complaint, which unfortunately overshadowed the good clinical care that was delivered. This was fed back to the ward team for reflection.

- Lack of evidence of patient advocacy, in addition to lack of evidence of best interest decisions being made with family, despite patient lacking capacity.

7. MEDICAL EXAMINERS UPDATE
In Quarter 1, scrutiny was undertaken on **97%** of deaths that fall under the remit of the Medical Examiners office (**n=756**)
133 cases were referred to coroner.

12/756 (1.19%) referred for SJR in Quarter 1 due to concerns raised from the Medical Examiner. A further 9 cases were referred for a Specialty M&M discussion.

Dove House Hospice: 79 deaths in Q1, all scrutinised.

Community pilot started May 2023, Ridings Medical Centre and Sutton Manor Practice piloted. Roll out now starting September and 2 Surgeries have volunteered as well as our roll out plan of surgeries grouped together for a phased introduction

Main delay to completion of forms remains as a Doctor availability. Poor response to e mails requesting completion. Only one occasion where only Doctor who can do the paperwork has since left the Trust without completing.

Service Manager appointed and starting 3rd April with main duty to ensure rollout to community and compliance with legislation by April 2024

Priorities for Next quarter are;
- Continue to ensure the service is delivered in line with the statutory requirements by April 2024
- To ensure that turnaround times are measured, monitored and improved where necessary
- Pilot community scrutiny in selected GP practices and PCNs.
- Complete process mapping exercise for all deaths, coronial and non-coronial, with stakeholders across HUTH, GP and both local authorities.
- Agree plan of work within inter-agency steering group.
- Triangulation of data to inform the scrutiny and learning. BI developing dashboard
- Continue to raise awareness of the medical examiner service and its role across the Trust and with relatives and carers
- Continuation of QI work to reduce delays, new drive to involve junior doctors in the project
- Work with Mortuary and Bereavement services to review/ agree the key roles of each area
- review of Bereavement handbook

8. FURTHER ACTIONS AND NEXT STEPS
A number of key actions are underway to further imporve the mechanisms by which the Trust identifies and learns lessons from the review of patient mortality and morbidity.

- CQC Action relating to individualised end of life care.
  The Trust is adapting the current SJR model to allow for better data collection relating to patients individualised end of life care preferences.

  A question will now be asked within the SJR - ***What (if any) were the patient's end of life preferences? For example: Respect form details and/or discussions with the patients and/or next of kin. Is there evidence within the case-notes that this was delivered, or attempts made to deliver?***

- Development of a Medical Examiner's Office Power BI Dashboard, to assist in more robust data capture, deeper analysis and efficient identification of recurring themes and trends. The dashboard will also complement the existing Trust mortality dashboard and will allow for triangulation of data.

- The Trust is moving to a new digital software platform, which, among many other things, will provide a standardised digital solution for capturing actions and learning from Specialty Morbidity and Mortality meetings. This will further assist the analysis of themes and trends across the Trust. All learning outcomes and actions from each Speciality will be held centrally, which will then better inform any quality improvement projects, reports and work streams.

9. RECOMMENDATIONS
The Quality Committee is recommended to receive this report and:
- Decide if this report provides sufficient information
- Decide if any further information and/or actions are required

Chris Johnson
Effectiveness and Improvement Manager
August 2023

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST
NATIONAL AUDIT OUTCOMES FORM

PLEASE ENSURE THAT ALL FIELDS ARE COMPLETE AND THAT THE GOVERNANCE, AUDIT OR CLINICAL LEAD FOR THE SERVICE HAS READ AND SIGNED THIS FORM

Project No.	NA.2022.021	**Health Group and Speciality:**	Clinical Support Health Group – Palliative Medicine
Project Title	National Audit of Care at the End of Life (NACEL)	**Date Report Issued**	June 2023
Project Lead	Dr Kirsten Saharia	**Collaborating specialties/departments**	

Level of assurance

What level of assurance do the results of the audit provide?
See clinical audit report template for further information - Please tick

Key: Adherence to standards ≥ 80% | Adherence to standards 60% – 79% | Adherence to standards ≤ 59%

Are there any areas that require further discussion at the specialty governance meeting eg. issues to be considered for inclusion on the risk register? Yes / No (please circle)

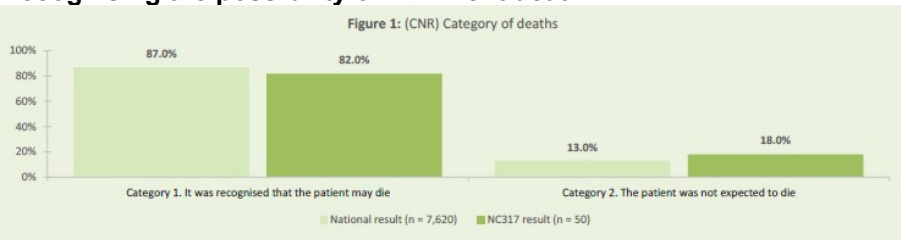
Results

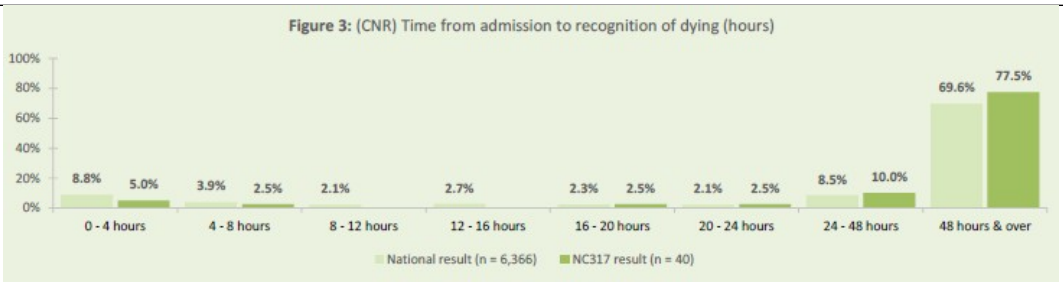
The information in this outcome form is taken from the National Audit of Care at the End of Life (NACEL) national report and its appendices, published by the NHS Benchmarking Network in June 2023.

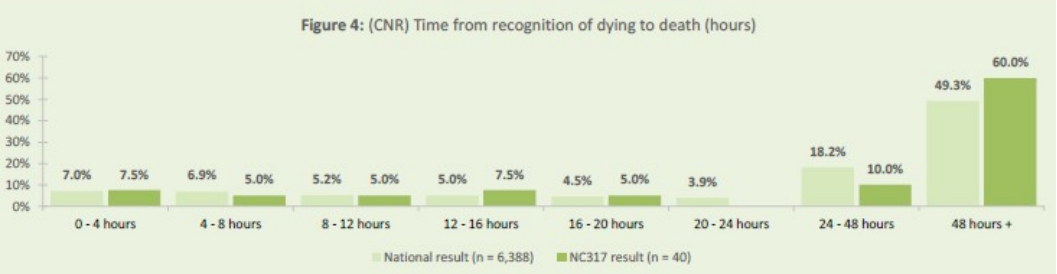
Key Themes Summary

Key Theme	National Summary Score	HUTH 2023	HUTH 2022
Communication with the dying person	8.0	8.5	8.3
Communication with families and others	7.1	7.0	7.2
Involvement in decision making	9.2	9.8	9.7
Individualised plan of care	7.6	7.5	8.3
Needs of families and others	5.5	-	-
Families' and others' experience of care	6.3	-	-
Workforce/specialist palliative care	8.1	8.1	8.1
Staff confidence	7.5	8.1	7.6
Staff support	7.1	6.7	6.0
Care and culture	7.6	7.1	7.1

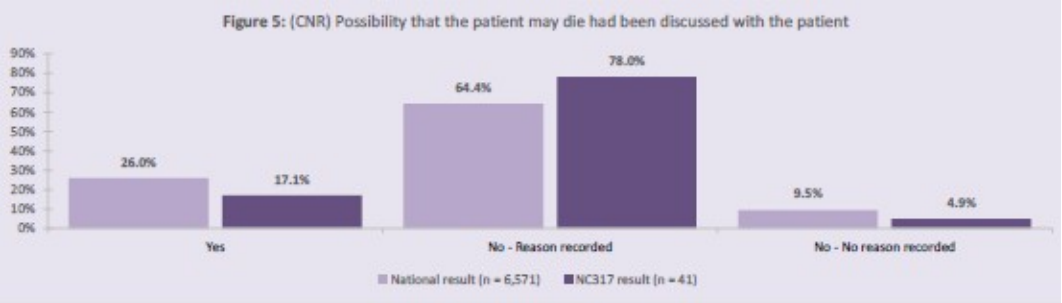
Recognising the possibility of imminent death

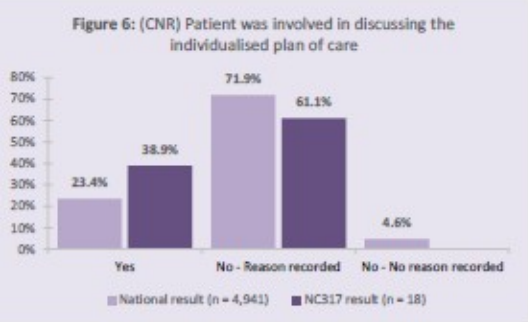


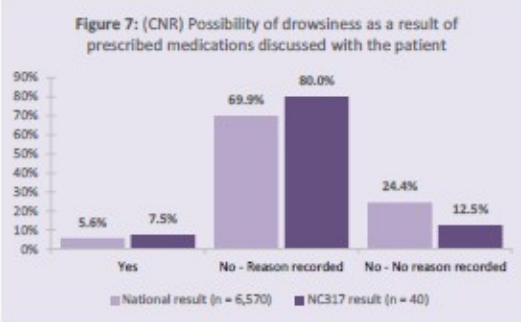


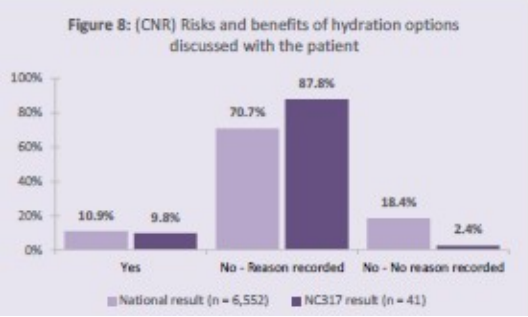


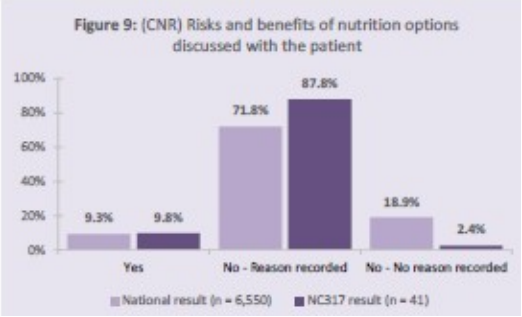
Communication with the dying person



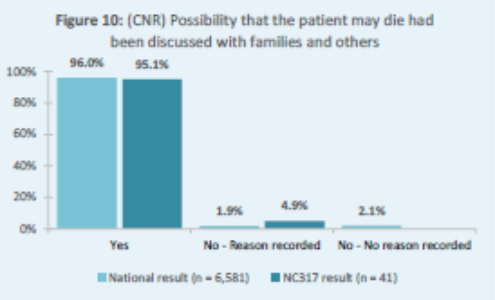


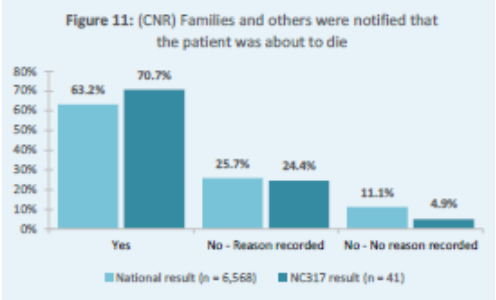


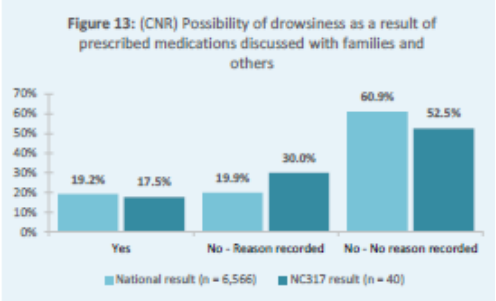


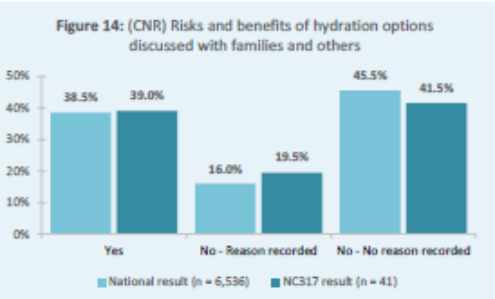


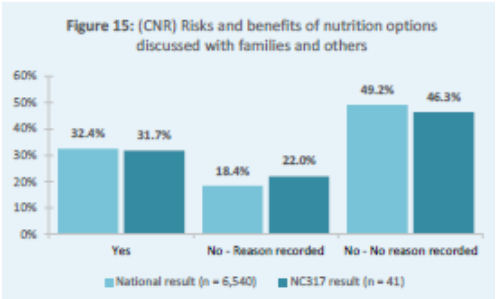
Communication with families and others



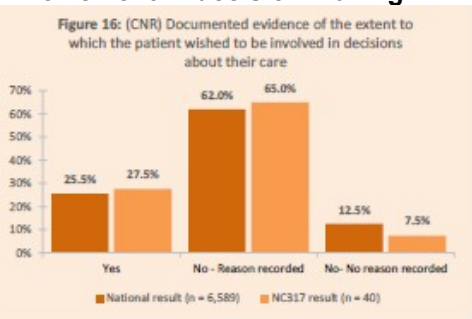


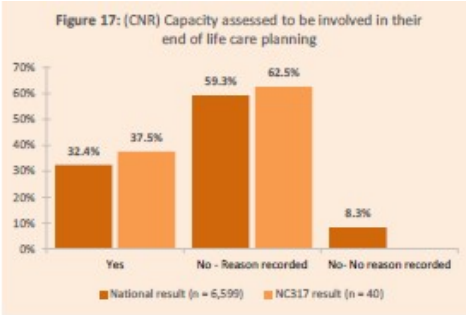


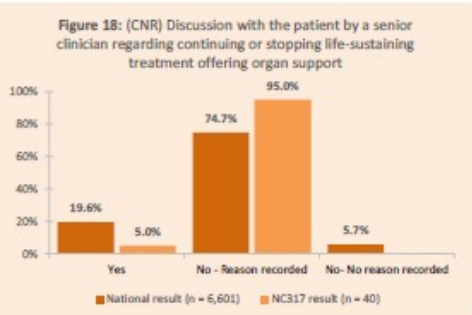


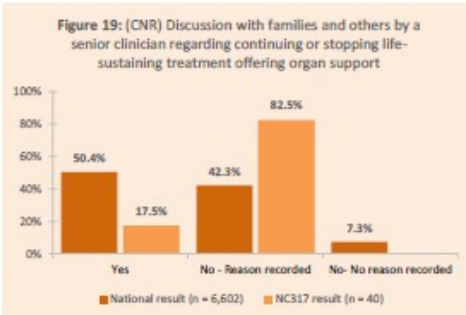


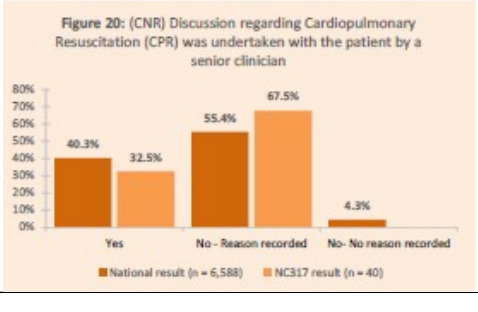
Involvement in decision making

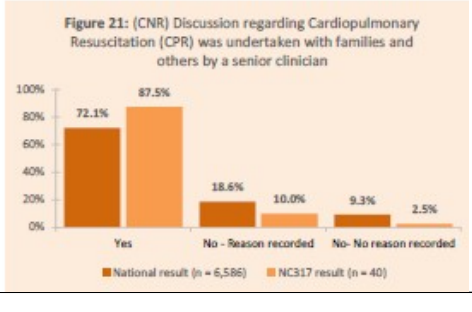




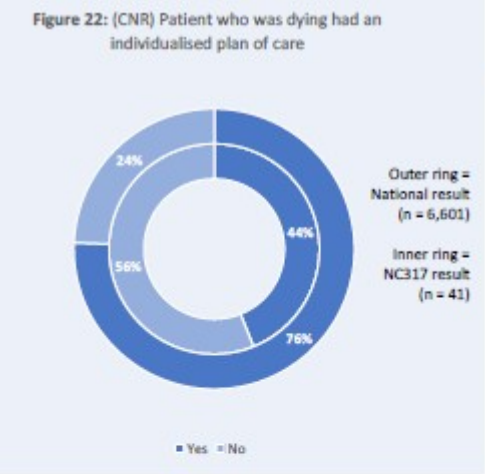


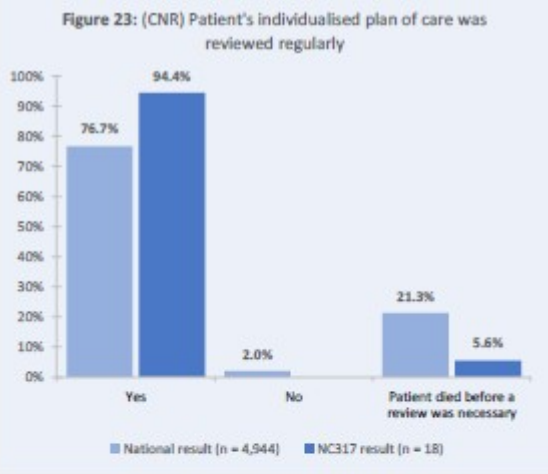


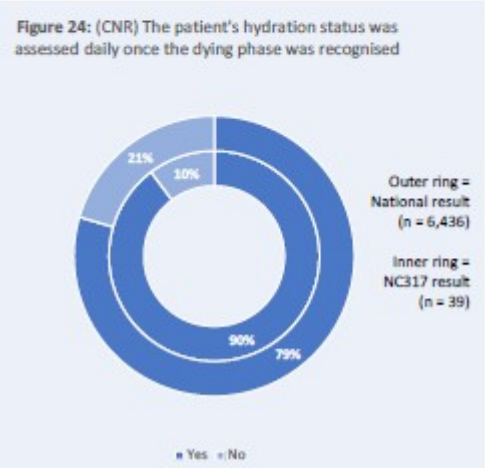


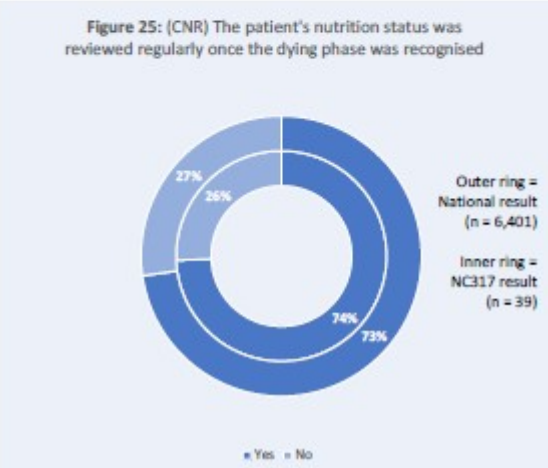


Individualised plan of care









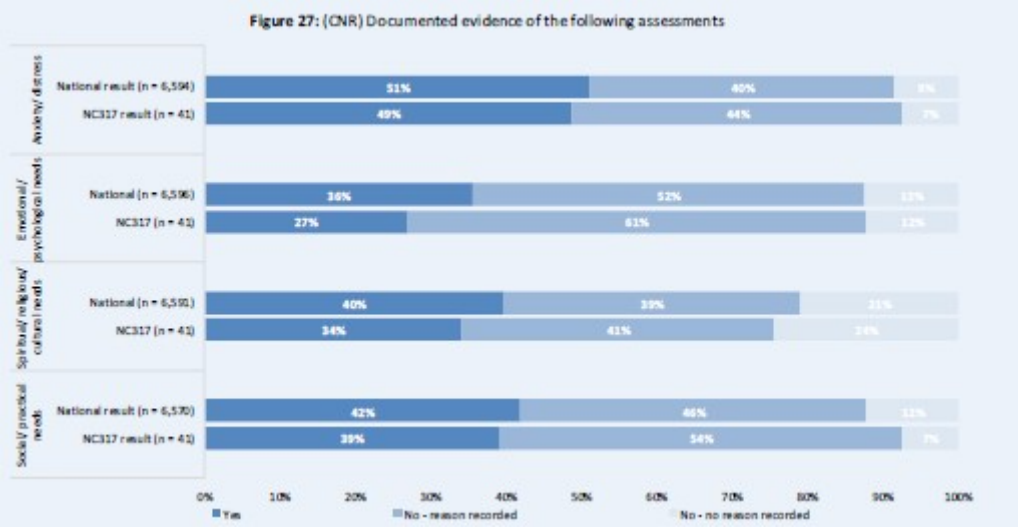


Figure 26: (CNR) Documented evidence of the following assessments

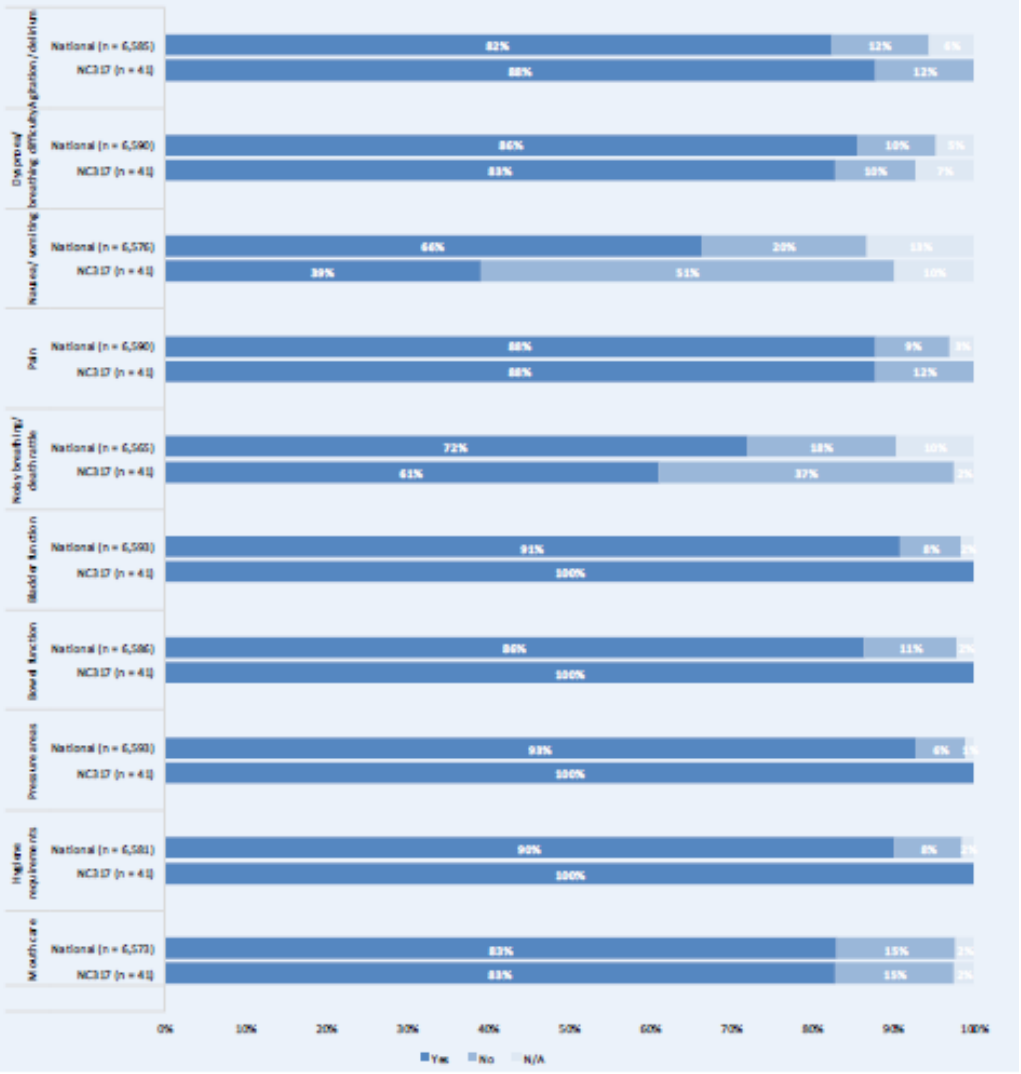


Figure 28: (CNR) The benefit of starting, stopping or continuing the following interventions documented as being reviewed in the patient's plan of care

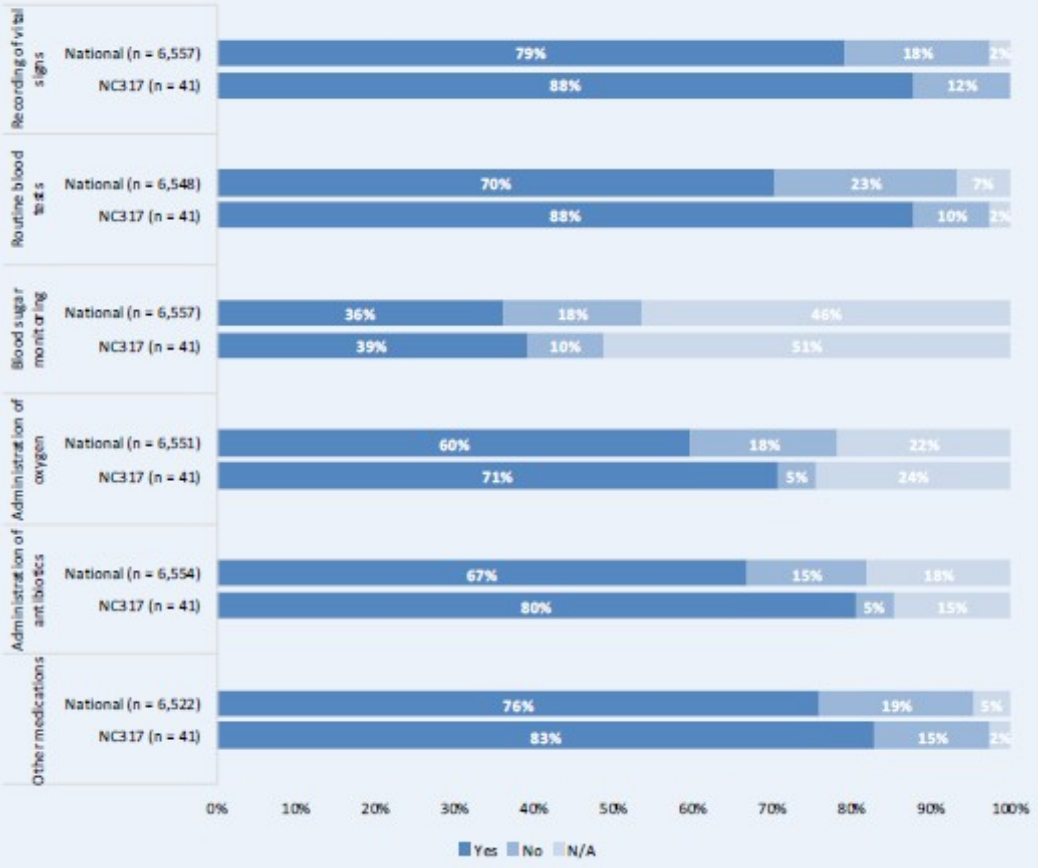
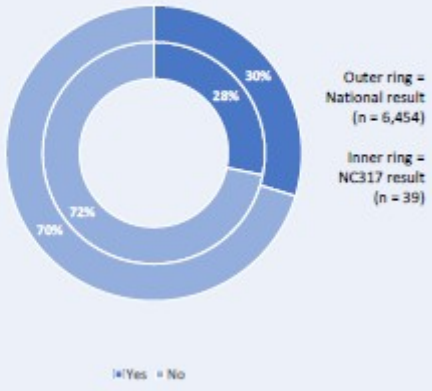
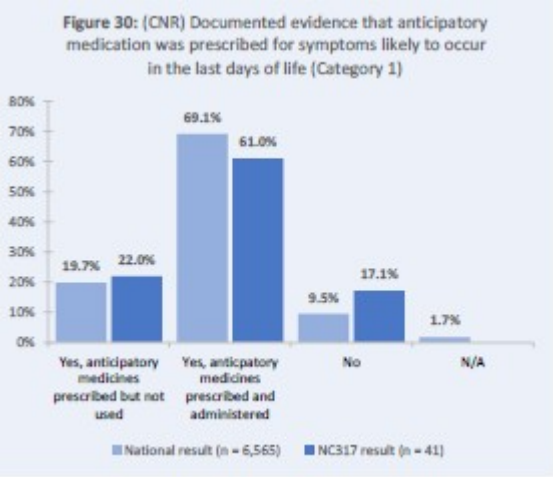
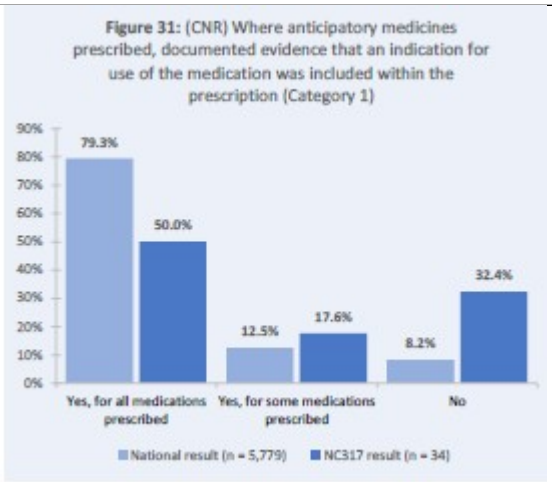
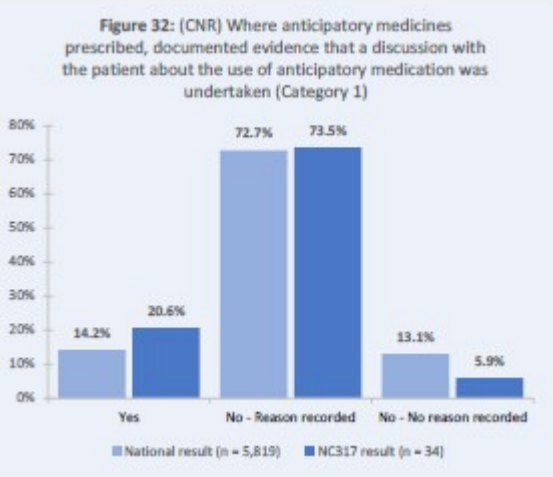


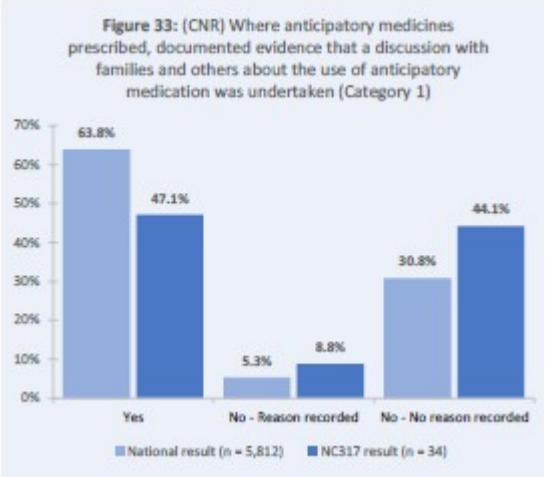
Figure 29: (CNR) Preferred place of death documented as indicated by the patient

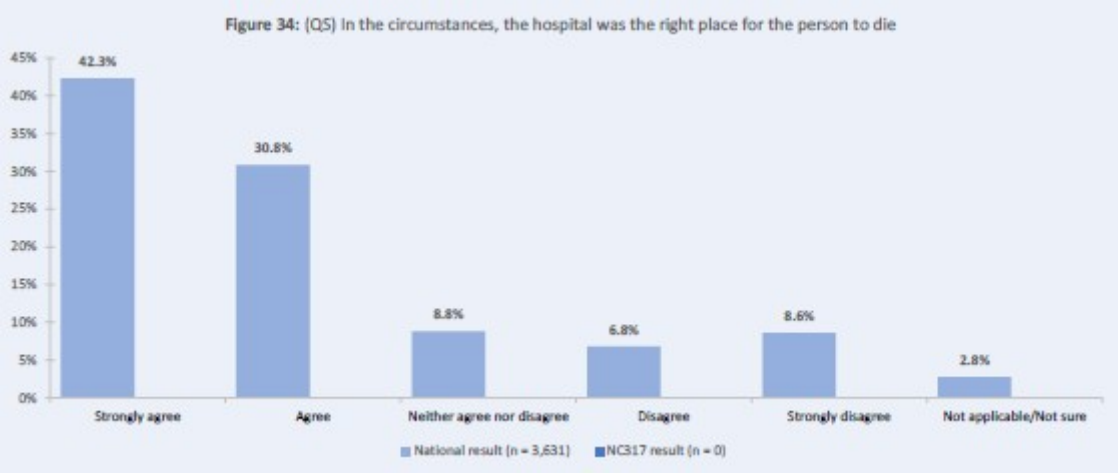












Needs of families and others

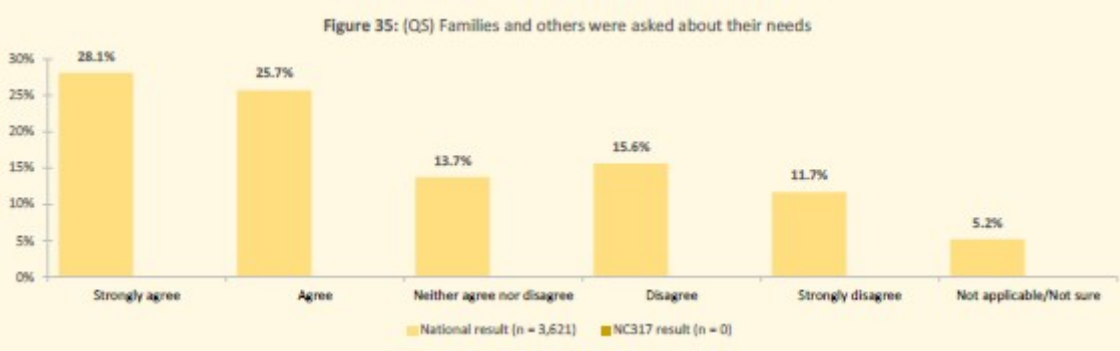



Figure 36: (QS) Families and others were given enough emotional help and support by staff
35%
30%
25%
20%
15%
10%
5%
0%
29.9%
27.1%
15.6%
12.8%
10.8%
3.9%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Not applicable/Not sure
National result (n = 3,631)
NC317 result (n = 0)

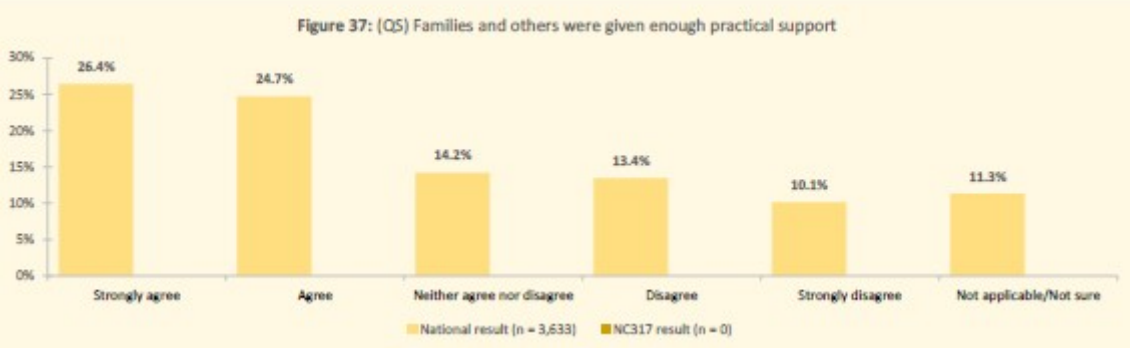


Figure 37: (QS) Families and others were given enough practical support
30%
25%
20%
15%
10%
5%
0%
26.4%
24.7%
14.2%
13.4%
10.1%
11.3%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Not applicable/Not sure
National result (n = 3,633)
NC317 result (n = 0)


Figure 38: (QS) Families and others were given enough spiritual/religious/cultural support
35%
30%
25%
20%
15%
10%
5%
0%
14.9%
16.6%
16.3%
11.8%
9.6%
30.8%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Not applicable/Not sure
National result (n = 3,622)
NC317 result (n = 0)

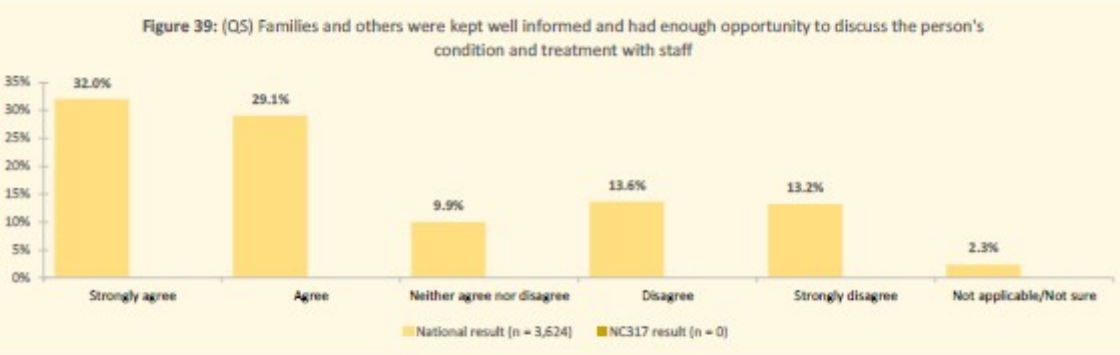
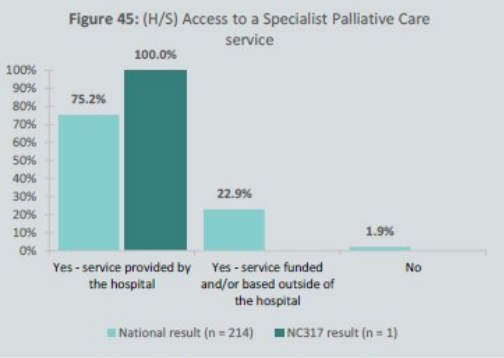


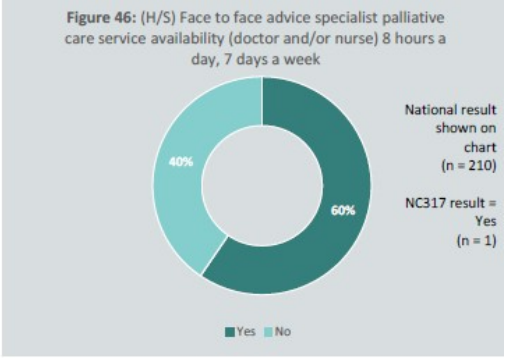
Figure 39: (QS) Families and others were kept well informed and had enough opportunity to discuss the person's condition and treatment with staff
35%
30%
25%
20%
15%
10%
5%
0%
32.0%
29.1%
9.9%
13.6%
13.2%
2.3%
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
Not applicable/Not sure
National result (n = 3,624)
NC317 result (n = 0)

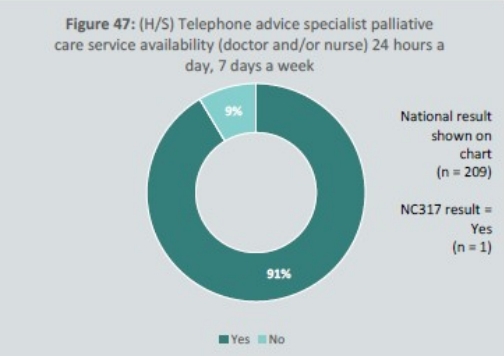

Figure 40: (QS) Families and others were involved in decisions about the person's care as much as they wanted to be
70%
60%
50%
40%
30%
20%
10%
0%
65.5%
25.5%
0.2%
5.6%
3.2%
I was involved as much as I wanted to be
I would have liked to be more involved
I would have liked to be less involved
I was not able to be involved
Not sure
National result (n = 3,634)
NC317 result (n = 0)

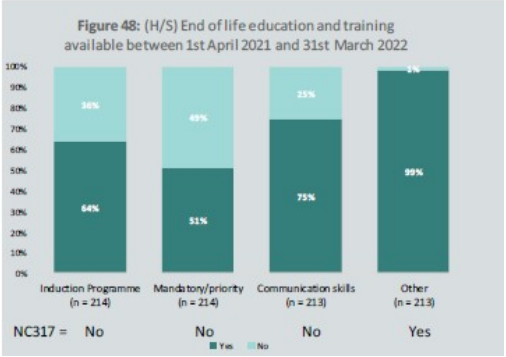
Families' and others' experience of care

Workforce / specialist palliative care

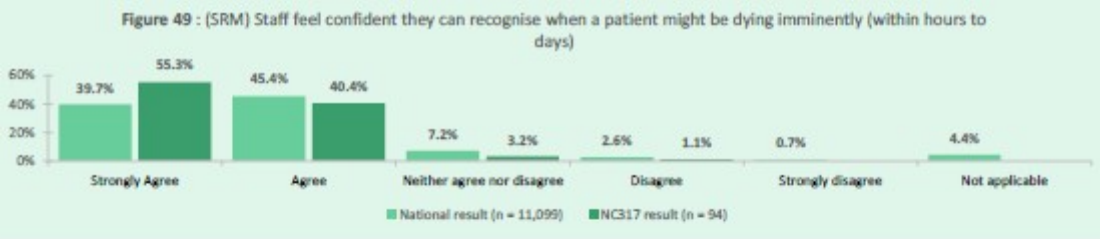


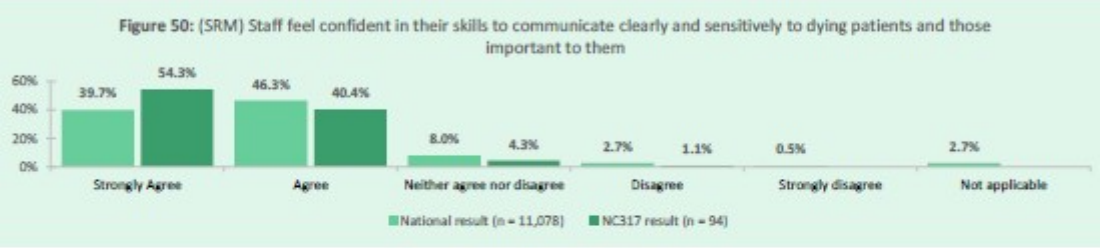


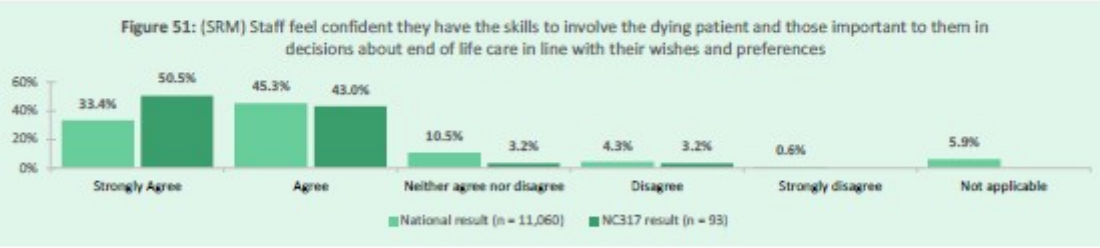


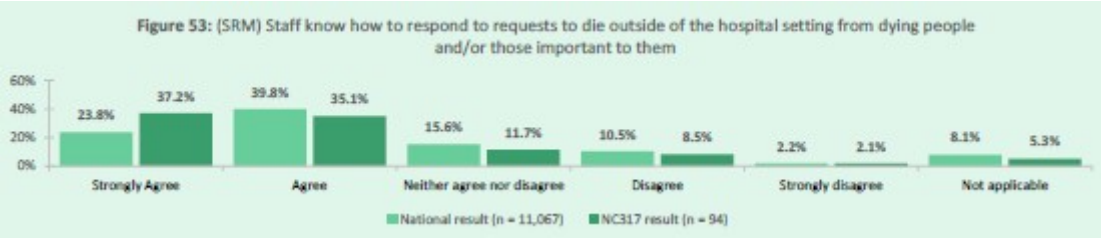


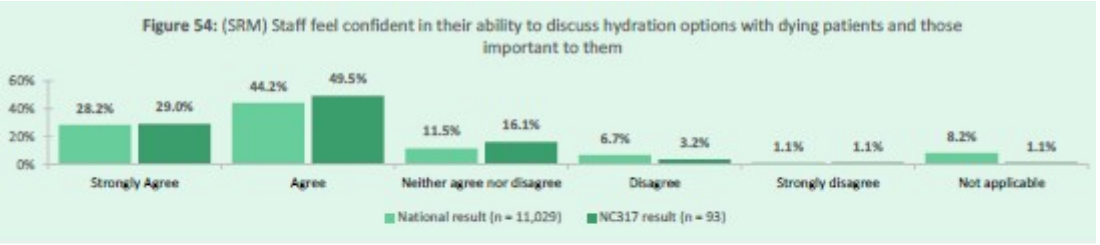
Staff confidence

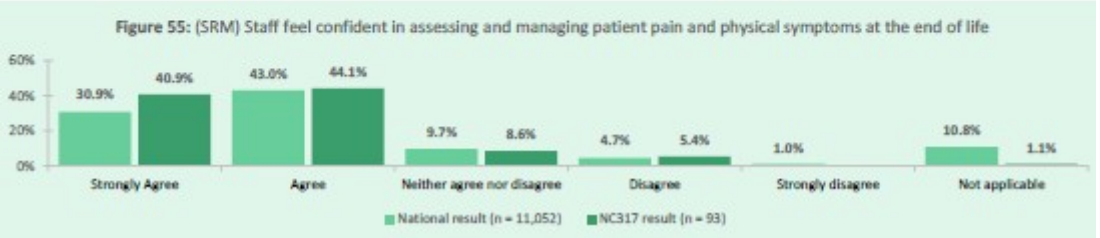


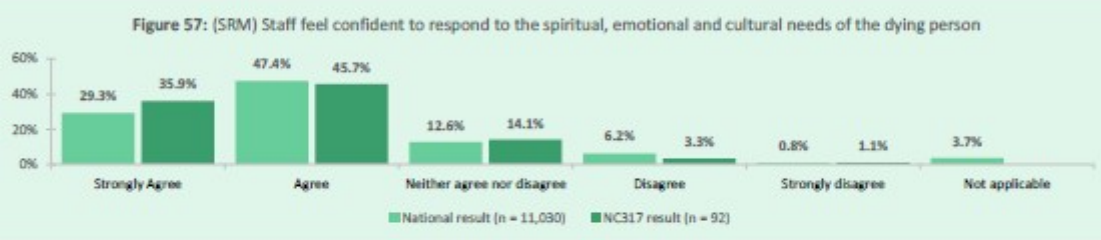


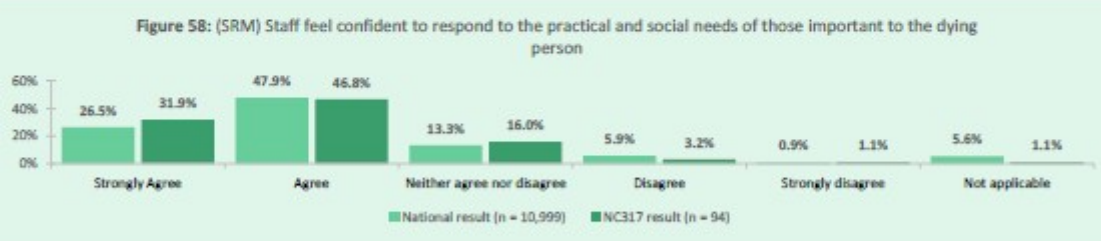




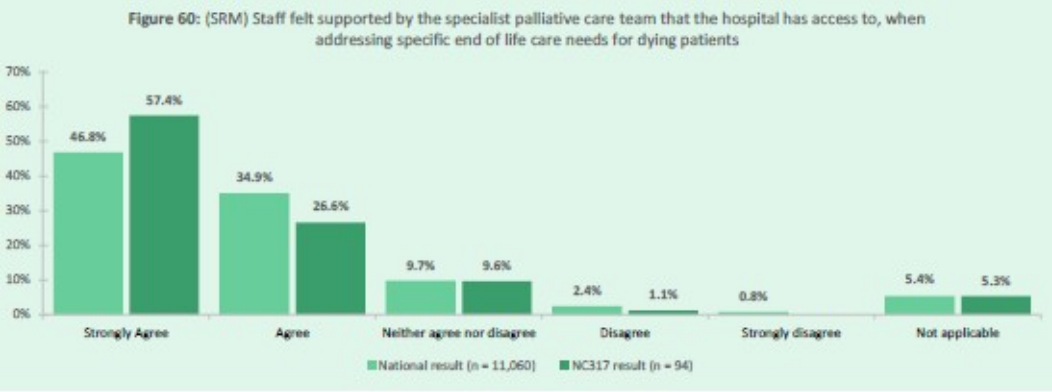








Staff support



Care and Culture

Key Successes

- '*Communication with the dying person'* has a summary score of 8.5. This is higher than both the national average of 8.0 and 2022 result of 8.3.
- '*Communication with families and others*' has a summary score of 7.0. This is similar to both the national average of 7.1 and 2022 score of 7.2.
- '*Involvement in decision making*' has a score of 9.8 in 2023. This is higher than the national average of 9.2 and similar to the 2022 score of 9.7.
- '*Individualised plan of care*' has a score of 7.5 in 2023. This is similar to the national average of 7.6. However, it is lower than the Trust 2022 score of 8.3.
- '*Workforce/specialist palliative care*' has a score of 8.1. This is the same as the national average of 2023 score.
- '*Staff confidence*' has a score of 8.1. This is higher than both the national average of 7.5 and the 2022 score of 7.6.

Key Concerns

- Data was not supplied for the following two key themes; '*Needs of families and others*' and '*Families' and others' experience of care*'.
- *'Staff support'* has a score of 6.7. This is slightly lower than the national average of 7.1. However, it is higher than the 2022 score of 6.0.
- *'Care and culture'* has a score of 7.1. This is the same as the 2022 score but slightly lower than the national average of 7.6.

Dissemination of results	

Actions (including re-audit)
If no action is required as the standards were met, please state 'no further action required' on line 1

	State action	Lead	Grade of action (see table below)	Date to be completed by
1.	To improve recognition of dying through education		**1 / 2 / 3**	
2.	To develop an electronic care plan for dying patients in Nerve Centre and to include sections regarding discussions about anticipatory medications and side -effects		**1 / 2 / 3**	
3.	To ensure end of life training is		**1 / 2 / 3**	

	included in induction training and priority training for staff who will be caring for patients at the end of life			
4.	To promote advance care planning discussions and sharing of ACP via EPaCCS			
5.	To establish links with medical examiners service to ensure that if requested, carer and family feedback can be obtained for subsequent round of audit			

The level of importance of actions is as follows:-

1 = Fundamental **2 = Significant** **3 = Requires Attention**

Examples: **1 - urgent staff training** **2 - a guideline/protocol** **3 - review of guideline at renewal date**

Please state the route of escalation if difficulties are encountered in implementing the action plan (ie. clinical lead, specialty governance meeting):-	
Please state how practice has changed as a result of this audit and any lessons that have been learned	

For completion following presentation at CEPPD			
Presented on		Presented by	

Agenda Item		**Meeting**	**Trust Board**	**Meeting Date**	12.09.23
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 Board is asked to receive the report.

Performance and Activity Report

June 2023 Performance

May 2023 for Cancer data

Produced July 2023

Table of Contents

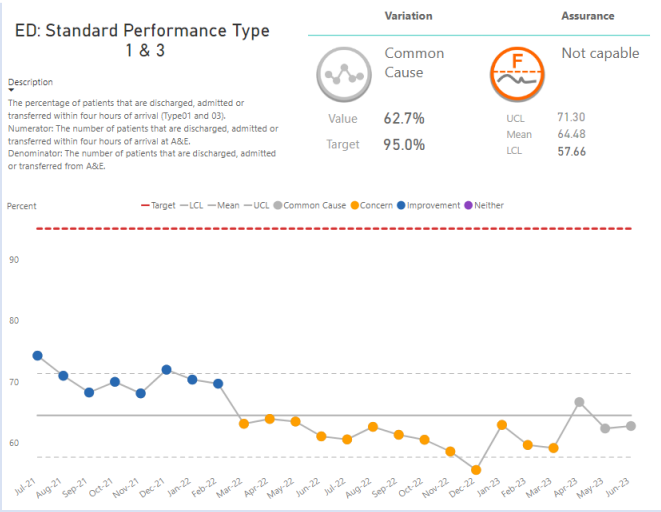
1. Executive Summary

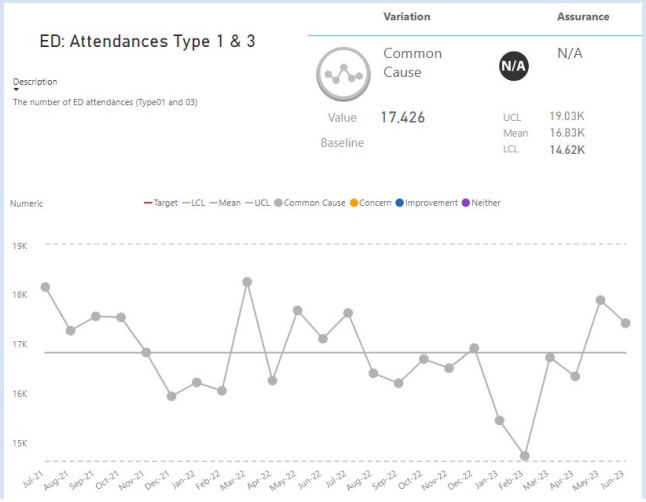
Areas requiring improvement	
Urgent Care performance – ED and Ambulance handovers	• For June 2023, the Ambulance handover position improved against May although remained slightly under the Improvement trajectory. Delivering 64.9% of Handovers within 30mins (target 68.6%). The average time for Handover improved to 34mins against 38 minutes in May. • ED achieved the improvement trajectory for the 4hr Quality Standard in June 2023 (62.7%) for Type 1 & 3 activity. • The number of patients in June 2023 with No Criteria to Reside continues to be the single largest factor affecting performance (although beginning to see a slight decrease) with a daily average of 191 patients per day remaining within the hospital who have no medical need for acute services.
Cancer performance	• Overall cancer performance remains comparable with previous months. Year to date there has been an 11.1% increase in 2WW referrals received. • In May 2023, the Trust failed to achieve the cancer waiting times' national standards. The combined Faster Diagnosis Standard (FDS) performance was just below target at 73.1%. In performance terms, long wait backlogs (+63 and +104 days) and FDS are the core metrics. • The number of patients on the 62-day Cancer PTL is currently ~1,600 and in itself is not monitored but used as the denominator when considering the scale/proportion of patients who fall into the +63 day backlog metric. From January 2023, in line with the required Cancer Waiting Times guidance, the Trust began reporting patients on the 62-day PTL from referral to treatment, which has increased the PTL by 500-700 patients on a weekly basis. • HUTH remains a Tier 1 provider for cancer performance and is the focus of the 2/52 NHSE assurance and recovery meetings – with particular emphasis on those patients +63 and +104 days. The new recovery trajectory to be achieved by 31 March 2024 is no more than 148 patients waiting 63 days or more. • The Trust has been formally advised that due recent deterioration (following the steady progress of the +63 day

	backlog), we continue to be monitored through the Tier 1 process. Whilst this is disappointing, services and all concerned will strive to recover the position following industrial action and Bank Holidays which have negatively impacted on the number of patients in the backlog. The impact being loss of tracking days, loss of theatre and OPA sessions, surgical capacity in urology and Gynae-oncology, and ongoing capacity issues in oncology & radiotherapy are contributing factors to the current backlog position. • Internally the 2/52 meetings with the top 4 tumour sites (colorectal, Gynae, urology and lung) are well established; chaired by the DCOO (Elective Recovery & Cancer) and attended by DGMs and the Trust Lead Cancer Manager. The focus of this meeting has shifted to patients earlier in the pathway (i.e. 28 – 62 days) to identify opportunities to expedite their next steps and reduce the number of 62 day RTT breaches, with MDT leads attending some meetings to consider further opportunities for improvement. • Late inter-provider transfers (IPTs) from within the HNY ICS primarily have an adverse effect on urology and lung; discussions with referring Trusts. The Cancer Alliance for HNY is leading on the improvement work to support more timely transfers and improved experience/outcomes for patients. • The NHSE Improvement Support Team (IST) have been invited to review our systems and processes by comparison to the national Cancer Waiting Times rules, and good practice from other organisations. At the time of writing this report the team were visiting the organisation.
Recovery of elective activity	• Recovery of elective activity in June 2023 against the operational plan: o New Activity 101% o Follow up Activity 104% o Day Case Activity 89% o Ordinary Elective Activity 89% • The 23/24 operational plan has a requirement to reduce outpatient follow ups without a procedure by 25% of the 19/20 baseline. In May 2023, follow up activity was 109% of the plan and 103% of baseline. There is on-going analysis and improvement projects linked to outpatient pathways to support this operational requirement, and a range of performance discussions at Health Group level related to the comparison to the GIRFT standards in 15 specialities.

	• Many of the HUTH pathways have a discharge rather than follow up, so a reduction and/or transfer to PIFU would not be appropriate. Additionally, many OP follow up activities are actually a procedure, albeit not attracting an HRG and work is underway to quantify this activity and address any data quality issues. • Ward C9a opened as a 7-day ward from 15 May 2023 to support the recovery for orthopaedics and neurosurgery, however in an attempt to create a firebreak for VRE on the 12th floor, the staffing resource has been moved to H1 and C9A is currently closed. • Mutual aid (largely and out-sourcing) continues albeit in limited numbers to improve waiting times and support the reduction of the overall size of the Trust's PTL.
Improving treatment times for long waiting patients	• The Trust was stepped down to a Tier 2 trust for long waits from November 2022 (regional oversight & assurance). • At the end of June 2023, the Trust reported zero x 104 week waits and 26 x 78 week wait breaches, a reduction from the position at May 2023. The Trust is forecasting zero breaches for the end of July 2023. • 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. • 3,428 patients have waited more than one year for their appointment/procedure, this is below the trajectory of 5,296.
Reducing the delays in people leaving acute setting	• In June 2023, there were 191 (average) patients per day with NCTR. This is 17% of the total general and acute beds and 27% of beds at HRI (total G&A 698 HRI/398 CHH). • NCTR patients who should be receiving appropriate care elsewhere with the support of other partner organisations or settings.

2. Emergency Care Standards – 4 hour Performance





What the chart tells us

The 4-hour performance delivery remains fairly static, although is significantly below the required standard. In June 2023, performance was 62.7% for all attendance types and above the improvement trajectory.

Intervention and Planned Impact

- CDU had 45 patients in June, of which only 6 prevented patients exceeding 4hrs in the Emergency Department this is significantly less than the planned impact. The Clinician seen time is driving the lack of performance improvement. CDU task and Finish has been asked to revaluate potential pathways.
- Mental Health Streaming facility (Humber Suites) opened 19th June.
- The New Build is due to accept the first NCTR patients from HUTH on the w/c 24th July

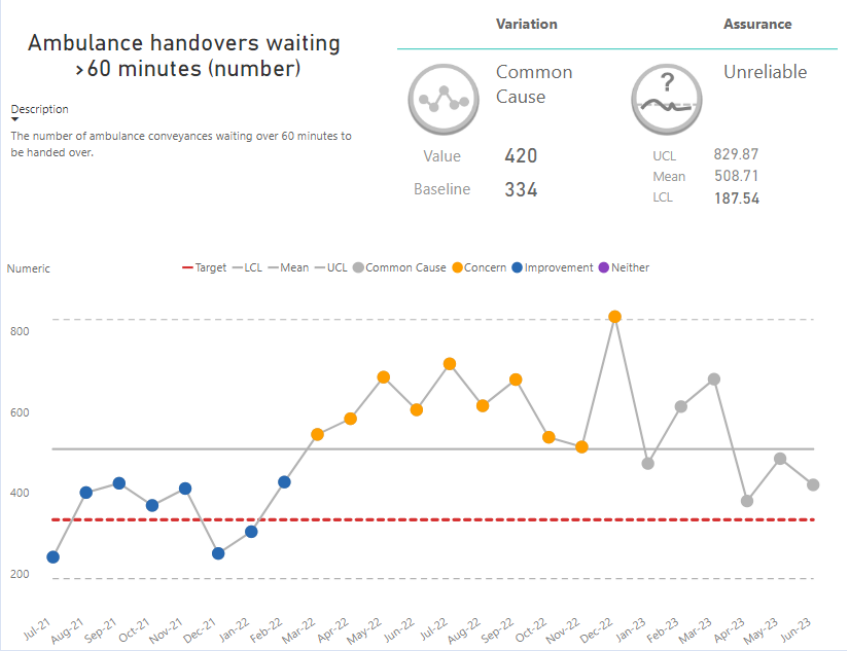
Risks / Mitigations

- Continued delays in flow and discharge are a significant impediment to an improvement in the initial assessment and majors' area; with some impact on ECA as rooms are occupied for an extended period.
- Continued/escalating industrial action by medical colleagues may impact both on Time in ED and flow across the Trust.

A&E trajectory for 2023/24

April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
51%	**55%**	**59%**	**63%**	**67%**	**71%**	**74%**	**77%**	**75%**	**75%**	**76%**	**76%**

3. Ambulance Handovers waiting over 60 minutes



What the chart tells us

There were 420 waits over 60 minutes reported in June 2023, which equated to 14.9% which is an improved position.

Intervention and Planned Impact

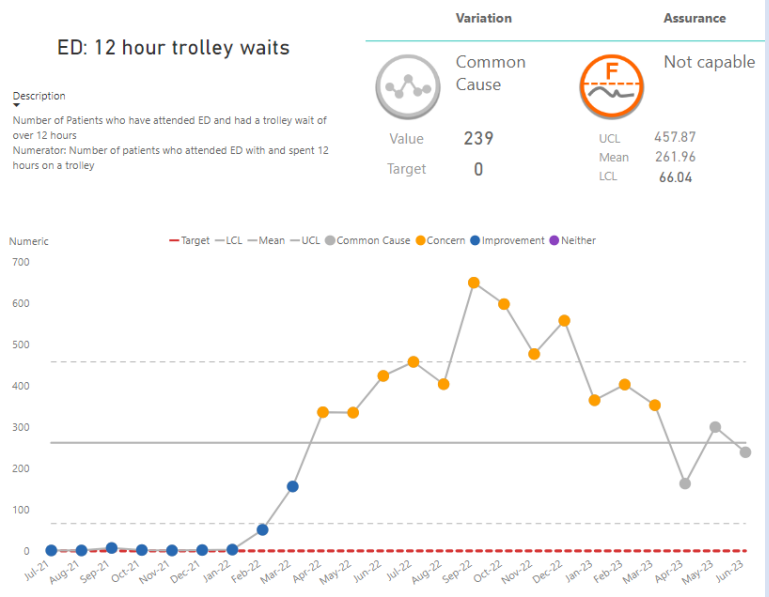
- From 19th June Co-horting by 24 Co-horting ability has been provided by the Trust to enable the earlier release of Ambulance Crews.
- An initial meeting was held on the 27th March 2023 to agree a joint Rapid Programme Improvement supported by both YAS and HUTH QI teams. Date currently being agreed to commence 8 week observation period followed by a 5-day workshop in June/July 2023. This has been delayed YAS have a number of improvement programmes to be prioritised.
- In June 2023 the Trust delivered 64.9% of Ambulances against a trajectory of 68.6% of Crews to be released in under 30 mins. The average handover time was 34 minutes against 38mins in May.

Risks / Mitigations

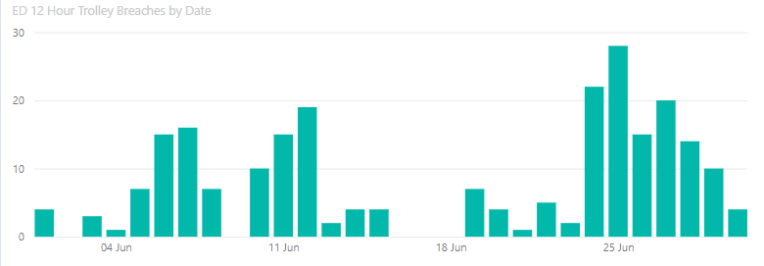
- Flow remains challenged as the number of patients with No Criteria to Reside, who are unable to be discharged, are occupying over 18% of the overall bed base.
- YAS are unable to use the EPR to capture the early handover of Resus Patients. This is currently being tested.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target:	53.5%	63.6 %	68.6%	80.3%	85.3 %	90.1%	95.4%	87.5 %	87.9%	87.9%	93.5%	100%
Actual:	64.9%	62.8 %	64.9%									

4. 12 Hour Trolley Waits (from DTA to Depart)



Day of Week Number	1 Mon	2 Tue	3 Wed	4 Thu	5 Fri	6 Sat	7 Sun	Total
ED Departures (Type 01)	1,550	1,513	1,417	1,854	1,774	1,327	1,366	**10,801**
ED 12 Hour Trolley Breaches	48	41	35	30	6	35	44	**239**
ED 4 Hour Standard Performance (Type 01)	45.5%	48.3%	48.4%	55.8%	53.8%	56.1%	54.0%	**51.8%**



What the chart tells us

There were 239 x12 hour trolley wait breaches in June 2023 with the longest wait from Decision to Admission (DTA) of 48 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 June 2023 was that 9.2% of patients (991 patients) waited over 12 hours against a national tolerance of 2%.

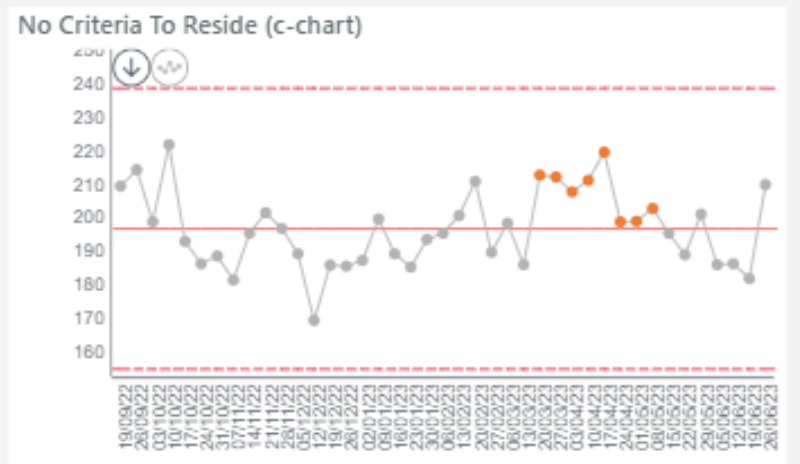
Intervention and Planned

- There has been sustain improvement in the number of lodged patients moved by 10am and starting to see an increase in the number moved by 14:00
- Mental Health Streaming facility became operational from 19th June 2023.

Risks / Mitigations

- High numbers of No Criteria to Reside patients, outside of the NCTR bed base are occupying acute beds reducing for acute work.
- Further strike action in July may impact on timely flow of patients.

5. No Criteria to Reside



What the chart tells us

On average, there were 191 patients per day with No Criteria to Reside in June 2023. There was an average impact of 4 days increase on Length of Stay due to the NCTR.

The NCTR accounted for 4,198 lost bed days in June 2023.

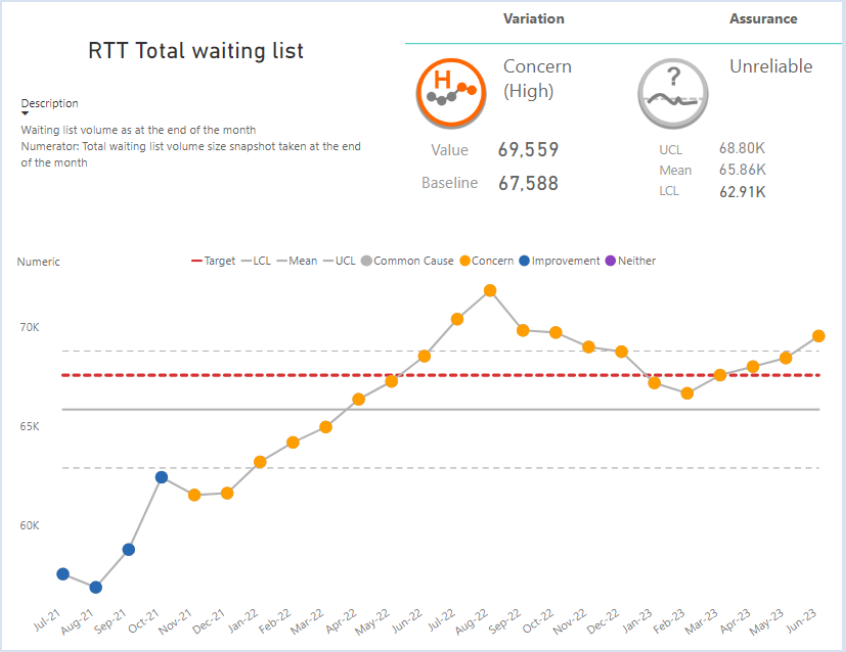
Intervention and Planned Impact

- System leaders are focused on reducing the number of NCTR patients to sub-100, with a system trajectory agreed to 100 (including in the new build) by March 2024.
- PSC have been commissioned by the system to provide project support for delivery of a Discharge to Assess (D2A) process.
- The new process for the 13th Floor commenced 26th June, all system partners in physically present for Daily MDTs. The new build for NCTR patients is scheduled for opening W/C 24th July 2023.

Risks / Mitigations

- Domiciliary capacity remains lower than demand.
- Recruitment challenges due to competition from retail sector
- New build will replace some existing capacity rather than be all new capacity

6. Referral to Treatment – Total Waiting List Volume



What the chart tells us

The Trust's total waiting list volume (WLV) has increased marginally, impacted by bank holidays and industrial action during 2023/34 Q1. At the end of June 2023, the waiting list volume was 69,559. The total WLV is above the trajectory of 68,334.

Overall, referrals in are 3.1% down on the previous year.

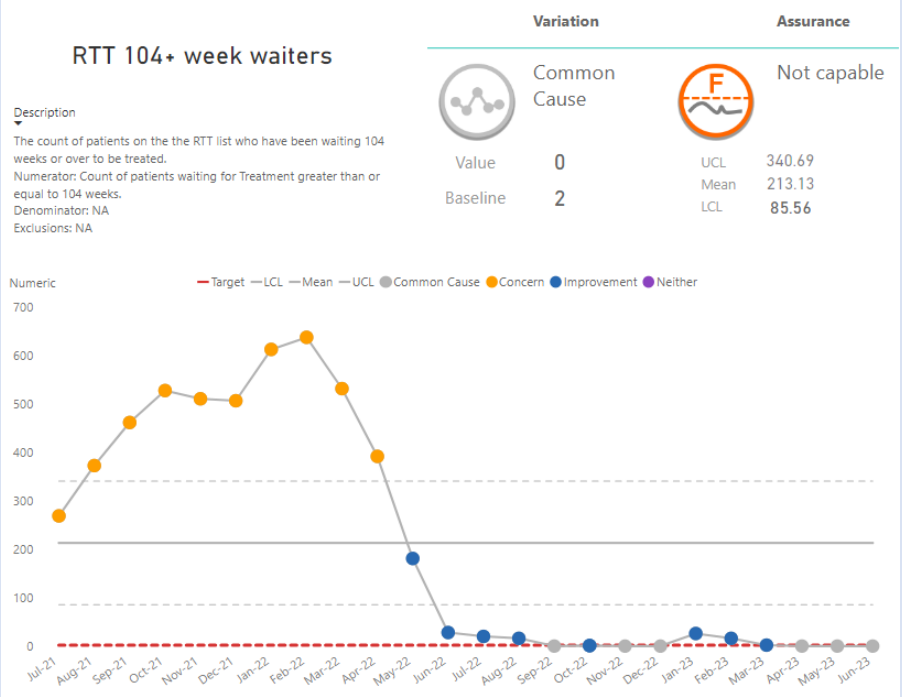
Intervention and Planned Impact

- Targeted HG & speciality meetings continue to reduce waiting
- Internal milestones set to reduce maximum waits
- Mutual aid/in-sourcing and out- sourcing to support the total WLV reduction.
- Capacity alerts in x6 pressured specialities are live – monitoring arrangements to consider the effectiveness and impact (5x specialities – referral rate reducing, with ENT referral rate flat)
- Additional support for Gynaecology was prioritised with capacity on-stream in March 2023 and continuing in May, into June 2023. This will be required into Q2.
- Text validation delivered as a business as usual validation process for the remainder of 2022/23 & into baseline from 2023/24.
- RTT pathway training to 1,700 staff across the Trust who are primarily involved with pathway management has commenced through Learn RTT e-learning.

Risks / Mitigations

- Increase in GP referrals – referral triage and A&G in place to mitigate
- Orthopaedic bed base reduction to support firebreak for VRE from beginning of June 2023
- Patients with No Criteria to Reside does not reduce
- Infections and the management of contacts reduces bed availability and/or affects staff availability
- Increase in non-elective demand displacing elective capacity
- Impact of any Industrial Action

7. 104 Week Waits & Planned Trajectory



What the chart tells us

At the end of June 2023, the Trust reported 0 x 104-week waits.

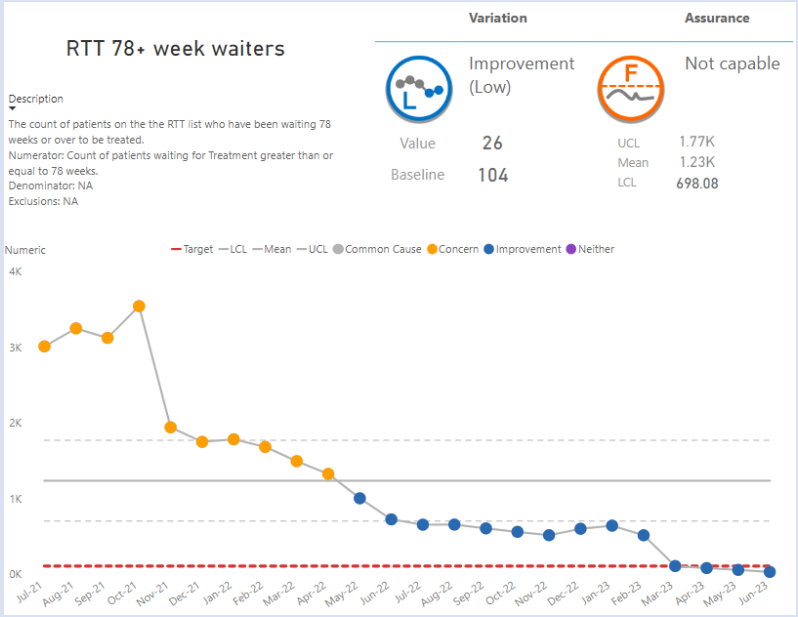
Intervention and Planned Impact

- 104-week patient – zero tolerance approach adopted

Risks / Mitigations

- BI reports and governance processes detect and manage any "pop-ups"

8. 78 Week Waits & Planned Trajectory



What the chart tells us

At the end of June 2023, the Trust reported 26 x breaches of the 78-week target, against a forecast position 19, with the majority of the breaches (19) in gynaecology.

The current position (at 13.7.23) is 98 total 78 week patients to treat by the end of July 2023. 74% of these have an appointment/TCI date booked before the end of June 2023; progress has been impeded by further Junior Doctor and Consultant industrial action in July 2023.

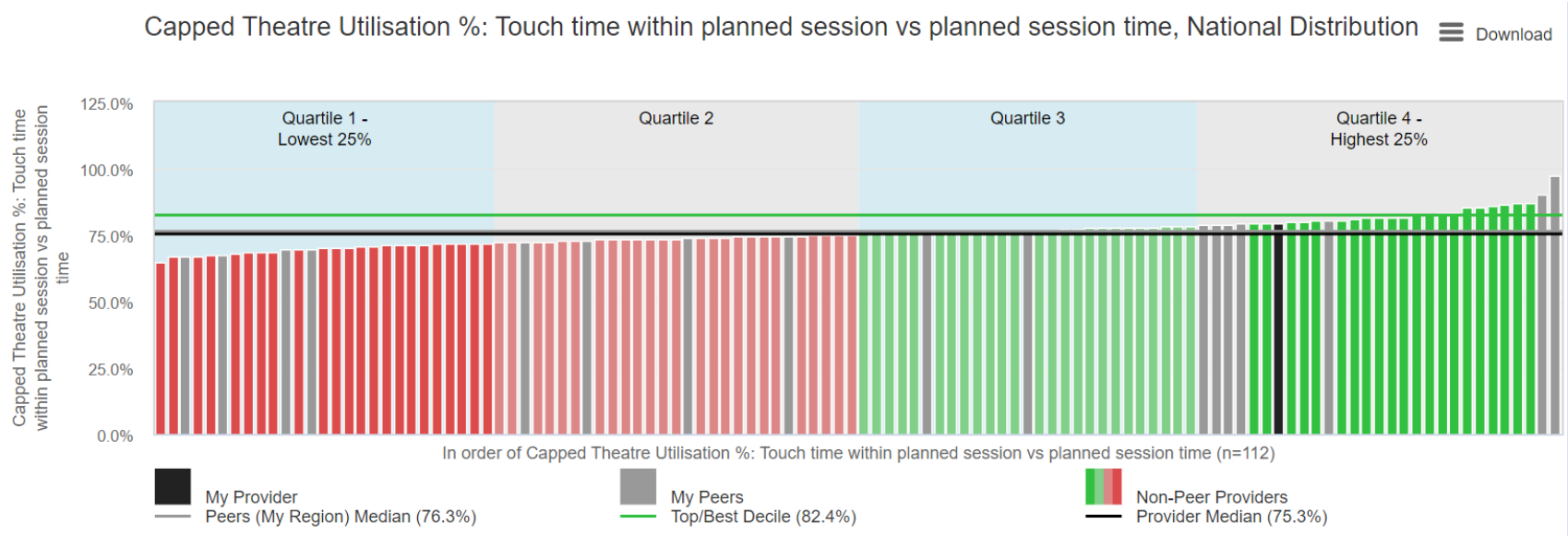
Intervention and Planned Impact

- Continued focus at speciality level of patients dated and/or risks now focussed to achieve zero 78-week waits by the end of July 2023.
- 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
- Continuing to in-source capacity where possible to support pressured specialities.

Risks / Mitigations

- Current patients dated are treated as planned – delivered through micro-management
- Corneal transplant (unmatched) pathways, previously managed by HUTH as planned, now amended to RTT ticking pathways as mandated by NHSE
- IPC risks including VRE affecting (staff absence & patient numbers
- NCTR and/or acute demand – impacting on elective bed base
- Staff absence increases or does not reduce
- 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
- Impact of BMA industrial action
- Speciality capacity risks:
  - Gynaecology (capacity and obstetric clinical prioritisation)
  - Plastic Surgery (immediate DIEP demand)
  - Ophthalmology (corneal transplant donor material)
  - Colorectal Surgery (complexity and ICU capacity)

9. Capped Theatre Utilisation



What the chart tells us

This new metric was introduced as a response to the Elective Recovery Self-Assessment requirements. The elective recovery standard is a minimum of 85% capped theatre utilisation.

Data from Model Health for 2022/23 (at 18.6.23) shows capped theatre utilisation at 79.6% and in the highest quartile nationally.
There is considerable variation in performance, with further work on-going with regards to data quality, theatre scheduling timings update, understanding the definitions and the Model Health outputs compared to the internal monitoring.

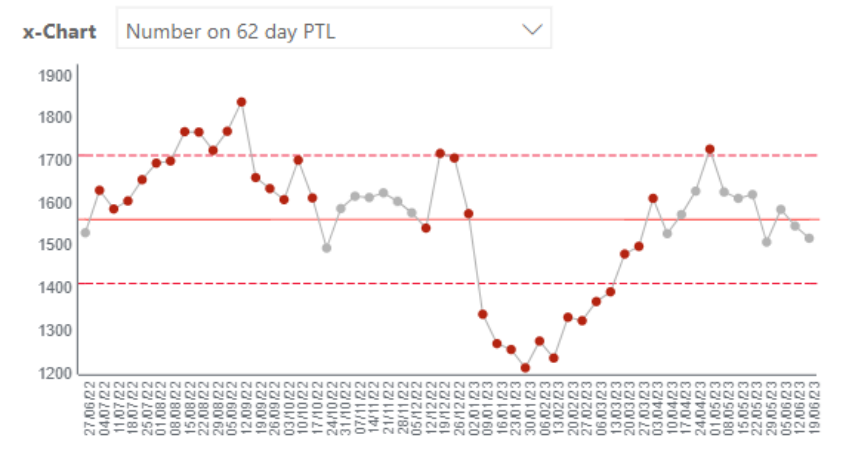
Intervention and Planned Impact

- Review of theatre timetable and configuration of ORMIS sessions. There are some theatres and sessions that need amending from elective to acute.
- Theatre timings being updated in the scheduler and implemented from March 2023.
- Some changes to consultant job plans required to utilise the Trust standard 4-hour theatre session
- Model Health to share the reporting methodology so that the capped theatre utilisation can be replicated for internal reporting at Trust and specialty level.
- All BI dashboards to be aligned to capped theatre utilisation methodology.
- Surgery HG to implement a Theatre Productivity Meeting from July 2023.

Risks / Mitigations

- Late starts and/or cancellations on the day as a result of being unable to confirm beds
- Delay in confirming/lack of ICU beds
- Inaccurate theatre timings used in ORMIS
- Consultant job plans do not match theatre schedule

10. Cancer 62 day Waiting List Volume



What the chart tells us

The number of patients waiting to start treatment or benign diagnosis patients waiting to be removed, on a 62-day pathway reduced to **1,325** at the end of February 2023 compared to 1,700 at the end of December 2022. There was a small increase that recorded in January (1,256).

At week commencing 10 July 2023, the PTL size was **~1,600**, which is remaining a static position. Referral rates have been reviewed and whilst spikes occur in the main referrals are within normal variation. In May, the Trust received ~2300 referrals which is small increase from the previous month and within the normal rates when compared with the year before.

At the beginning of July 2023 the number of patients 63 days and over was 327 compared to 302 at the beginning of April 2023.

The Colorectal backlog is beginning to slowly reduce however, many patients will remain on the PTL until diagnostic tests confirm benign disease and will be removed or cancer when the patients will progress through the pathway. Recruitment to the triage nursing has completed with start dates agree for the beginning of August then, following a short period of training a nurse led triage service will be implemented. It should be noted that improvements are not expected until Q3 2023/24 (including been FDS performance).

The Urology remains static with delays along each of the stages of the prostate cancer pathway. Long lead times for surgery is now reaching 9 weeks and continue to cause delays from decision to treat to treatment. Since the middle of June 2023 the service have been carrying a consultant surgeon vacancy which explains the increase in access to surgery.

Gynae-oncology – ongoing review, revision and implementation of pathways, which are consultant led, continues Q1 2023/24; additionally, surgical capacity remains a tangible risk however, the service are making strides to secure additional capacity by accessing IS providers.
In May, Lung saw a small deviation from the 63+ backlog and was slightly over trajectory however, 104+ days achieved no more than the trajectory. FDS failed to

achieve and following a review of the breaches all patients had complex diagnostic pathways. Capacity for access to navigational bronchoscopy is a main constraint concern, as is timely oncology out-patient appointments to discuss treatment options.

Late IPTs continue to be a factor in regards to the HUTH +63 day backlog, mainly urology, lung and Gynae-oncology. An ICS wide improvement project led by the Cancer Alliance is being developed. A first meeting is scheduled for 19 July 2023

The Subsequent Radiotherapy 31-day target of 94% has not been achieved since May 2022; a dip in achievement for the first time in the life of the Cancer Waiting Times targets. Performance in May was 45.1% which an improvement on the previous month (April 40.7%)

Intervention and Planned Impact
The capacity and/or pathway issues fall into 5 broad categories and remain so as follows:

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 waiting times now at **approximately 10 days** compared to 10-weeks in June 2022; which has supported the improvement of the colorectal PTL. This change supported initial improvement in Faster Diagnosis Standard in the colorectal pathway (January 2023 31.9% & February 2023 51.6%). May's performance was 23.1% (April = 22%; (March = 33.2%).
- Colonoscopy capacity continues to be a challenge and is a primary cause of delays and failure of FDS target.

Histology capacity/delays –whilst TATs for skin and gynae-oncology improved due to outsourcing companies being utilised, other tumour sites such as prostate and colorectal biopsy results have been delayed. Consultant Pathologists' planned and unplanned absences throughout the year often affect different tumour site TATs temporarily.

The following actions remain current

- Daily results file had ceased for a number of weeks due to pathology

administrative staff leave but have been reinstated in July.
- Escalations to the SHYPS manager are communicated where results remain outstanding
- Longer to medium term related to workforce solutions through the NEY Regional Clinical Leads continues with monthly meetings however the impact is yet to be seen in the backlog
- National cancer recovery funding for temporary administration support to reduce the reporting backlog agreed commenced 12 December 2022 with metrics developed to monitor improvement. Further funding from the HNY Cancer Alliance has allowed thus support to be extended into 2023/24.

Tracking capacity and decision making
- The PTL volume had reduced the ability for tracking staff to cross cover tumour sites for planned absences.
- Temporary funding has supported a floating tracker post for proof of concept for recurrent support. Post holder in post January 2023 and training completed. When the department is fully staffed (no vacancies) the post has provided the cover required for staff absences.
- A review of the tracking/MDT staff working schedules have been reviewed and new processes have been introduced to avoid variation due to public holidays which affect tracking capacity.

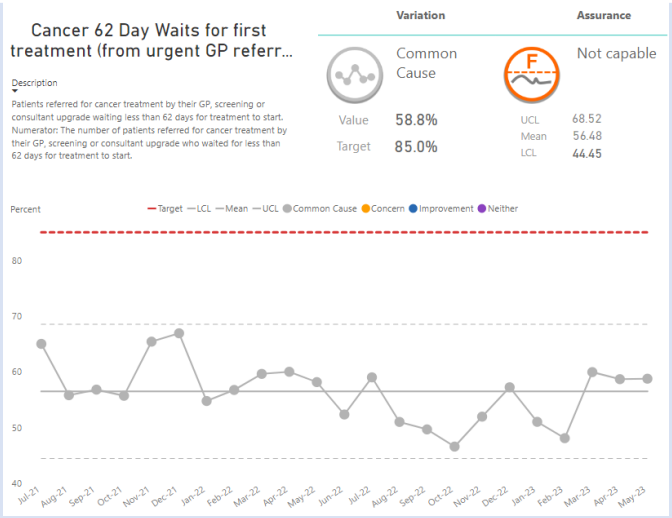
Radiotherapy capacity/delays
- Radiotherapy - on-going radiotherapy workforce constrains, with prioritisation process in place. Approval for rolling advert to recruit to Band 5 & 6 vacancies as appropriate
- Physics – the role of 'Duty Physicist' has been introduced in an attempt to improve efficiency
- Mutual aid arrangements with United Lincoln Hospitals, previously stalling progress, have now been resolved with a plan in place to progress with mutual aid

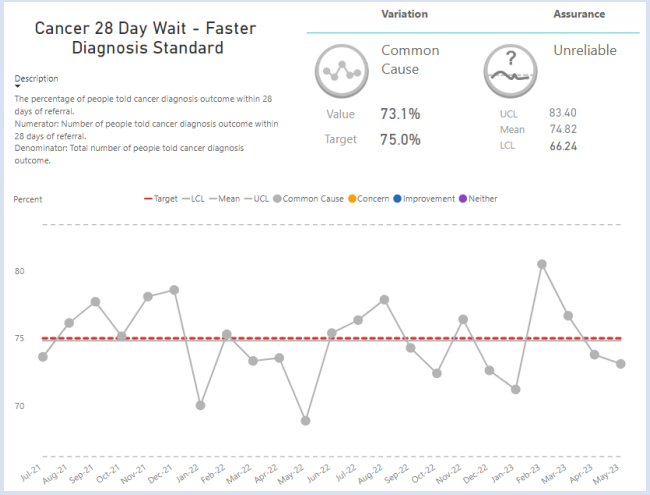
Transformation Opportunities
- Improvement in the Lower GI triage processes will shorten the pathway and lead to performance improvement – non-recurrent funding in place; will

	need recurrent support from the 23/24 & 24/25 growth for cancer – plans have been developed and agreed by the Cancer Alliance. Planned improvements at the front end of the pathway are expected in Q3 23/24 when recruitment and training of triage nurses is complete. • Increasing numbers of 2WW referrals received with a FIT test result remain static at 72% in June 2023 (72.9%) • Recent upgrade to the Endoweb system included a mandatory field for clinicians to determine whether patients on a fast track pathway can be removed where cancer is not indicated. This will facilitate the tracking team to remove patients from the PTL at an earlier stage which in turn should support the volume of patients in the PTL. • Gynae-oncology – the improved PMB pathway has been approved and ready for implementation. Further discussions to implement the pathway continue within the service (Consultant led). • Urology – recent meeting with the regional GIRFT lead urologist provided some useful suggestions including outsourcing haematuria patients to Goole where capacity has been identified; explore outsourcing some of the prostatectomy backlog to nearby centres if capacity available • Upper GI – the number of patients on the PTL has reduced and being well managed. A recent improvement action planning meeting was held an actions agreed including reducing the number of times NLAG patients are discussed at an MDT therefore potentially avoiding patients being added to the backlog unnecessarily • Head and Neck – test bundling has been reviewed and confirmed that this is now implemented. Performance in Q1 2023/24 will be monitored for progress. • Actions form part of the overall Cancer Transformation programme of work
	Risks / Mitigations • Referral rates since April have remained constant ~2500 patients per month • High profile patients and national cancer awareness media coverage result in an influx of referrals - recent Bowel Screening TV campaign has coincided with an spike in colorectal 2WW referrals and the increase continues with the highest number seen in March 2023 (550 referrals); many of these were still in the system in April and May and June 2023 • Histology tracking systems implemented locally to prioritise long-wait patients – skin and Gynae continue to receive reasonable turnaround times • Radiotherapy delivery continues to be a considerable challenge

	• Improvement plans fail to impact on performance metrics • Mutual aid for radiotherapy has been a challenge; plans to work with ULHs in in progress • The required additional haematuria clinics have not been fully implemented due to lack of sufficient staff to support them. Consideration is being given to outsourcing the backlog • Cancer Transformation programme • Review of late IPT referrals by the Cancer Alliance to increase the number received by Day 38

11. Cancer 62 day Performance





What the chart tells us

Performance for May 2023 was **58.8%, a small improvement** since April; performance has not been achieved for some time. The Faster Diagnosis Standard (combined) May 2023 failed to achieve the 75% target with performance of 73.1% at (April = 73.8%).

Intervention and Planned Impact

Largely the same as Section 8. Above.

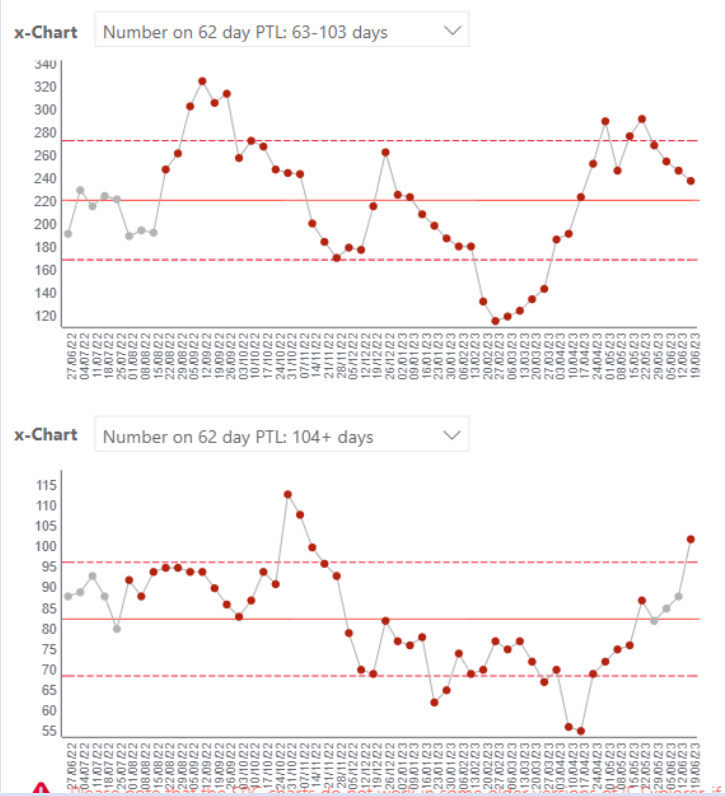
- Administration processes continue to be reviewed and actions implemented as appropriate with the IST invited to review during July 2023
- Improvements in the process to despatch times of bowel preparation for CTC slots utilisation, leading to improved access to CT Colon should have a direct impact on FDS performance for colorectal. All elements of the improvement work when fully implemented should begin to demonstrate improvements in Quarter 3, 2023/24
- Timely access to colonoscopy is still required. A regional gastro-enterologist (Matt Rutter) will meet with the Endoscopy service in the coming weeks to offer support with a view to improving colonoscopy utilisation
- Radiotherapy capacity and patient prioritisation continues to adversely affect performance with no mutual aid available in the region to date
- Urology – exploring outsource options to reduce backlog of haematuria patients and prostatectomies
- Gynae-oncology – pathway review, revisions and implementation. FDS performance made good progress in March 2023 – 49.7%, (February 2023 – 43.9%), however, April's performance dipped to 42.9% which was due to the increase in referrals in March 2023. May's performance was 45.2%
- FDS for tumour sites not achieving the target under review and process improvements being considered for implementation. Lung met the standard in April with performance reaching 81%

Risks / Mitigations

- Referral rate catch up impacts on the cancer PTL and waiting times; referrals continue to be high in certain tumour sites
- Loss of OPA capacity (treatment option discussions and results clinics) as well as reduced number of patients being discussed at MDT meetings due to junior doctor strike reducing activity
- Colorectal referral increase is sustained due to Bowel Screening Campaign (PTL volume increase; further demand/pressure on CTC/colonoscopy) continues to

	impact on the number of patients on the PTL • Staff gaps (vacancies and absence) further impact on diagnostic capacity, radiotherapy & waiting times) • Mobile CT capacity continues to be provided by the IS

12. Cancer 63 day+ Performance – Lower GI, Urology, Skin



What the chart tells us

This metric has been added in response to the Elective Recovery Self-Assessment requirements specifically related to FIT with referral (Lower GI), teledermatology (Skin) and npMRI (urology).

Intervention and Planned Impact

Skin has maintained an improved position 63+ and 104+ day backlog and achievement of FDS each month. The provision of dermatoscopes to GP practices in Hull and East Riding means that 2WW referrals with image are contributing to this performance, there is further work for the Cancer Alliance and the Hull and East Riding Place teams to support.

Urology backlog continues to remain static – access to npMRI is outside the best practice timed pathway and an areas of focus for the improvement actions.

- The front end of the Prostate cancer pathway has been identified for transformation intervention to ensure the right patient is on the right prostate pathway (there are 3 distinct treatment pathways); improvement in backlog numbers and Faster Diagnosis Standard is the expected impact. Progress against this plan has been reinvigorated at a meeting in early May 2023.

Colorectal – 2WW referrals with a FIT test/result remains at a regular 72%; there is work for the Cancer Alliance to support to increase the rate to a target of 80%. A meeting with primary care cancer lead managers and clinicians and the cancer alliance convened in early June to begin a joint plan of action to improve the compliance for GPs to ensure a FIT result is available at the time of 2WW referral.

- LGI Nurse led triage, currently in development, is intended to remove up to 7 days at the front end of the pathway (removes a two-step triage process). Two nurses have been recruited with start date of early August; a period of training will ensue with a view to a fully nurse led triage service up and running in Q3 2023/24.

Risks / Mitigations

- Additional tracking resource for LGI, funded by the Cancer Alliance, demonstrated benefits as the primary PTL was reducing; recent increase in referrals has impacted on recovery. The Trust backlog does not exceed 148 by 31 March 2024. Colorectal contribution is no more than 45 by the end of 2023/24 (currently at 170 over 63 days)
- Urology service improvement action plan has been developed and agreed to address gaps and delays

	• Urology – additional Haematuria capacity, funded by the Cancer Alliance, to reduce the backlog and reduce the PTL volume whilst ensuring patients are on the correct clinical pathway (or discharged). New clinics scheduled in April and May has proven difficult to provide due to lack of sufficient trained staff to support them

13. Elective Recovery Fund

Activity data up to	11/07/2023		Apr	May	Jun
			*Actual activity for current month is projected u		
			Plan activity is from health group submissions w		
Indicative Activity Requirement (% of baseline):			104%	104%	104%
Ceiling target for follow up activity (% of baseline):			75%	75%	75%
TRUST TOTAL	New	Baseline	17,637	17,096	16,632
		Plan	13,078	14,532	15,985
		Actual*	13,572	15,807	16,118
		Plan %	104%	109%	101%
		19/20 Baseline %	77%	92%	97%
	Follow Up	Baseline	33,158	37,048	34,967
		Plan	31,562	35,069	38,576
		Actual*	33,472	39,393	40,231
	(minimise)	Plan %	106%	112%	104%
	(minimise)	19/20 Baseline %	101%	106%	115%
	Day Case	Baseline	6,080	6,198	5,817
		Plan	6,121	6,801	7,481
		Actual*	5,616	6,621	6,647
		Plan %	92%	97%	89%
		19/20 Baseline %	92%	107%	114%
	Ord Elect	Baseline	1,203	1,276	1,296
		Plan	1,079	1,199	1,318
		Actual*	1,016	1,074	1,176
		Plan %	94%	90%	89%
		19/20 Baseline %	84%	84%	91%

What the chart tells us

Recovery of elective activity in June 2023 against the operational plan delivered:

- New Activity 101%
- Follow up Activity 104%
- Day Case Activity 89%
- Ordinary Elective Activity 89%

Intervention and Planned Impact

Access to HOB and ICU capacity remain the limiting factor in relation to IP elective recovery; as is the use of C9A – which was briefly opened to orthopaedics and neurosurgery during April and May 2023, now supporting the HRI 12th floor firebreak for VRE management.

Additional funding to support HOB expansion at HRI however, physical space and workforce is limiting the delivery respectively.

The on-going Junior Doctor Industrial Action impacted during 2023/24 Q1 – cancer performance, OPA and elective activity.

Day case delivered 89% of plan (activity) in June 2023 (114% of 19/20).

OP 1st attendances (activity) achieved 101% of the plan in June 2023 and 97% of 19/20 baseline.

OPFU (activity) continue to over-perform at 104% of the plan and 115% of the 19/20 baseline, income is capped at 85% of 19/20 baselines; further information received in regard to the 2023/2024 planning round will see follow ups with a procedure removed from the requirement to reduce by 75%, which will likely improve the achievement of this metric for HUTH.

Focussed review of OPFU rates and comparison to regional and national performance is continues with the development of OP Transformation Plans at Health Group speciality level. Many procedures are counted/coded in the HUTH follow-ups – work is underway to understand if this activity should be excluded from the reduction in follow up rates.

Risks / Mitigations

- On-going anaesthetic staff shortfalls – rolling recruitment in place and development of Anaesthetic Assistant roles
- 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

14. Non-Elective Activity

Activity data up to	11/07/2023		Apr	May	Jun
			*Actual activity for current month is projected u		
			100%	100%	100%
TRUST TOTAL	Non-elective	Baseline	4,735	4,952	4,603
		Plan	4,928	5,093	4,928
		Actual*	4,847	5,151	4,995
		Plan %	98%	101%	101%
		19/20 Baseline %	102%	104%	109%

What the chart tells us

Non-elective activity in June 2023 was higher than the baseline of 19/20.

Intervention and Planned Impact

-

Risks / Mitigations

-

Hull University Teaching Hospitals NHS Trust

Trust Board

Agenda Item		**Meeting**	Trust Board	**Meeting Date**	12.09.23
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

12th September, 2023

Our People

1. Purpose

The purpose of the report is to provide the Board with an overview of the key people issues.

2. Background

The Trusts workforce remains under significant pressure with demand for some services outstripping supply. A key challenge remains the number of 'No Criteria to Reside' patients in a hospital bed which is currently 132 patients as of 31st August 2023, which affects the number of surgical patients that can be seen and treated. The Trust's Emergency Department also remains under extreme pressure and the flow of patients through our acute assessment areas and wards. The continued medical industrial action is also having an impact upon our elective recovery programme and ED waits.

3. Key Issues

The total staff sickness absence for the financial year 2022-23 was 4.4%. The total absence including sickness and Covid-19 for 2022-23 was 4.8%. The Trust attendance target for 2023/24 is 96.1% (sickness not to be greater than 3.9%).

The Trust total sickness and Covid-19 absence is currently 4.2%. This is a decrease from 4.5% as at the last Board meeting in July 2023.

4. Staff Vacancies

The Trusts overall vacancy position as at 31st July 2023 is as follows:

Staff Group	Establishment WTE	Staff in Post WTE	Temp Workforce WTE	Vacancies WTE	Vacancy Rate %
Additional Clinical Services	1491.5	1387.1	58.7	45.7	3.1%
Add Prof Scientific and Technical	373.4	340.2	1.4	31.8	8.5%
Administrative and Clerical Staff	1631.6	1669.3	14.5	0.0	0.0%
Allied Health Professionals	523.5	508.0	2.7	12.8	2.4%
Estates and Ancillary	615.6	544.2	4.6	66.8	10.9%
Healthcare Scientists	177.2	159.0	0.1	18.1	10.2%
Medical & Dental - Consultant	524.4	486.2	13.0	25.2	4.8%
Medical & Dental - SAS	77.6	57.6	0.1	19.9	25.6%
Medical & Dental – Trainee Grades	723.2	681.7	26.2	15.3	2.1%
Nursing and Midwifery	2561.0	2524.6	32.1	4.3	0.2%

Registered					
Trust Total	8699.0	8357.8	152.2	187.7	2.2%

Overall the Trust vacancy position is 2.2%. The Consultant vacancy rate has increased to 4.8%. The vacancy rate for Registered Nursing and Midwifery is currently 0.2% across the organisation, however this includes 51 international registered nurses who are currently taking their OSCE exam and will be working in a ward area shortly. Please note that the vacancies for Registered Nursing and Midwifery is excluding ODPs and Nurse Associates.

6. Communications and engagement

Group Communications

A new monthly cycle of Group Communications activities has been agreed:

- Chief Executive's all staff bulletin issued to all staff by email every Friday
- Ask the Chief Executive – monthly virtual meeting open to all staff will include exec updates and the option to post questions to the team. The first session will take place on Friday 15th September at 1pm.
- Core brief – issued on a monthly basis. Managers are asked to cascade this brief to their teams at the next available team meeting.

A suite of Group communications materials is under development, including PowerPoint templates, email signature, letterhead and email bulletins.

Discussions around Group websites and intranet have also commenced.

National Staff Survey

The National Staff Survey will go live at the end of September. A Group-wide communications campaign will be launched at go-live, including an agreed package of incentives for staff to complete the survey. Managers are being encouraged to improve the response rate in their areas with a target of 60% return rate for 2023.

7. Staff Support

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, Clinical Psychology, Coaching Services and the Pastoral and Spiritual Care Team for general mental wellbeing support. 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 email address.

Well-Being Update

- Staff Support psychology are providing 2 hour online training on stress management and how to improve sleep
- 8 staff have referred themselves into Staff Support Psychology service in July and August
- 8 TRiM incidents in July and August, resulting in 43 staff receiving Traumatic Incident briefing, and 8 staff requesting and accessing a Trauma Risk Assessment.

8. Learning and Organisational Development

Organisational Development (Leadership Programmes)

- Senior Manager PaCT (Professionalism and Culture Transformation) briefings are now being delivered online and can be booked via HEY 24/7 https://hey247.net/enrol/index.php?id=2819

- HUTH now has a Mary Seacole facilitator which secures us 5 places per cohort
- Development of Registrar to Consultant development programme and SAS Doctors leadership programme
- Development of Inclusion Academy
- 106 staff have completed Great Leaders programmes in FY 2023/24 to date with a further 234 actively progressing through

Organisational Development (Bespoke)

- ICU- development of Clinical Supervision model and Nursing leadership development
- ED-Supporting Nursing leaders with Professionalism and Cultural improvement
- Ongoing progression of improvements to the Appraisal system and process
- Systemic Team Coaching with Infectious Diseases services now happening in September

New OD Interventions

- Theatres-Supporting Nursing Leaders with Professionalism and Cultural Improvement
- Development of Inclusion Academy
- Development of Registrar to Consultant development programme and SAS Doctors leadership programme
- Development of a PNA/PMA (Professional Nurse/Midwife Advocate) network across HUTH

Focus on Maternity

- Ongoing delivery of culture workshops on 'Kindness, Professionalism and Compassion within Maternity Services' from January 2023 – January 2024 for midwives and midwifery assistants. Workshops will expand in October 2023 to invite all staff within Maternity Services
- Incivility Reporting tool has been launched enabling any staff member to report negative behaviours using a QR code which will trigger support from an independent Circle Group (Representatives from Human Resources, Freedom to Speak Up Guardian, Organisational Development)

- Midwifery Leadership Team participating in development activities which involves a team development programme and individual 1-2-1 exploratory meetings.

- Regular tea trolley visits ongoing within Maternity Services to promote the listening sessions and Incivility Reporting tool along with promotion flyers/business cards.

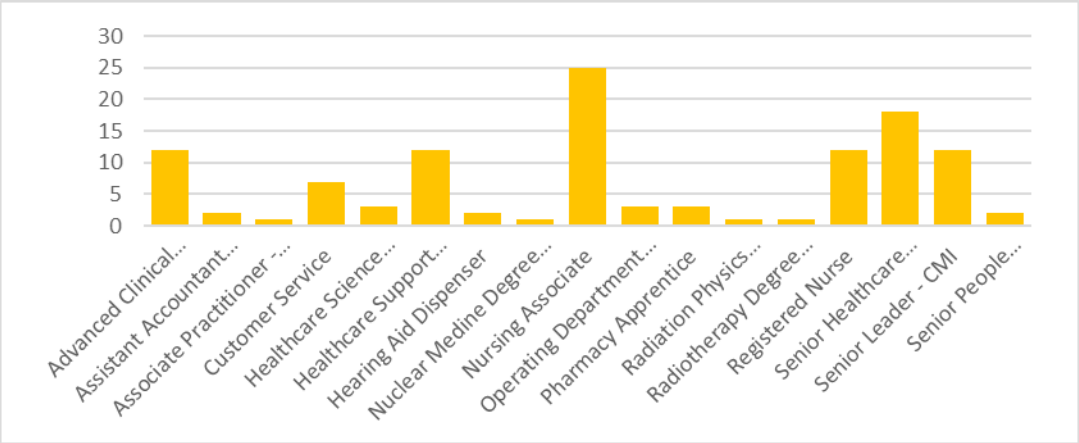
Online support booklet on how to manage your behaviours including how to report.

Staff Appraisal

The Learning Team is currently supporting a working group led by the Organisational Development Team to revise the Trusts appraisal processes and online recording tool – My Appraisal Online/HEY247. The policy is currently under review and will be updated shortly.

Apprenticeships

The graph below summarises planned apprenticeship starts for September & October 2023:



Work Experience Update

Placements have increased significantly this year with close to 100 work experience opportunities booked between September 2022 and November 2023. We are currently working on requests for the academic year 2023-24.

Currently there are 37 different areas across the Trust open to hosting work experiences for those in Years 10, 11, and 12 of full time education. It is hoped to expand opportunities with a review of the current work experience policy, aiming to open up additional areas for young people in these year groups from September.

The WP team are also exploring options with the Trusts' EDI leads to link with local charities to explore options to offer increased access to work experience, and apprenticeships, for talented young people with physical disabilities and/or neurodiversity.

Career Engagement

The team, along with a cohort of 107 career ambassadors, continue to support a scope of career activities across the Hull, East Riding and North Lincs areas (in partnership with colleagues at both NLAG and York Trusts). The team is looking at ways to widening career engagement and knowledge, including a potential project with the ICB/HEY LEP to offer experience days to local teachers to help cascade knowledge and embed health careers within local curriculum delivery.

Human Tissues Licence Update

The Surgical Skills Centre have been granted a licence to run courses using Human Tissue. The first course is set to run on 16th October 2023. The centre are now taking bookings and have interest from several companies who want to run their activities within.

09. 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

Workforce Education and Culture Committee

12th June 2023

Medical Undergraduate Progress report

1. Purpose

The Committee receive a regular progress report detailing undergraduate medical education. The report gives a summary of activity as of 12th June 2023

2. Background

HUTH is the largest single clinical placement partner in the Hull York Medical School NHS partnership area and offers clinical placements across all years of the undergraduate medicine programme (MBBS), including the preceding Gateway year and the 2 year MSc in Physician Associate studies (PA) programme.

Currently at peak delivery times we provide clinical placement opportunities to approximately **579 students** across all programmes.

3. Staffing Update

No new major changes to staffing structure or numbers to report since last update.

We have interviewed and recruited to all clinical teaching fellow (CTF) positions for the next academic year (August 2023).

4. Academic Year 2022/23

Clinical placements for all MBBS years have now finished. Year 5 students have completed their final examinations and their assistantship programme. Year 4 students will have an elective period before returning to placement (as final year students) in August 2023.

Physician associate students remain on placement until July 2023.

5. Achievements – celebrating success and the Student Voice

The **"student voice"** through University and Trust led feedback, forms a key aspect of quality improvement for the HYMS@HUTH team.

Biannual University led, anonymised student surveys provide global scores (out of 10) for each year group's experiences on clinical placement.

In addition, all students are invited to attend end-of-block reviews to discuss their thoughts on what works well, what doesn't and to provide suggestions (Rose – Thorn – Bud). These are, for the most part facilitated by our CTFs, allowing for near peer interactions.

Regular "temperature checks" occur through each rotation. These are facilitated through student liaison officers (SLOs), associate clinical deans (ACDs), clinical dean (CD) and the head of undergraduate medical education.

We operate an "open door" policy allowing students to drop-in to chat and feedback concerns. This may be from a curriculum or personal wellbeing perspective.

HYMS Teachers of Excellence Awards 2023

These awards are voted for, shortlisted and the winners chosen by the student body. As a result they are highly regarded by tutors.

This academic year 28 tutors from the Trust were nominated across a variety of categories.

I am pleased, and proud to announce four winners

Dr Benjamin Huggon	Clinical Teaching Fellow
Dr Mustafa Kayser	Clinical Teaching Fellow
Mr Steven Dumont	PA and Clinical Teaching Fellow
Mrs Tracy Parker	Clinical Skills Facilitator

Hull University Teaching Hospitals Trust Teaching Awards 2023

Mrs Katie Firth	Contribution to Education in the Trust winner
Dr Rob Desborough	Educational Supervisor of the year winner

Golden Hearts Short Listed Nominee 2023

Dr Sebastian Spencer	Previous Senior Clinical Teaching Fellow

Student Survey Free text Feedback (December 2022) – Tutors mentioned

Students took the time to provide positive feedback to named tutors.

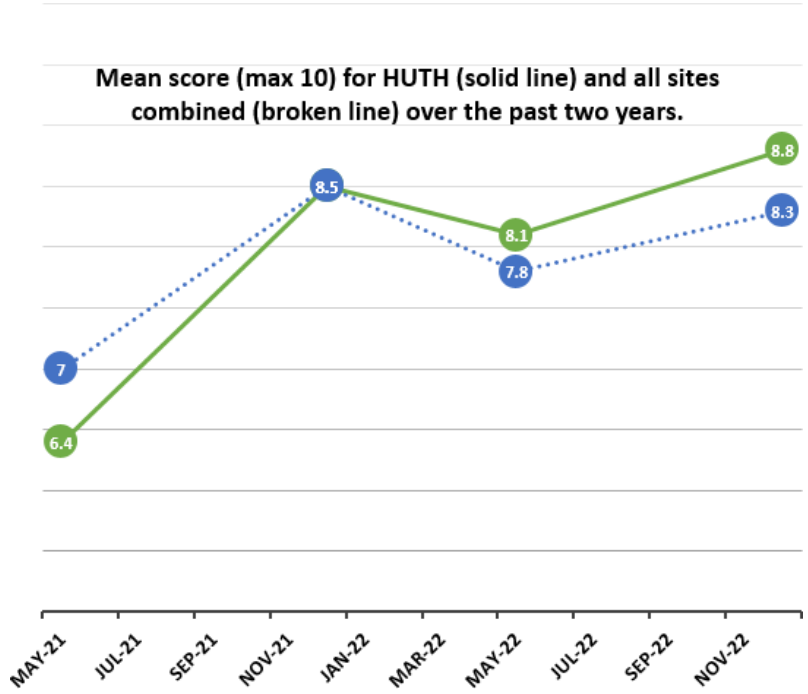
In total **65 individual tutors** received praise across all years of the MBBS programme.

A total of **164 comments** were made.

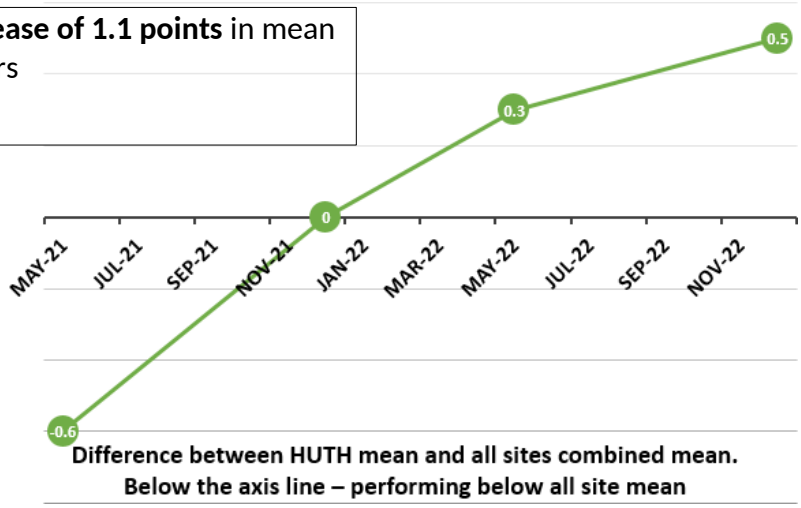
Tutors for specific praise include;

Dr Iszy Lord	Clinical Teaching Fellow	10 comments
Dr Mustafa Kayser	Clinical Teaching Fellow	9 comments
Dr Alex Abel	Clinical Teaching Fellow	8 comments
Dr Remy Toko	Associate Clinical Dean	7 comments
Dr Alec Ming	Consultant Neurologist	5 comments

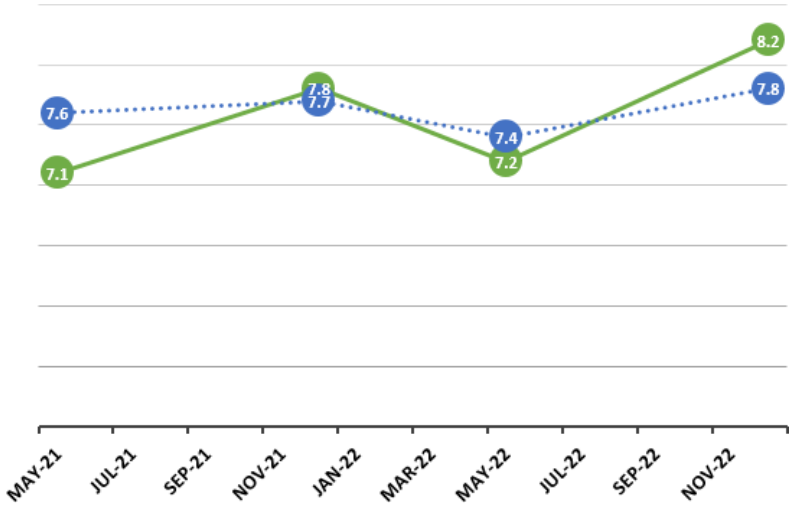
Year 1 MBBS Rating



We have seen an **increase of 1.1 points** in mean student score in 2 years

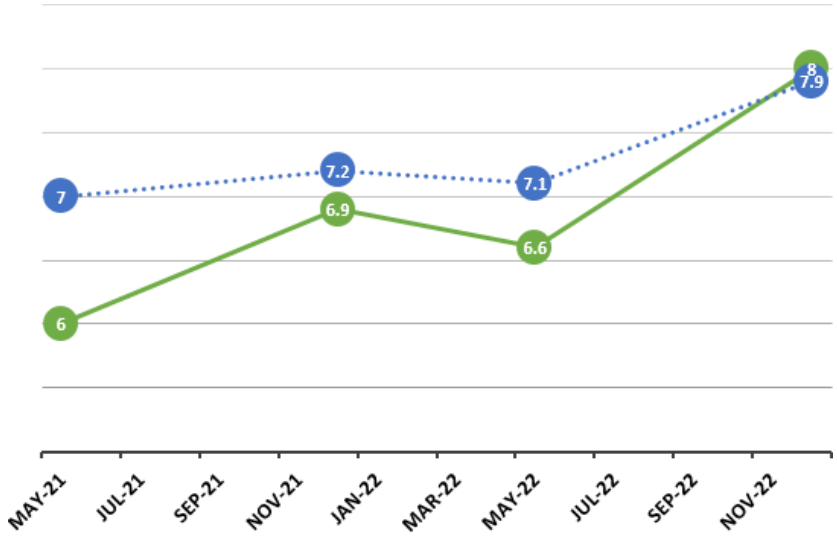


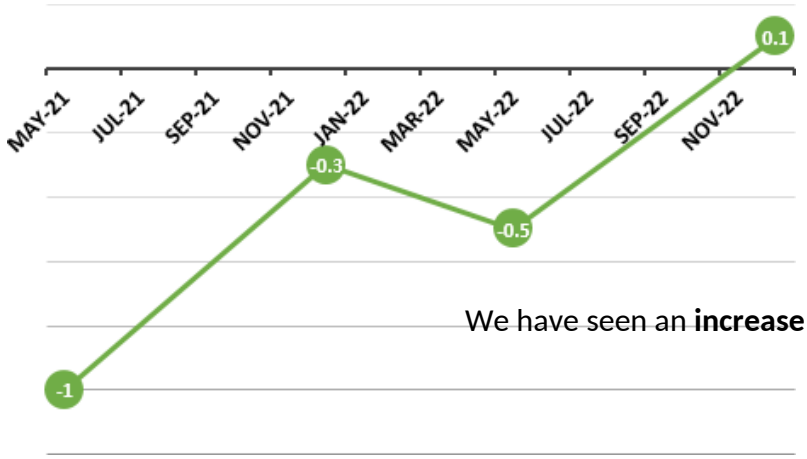
Year 2 MBBS Rating



We have seen an **increase of 0.9 points** in mean student

Year 3 MBBS Rating

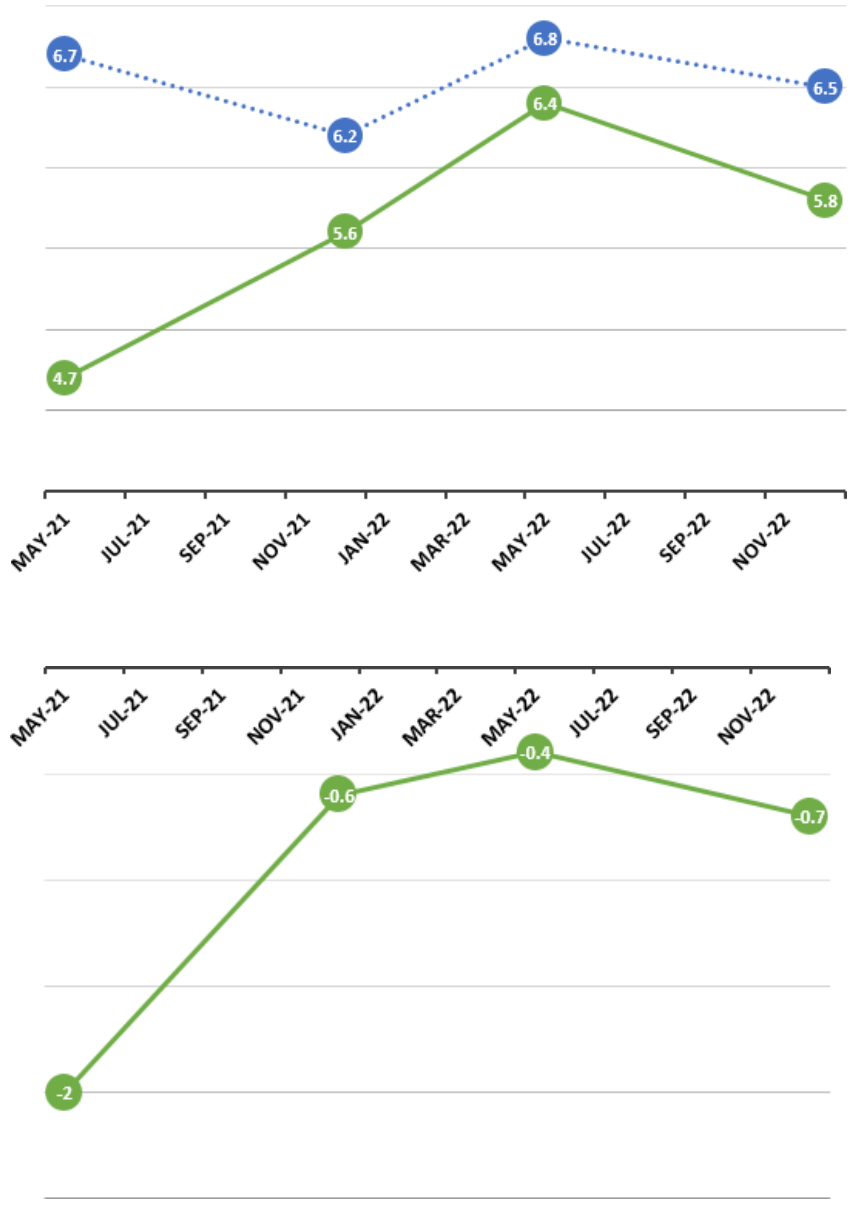




We have seen an **increase of 1.1 points** in mean student

6. Challenges for academic year 2023/24

(i) Year 4 delivery



Women's Health – Year 4 block

A consistent theme from the student free text survey responses is the quality of delivery of the Women's Health (WH) block in year 4.

Key points

Inconsistent experience in different areas of WH – lack of equity
Low level of student focused "bedside teaching" from Consultants
Clinics invariably observational leading to students feeling ignored
Cancellation of teaching activities

Although the majority of tutors are highly regarded, it appears to be the lack of timetabled opportunities within the department. There is inevitably going to be high demand from other non-MBBS trainees and this creates pressure within the department.

It is clear that the Consultants and other healthcare professionals are keen, experienced and excellent educators. However, the need to cover service provision due to staffing levels impacts on student experience.

It also impacts on the positive promotion of the specialty and future recruitment to training in WH.

Work so far

The head of undergraduate education and clinical dean have improved relationships with the WH department and gained a greater understanding of the barriers from their perspective.

We have now recruited two newly appointed Consultants, who will have one PA within their job plan, dedicated to MBBS student teaching.

In addition we have an ST6 trainee from WH, who will be taking 12 months out of training to work as a CTF within the Trust. She will deliver bedside teaching, but also Work with the WH department, ACD and CD on a QIP, looking at how to make best use of the available resources.

We aim to include a focus group of year four students to help.

(ii) Physical Space

Since 2018/19 student numbers have risen from **370 to 579** for 2023/24.

This is a **56% increase**.

Physical teaching space has not increased during this time. In fact, the reverse is likely to be true. The majority of wards, previously had dedicated teaching rooms (HYMS) which were part of the initial set up oh HYMS back in 2003.

There has been a gradual erosion of these teaching rooms, having a direct impact on student experience. For example, there are no teaching spaces in WH.

The purpose built HYMS building at HRI and the first floor in the Daisy Building at CHH have not changed since they were built.

This is a major risk for student experience and potentially for encouraging HYMS graduates to stay within HUTH as junior doctors.

Conclusion

Despite the considerable pressures concerned with student expansion, COVID and tutor recruitment we have assembled a strong and dynamic faculty.

- We are looking at how we can modify current clinic rooms within the HRI HYMS building to create more multipurpose areas on the ground floor. Although this will not solve the issue, it will help to use what space we do have more creatively
- To work with stakeholders to look at what other options are available to increase space (e.g. feasibility of adding a third floor to the current HYMS HRI building)
- Working with the University to look at strategies to increase tutor recruitment and retention (e.g. working with specialties with Consultant vacancies (e.g. haematology) to see if combined education (1- 2 PAs) with clinical (8 – 9 PAs) may be more attractive to applicants)

8. Recommendation

The Committee is requested to note the content of the report and provide any feedback.

Officer to contact:

Dr Makani Purva, Chief Medical Officer