ENCLOSURE 5

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

DEPARTMENT OF PLANNING AND BUSINESS DEVELOPMENT

BOARD OF DIRECTORS

JULY 2017

PERFORMANCE REPORT

INTRODUCTION

Please find enclosed the Performance Report for June 2017 which updates Directors on performance against key national targets.

EXECUTIVE SUMMARY

Performance – NHS Improvement (NHSI) Operational Performance Indicators

The Trust's position in relation to NHSI's operational performance indicators is as follows:

A&E 4 hour target

Performance for June was above the 95% target at 95.82%. In line with agreement from NHS Improvement to view the performance of the system, reported performance includes the urgent care centres in Sunderland.

In terms of attendances to our A&E departments, we experienced a 10% increase in attendances compared to June 2016 (excluding the mid-year counting change there was a 3% increase). We were above our STF trajectory of 90.3% for June and 90% for Q1 (performance for Q1 was 94.89%).

The national performance for May was 89.7%. We remain in the upper middle 25% of Trusts nationally.

Referral to Treatment Time (RTT)

Performance remains above target at 94.67%. At specialty level T&O, Oral Surgery and Thoracic Medicine remain under target with recovery plans in place for these specialties. Urology is marginally under target this month due to a reducing number of incomplete pathways. This is being discussed with the team as performance has remained close to standard for a number of months.

National performance for May remains below the standard at 90.4%.

Cancer targets (2 week, 31 and 62 day waits)

Due to cancer reporting timescales being 1 month behind, the performance report includes May's confirmed position. The Trust met all cancer waiting time standards with the exception of cancer 62 day waits from GP referral (69.77%) and consultant upgrade (84%).

As flagged last month we have seen a high number of 62 day breaches in Urology and other tumour groups resulting in the lowest performance in the last 12 months. Performance against the 62 day standard remains a risk going forwards linked to Urology and various actions are underway with the team.

Also as flagged last month there are a number of potential 31 day breaches in June and July in Urology and Head and Neck. Indicative performance for June is currently above target however.

National performance against the 62 day standard remains below target at 81%.

Diagnostics

Performance for June remains above the 1% standard at 2.58% of patients waiting over 6 weeks for their diagnostic test. A revised recovery trajectory has been provided to NHS Improvement which shows achievement by September.

There is a risk of breaches in neurophysiology which have not been factored into the recovery trajectory. These are linked to capacity and the Directorate are looking at securing additional capacity to address this.

National performance for May was 1.9%.

FINANCIAL IMPLICATIONS

For June there are minimal local penalties to be applied relating to cancelled operations 28 day breaches. The STF funding relating to A&E performance will not be achieved given the financial control total was not met (139K).

RECOMMENDATIONS

Directors are asked to accept this report and note the risks going forwards.

Alison King
Head of Performance and Information Management

City Hospitals Sunderland chs

Performance Report
June 2017

City Hospitals Sunderland Performance Scorecard

The Performance Report / Corporate Dashboard utilises a visual management approach to the Trust's monthly Performance, covering NHS Improvement Single Oversight Framework metrics as well as national performance measures from the NHS Standard Contract 2017/18 and 'NHS Operational Planning and Contracting Guidance 2017 to 2019'.

Indicator	Director Lead	Target	2016/17	2017/18						12-month trend	Page
			Actual	Month[1]	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD		
Operational Performance Measures - NHSI SOF: These metrics are used by NHS Improvement and form one of the five themes from the Single Oversight Framework, which is used to assess our operational performance. This will influence our segmentation and level of support. They also form part of the 2017/18 NHS Standard Contract.											
A&E - % seen in 4hrs	Sean Fenwick	≥95%	92.97%	95.82%	94.89%				94.89%		4
RTT - % incompletes waiting <18 wks	Sean Fenwick	≥92%	94.00%	94.67%	94.55%				94.55%		5
Cancer waits - % 62 days	Sean Fenwick	≥85%	84.00%	69.77%	77.05%				77.05%		6
% Diagnostic tests ≥6 wks	Sean Fenwick	<1%	2.14%	2.58%	2.75%				2.75%		7
National Operational Standards: These are national targets that the NHS must achieve, mostly falling under the domain of quality, which are linked to delivery of the NHS Constitution. They also form part of the 2017/18 NHS Standard Contract.											
Cancelled operations 28 day breaches	Sean Fenwick	0	34	2	11				11		N/A
Cancer waits - % 2ww	Sean Fenwick	≥93%	95.91%	97.18%	97.14%				97.14%		8
Cancer waits - % 31 days	Sean Fenwick	≥96%	98.67%	98.73%	98.00%				98.00%		9
Cancer waits - % 31 days for subsequent treatment - surgery	Sean Fenwick	≥94%	98.40%	96.15%	96.49%				96.49%		9
Cancer waits - % 31 days for subsequent treatment - drugs	Sean Fenwick	≥98%	99.90%	100.00%	100.00%				100.00%		9
Cancer waits - % 62 days from screening programme	Sean Fenwick	≥90%	100.00%	100.00%	100.00%				100.00%		6
Cancer waits - % 62 days from consultant upgrade	Sean Fenwick	≥85%	88.20%	84.00%	82.61%				82.61%		6
National Quality Requirements: These also form part of the 2017/18 NHS Standard Contract. In addition there are a number of zero tolerance indicators that are reported by exception, including Mixed Sex Accommodation breaches, A&E 12-hour trolley waits and urgent operations cancelled for the second time											
RTT - No. incompletes waiting 52+ weeks	Sean Fenwick	0	0	0	0				0		N/A
A&E / ambulance handovers - no. 30-60 minutes	Sean Fenwick	0	1349	38	239				239		4
A&E / ambulance handovers - no. >60 minutes	Sean Fenwick	0	381	5	41				41		4
% VTE risk assessments	Ian Martin	≥95%	98.49%	98.62%	98.64%				98.64%		N/A

1. Performance is one month behind normal reporting for all Cancer indicators (May 2017)

City Hospitals Sunderland Performance Report Overview

This page explains the general layout of the indicator pages that form the bulk of the report

Key:

- Actual performance
- Target, operational standard, threshold or trajectory
- Sustainability & transformation fund (STF) trajectory
- Benchmark (National, Regional or Peer Group)
- Comparative performance for the previous year
- Performance achieving the relevant target
- Performance not achieving the relevant target

Page title representing a key performance indicator or a

Indicator group

Indicator information, including a brief description, the name of the Director lead and consequence of failure

Narrative highlighting recent performance and corrective actions, where applicable

Chart or table relevant to the indicator(s), often displaying Directorate level performance or other supporting information

Cancer 2 Week Waits

National Operational Standards

1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience, clinical outcomes & financial sanction

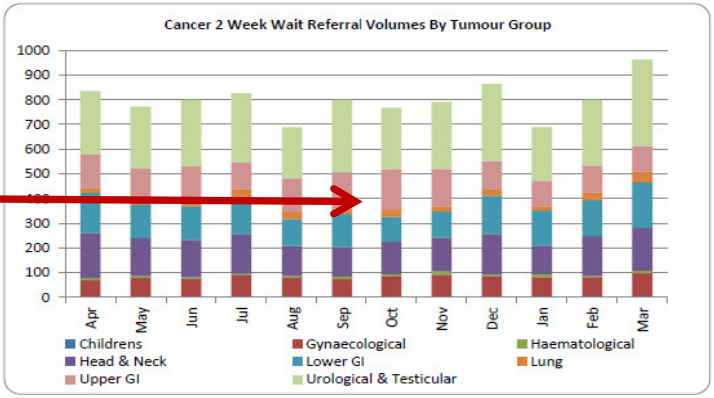
Potential financial sanction if standard not achieved = £200 per breach

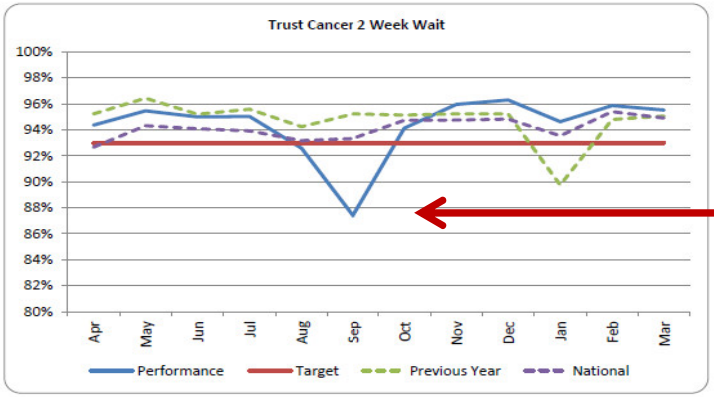
2WW performance has remained stable in March at 95.5%, which continues to perform above target. At tumour site level, all areas achieved the target this month.
March's performance demonstrated that all tumour groups are performing about the same or better than the equivalent national benchmarking position.
The finalised position for quarter 4 was above target at 95.4%.
Referral volumes were higher than usual in March, with significantly more referrals compared to average within Lung, Lower GI and Urological tumour groups.
Indicative 2WW performance for April is slightly below target.

Referrals for Suspected Cancer - March 2016*	Volume	Total Breached	Performance	National Benchmark	YTD
Target			93%	93%	93%
Acute Leukaemia	0	0	-	-	100.00%
Children's Cancer	1	0	100.00%	95.7%	100.00%
Gynaecological	97	1	98.97%	95.1%	97.78%
Haematological (Excluding Acute Leukaemia)	10	0	100.00%	96.6%	99.06%
Head & Neck	173	10	94.22%	95.0%	96.25%
Lower Gastrointestinal	185	11	94.05%	94.3%	93.46%
Lung	44	2	95.45%	95.9%	95.56%
Testicular	15	0	100.00%	96.3%	97.90%
Upper Gastrointestinal	103	7	93.20%	92.4%	86.79%
Urological (Excluding Testicular)	334	12	96.41%	95.0%	96.07%
Total	962	43	95.53%	94.9%	94.40%

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales

Table showing current performance compared to target (where relevant)





Trend chart displaying the performance over the past 12 months or year to date

Accident & Emergency

NHSI SOF Operational Performance, National Operational Standard & National Quality Requirements

1. % patients who spent 4 hours or less from arrival to admission, transfer or discharge
2. Ambulance handover delays between 15-30 minutes, 30-60 minutes & over 60 minutes

Director Lead: Sean Fenwick

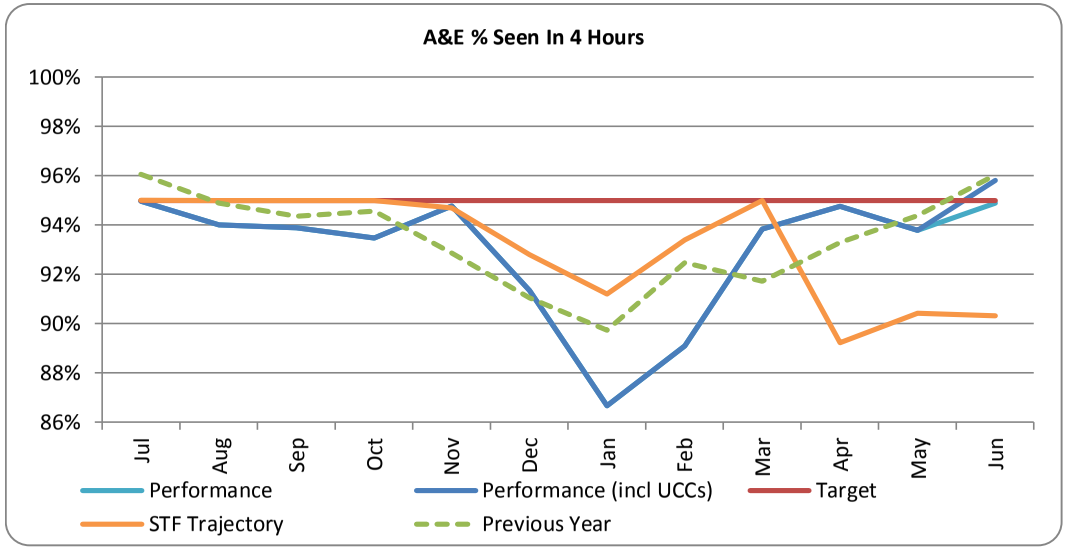
Consequence of failure: Patient experience, quality, access, reputation & financial impact if the STF trajectory is not achieved, which equates to £139k per month during quarter 1

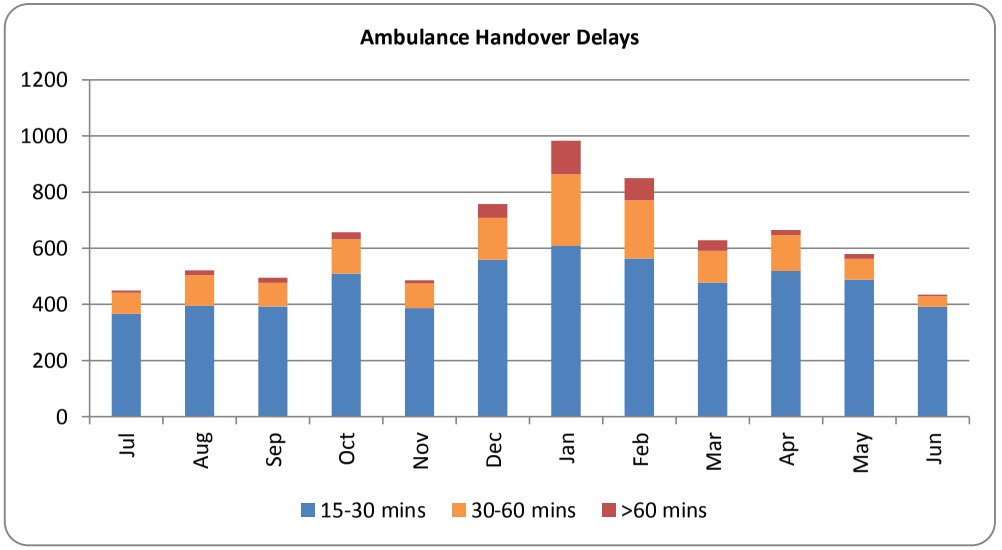
The total proportion of patients seen in A&E within 4 hours increased during June to 94.89%. When taking in to account activity at urgent care centres (UCCs) the proportion of patients increased to 95.82%. This is the first time the Trust has been above the standard since June 2016. Operational pressures reduced slightly in June; the Trust remained at the lowest OPAL status throughout the month. Our performance for May remained in the upper middle 25% of trusts nationally.

There were 13,039 attendances this month, which is 10% higher than June 2016 (type 1 was up by 9%, type 2 was up by 6% and type 3 was up by 16%). Discounting the counting change, there was a 3% increase in attendance numbers year on year.

There were 2,538 ambulance arrivals this month, which is about the same as June 2016. This continues to represent the third highest volume of ambulance arrivals for any hospital across the North East. The number of handover delays were less than May and constitutes a saving of 2462 minutes in ambulance crew time.

A&E Indicators - June 2017	Target	Month	YTD
A&E % seen in 4hrs - Trust Total (incl. UCCs)	≥95%	95.82%	94.89%
A&E % seen in 4hrs - Trust Total	≥95%	94.89%	94.47%
A&E < 4 hrs - Type 1	≥95%	91.64%	90.98%
A&E < 4 hrs - Type 1 - High Acuity	≥95%	82.86%	80.90%
A&E < 4 hrs - Type 1 - Low Acuity	≥95%	91.85%	90.84%
A&E < 4 hrs - Type 1 - Paediatrics	≥95%	97.75%	98.59%
A&E < 4 hrs - Type 2 - SEI	≥95%	99.44%	99.27%
A&E < 4 hrs - Type 3 - Pallion walk in centre	≥95%	99.68%	99.81%
A&E < 4 hrs - Type 3 - UCCs	≥95%	98.26%	98.26%
A&E Attendances - Trust Total (incl. UCCs)		17,989	43,903
A&E Attendances - Trust Total		13,039	38,953
A&E Attendances - Type 1		7,687	23,144
A&E / ambulance handovers - no. 15-30 minutes	0	392	1,401
A&E / ambulance handovers - no. 30-60 minutes	0	38	239
A&E / ambulance handovers - no. >60 minutes	0	5	41





Referral to Treatment (RTT)

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients waiting on an incomplete RTT pathway at month end
2. Number of patients on an incomplete RTT pathway waiting 18 weeks or more
3. Percentage of patients waiting less than 18 weeks on incomplete pathways
4. National RTT Stress Test - % risk of failing the incomplete standard in next 6 months

Director Lead: Sean Fenwick

Consequence of failure: Patient experience, quality, access & reputation.

The finalised aggregate level performance for incomplete pathways at the end of June was above target at 94.7%, which is the same as last month. The Trust remains above the national target of 92.0%.

At specialty level Thoracic Medicine, Trauma & Orthopaedics (T&O), Oral & Maxillo Facial Surgery (OMFS) and Urology.

T&O performance improved by over 1% in June, however, remains in formal escalation and is at risk of meeting the August recovery target. Thoracic Medicine has maintained May's performance at 84.0%. The specialty's performance continues to be monitored closely.

OMFS also remains in formal internal escalation. Their performance reduced in June we and are currently assessing achievement of the standard planned for in August.

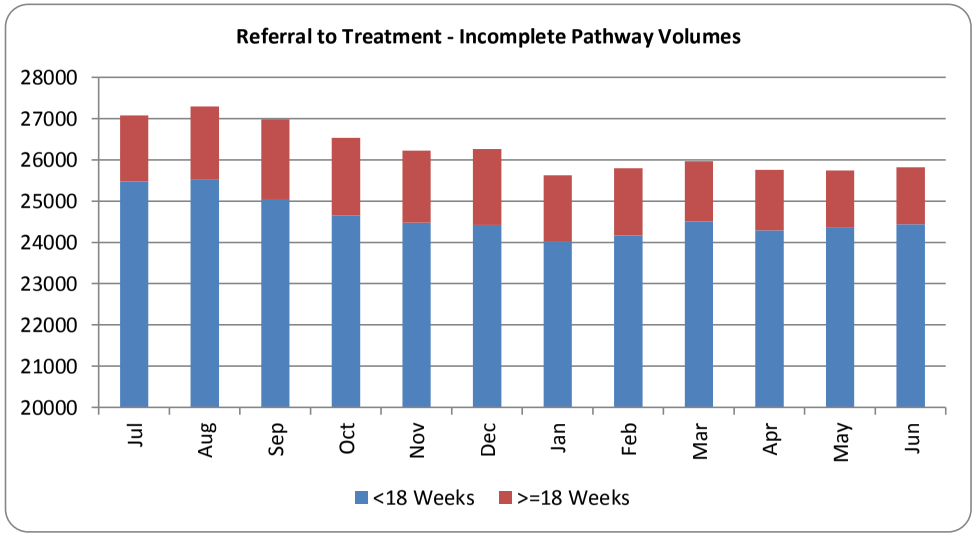
Urology failed to meet the standard in June at 91.9%. Performance will be monitored to ensure recovery.

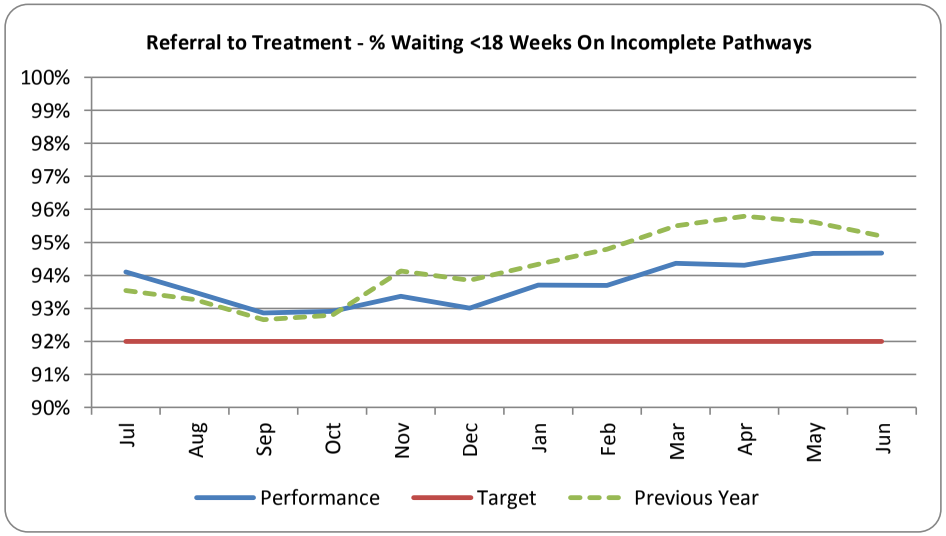
The Trust's RTT stress test risk rating has reduced in May and is assessed as having a 10% chance of failing the RTT operational standard in the next 6 months. We are ranked 20th (best) nationally, an reduction of 2 places on the previous month.

RTT Incompletes - June 2017	Volume	No. ≥18 Weeks	% <18 Weeks*
Target			**≥92%**
Cardiology	627	0	100.00%
Ear, Nose & Throat	2,714	128	95.28%
Gastroenterology	334	1	99.70%
General Surgery	1,802	83	95.39%
Geriatric Medicine	418	13	96.89%
Gynaecology	1,144	45	96.07%
Neurology	793	15	98.11%
Ophthalmology	3,983	30	99.25%
Oral & Maxillo Facial Surgery	1,876	200	89.34%
Rheumatology	621	23	96.30%
Thoracic Medicine	868	139	83.99%
Trauma & Orthopaedics	2,890	417	85.57%
Urology	2,599	210	91.92%
Other	5,152	71	98.62%
Trust Total	**25,821**	**1,375**	**94.67%**

**De minimis* level >= 20 pathways in total

RTT Stress Test	Mar-17	Apr-17	May-17
% Risk of failure in next 6 months	11.46%	12.47%	9.61%
National rank (1st is best)	20/153	18/152	20/153





Cancer 62 Day Waits

NHSI SOF Operational Performance & National Operational Standard

1. Number of patients receiving first definitive treatment for cancer following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
2. Number of patients receiving first definitive treatment for cancer 62 days or more following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
3. % patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade
4. Number of patients receiving first definitive treatment for cancer 104 days or more following an urgent GP referral for suspected cancer / NHS Screening Service referral / consultant upgrade

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience & clinical outcomes.

62 day performance was below target, STF trajectory and the national average in May at 69.8%. Most of the tumour groups were below target this month with Lung, Sarcoma, Upper Gastrointestinal, Urological, Lower Gastrointestinal and Breast falling below target. There were 26 breaches in total, of which the majority were attributable to complex/diagnostic delays, medical, capacity and patient choice. There were a higher number of breaches than usual in Lung due to patient complexity. The breaches in Urology were as a result of increased 2ww referrals in March, lower theatre capacity and a higher proportion of patients who required surgery.

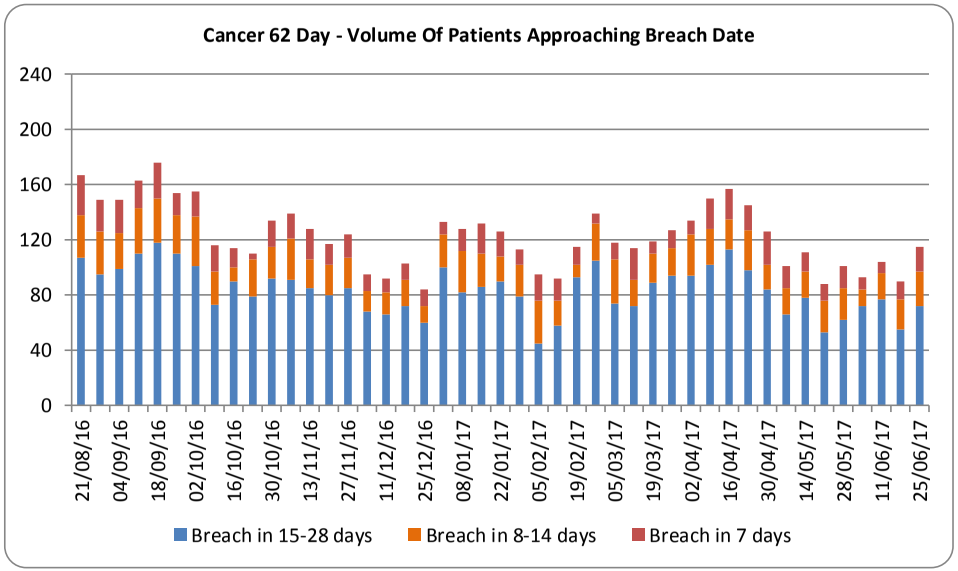
Patients who are approaching their breach date are increasing after recent reductions.

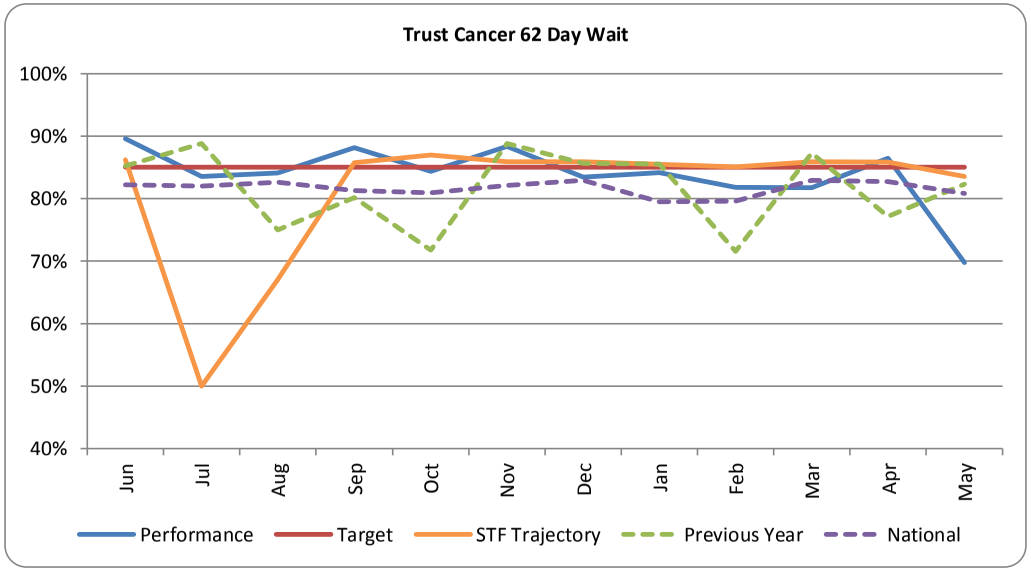
Indicative performance for June is currently below the national target. Achievement of the STF trajectory and operational standard remains a risk going forwards. Actions are underway for Urology in particular.

First Definitive Treatment - May 2017*	Volume	Total Breached	Performance	National Performance	YTD	Number ≥104 days
Target			**85%**	**85%**	**85%**	**0**
Breast	2.0	0.5	75.00%	93.2%	80.00%	0
Gynaecological	1.5	0.0	100.00%	78.1%	100.00%	0
Haematological (Excluding Acute Leukaemia)	8.0	0.0	100.00%	78.8%	100.00%	0
Head & Neck	6.5	0.5	92.31%	65.4%	84.00%	0
Lower Gastrointestinal	7.5	2.0	73.33%	68.4%	77.14%	0
Lung	7.5	4.5	40.00%	72.2%	58.33%	1
Other	0.0	0.0	-	77.3%	100.00%	0
Sarcoma	2.0	1.0	50.00%	66.3%	50.00%	0
Skin	2.5	0.0	100.00%	96.1%	87.50%	0
Upper Gastrointestinal	3.5	1.5	57.14%	72.6%	76.92%	1
Urological (Excluding Testicular)	45.0	16.0	64.44%	75.2%	74.53%	5
Total	**86.0**	**26.0**	**69.77%**	**80.8%**	**77.05%**	**7**

Non GP Referrals						
Screening (Target: 90%)	0.5	0.0	100.00%	92.0%	100.00%	0
Consultant Upgrade (Target: 85%)	12.5	2.0	84.00%	87.9%	82.61%	0

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





Diagnostics

NHSI SOF Operational Performance & National Operational Standard

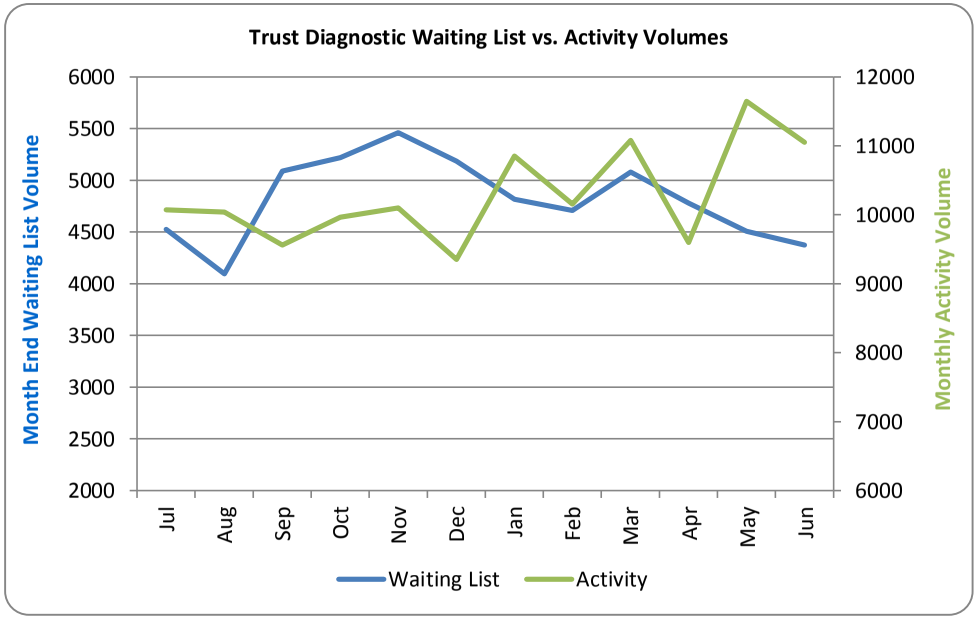
1. Number of patients on the diagnostic waiting list at month end
2. Number of patients on the diagnostic waiting list at month end waiting 6 weeks or more
3. % patients waiting 6 weeks or more for a diagnostic test at month end
4. Number of diagnostic tests/procedures carried out in month

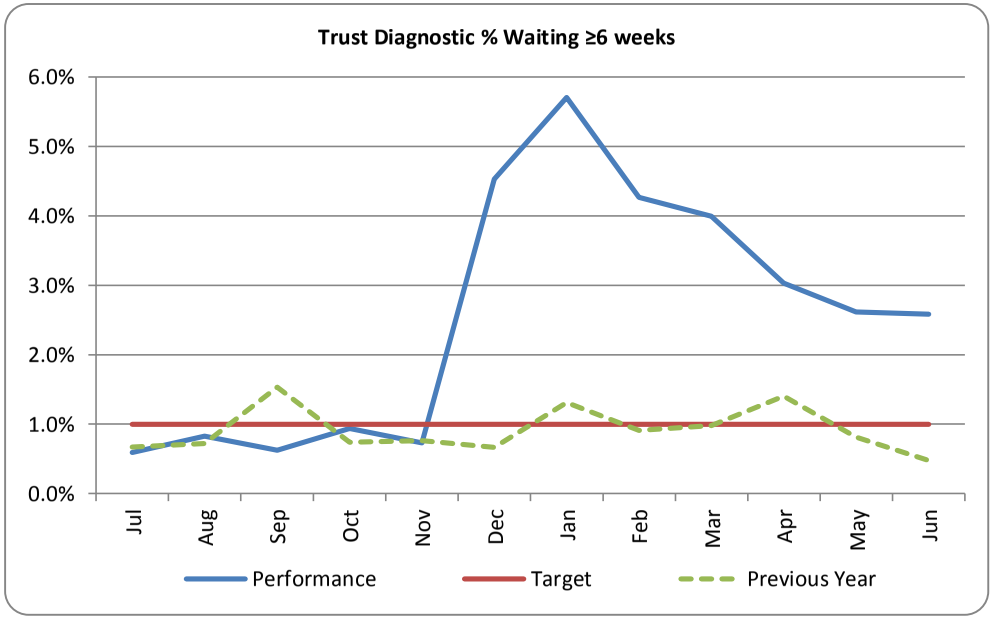
Director Lead: Sean Fenwick

Consequence of failure: Patient experience, quality, access & reputation

The proportion of patients waiting 6 weeks or more at the end of June was about the same as last month at 2.6%; this is above both the national operating standard of <1%, however below the revised NHSI recovery trajectory of 2.63%. Cardiology, Urodynamics and Audiology exceeded the standard this month with the majority of the breaches being attributable to echo and videocystometrography (VCMG) tests. However there were fewer echo breaches than May. Cardiology continue to provide additional capacity. Urology are actively reviewing patients on the VCMG waiting list and referring for alternative tests where clinically appropriate. Additional capacity is now in place with increased cases per list where appropriate. The standard is now predicted to be achieved in September however, there is concern over a short term capacity issue in Neurophysiology that presents a risk to recovery in September. Additional capacity is being sought.
The number of patients waiting at the end of the month decreased in June mainly due to reductions in Magnetic Resonance Imaging, Urodynamics and Audiology . Activity decreased in June. The main decreases were seen in Audiology, Computed Tomography and Cystoscopy.

Diagnostics - June 2017		WL Volume	No. ≥6 weeks	%≥6 weeks	Activity
Target				≤1%	
Imaging	Magnetic Resonance Imaging	563	0	0.00%	1,311
	Computed Tomography	498	0	0.00%	2,966
	Non-obstetric ultrasound	1,019	0	0.00%	3,048
	Barium Enema	37	0	0.00%	9
	DEXA Scan	132	0	0.00%	191
Physiological Measurement	Audiology - assessments	169	14	8.28%	1,090
	Cardiology - echocardiography	886	79	8.92%	906
	Neurophysiology - peripheral	146	0	0.00%	126
	Respiratory physiology - sleep studies	67	0	0.00%	80
	Urodynamics - pressures & flows	202	18	8.91%	134
Endoscopy	Colonoscopy	130	0	0.00%	257
	Flexi sigmoidoscopy	65	0	0.00%	95
	Cystoscopy	309	1	0.32%	525
	Gastroscopy	151	1	0.66%	313
Trust Total		**4,374**	**113**	2.58%	**11,051**





Cancer 2 Week Waits

National Operational Standard

1. Number of urgent GP referrals for suspected cancer
2. Number of patients seen after more than two weeks following an urgent GP referral for suspected cancer
3. % patients seen within two weeks of an urgent GP referral for suspected cancer

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience & clinical outcomes

2WW performance was 97.2% in May, about the same as the previous month and better than May last year and the national average. At tumour site level, all areas achieved the target with the exception of Haematological tumour group which is subject to low volumes.

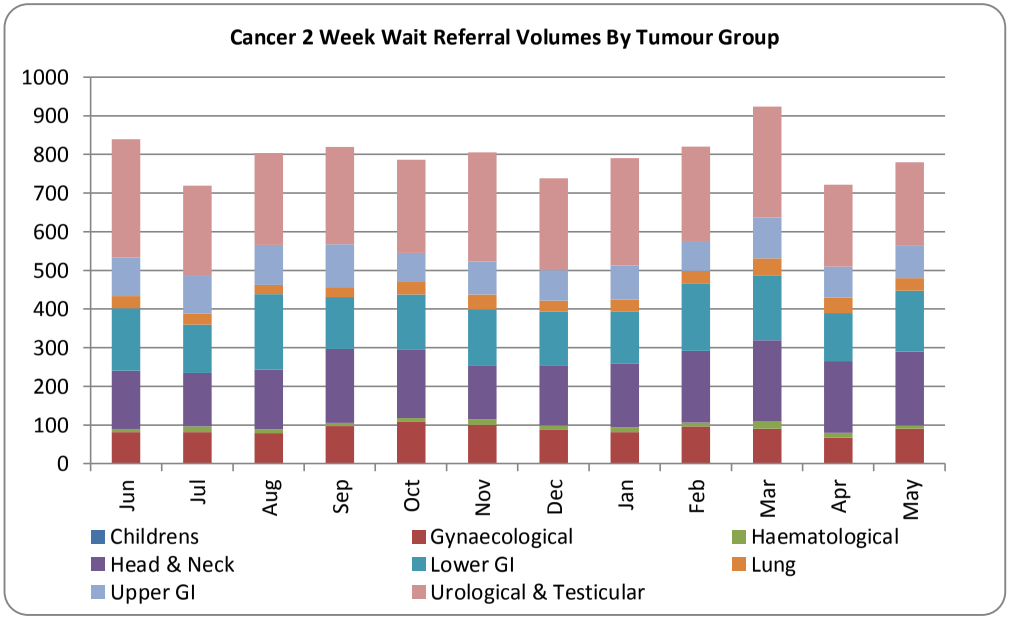
May's performance demonstrated that all tumour groups with the exception of Haematological, performed about the same or better than the equivalent national performance position.

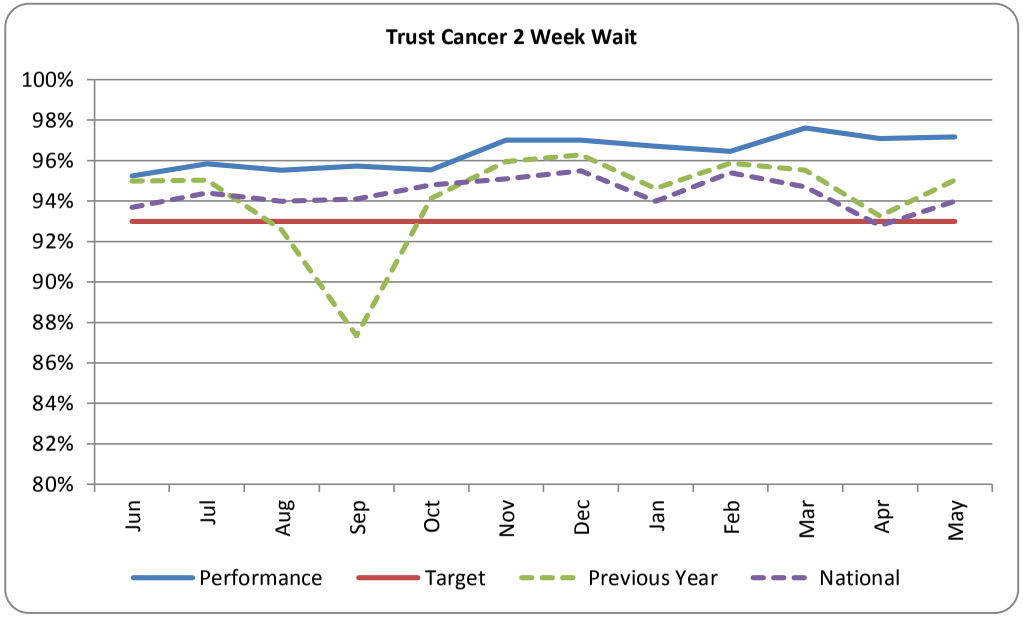
Overall referral volumes increased during May. However Urological & Testicular and Upper Gastrointestinal have decreased compared to the average over the last 12 months.

Indicative 2WW performance for June is above target.

Referrals for Suspected Cancer - May 2017*	Volume	Total Breached	Performance	National Performance	YTD
Target			**93%**	**93%**	**93%**
Acute Leukaemia	0	0	-	-	-
Breast	0	0	-	94.5%	-
Children's Cancer	1	0	100.00%	95.1%	100.00%
Gynaecological	90	3	96.67%	95.8%	96.20%
Haematological (Excluding Acute Leukaemia)	8	1	87.50%	96.3%	95.00%
Head & Neck	192	5	97.40%	95.9%	97.62%
Lower Gastrointestinal	157	6	96.18%	92.7%	96.80%
Lung	32	1	96.88%	95.7%	98.61%
Other	0	0	-	97.5%	-
Testicular	10	0	100.00%	97.2%	100.00%
Upper Gastrointestinal	84	3	96.43%	93.0%	95.73%
Urological (Excluding Testicular)	206	3	98.54%	94.7%	97.54%
Total	**780**	**22**	**97.18%**	**94.0%**	**97.14%**

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





Cancer 31 Day Waits

National Operational Standard

1. Number of patients receiving first definitive treatment following a cancer diagnosis
2. Number of receiving first definitive treatment more than one month of a decision to treat following a cancer diagnosis
3. % patients receiving first definitive treatment within one month of a decision to treat following a cancer diagnosis
4. % patients receiving subsequent surgery or drug treatments for cancer within 31 days

Director Lead: Sean Fenwick

Consequence of failure: Timely access to treatment, patient experience & clinical outcomes.

There were two 31 day breaches overall during May. Aggregate level performance was above target at 98.7%. All tumour groups achieved the target with the exception of the Skin tumour group which is subject to low volumes. Performance across all tumour groups, with the exception of Skin, was better than the equivalent national average.

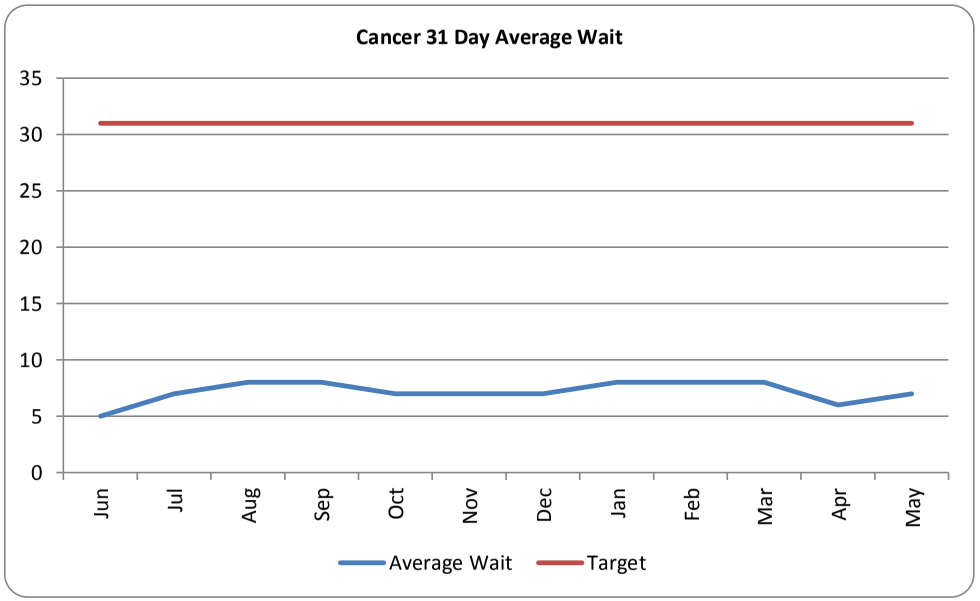
Indicative performance for June is currently below target due to breaches in Head and Neck which were flagged last month. Validation is ongoing.

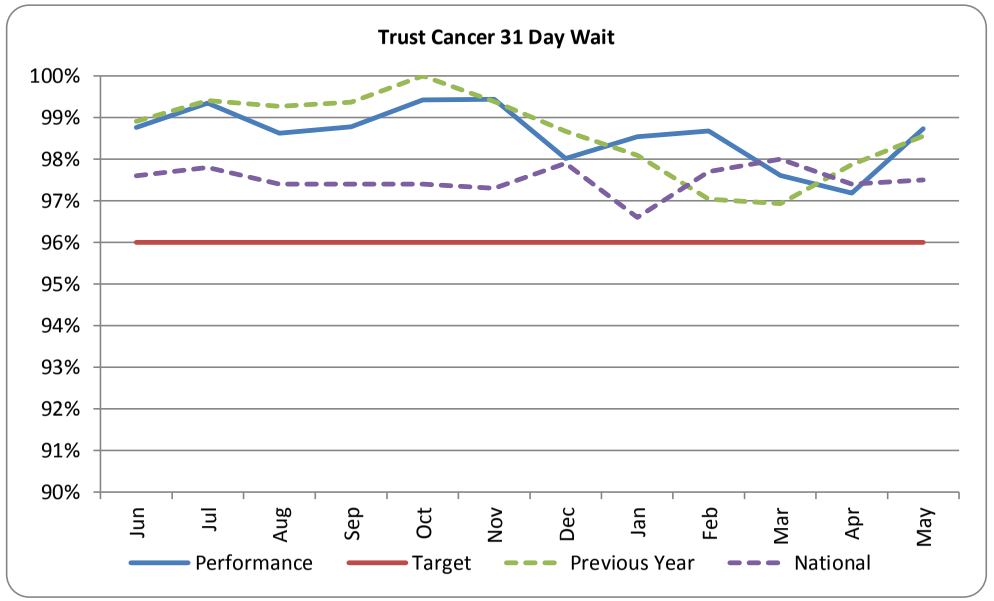
The final performance for both subsequent surgical and drug treatments were above target for May at 96.2% and 100% respectively.

First Definitive Treatment - May 2017*	Volume	Total Breached	Performance	National Performance	YTD
Target			**96%**	**96%**	**96%**
Breast	4	0	100.00%	98.0%	100.00%
Gynaecological	5	0	100.00%	96.9%	100.00%
Haematological	17	0	100.00%	99.8%	100.00%
Head & Neck	8	0	100.00%	94.9%	100.00%
Lower Gastrointestinal	13	0	100.00%	97.3%	100.00%
Lung	16	0	100.00%	98.3%	100.00%
Other	1	0	100.00%	99.1%	100.00%
Sarcoma	2	0	100.00%	95.8%	100.00%
Skin	5	1	80.00%	98.0%	87.50%
Upper Gastrointestinal	6	0	100.00%	98.5%	100.00%
Urological	81	1	98.77%	95.6%	96.69%
Total	**158**	**2**	**98.73%**	**97.5%**	**98.00%**

Subsequent Treatments					
Surgery (Target: 94%)	26	1	96.15%	96.1%	96.49%
Drug (Target: 98%)	79	0	100.00%	99.3%	100.00%

*Please note that reporting of official cancer waiting times fall 1 month behind normal reporting timescales





CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

JULY 2017

SAFEGUARDING ADULTS ANNUAL REPORT 2016-17

EXECUTIVE SUMMARY

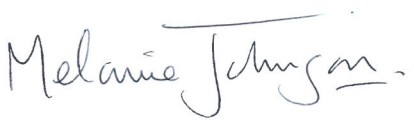
The Care Act (2014) sets out the statutory framework for adult safeguarding, stipulating local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. Partner agencies have a duty to cooperate placed upon them under the Act. What this means in practice is that where agencies are asked to provide information, undertake actions from a safeguarding enquiry, or to attend and or to support the safeguarding process in other ways they have a legal duty to cooperate with reasonable requests/enquiries made by the Local Authority. This puts safeguarding adults on the same statutory footing as safeguarding children.

Additionally, the criteria for safeguarding adults have been broadened in the Act, with the person no longer having to be in receipt of services to be considered under safeguarding procedures. The types of abuse set out in the Act have also been extended to include a wider range of concerns, including for example self-neglect among others.

There have been significant changes in relation to Deprivation of Liberty Safeguards over 2016-17, following the decision of the Supreme Court (Cheshire West March 2014), which resulted in a significant rise in the number of Deprivation of Liberty Safeguards (DoLS) applications within the Trust.

In January 2017 the Court of Appeal handed down a judgement (The Ferreira case 2017) in relation the Deprivation of Liberty in the administration of life saving treatment, particularly in relation to patients cared for in an intensive care setting. This has resulted to changes to the DoLS application on both City Hospitals Sunderland Foundation Trust (CHSFT) and South Tyneside Foundation Trust (STFT) sites.

This report provides a summary for 2016-17 of the safeguarding adults activity and the arrangements in place at STFT and CHSFT with regard to the statutory responsibilities under the Care Act (2014).



Melanie Johnson
Executive Director of Nursing and Patient Experience

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CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

JULY 2017

SAFEGUARDING ADULTS ANNUAL REPORT 2016-17

1.0 BACKGROUND

1.1 The Care Act (2014) sets out the statutory framework for adult safeguarding, stipulating local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. Partner agencies have a duty to cooperate placed upon them under the Act. What this means in practice is that where agencies are asked to provide information, undertake actions from a safeguarding enquiry, or to attend and or to support the safeguarding process in other ways they now have a legal duty to cooperate with reasonable requests/enquiries made by the Local Authority. This puts safeguarding adults on the same statutory footing as safeguarding children.

1.2 Additionally, the criteria for safeguarding adults have been broadened in the Act, with the person no longer having to be in receipt of services to be considered under safeguarding procedures. The types of abuse set out in the Act have also been extended to include a wider range of concerns, including for example self-neglect among others. This will mean that a number of concerns which previously were not considered a safeguarding issue will now be covered by the safeguarding procedures.

1.3 The South Tyneside Safeguarding Adults Board (SAB), Gateshead Safeguarding Adults Board (GSAB) and the Sunderland Safeguarding Adults Board (SSAB) are responsible for their Safeguarding Adult Procedures for responding to suspicions or allegations of abuse, which complies with the statutory requirements of the Care Act (2014) and provides comprehensive guidance for staff. These changes have provided further responsibility on partner agencies to embed "Making safeguarding personal", especially in terms of ensuring the person is involved at the beginning of the process, seeking consent, ascertaining what outcomes the person wants and where possible helping to achieve those outcomes through the safeguarding process.

2.0 ROLES AND RESPONSIBILITIES

2.1 Our statutory duty to safeguard adults at risk means that robust internal systems need to be in place. At CHSFT there has been further investment in relation to Safeguarding Adults. Two secondment posts were agreed following funding from Sunderland Clinical Commissioning Group (CCG). A Safeguarding Adults Lead was recruited in June 2016 and a Safeguarding

Adults Administrator was recruited in August 2016. A number of staff have key statutory responsibilities for safeguarding in STFT and CHSFT, these are:

Executive Lead for Safeguarding Adults and Children, Mental Health	Melanie Johnson, Executive Director of Nursing and Patient Experience (STFT and CHSFT)
Safeguarding Adults Lead PREVENT lead	Margaret Deary, Safeguarding Adults Lead (CHSFT) Christine Johnson, Named Nurse Safeguarding Adults (STFT) Tracy Dawson Adult Safeguarding Advisor (STFT)
Clinical Lead for Mental Capacity Act/DoLS	Dr Lesley Young, Consultant Care of the Elderly (CoTE) (CHSFT) Dr Nasser, Associate Medical Director, Mental Capacity Lead (STFT)
Learning Disability lead	Ashley Murphy, Acute Liaison Nurse, Learning Disabilities (NTW) Pauline Henry, Liaison Nurse (STFT)
Public Protection lead (MAPPA)	Alan Clark, Principal Safety Advisor (CHSFT) Christine Johnson (STFT)
MARAC representative	Margaret Deary, Safeguarding Adults Lead (CHSFT) Lesley Schuster, Named Nurse Children Community (STFT)

3.0 MEMBERSHIP OF THE SOUTH TYNESIDE, GATESHEAD AND SUNDERLAND SAFEGUARDING ADULTS BOARDS (SAB / GSAB / SSAB) 2016-17

3.1 The South Tyneside Safeguarding Adults Board (SAB), Gateshead Safeguarding Adults Board (GSAB) and Sunderland Safeguarding Adult Board (SSAB) ensure that local adult protection arrangements are developed and maintained in accordance with national and local guidance. STFT and CHSFT are active partners in implementing such arrangements.

3.2 The Executive Director of Nursing and Patient Experience was the Trust representative on the SAB, GSAB and SSAB in 2016-17. The SAB, GSAB and SSAB have conducted a review of their membership and meeting arrangements in 2017, to take effect from 1 April 2017.

3.3 STFT and CHSFT also has representatives on all the multi-agency sub committees of the SAB, GSAB and SSAB, namely the Quality Assurance, Learning and Improvement in Practice, policy and procedures, performance management and evaluation and Education & Training Groups. The Safeguarding Adults Lead within CHSFT is also the Trust representative on the Sunderland Domestic Violence Partnership.

3.4 Information from these meetings is cascaded and actioned within the Trust through the Safeguarding Assurance Group in STFT and the Safeguarding Children and Adults Assurance Group (SCAG) in CHSFT.

4.0 GOVERNANCE ARRANGEMENTS

4.1 The following arrangements are in place across South Tyneside, Sunderland and Gateshead local authority areas.

a) Safeguarding Adult Board Sub groups and Task and Finish groups are predominantly supported by the Named Nurse Safeguarding Adults, Safeguarding Adults Lead and Safeguarding Adults Advisor.

b) Safeguarding Adults Boards/Business Planning Groups across the three localities are attended by the Executive Director of Nursing and Patient Experience.

c) Strategic Safeguarding Groups chaired by the respective CCG's Director of Nursing are attended by the Executive Director of Nursing and Patient Experience or Deputy Director of Nursing and Patient Experience.

d) Safeguarding Assurance Group (SAG) / Safeguarding Children and Adults Group (SCAG) within each Trust has senior representation from each division to provide leadership and risk management of safeguarding issues in order to provide assurance via the Choose Safer Care Sub-group to Trust Board level within STFT and Trust clinical Governance steering group within CHSFT .

5.0 SAFEGUARDING ADULTS ACTIVITY 2016-17

5.1 A safeguarding referral is generated when the following criteria are met:

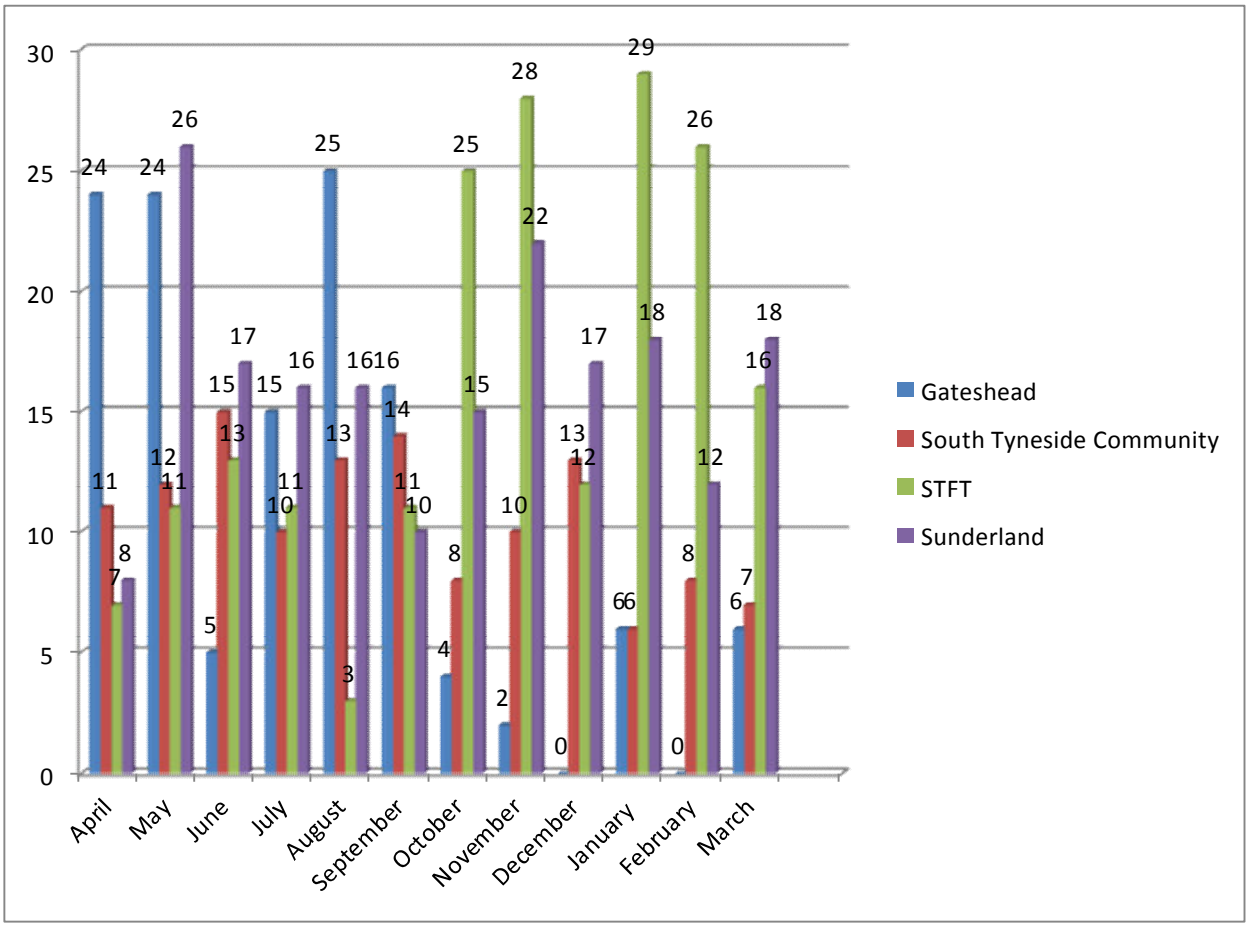
- Person is aged 18 or over
  and
- has needs for care and support (whether or not the authority is meeting any of those needs)
- is experiencing, or is at risk of, abuse or neglect
  and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

5.2 Commissioners require reports on safeguarding activity, in the form of a safeguarding adults and children dashboard which are submitted to the Joint Strategic Safeguarding Group on a quarterly basis. STFT safeguarding activity is collated from STFT hospital referrals, Gateshead community service referrals, South Tyneside community service referrals and Sunderland community service referrals. CHSFT referral activity is collated from City Hospitals Sunderland referral data.

STFT Safeguarding Adult Referrals 2016 – 17

2016/17	STFT Acute Safeguarding referrals	STFT Community Safeguarding referrals	Gateshead Community Safeguarding referrals	Sunderland Community Safeguarding referrals
Q1	31	39	53	51
Q2	25	37	56	42
Q3	65	31	6	54
Q4	81	21	12	48
TOTAL	202	128	127	195

STFT Safeguarding Adult Referrals Per Month Via Locality

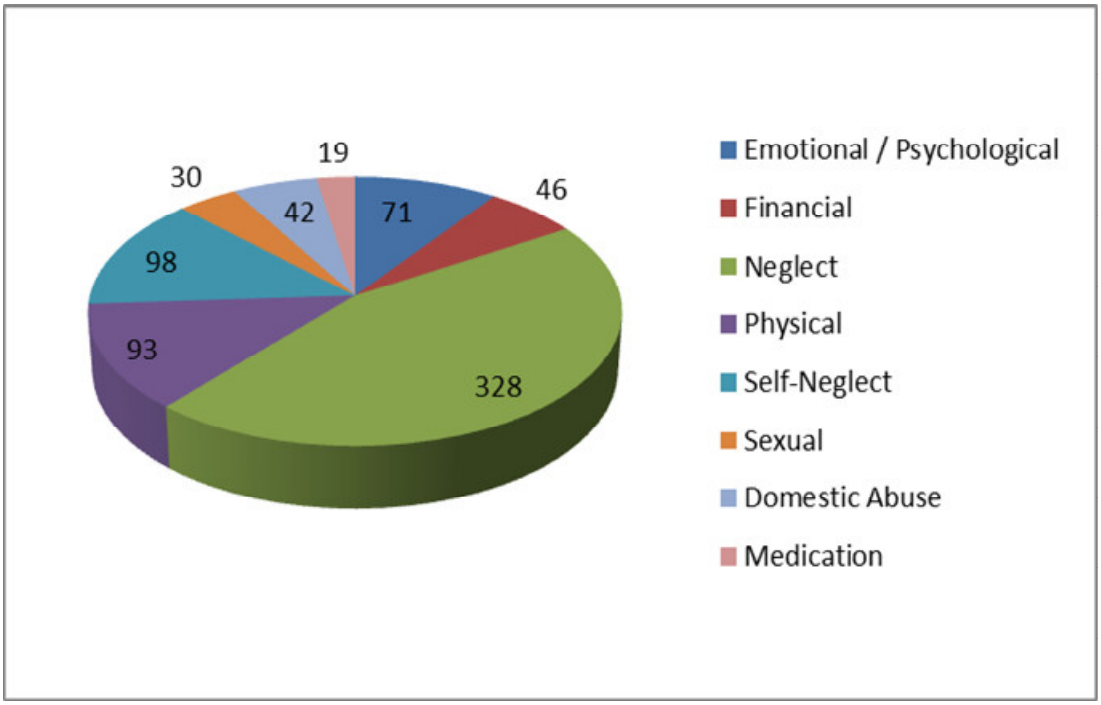


5.3 In 2016-17, there were a total of 652 safeguarding adult referrals made from STFT to the LA Safeguarding Units within South Tyneside, Gateshead and Sunderland. Overall, this is a decrease of 0.4% compared to referrals made in 2015-16.

5.4 Main referral themes pertain to neglect (328 cases), self-neglect (98 cases) and physical abuse (93 cases). This is a similar trend as identified in the 2015/16 report.

5.5 Categories of abuse identified from the **652** safeguarding adult referrals made by STFT staff are highlighted in the following pie chart.

STFT Categories of Abuse



5.6 There were many more safeguarding considerations which were managed internally. The primary reasons for not progressing considerations to a referral were that the underlying problem was a mental health issue or a care management issue as opposed to a concern, suspicion or allegation of abuse. These concerns are managed out with safeguarding adult procedures, by referring the patients to the mental health team or LA adult services for a care management review or quality review by commissioning, as appropriate.

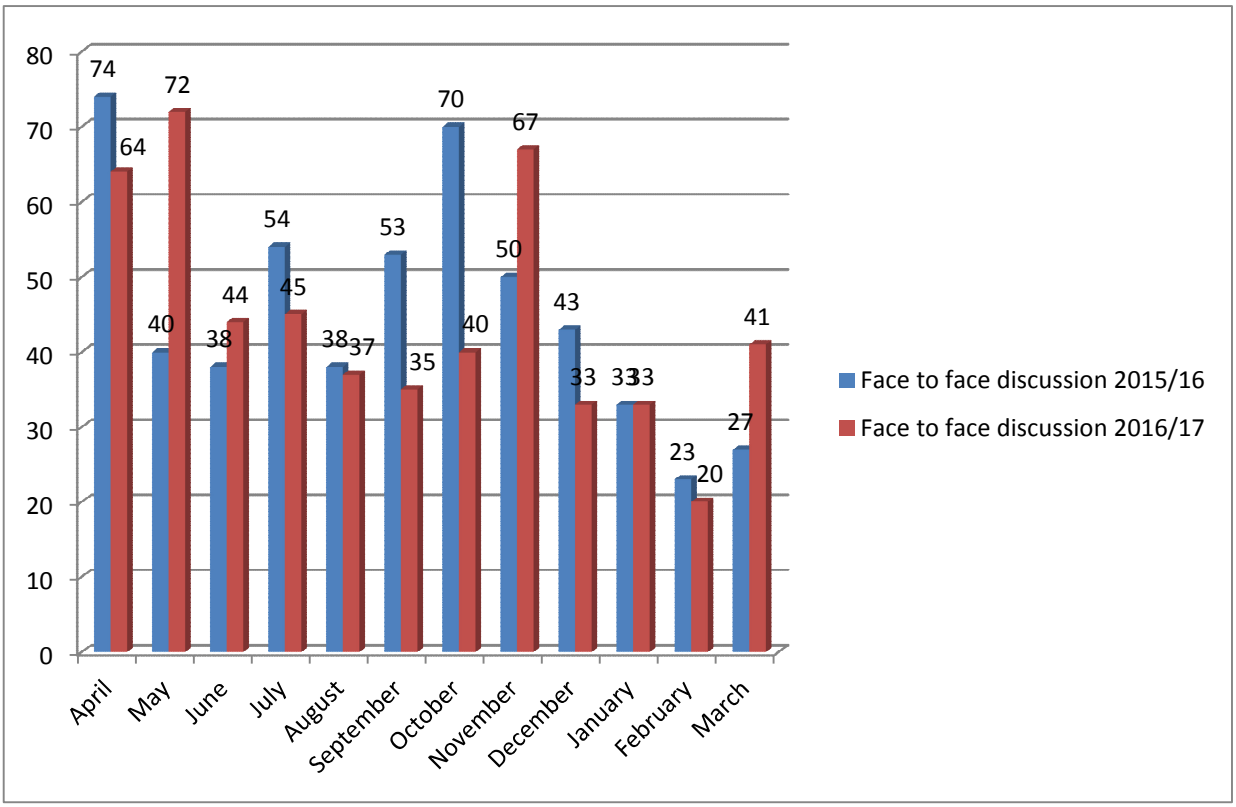
5.7 There were an additional **14** safeguarding adult referrals made by other agencies regarding the care of patients who received service input from STFT. These cases required STFT input into the subsequent investigation and multi- agency complex panel information sharing meeting discussion. Themes pertain to unsafe hospital discharge (**six** cases), supervision whilst in patient (**one** case), DoLS application requirement (one case), physical abuse allegation (one case) and medication administration concern (**one** case). From a Sunderland and South Tyneside community perspective, concerns were raised regarding pressure area care (two cases), medical intervention (**one** case) and actions taken following a self-neglect observation (one case). In all but one STFT case, where robust training and lessons learnt was invoked pertaining to the timely application of a Deprivation of Liberty Safeguard (DoLS), the abuse was not substantiated.

5.8 All safeguarding activity undertaken by the team can vary in complexity and it is not solely the numbers but the nature of the individual case which determines the time required.

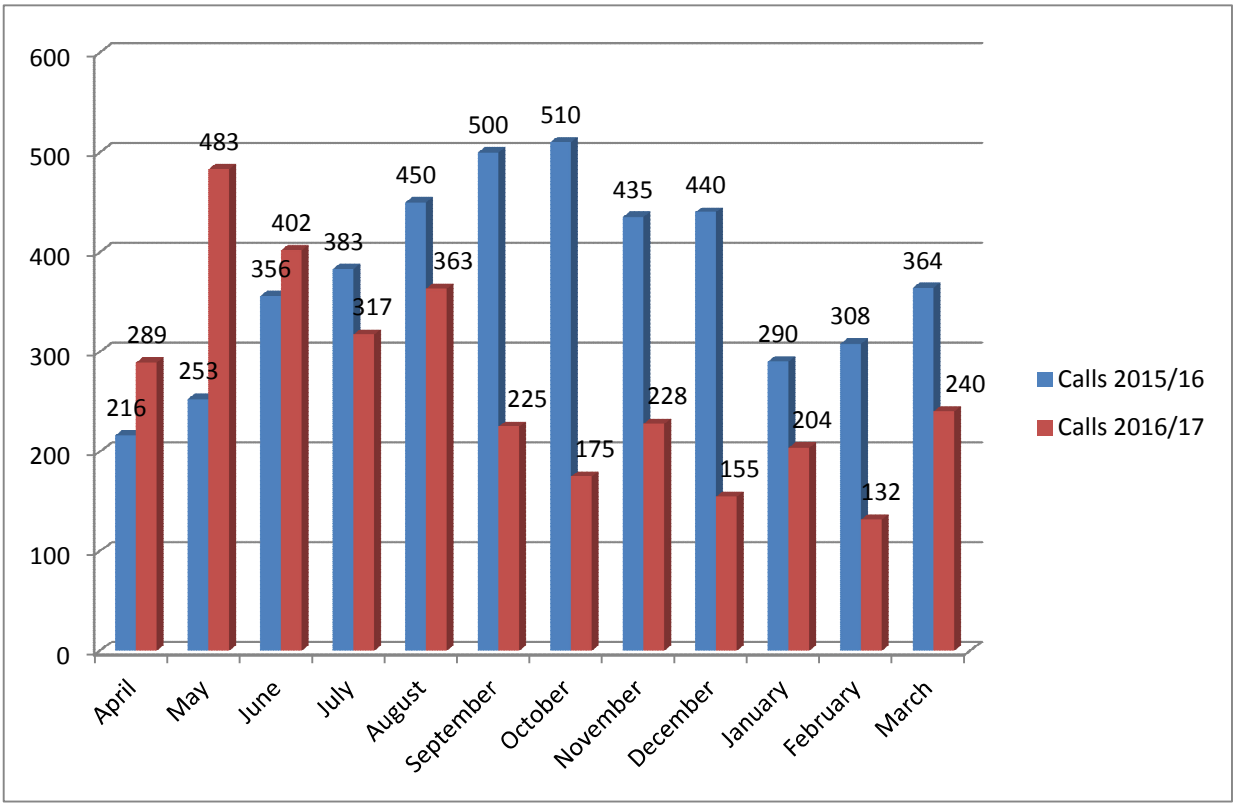
5.9 There has been a decrease in the amount of telephone calls (4,505 calls in 2015/16 compared to 3,213 calls in 2016/17 = 1,292 less calls) and face to face advice, support and guidance (543 face to face discussions in 2015/16

compared to 531 face to face discussion in 2016/17 = 12 less face to face discussions) provided by the Safeguarding Adults Team. On analysis, this can be explained due to the loss of the Gateshead community services as this locality made the most telephone contact with the team and produced the largest amount of referrals. Telephone and face to face activity is represented in the graphs below.

STFT - Face to Face Discussion Safeguarding Team 2015/16 and 2016/17



STFT - Telephone Calls Made to Safeguarding Team 2015/16 and 2016/17.



City Hospitals Sunderland Safeguarding Activity

5.10 Sunderland Clinical Commissioning Group Commissioners require reports on safeguarding activity, in the form of a safeguarding adults & children dashboard which are submitted to the Designated and Named Safeguarding Assurance Group on a quarterly basis.

5.11 CHSFT also review safeguarding adults' activity on a monthly basis in the form of the Quality and Risk Assurance Report (QRA).

5.12 CHSFT have reviewed the safeguarding referral process and eliminated the use of internal fax machines and moved to an electronic referral process. This has enabled the Safeguarding Adults Team to quality check referrals prior to receipt by Safeguarding and Social Care Governance Team, Sunderland City Council.

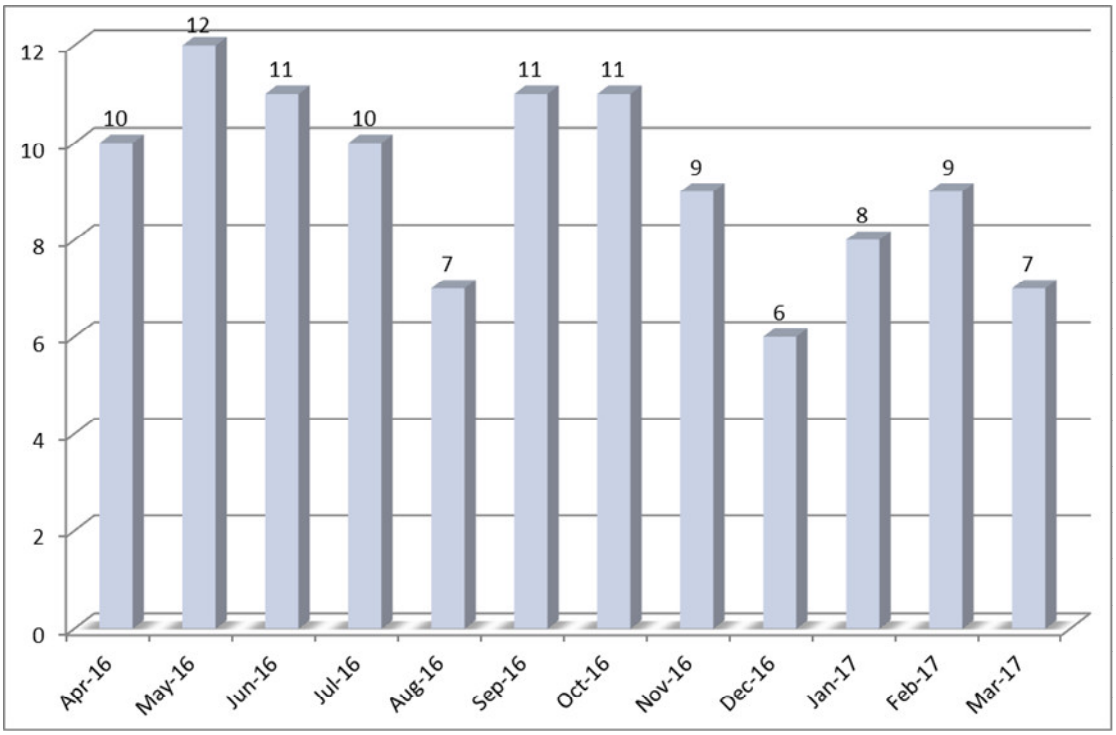
CHSFT Safeguarding Adult Referrals Per Quarter 2016 – 17

	CHSFT SAFEGUARDING REFERRALS
Q1	**33**
Q2	**28**
Q3	**26**
Q4	**24**
TOTAL	**111**

5.13 In 2016-17, there were a total of **111** formal safeguarding adult referrals from CHSFT to the Safeguarding and Social Care Governance Team, Sunderland City Council. This was an increase from the 90 referrals made over 2015-16.

5.14 During this period the CHSFT Safeguarding Adults Team have also received a significant amount of telephone calls detailing safeguarding concerns relating to patient who reside out with Sunderland. A total of 20 have been recorded from October 2016. The majority of these relate to County Durham residents (14 cases) the remaining cases reside in South Tyneside, Gateshead and one case resided in Hartlepool.

CHSFT Safeguarding Referrals Per Month 2016 - 17

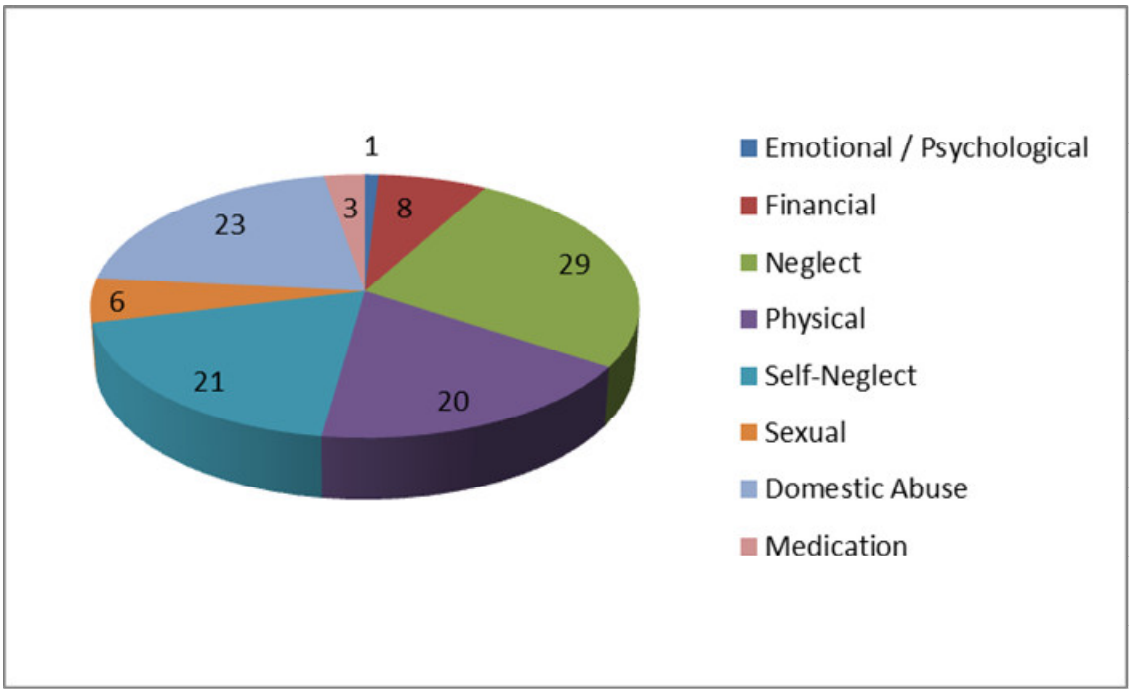


5.15 The table above demonstrated that referral figures have declined in Q4. Further work and education to staff has been provided by the Safeguarding Adults Team. The Safeguarding Adults Lead has also relocated to a base in the hospital setting following a move from Trust Headquarters. This relocation has enabled the Safeguarding Adults Lead to be accessible and visible to staff which has facilitated some face to face training and support. Referral figures have increased in Q1 of 2017 – 18.

5.16 There is still a number of safeguarding considerations which were managed internally as the primary reasons for not progressing considerations to a referral were that the underlying problem was a mental health issue or a care management issue as opposed to a concern, suspicion or allegation of abuse. These concerns are managed out with safeguarding adult procedures, by referring the patients to the mental health team or adult services for a care management review as appropriate.

5.17 At CHSFT the Safeguarding Adults Team were in involved in investigating **20** cases where evidence required as part of an Enquiry Action Report by Sunderland City Council Safeguarding Adults Team. In some of these cases the meetings were in relation to referrals made by other agencies regarding the care of patients who received service input from CHSFT (**seven** cases). Of these seven cases **six** were related to unsafe hospital discharge and **one** case related to failure to administer medication. In **five** of these cases the abuse was not substantiated. Two cases identified lessons learnt involving communication between the discharging ward and care home in relation to the handover of patient information and the importance of detailing this communication in the patient's records. As in both cases hospital staff were confident that patient information was verbally communicated to care homes, however this was not documented.

CHSFT Categories of Abuse



5.18 Main referral themes pertain to neglect (**29** cases) followed by domestic abuse (**23** cases). Categories of abuse identified from the **111** safeguarding adult referrals made by CHSFT staff are highlighted in the chart above.

5.19 CHSFT do not currently record face to face safeguarding adults' discussions and telephone calls made to the Safeguarding Adults Team. Following the establishment of the Integrated Safeguarding Adults team as part of the Sunderland and South Tyneside care group, a priority for 2017/18 is to commence capturing this information for reporting purposes.

6.0 SAFEGUARDING ADULT REVIEWS (SAR) / INDIVIDUAL MANAGEMENT REVIEWS / DOMESTIC HOMICIDE REVIEWS

6.1 In 2016-2017, CHSFT and STFT were required to complete one Adult Safeguarding Adult Review (*"Tracy SAR"*) commissioned by the Sunderland Safeguarding Adults Board. The SAR was published in February 2017 and involved concerns regarding Domestic Abuse. A multi- agency action plan was implemented to seek assurance that all partner agencies would learn lessons in respect of recognising and responding to Domestic Abuse.

Individual agency recommendations for CHSFT were identified as:

- Domestic Abuse Awareness training will be included in mandatory training for all staff.
- The Discharge Policy will be updated to ensure that there is a clear procedure on the need for multiagency pre - discharge meetings where there is significant safeguarding (including domestic abuse) risk, especially if the patient is likely to be homeless on discharge.
- The process for flagging patients where domestic abuse risks are known to staff will be audited and the outcome acted upon accordingly.
- The process to review and update Next of Kin details on patient's electronic record at every inpatient/outpatient admission and attendance will be audited.

The above recommendations have been completed, however a review of the process of confirmation of Next of Kin has been expanded following the audit to ensure that there is a safe system in place for patients to protect them against perpetrators.

No individual agency recommendation were identified for STFT.

6.2 A further four cases went to a SSAB "scoping meeting", the purpose of which is to share the information within the individual agencies reports and look at the Safeguarding Adult Review criteria in order to decide whether the case meets the criteria or if there are any identified lessons to be learnt that agencies can take back to their own organisation. Of these four cases; one case required a LeDeR review (Learning Disability Mortality Review Programme), two cases required specific actions but no further review was required. One case is currently being considered as requiring a Safeguarding Adults Review.

6.3 In 2016/17 STFT were required to complete one Adult SAR (Case D) commissioned by the South Tyneside Safeguarding Adults Board. A multi-agency action plan was implemented to seek assurance that all partner agencies would learn lessons in respect of recognising and responding to self-neglect. A further two cases went to a SAB scoping meeting. A learning event was held in one case in order to provide opportunity for all partner agencies to learn lessons from the inquiry. A further case required no further action.

6.4 Within the Gateshead locality, STFT safeguarding team attend the SARG subgroup where there were nine referrals for potential SAR. Four cases required no further action, three cases resulted in a single agency action to be completed and two cases are currently being considered as requiring a Safeguarding Adults Review.

7.0 DOMESTIC ABUSE

7.1 NICE guidance "Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively" (PH50 2014) reiterates the need for health care staff to have knowledge of the referral pathways, policies and procedures for people who experience or perpetrate domestic violence and abuse.

7.2 During 2016-17, a programme of work has been undertaken within STFT to support staff to recognise and respond to Domestic Abuse. The safeguarding team have targeted ward huddles and amended guidance to support staff to recognise Domestic Abuse. A successful Domestic Abuse conference was held which evaluated very positively. There has been a demonstrable increase in the amount of Domestic Abuse referrals now being made in the trust. STFT does not have individual Domestic Abuse champions, as this role is incorporated into the role of the safeguarding champion. Safeguarding Champion forums are held bi-monthly and all wards and departments are represented.

7.3 Within CHSFT there are now eight *Domestic and Sexual Violence Champions* as part of the Sunderland Champions Network. The role of a Champion is to be the link between their agency and the Network, to be a conduit for information, and to assist their agency to enhance their response to individuals affected by domestic and sexual violence in Northumbria. The CHSFT Champions have actively participated in the Domestic Abuse & Violence campaigns over 2016-17 to generally raise awareness across the Trust.

8.0 MULTI-AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

8.1 From September 2016, CHSFT have actively engaged with the Multi - Agency Risk Assessment Conference (MARAC). MARAC is a monthly risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan. A considerable amount of work has been undertaken to ensure that CHSFT collaborate with MARAC. A system is now in place to ensure that research from the hospital is provided to the MARAC coordinator and

attendance from the Safeguarding team is assured at the fortnightly MARAC meetings.

8.2 There is a procedural document in place to ensure that MARAC research is provided and actions will be completed by relevant services within appropriate timescales. This process is now embedded and provides a safety plan for CHSFT patient where domestic abuse has occurred.

9.0 THE INDEPENDENT DOMESTIC VIOLENCE ADVOCATE (IDVA)

9.1 In December 2016 a full-time Independent Domestic Violence Advisor has been employed within CHSFT. This role has been commissioned by the Clinical Commissioning Group and the IDVA is employed by Wearside Women in Need (WWIN) and has an honorary contract with CHSFT. The role of the Hospital IDVA is to provide support and guidance to patients who are suspected of being victims of domestic abuse. The IDVA provides cover in the Emergency Department two evenings per week (Friday and Saturday, 20:00 – 02:00) and is also available to support in – patients when required, the IDVA role is flexible to meet patient need. The IDVA also provides training to staff in relation to domestic abuse awareness and the MARAC referral process. Performance data has been agreed and this is reviewed monthly, this includes data for both new and repeat MARAC referrals, referral areas, training figures and case outcomes.

9.2 Following the implementation of the Hospital IDVA there has been some positive outcomes involving both the hospital staff and the IDVA in relation to supporting patients where domestic abuse has been disclosed.

9.3 This IDVA post is to be replicated in STFT A&E department, with a named IDVA due to commence in post.

10.0 MULTI-AGENCY PUBLIC PROTECTION ASSESSMENT (MAPPA)

10.1 Multi-Agency Public Protection Arrangements (MAPPA) were introduced by the Criminal Justice and Courts Services Act 2000 to address the need for the public to be protected from dangerous offenders. The legislation, which was implemented in April 2001, placed a statutory duty upon police and probation services (the Responsible Authority) to establish arrangements to assess and manage the risks posed by relevant sexual and violent offenders. The Criminal Justice Act (2003) contained within it places a statutory duty on health and other bodies to co-operate with MAPPA.

10.2 It is recognised that all staff working in STFT and CHS may through their work identify areas of risk relating to Multi Agency Public Protection and may be required to consider and manage the process of referring. If required, staff are supported through this process by Named Nurse Safeguarding Adults.

10.3 The safeguarding adults team represent both CHSFT and STFT at Multi-Agency Public Protection meetings (MAPPA) at level 2 and level 3 panels across South Tyneside and Sunderland Locality.

10.4 In 2016/17, the safeguarding team produced 100 MAPPA reports and attended 98 MAPPA meetings. A majority of the meetings are at Level 2.

11.0 MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

11.1 The House of Lords Select Committee Report (2014) on the Mental Capacity Act (2005) highlights significant shortfalls in the implementation of the Mental Capacity Act. The Committee found a general lack of awareness and understanding of MCA and the Deprivation of Liberty Safeguards (DoLS) and has recommended that the issue of low awareness among professionals be addressed as a matter of urgency.

11.2 Within both CHSFT and STFT, joint work has been undertaken with the Local Authority MCA/DoLS lead. This has provided an efficient application process for those making DoLS applications. It is envisaged that this work will continue to develop throughout 2017/18 to ensure that all staff work within the legislative framework.

11.3 The safeguarding teams across both sites provide advice and support to frontline staff making a DoLS application. Within CHSFT, the safeguarding adult's team maintains a database of applications/authorisations and undertakes the CQC statutory notifications. Within STFT, the database is maintained by Risk and Compliance and the risk team are responsible for also notifying CQC. Following the streamlining of STFT DoLS process, there has been positive feedback received from trust staff.

11.4 Within CHSFT and STFT, there are MCA/DoLS Champions. The MCA Champions provide leadership to embed their learning into their area of work, acting as a contact person within their team to offer advice and guidance to colleagues when assessing mental capacity or making DoLS applications. Within STFT, there are MCA /DoLS Champions networks which are held bi-monthly and are well attended by all Wards and Departments. There are plans to further embed MCA/DoLS Champions within CHSFT throughout 2017/18.

11.5 An MCA/ DoLS Level 2 Masterclass is planned to be held during April 2017, with the outcome of this being reported via SAG.

CHSFT DoLS Applications 2016-17:

	URGENT APPLICATIONS
Q1	**344**
Q2	**297**
Q3	**336**
Q4	**473**
TOTAL	**1450**

11.6 In 2016-17, there were a total of **1,450** DoLS Urgent Authorisations/ requests for Standard Authorisations made within CHSFT. This has been a significant sustained increase from previous years (**938** in 2015/16 and **148** in 2014/15). Throughout this period the Safeguarding Adults Team at CHSFT and the MCA/DoLS Team at Sunderland City Council (SCC) have worked collaboratively to streamline the application process. This has involved the implementation of an online application system that provides a quality assurance check prior to secure email of the DoLS application to the Safeguarding Team at SCC.

STFT DoLS Applications 2016-17:

	URGENT APPLICATIONS
Q1	**35**
Q2	**34**
Q3	**53**
Q4	**87**
TOTAL	**209**

11.7 In 2016-17, there were a total of **209** DoLS Urgent Authorisations / requests for Standard Authorisations made within STFT. This is almost a 33% increase from 2015-16, where there were a total of **156**.

12.0 EDUCATION & TRAINING

12.1 Throughout 2016/17, the adult safeguarding training strategy was reviewed and amended. The strategy now details Level 1 training for non-clinical staff and Level 2 training for clinical staff.

12.2 Adult safeguarding training is now mandatory for all STFT and CHSFT staff. This will ensure that both Trusts comply with the statutory requirements for safeguarding adults and that all members of staff have some basic awareness of safeguarding issues staff are expected to comply with in 2017/18

12.3 An E-Learning training package has been developed which incorporates the following elements: - Safeguarding Adults Domestic Abuse/Prevent, Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS), Dementia, Learning Disability and Mental Health Act awareness. This E-Learning module has been implemented from 1 April 2017 within CHSFT and May 2017 within STFT. Training compliance will be recorded on staff electronic staff records (ESR). Training compliance will be monitored via quarterly dashboard submission and also on a monthly basis at the safeguarding assurance group (SAG) and Safeguarding Children and Adult Group (SCAG)

12.4 Within both CHSFT and STFT, the safeguarding teams throughout 2016/17 have delivered safeguarding conferences and an MCA Masterclass

in order to assist staff with compliance. The team also continues to support staff at ward huddles and team meetings to

13.0 DEPARTMENT OF HEALTH "PREVENT" STRATEGY

13.1 The DH Prevent programme is a national multi-agency approach to anti-terrorism/radicalisation. Trusts are required to ensure staff are trained in the identification of potential victims of radicalisation who may be involved in terrorist activities. The NHS as a universal service is seen to be a key organisation in safeguarding vulnerable people as it provides an opportunity for healthcare professionals to identify people who are at risk of abuse and neglect.

13.2 Within CHSFT, staff within key areas (Patient Safety & Risk Team, ED, maternity, paediatrics, out-patients and therapies) have undertaken the Home Office approved training to allow them to function as Prevent Trainers and deliver "HealthWRAP3" (Workshop to Raise Awareness of Prevent) within their teams. The Named Nurse adult safeguarding coordinates this activity and reports to the Commissioners via the quarterly Safeguarding Dashboard.

13.3 Within STFT, there are 5 members of staff who have undertaken the Home Office approved training to allow them to function as Prevent Trainers and deliver "HealthWRAP3" (Workshop to Raise Awareness of Prevent). The Named Nurse Safeguarding Adult acts as PREVENT lead.

13.4 If CHSFT and STFT staff have any concerns, suspicions or allegations that an individual is at risk of or experiencing this form of abuse, then they follow the Trust's safeguarding adults (or children) policy. There have been two PREVENT referrals made by STFT from April 16 - March 17.There have been no PREVENT referrals made from CHSFT.

14.0 MENTAL HEALTH

14.1 Patients with mental health problems also have particular requirements which may necessitate application of the Mental Health Act (1983) in order to detain them in hospital in order to keep them safe. CHSFT has a Service Level Agreement (SLA) with Northumberland, Tyne & Wear (NTW) NHS FT:

a) To provide a comprehensive service for the administration of the Mental Health Act 1983 (MHA) to CHSFT in order to comply with the current legislation.
b) To ensure that anyone detained under the MHA Act within the Trust for whom CHSFT is the detaining authority, are allocated an appropriate Approved Clinician in order to undertake the role of Responsible Clinician (RC).

14.2 There is representation from the NTW Mental Health Team at CHSFT SCAG meeting. The Safeguarding Adults Team also receives an annual report from NTW in relation performance data from the Mental Health Team. This includes data on the number of patients detailed under Mental Health Act 103 and 2007 under sections 2, 3, 4, 5 and 136.

14.3 A Service Level Agreement between STFT and NTW is currently under review. STFT staff utilise the Mental Health Liaison and Crisis teams if required to meet the Mental Health needs of their patient's.

15.0 LEARNING DISABILITY

15.1 People with learning disabilities may have complex care needs which they are unable to communicate fully and/or comprehend the information they are given. They may also present with challenging behavioural problems or psycho-social health needs which necessitate additional support to enhance the standard of care whilst they are in hospital. CHSFT and STFT have a well-established "Acute Liaison Service for People with Learning Disabilities" which supports the care of patients with a learning disability when they access acute hospital services. The LD team ensures that the Acute Needs Assessment is completed and that appropriate care pathways are utilised and reasonable adjustments made to enhance the quality of their care and patient experience. An Acute Hospital Passport is in use which enables carers to ensure that documentation is available for staff about the specific needs of patients with learning disabilities so that any reasonable adjustments to the environment/nature of care or treatment can be made. Patients with a learning disability are flagged on V6 within CHSFT and on the PAS system within STFT so that staff are aware of their specific needs.

16.0 THE LEARNING DISABLITIES MORTALITY REVIEW (LeDeR) PROGRAMME

16.1 The LeDeR programme is delivered by the University of Bristol and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.

16.2 A key part of the LeDeR Programme is to support local areas to review the deaths of people with learning disabilities. The Programme is developing and rolling out a review process for the deaths of people with learning disabilities, helping to promote and implement the new review process, and providing support to local areas to take forward the lessons learned in the reviews in order to make improvements to service provision. The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements.

16.3 Both CHSFT and STFT are working collaboratively with the CCG to support the LeDeR Programme.

16.4 There has been 1 LeDeR review which involved safeguarding components in CHS in the 2016/17 reporting period. There have been no LeDeR reviews within STFT which incorporated safeguarding concerns.

17.0 MORTALITY REVIEW PANEL

17.0 Within CHSFT, there is an established weekly Mortality Review Panel and a process to “flag” any patients with a learning disability who have died in hospital. This prompts a specialist LD review by the LD Acute Liaison Nurse. Within STFT, each department within the Trust has a mortality lead clinician who coordinates multi-disciplinary mortality meetings within their department. These meetings occur regularly to discuss all deaths that have occurred since the last meeting. Deaths in patients with a learning disability are all reviewed (100%) in line with national guidelines.

18.0 PRIORITIES FOR 2017-18

1. The STFT and CHSFT Safeguarding Adults Team will continue to implement and embed actions and lessons learnt from recommendations of SAR’s/DHR’s and Trust patient safety investigations.

2. CHSFT and STFT will have a joint audit cycle which will continue to compare existing practice with best practice guidelines to continuously identify any areas for improvement.

   Audit cycle for 2017/8 will include:
   - The significant events form in community nursing records
   - The multi-agency meeting attendance form within community nursing records
   - Inclusion of routine & selective enquiry evidence within community nursing records
   - The inclusion of routine and selective enquiry in the Trust Emergency Department
   - The audit of Safeguarding Policies and Procedural Documents
   - A review of actions from the “Tracy” SAR
   - A review of actions implemented into podiatry practice following SAR Case B (STFT only)
   - MCA / DoLS Policy and Guidance compliance.

3. The safeguarding team will continue to develop and update existing safeguarding policy and procedural guidance in line with Government recommendations and lessons learnt from SAR’s/DHR’s. As a priority the following policies will be ratified and implemented within CHSFT:
   - Restraint
   - Domestic Abuse policy for staff
   - Raising safeguarding allegations against staff
   - Safeguarding adult’s supervision procedural document.

4. The Lead Nurse Safeguarding (CHSFT), Named Nurse Adults Safeguarding and Advisor for Adult Safeguarding (STFT) will continue to provide advice, support, supervision and training to all services across each Trust in order to embed safeguarding into practice, thus improving patient safety across the organisation.

5. A Safeguarding Champions network will be launched within CHSFT in line with the established network within STFT.

6. The PREVENT lead will support all staff across STFT and CHSFT to notice, check and share concerns where they come into contact with vulnerable and susceptible adults who may be targeted by radicalisers and drawn into terrorism.

7. The safeguarding team will continue to attend MARAC meetings and will review the joint working relations within STFT community team to reduce the risks of duplication at meetings.

8. Safeguarding training compliance is identified as a priority for 2017/18. The team will continue to work with Learning and Development colleagues and individual service leads to identify areas where compliance is low to support the achievement of acceptable levels as determined within the Safeguarding Training Strategy.

9. The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves. The Safeguarding Team will support the MCA / DoLs Advisor in raising the profile to staff across both Trusts to improve statutory compliance.

10. The Safeguarding Team in collaboration with the MCA/DoLS Advisor will continue to enhance the MCA/DoLS application process to quality assure that applications are appropriate and outcomes are realistic.

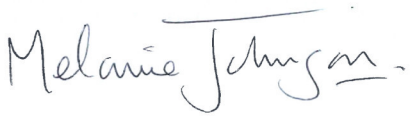
11. During 2017/18 the team will further develop the STFT and CHSFT Trust intranet sites for safeguarding adults, providing staff access to current and relevant safeguarding information.

12. The team will continue to raise their profile and awareness of the team vision which is to make safeguarding personal, working within a culture that safeguarding is everybody's business, with a staff workforce who will not tolerate abuse.

13. CHSFT will implement the interface of Safeguarding Referrals through the Ulysses Safeguarding module.

14. The safeguarding adult's team will work collaboratively with Local Authorities to implement clear discharge processes for homeless/potentially homeless patient, as part of the requirements of the Homelessness Reduction Bill.

15. The Team will work to standardise recording documentation across both sites.



Melanie Johnson
Executive Director of Nursing and Patient Experience

CITY HOSPITALS SUNDERLAND NHS FOUNDATION REPORT

BOARD OF DIRECTORS

HEALTH AND SAFETY REPORT 2016/17

JULY 2017

EXECUTIVE SUMMARY

This Health and Safety Report is an update of the Trust's management of health and safety from April 2016 to March 2017. The report outlines health & safety policies, accident trends, workplace risk assessments and health and safety strategic objectives.

Good progress continues to be made against the Trust's health and safety objectives this year, however, we have also reported a 10% increase in the number of reported staff accidents. This is considered to be mostly attributable to reported violent incidents which have risen by 28% this year.

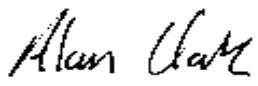
We had one Health and Safety Executive intervention in May 2016 this year following an allegation from a former member of staff with regard to the management of radiation in the Cardio Catheter Laboratory. The HSE found that no further action was required with regard to the allegation, however, they did serve us a 'Notification of Contravention' for some other concerns raised during their investigation. These concerns were satisfactorily dealt with promptly and fed back to the HSE in July 2016.

The report highlight a £110k reduction in the Trusts costs relating to employee and public liability claims this year.

The health and safety strategic objectives have been reviewed and updated in this report with **Appendix 6** giving a detailed overview of progress made and recommended actions for 2017/18.

RECOMMENDATIONS

Directors are asked to accept the Health and Safety Report for 2016/17 and continue to support the health and safety strategic objectives for 2017/18 as detailed in the action plan (**Appendix 6**).



Alan Clark
Principal Safety Advisor

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

HEALTH AND SAFETY REPORT 2016/17

JULY 2017

INTRODUCTION

This Health and Safety Report is an update of the Trust's management of health and safety from April 2016 to March 2017. The report outlines health & safety policies, accident trends, workplace risk assessments and health and safety strategic objectives.

POLICIES

The key health and safety policy which underpins all of our health and safety policies is the General Policy on the Management of Health and Safety at Work. Following a review of the Health, Safety and Welfare Policy and the Work Equipment Policy these policies have been integrated into an updated General Policy on the Management of Health and Safety. This updated and reviewed policy has been presented to the Health and Safety Group for consultation and is now in the ratification process.

Following a review of latex management issues discussed in the Health and Safety Group it has now been decided to up-date the 2003 Latex Policy. This updated policy will cover both staff side arrangements and patient safety requirements.

H&S ACCIDENT REPORTING

Accident and incident investigation arrangements are in place in-line with the Trust's Risk Management Strategy and incident reporting procedures. All significant (moderate harm or worse) incidents and their subsequent investigations are reported and monitored via the Rapid Review Group. All other incidents continue to be monitored/ investigated by the appropriate local directorate management team.

The Trust's incident reporting system (Ulysses) **reported 972** (882) (952) (943) (765) staff accidents in 2016/17. The 5 year trend of all staff accidents is given in **Appendix 1**.

Appendix 2 gives a 5 year trend of the top 4 staff accidents.
Note: Previous years figures in brackets. Figures quoted in this report do not include clinical incidents.

Top 4 staff accident summary

192 (150) (146)	Physical Violence	**+28%** (+1%) (+21%)
289 (227) (239)	Non-Physical Violence	**+27%** (-5%) (-24%)
481 (377) (385)	**Total violence**	**+28% (-2%) (-11%)**
176 (173) (210)	Sharps/inoculation	**+2%** (-18%) (+1%)
62 (59) (77)	Slips Trips Falls	**+5%** (-23%) (+1%)
74 (76) (77)	Manual Handling	**-3%** (-1%) (0%)
972 (881) (952)	**Total Staff**	**+10% (-7%) (+1%)**

The total number of staff incidents has significantly increased this year from 881 in 2015/16 to 972 in 2016/17 by 91 (10%). This is mostly due to a significant rise (104; +28%) in the number of reported violent incidents this year.

As with previous years the majority of physical violence is attributed to clinical condition (90%) reported mostly in Rehab and Elderly Medicine. Emergency Medicine reported the majority of intentional physical violence with alcohol and drugs being the common contributing factor.

The next highest staff accident cause group continues to be sharps/inoculation incidents. Of the 176 reported incidents 130 (73%) were attributable to exposure high/low risk sharps incident. The highest number the high/low risk sharps incidents were reported in Emergency Medicine (25), Theatres (18) and Rehab and Elderly Medicine (16).

The figures in Table 1 confirms a positive incident reporting culture, whereby, there is a consistent high number of minor and no-harm incidents reported compared to moderate and major harm incidents.

Table 1. Staff accident severity rating comparison						
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Major (4)	0	4	0	3	0	0
Moderate (3)	104	25	17	20	28	8
Minor (2)	410	553	627	608	536	630
No harm or near miss (0 or 1)	150	181	299	321	317	334

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) require that we report lost time (over 7 days) injuries from

work-related accidents as well as any scheduled dangerous occurrences and diseases.

The total number of staff RIDDOR reportable incidents for 2016/17 was 18 (25) (24). The total number of patient RIDDOR reportable incidents for 2016/17 was 2 (Fracture wrist and NOF due to a fall from a seated position).

A breakdown of staff RIDDOR incidents shows that in 2016/17 there were:

- **16 (23)** (21) Lost time accidents over 7days
- **0 (0)** (5)Prescribed Diseases
- **2 (2)** Major injuries (Fractures due to a violent incident and struck fixture)

Attributable to:

- **4** (5) (9) Slip, trip or fall on the same level
- **6** (15) (7) Lifting and handling
- **3** (1) (2) Physical Violence
- **2** (1) (5) Struck by fixed or moving objects
- **0** (2) Posture/mobilising
- **3** Other

Table 2 shows the highest number of total reported staff accidents are from Rehab & Elderly (R&E) and Emergency Medicine (EM). As in previous years the majority of accidents reported in EM are attributable to non-physical intentional violence and in R&E are attributable to physical clinical violence.

Table 2. Directorate 2016/17 staff accident rate per 1000 (FTE) staff

Directorate/Service	Accident Rate	Total Accidents	FTE
Rehab & Elderly	473	186	393.41
Emergency Medicine	417	200	479.45
Estates & Facilities (CHoICE FS)	365	101	277
T & O	339	57	168.24
GIM	243	52	213.63
Theatres	207	90	434.79
Medical Specialities	200	43	214.8
Obs & Gynae	158	39	246.74
Diagnostic Imaging	156	27	173.25
Child Health & Paeds	148	29	195.74
Ophthalmology (inc. OPD)	147	37	251.46
Head & Neck	146	24	163.96
Therapy Services	101	30	297.93
Urology	98	10	101.76
Pharmacy	74	12	161.44
Gen Surgery	73	14	193
Central Services	40	21	523.5
Trust Wide		**972**	***4490.40***

1. Cost of Claims

Safety related Employer and Public Liability Claims Closed by Category (2016/17)

Table 3a. Employer Liability				
Category	***Total Claims***	***Repudiated***	***Settled***	***Total Costs***
Needle Stick/Sharps	*5 (6) (3)(3)*	*1*	*4*	*£7847*
Manual Handling	*3 (3) (2)(2)*	*3*	*0*	*£0*
Slipping/Tripping	*1 (2) (4)(10)*	*1*	*0*	*£0*
Injury Harm (Others)	*2 (5) (5)(1)*	*1*	*1*	*£5425*
Injury by patient	*1*	*1*	*0*	*£0*
Industrial disease (Asbestos)	*1 (0) (3)*	*0*	*1*	*£8547*
Total	***13 (16) (19) (21)***	***7***	***6***	***£27,204***

The total cost of settled employer liability claims in 2016/17 was £27k.
Figures for previous years: £101k; £130k; £124k; £138K; £105k.

Table 3b. Public Liability				
Category	***Total Claims***	***Repudiated***	***Settled***	***Total Costs***
Needle Stick/Sharps	*2 (6) (2)(12)*	*0*	*2*	*£4760*
Slipping/Trip/Fall	*3 (6) (3)(1)*	*2*	*1*	*£3730*
Appointments	*1*	*0*	*1*	*£5106*
Manual Handling	*1*	*1*	*0*	*£0*
Injury Harm (Others)	*0 (2) (2)(1)*	*0*	*0*	*£0*
Total	***6 (13) (9)(14)***	***3***	***4***	***£13596***

The total cost of settled safety related public liability claims in 2016/17 was £13.5k; figures for previous years:£51k £100k; £60k.

Total cost of safety related employer and public liability claims for 2016/17 was £41k; figures for previous years: £151k; £230k; £184k.

The report notes a significant reduction of £110k for all settled claims this year which reflects all the hard work and effort put in by the litigation management team.

2. Workplace H&S Risk Assessments

the Trust's General Management of Health and Safety Policy reinforces and clarifies the requirement for all wards and departments to undertake suitable and sufficient risk assessments.

Risk assessments are to be reviewed annually, or following the introduction of a new work process or hazards, or following an incident which indicates an assessment is no longer valid. (Ref: General Management of Health and Safety Policy)

Model Health and Safety standards and risk assessment forms and guides are available via the Trust's intranet. As part of the risk assessment review process all wards and departments are expected to complete and return a Local H&S Risk Assessment Review Form which:

- Identifies local organisation and responsibilities are in place; and
- Maintains a record of a full annual review of all H&S risk assessments.

A requirement of our 2016/17 health and safety strategic objectives was for all wards and departments to complete and return a Local H&S Arrangements and Risk Assessment review form. We have seen an increase in the level of compliance from 85% in 2015/16 to 98% in 2016/17.

3. Health and Safety Executive interventions

We have had one Health and Safety Executive (HSE) intervention in May 2016. This was as a result of a member of staff making an allegation to the HSE with regard to our radiation safety arrangements and practices in the Cardio Catheter Laboratory. The HSE visited the Cardio Catheter Laboratory on the 20th May 2016 and subsequently concluded no further action to be taken with respect to the allegation. However, during the course of their visit they did identify other contraventions requiring action. **Appendix 3** contains a copy of the HSE's Notification of Contravention and their '*appendix1'* detailing the contraventions requiring action.

All required actions were satisfactorily responded to within the required time frame to the HSE (see **appendix 4** detailing our final response to the HSE in July 2007).

The HSE will only carry out an intervention if it is triggered as a result of a formal investigation into a statutory breach of health and safety law. The HSE will charge £124 per hour if they determine we are in breach of a statutory duty. The HSE are the lead safety inspectorate and enforcement body under the staff and all non-patient safety incidents under the Health and Safety at Work Act etc. 1974.

The CQC are the lead patient safety inspectorate and enforcement body under the Health and Social Care Act 2008. The CQC remit covers the safety, quality, treatment, and care of patients and users in receipt of health or adult social care from providers registered with CQC.

In the healthcare sector the most common causes for intervention/prosecution include:

- Management and control of asbestos (HSE)

- Patient falls from windows (CQC)
- Scalds when bathing or showering patients (CQC)
- Measures for controlling the risks from legionella in hot and cold water systems (HSE/CQC)
- Manual handling risk assessments (HSE/CQC)
- Use of safer sharps (HSE)
- Management of hazardous substances (HSE)

The statutory requirements for the notification of non-patient incidents will continue for the present (e.g. RIDDOR and CQC's notification requirements).

We have completed a review of the reporting criteria/triggers for reporting of patient safety incidents via RIDDOR and the Trust's 'Rapid Review Group' now flag up any potential patient RIDDOR reportable incident to the Fire & Safety Department for further investigation in-line with the following criteria detailed in **appendix 5**.

7. Trust Health and Safety Group

The Trust's Health and Safety Group continues to meet monthly. Due to organisation changes chairing the Group was handed over by the Director of Estates to the Director of Corporate Affairs in February 2017. Good representation and support continues to be made with attendance by Staff Side Trade Union Appointed Safety Representatives, Trust Managers, and Specialist Advisors.

8. Asbestos Management

The management of asbestos remains a high priority within the Estates Directorate. Following a comprehensive resurveying of all of our premises in 2014 we continue to prioritise remedial action on areas identified as high priority based on the overall asbestos priority scoring. Areas for priority actions in 2016/17 have included:

- Full refurbishment and demolition surveys (R&D) for all our capital schemes and other minor works involving the disturbance of the fabric of our buildings built before 2000
- Asbestos removal and remedial work at Sunderland Eye Infirmary basement areas
- Asbestos emergency remedial action at the Children's Centre due to water leaks in the service ducts
- Asbestos emergency remedial action in the Boiler House at Sunderland Royal Hospital due to steam leak damaging pipe insulation known to be contaminated with asbestos containing materials

The Estates Engineering Manager continues to run a bi-monthly Estates Asbestos Management Group. The group provides assurance the Trust is maintaining a strict and robust management procedure for the Control and Management of Asbestos Containing Materials.

The Director of Estates (now CHoICE FS) commissioned a full independent review of the Trust's management of asbestos the final report on its findings is expected by no later than May 2017.

The planned annual re-inspection of all known asbestos containing materials by Lucion Environmental Services is planned to be complete by the end of April 2017.

The findings of the independent asbestos management review and asbestos re-inspection report will inform priority removal/remediation work for 2017/18.

9. CHS Internal Audit of Health and Safety Management

Summary of key health and safety actions required to mitigate weaknesses identified by internal audit include:

- Governance – Requirement for all directorates and service areas to comply with the Trust's Health and Safety Policies and H&S specific strategic objectives to be included in the Trust's OSGM strategic plan for 'Highest Safety' – ***Key directorate/operational health and safety objectives to be set and agreed by the health and safety group.***
- Provision of specific health and safety training for Board members and senior managers – ***1 hour workshop planned for Executive Committee focusing on current statutory and regulatory requirements/ enforcement strategies and changes to the sentencing guidelines.***
- Manual review of staff nominated to attend safety management training (risk assessments etc.) - ***Liaison with ETC to flag up and prompt attendance (AC & MP), quarterly compliance reports required to be set up reporting to H&S and DJM's/Heads of Service)***

10. H&S Strategic Objectives

The Trust's health and safety objectives are identified and reported on via the Health and Safety Group Strategic Action Plan **(Appendix 6).**

Appendix 6 contains a detailed update on progress made against the 2016/17 strategic objectives as well as a more detailed overview of key areas to be progressed in 2017/18.

11. Conclusion

Good progress continues to be made against the Trust's health and safety objectives this year, however, we have also reported a 10% increase in the number of reported staff accidents. This is considered to be mostly attributable to reported violent incidents which have risen by 28% this year.

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12. Recommendations

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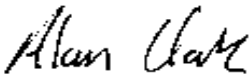
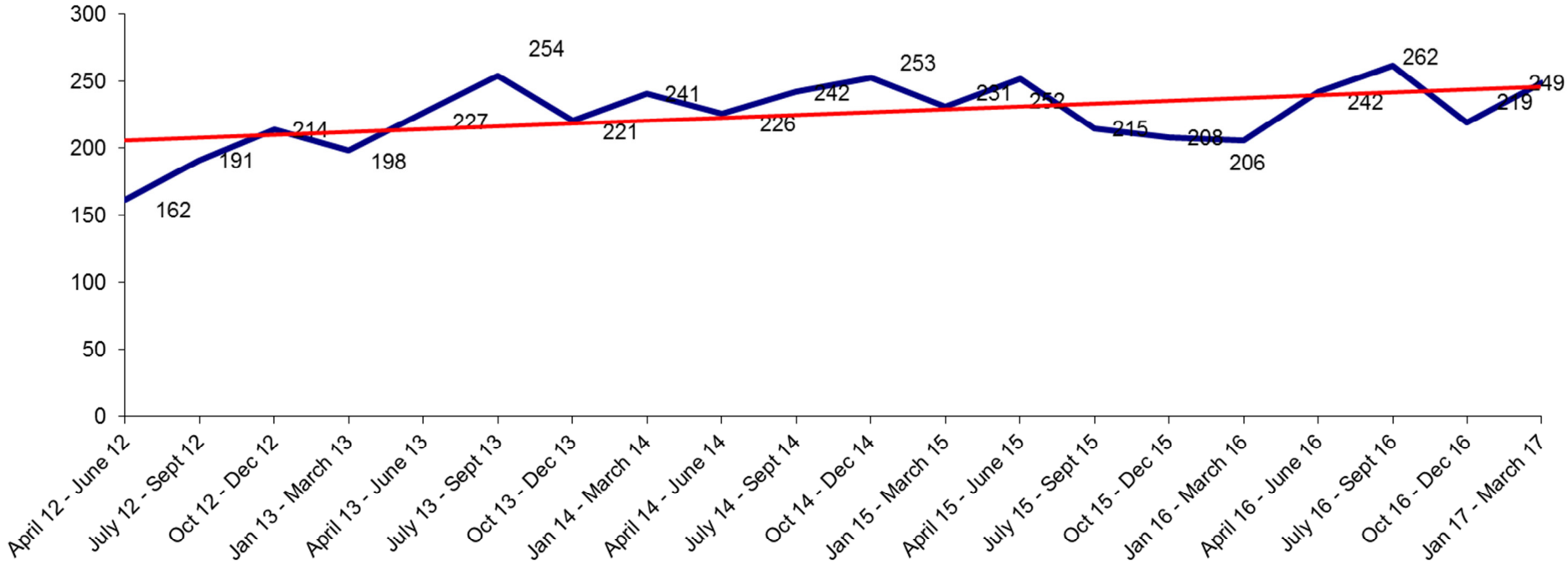


Alan Clark
Principal Safety Advisor

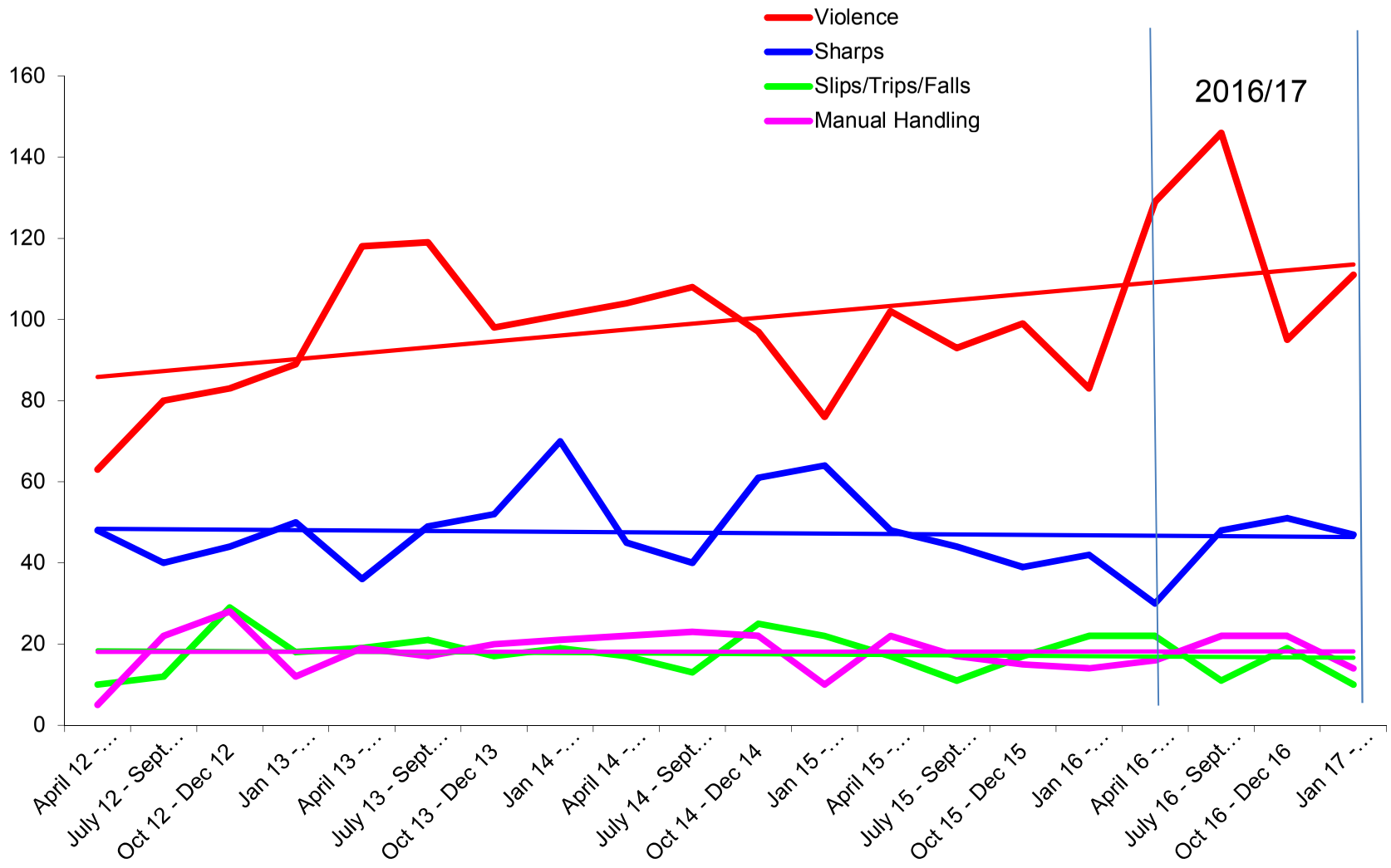
Appendix 1

All Staff Accidents (by Qtr) April 2012 - March 2017



Appendix 2

Top 4 Staff Incidents (By Qtr) April 2012 to March 2017



Appendix 3

HSE

Health and Safety Executive

Notification of Contravention

Field Operations Directorate

Paul Wilson

Scotland & Northern England
BP6301, Alnwick House,
Benton Park View, Benton Park
Newcastle Upon Tyne,
NE98 1YX

Tel: 0191 2026291
Fax: 0191 2026300
paul.wilson@hse.gsi.gov.uk

http://www.hse.gov.uk/

Principal Inspector
Mrs Eileen Anderson

Sunderland Royal Hospital,
(City Hospitals Sunderland
NHS Foundation Trust),
Kayll Road,
Sunderland,
SR4 7TP.

Reference SVC4324147

For the attention of Ms Julia Patterson, Deputy Chief Executive.
Cc. Mr Alan Clarke, Principal Safety Advisor

Date 23rd May 2016

Dear Sirs

HEALTH AND SAFETY AT WORK ETC ACT 1974

I am writing following my visit to above address on the 20th May 2016, where I was accompanied by Mr David Orr (HM Specialist Radiation Inspector). During this visit we met with Mr Alan Clarke (Principal Safety Advisor), Mr Andy Night (Head of Medical Physics), Ms Joanna Spence (Cath Lab Manager), Ms Michelle Fort (Radiation Protection Supervisor), Mr David Rawlings (Radiation Protection Advisor) and Mr Mark Gannon (Radiation Protection Advisor).

We visited to inspect health and safety arrangements at the premises, specifically with respect to radiation protection within the cardiac catheter laboratory. This was further to a reported concern made to the HSE, regarding allegations of unsafe radiation exposures in this area.

I write to confirm that HSE enquiries into the reported concern have concluded and no further action with respect to that concern will be taken. However, during the course of our visit we did identify other contraventions of health and safety law that require your action.

ACTION REQUIRED

In **Appendix 1** I have explained those contraventions. I require you to take action to ensure that you are managing health and safety more effectively and complying with the law. If you do not understand the action required or why it is necessary for you to comply with the law, please contact me or my Principal Inspector as soon as possible.

Please write to me confirming the action you have taken on each of these contraventions by **29th July 2016**.

If you do not take this action, I am required to consider further enforcement.

Important information

Please read the important information enclosed which informs you that a fee will now be payable by you. This fee covers our costs in these circumstances, and is applicable because I have observed significant contraventions of the law.

Section 28(8) of the Health and Safety at Work etc. Act 1974 requires me to give information to your employees about matters affecting their health and safety. I have, therefore, enclosed a copy of this letter to the employees for their information.

If you require further information or advice please visit HSE's website or contact me.

Yours faithfully

Paul Wilson
HM Inspector of Health & Safety

Enc: Appendix 1
Information on Fee for Intervention

4. IMPORTANT INFORMATION

The Health and Safety and Nuclear (Fees) Regulations 2016

RECOVERY OF COSTS

Under regulations 22 and 23 of the Health and Safety and Nuclear (Fees) Regulations 2016, HSE will recover the costs that it incurs for the work it does in relation to certain contraventions of health and safety law. These contraventions are known as 'material breaches'. The costs for the whole visit where a material breach is first identified are recoverable, along with other associated work.

This cost recovery is known as 'Fee for Intervention'. Further information is available on HSE's website at http://www.hse.gov.uk/fee-for-intervention/ .

I am notifying you that the contravention(s) listed in **Appendix 1** are, in my opinion, material breaches for which a fee is payable by you to HSE under Fee for Intervention. The reasons for my opinion are also given in Appendix 1.

HSE will send you one or more invoices for the costs incurred.

Under regulation 24(5) of the Fees Regulations 2016 you have the right to dispute the invoice. You can find further information about Fee for Intervention and details of the terms on which you can dispute an invoice in the leaflet HSE 48 - *Fee for Intervention: What you need to know* at http://www.hse.gov.uk/pubns/hse48.pdf.

There are exemptions and disapplications, where HSE cannot recover its costs for carrying out its functions which can be found in HSE 47 - *Guidance on the Application of Fee for Intervention* at http://www.hse.gov.uk/pubns/hse47.pdf.

APPENDIX 1 – MATERIAL BREACHES

Ionising Radiations Regulations 1999 ('*IRR 1999*')

1. In accordance with Regulation 16 of IRR 1999, you had designated the Cath Labs as a controlled area. But with respect to the management of those areas, you had not made adequate provision for the temporary handover of responsibility where appropriate i.e. between you and appointed service/ QA engineers.

   With respect to the management of the controlled areas, implement a system for the formal handover between you and third party providers. The arrangements should make clear who has control, the period of that control and the responsibility that that will entail.

2. In accordance with Regulation 32 of IRR 1999, you had implemented a quality assurance (QA) programme. However, said arrangements were considered insufficient because –

   a) In the event that the QA tests recorded a result outside of the specified range, the remedial actions that you would require of the radiographers were not clear. This included specifying at what point immediate removal from clinical use would be required (suspension level); and,

   b) Similarly, in the event of equipment fault, the remedial actions that you would require of the radiographers were not clear, including the actions/ decisions to be taken to ensure adequate testing before the equipment was returned to clinical use.

   In light of the above comments, you should review your QA programme in consultation with your radiation protection advisor.

   You are also advised to consider how you can better identify any significant deviation between the QA measurements and the baseline data. For example, I would advise that you include the tolerance on the plotted graphical illustration, and/ or programme the excel spreadsheet to visually highlight if results are out of tolerance.

3. In accordance with Regulation 17 of IRR 1999, you had implemented local rules. However, the local rules were noted to be insufficient in their description in some areas. For example –

   - the radiation protection measures e.g. personal protective equipment requirements, where not clearly listed in Appendix 4, titled '*Brief Reminder on Compliance with Local Rules for Radiation Protection in Fluoroscopy Rooms/ Cath Lab*', as would be expected;
   - In the event of a problem with the x-ray equipment the initial safety steps to be taken in the contingency plans were not clear, nor were the factors to be considered in deciding if further investigatory steps would be required;
   - With respect to pregnant workers, the policy you described in verbal explanation did not reflect that which was recorded in the local rules i.e. you stated that any pregnant worker would simply be removed from the controlled area, however your local rules was vague, stating pregnant workers should 'take additional precautions'.

   In consultation with your RPA, you should review your local rules and ensure that they show the key work instructions. These should be clear, sufficient and concise.

4. IMPORTANT INFORMATION

The Health and Safety and Nuclear (Fees) Regulations 2016

RECOVERY OF COSTS

Under regulations 22 and 23 of the Health and Safety and Nuclear (Fees) Regulations 2016, HSE will recover the costs that it incurs for the work it does in relation to certain contraventions of health and safety law. These contraventions are known as 'material breaches'. The costs for the whole visit where a material breach is first identified are recoverable, along with other associated work.

This cost recovery is known as 'Fee for Intervention'. Further information is available on HSE's website at http://www.hse.gov.uk/fee-for-intervention/ .

I am notifying you that the contravention(s) listed in **Appendix 1** are, in my opinion, material breaches for which a fee is payable by you to HSE under Fee for Intervention. The reasons for my opinion are also given in Appendix 1.

HSE will send you one or more invoices for the costs incurred.

Under regulation 24(5) of the Fees Regulations 2016 you have the right to dispute the invoice. You can find further information about Fee for Intervention and details of the terms on which you can dispute an invoice in the leaflet HSE 48 - *Fee for Intervention: What you need to know* at http://www.hse.gov.uk/pubns/hse48.pdf.

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Appendix 4

City Hospitals Sunderland NHS
NHS Foundation Trust

Deputy Chief Executive/Executive Director of Finance: Julia Pattison

Sunderland Royal Hospital
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Tyne & Wear SR4 7TP

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Paul Wilson
Scotland & Northern England
BP6301, Alnwick House
Benton Park View
Benton Park
Newcastle Upon Tyne
NE98 1YX

27 July 2016

Dear Mr Wilson

Notice of Contravention Sunderland Royal Hospital
Reference SVC4324147

I am writing in response to the above Notice of Contravention and the material breaches that were identified during your visit on the 20th May 2016. In Appendix 1 you will find the actions the Trust has taken to remediate the deficiencies noted.

Staff are now being trained in these changes to documentation and procedures. Recorded training of all staff involved in these procedures will be completed by 31st August 2016 (date reflects current holiday period).

To ensure these changes are fully adopted two audits of compliance with the new procedures will be completed and sent to the Radiation Safety Group for the meetings of September 2016 and March 2017.

Please let me know if you require any further information.

Yours sincerely

J Pattison
Deputy Chief Executive/Executive Director of Finance

Appendix 1

Actions taken to remediate deficiencies noted during HSE inspection of 20th May 2016

Deficiency 1
"In accordance with Regulation 16 of IRR 1999, you had designated the Cath Labs as a controlled area. But with respect to the management of those areas you had not made adequate provision for the temporary handover of responsibility where appropriate i.e. between you and appointed service/QA engineers. (With respect to the management of the controlled areas, implement a system for the formal handover between you and third party providers. The arrangements should make clear who has control, the period of that control and the responsibility that that will entail.)"

Corrective Action 1
The standard operating procedure (SOP) "Handover of Cardiac Cath Lab and Equipment to Service Agents" now instructs staff in the process of handing over control of the controlled area to field service engineers or medical physics staff. A form "X-ray Equipment and Controlled Area Handover" will be used to formally record the period of time that the Controlled Area has been under the control of the outside contractors and when control has been passed back to the Trust. The SOP and form also cover the process of assessing that the equipment is suitable to be returned into clinical use.

Deficiency 2a
In accordance with Regulation 32 of IRR 1999, you had implemented a quality assurance (QA) programme. However, said arrangements were considered insufficient because - In the event that the QA tests recorded a result outside of the specified range the remedial actions that you would require of the radiographers were not clear. This included specifying at what point immediate removal from clinical use would be required (suspension level);

Corrective Action 2a
The SOP "Actions to be take in the event of an out of specification QA result" now instructs the staff in the process to be followed to investigate an out of specification QA result, including when and how the equipment should be suspended from clinical use.

Deficiency 2b
Similarly, in the event of equipment fault, the remedial actions that you would require of the radiographers were not clear, including the actions/decisions to be taken to ensure adequate testing before the equipment was returned to clinical use.

Corrective Action 2b
The SOP "Actions to be taken following radiation equipment fault" now instructs staff in assessing when an equipment fault requires the equipment to be suspended from clinical activities and the process that is required to ensure it is suitable for clinical use after remedial action has been carried out. As noted in Corrective Action 1, the form "X-ray Equipment and Controlled Area Handover" also guide staff in the process of accepting equipment for clinical use after work by field service engineers.

Deficiency 2c
You are also advised to consider how you can better identify any significant deviation between the QA measurements and the baseline data. For example I would advise that you include the tolerance on the plotted graphical illustration, and/or programme the excel spreadsheet to visually highlight if results are out of tolerance.

Corrective Action 2c
The spreadsheet that was inspected during the visit has been modified by medical physics to ensure that out of specification limits are displayed on all graphs and that out of specification values are highlighted in colour in all tables.

Deficiency 3
In accordance with Regulation 17 of IRR 1999, you had implemented local rules. However, the local rules were noted to be insufficient in their description in some areas.

Corrective Action 3
The Local Rules have been rewritten; these now have specific instructions for the Cath lab in a one sheet appendix 4. The amendments address the deficiencies noted:

- Local Rules gives clear instructions for the PPE required in the Cath lab.
- Contingency plans within the Local Rules now provide clear instructions on initial safety steps to be taken in the event of equipment problems and how to decide whether further investigatory steps are required.
- Local Rules now make it clear that a worker who becomes pregnant must inform the RPS who will ensure an individual risk assessment is completed. The risk assessment would then inform whether alterations to duties would be required.

Appendix 5

Criteria for identifying Patient RIDDOR reportable incidents

An injury to a patient is RIDDOR reportable if it results from an accident (definition: an event which results in injury or ill health) arising out of or in connection with work being undertaken by others, happens at hospital and involves a "specified injury".

RIDDOR SPECIFIED INJURIES

- Fractures, other than to fingers, thumbs and toes. So a patient fall where equipment of the work environment (including how or where the work is carried out, organised or supervised) are involved which results in a #NOF would be RIDDOR reportable, for example.
- Amputations (due to an accident)
- Any injury likely to lead to permanent loss of sight or reduction in sight. Could particularly apply to some SEI patient safety adverse events.
- Serious burns (including scalding) which cover more than 10% of the body or cause significant damage to the eyes, respiratory system or other vital organs; might apply to some theatre adverse events
- Any loss of consciousness caused by a head injury or asphyxia; again, some patient falls could be captured by this
- Any crush injury to the head or torso causing damage to the brain or internal organs
- Any scalping requiring hospital treatment
- Any other injury arising from working in an enclosed space which leads to hypothermia or heat-induced illness; or requires resuscitation or admittance to hospital for more than 24 hours

OTHER RIDDOR SPECIFIED PATIENT INCIDENT EXAMPLES

- A patient falls from a window on an upper floor and is badly injured
- A patient requires hospital treatment after sliding through a sling whilst being hoisted
- A patient suffers a serious injury as a result of a power failure during an operation (not caused by the conduct of the operations

Note: all potential RIDDOR reportable patient accidents must be forwarded on to the Fire and Safety Team for further investigation.

Appendix 6

Health and Safety Group Strategic Action Plan Progress and actions for 2017/18

Description of Key Objective	2016/17 progress	2017/18/ planned actions	Target Date
Review and update of Health and Safety Policies	▪ General policy on the Management of Health and Safety at Work reviewed and updated to include arrangements for: workplace health safety and welfare; and work equipment. Once ratified this will allow us to remove the Workplace and Work equipment Policies. ▪ The Operational Fire Policy has completed the ratification process.	▪ The updated General Policy on the Management of Health and Safety at Work to be ratified. ▪ Review and update the Trust's Management of Latex Policy. ▪ Fire Policy to be launched once current IT issues with Confirmer have been resolved.	▪ September 2017 (AC) ▪ September 2017 (AC ▪ September 2017 (AC)
Annual review of local Health & Safety Arrangements and risk assessments	▪ Improved and maintained level of compliance at (80%) (85) 98%. *Note: The next request for a local health and safety return is not planned to commence until April 2018. This will re-set the returns to be completed by all in April-May 2018.*	▪ All staff identified as requiring competency training as Workplace Risk Assessors to be monitored and tracked via ESR. ▪ Information on staff requiring WRA training to be forwarded to DM's for local action	▪ July 2017 (Mary Pollard and AC) ▪ June 2017 (AC)

Description of Key Objective	2016/17 progress	2017/18 planned actions	Target Date
Implementation of Safer Sharps	• Sharps incidents monitored and reviewed by the H&S Group. A detailed monthly sharps incident review commenced by H&S and Occ Health. • The H&S Group have recommended that the Sharps Group be reformed with a Clinical/Nursing lead to review compliance with the introduction of safer sharps and identify any additional training needs. • New sharps procurement process completed which include the provision of safer sharps and the provision of training. • Overall reported sharps incidents have remained the same during 2016/17 after an initial 18% reduction in 2015/16.	▪ Confirm clinical lead for reformation of Sharps Task and Finish Group to review compliance with Safer Sharp Regulations and confirm any additional training needs. ▪ Continued monthly review of sharps incidents to confirm accuracy of data and identification of any trends.	June 2017 (CH) Ongoing April 2017 to March 2018 (AC & AP)

Description of Key Objective	2015/16 progress	2016/17 planned actions	Target Date
Implementation of updated COSHH risk assessment process	▪ Review of COSHH substances on the on-line database continued with priority given to those substance which are classified as a Priority 1 risk. ▪ Commenced a full review of the COSHH risk assessment process and documentation with the aim of making the process and forms as user friendly as possible. ▪ All wards/departments required to confirm who their nominated COSHH risk assessors are on their annual H&S return form	• Continue to review, maintain and update COSHH information on the on-line database. • Complete review and update of COSHH risk assessment process and forms. • Review and update COSHH training in-line with above. • All staff identified as requiring competency training risk assessors to be monitored and tracked via ESR • Information on staff requiring COSHH training to be forwarded to DM's for local action	Ongoing April 17 to March 18 (H&S) May 2017 (H&S) May 2017 (H&S) July 2017 (Mary Pollard and AC) June 2017 (AC
Health and Safety Benchmarking	▪ New H&S incident benchmarking arrangements set up and trialled via the Northern HEFMA H&S Group based on incident data	▪ Continue to seek benchmarking opportunities via peer groups and other readily available sources (data published on the intranet).	Ongoing (AC and HEFMA H&S Group)

Description of Key Objective	2015/16 progress	2016/17 planned actions	Target Date
Further monitoring and review of key safety risk standards to seek assurance of appropriate level of organisation wide compliance.	**a. Site Vehicle safety** • Review and report of the findings of the vehicular/pedestrian risk areas completed with agreed recommended priorities. **b. Latex** • Following consultation with the Deputy Medical Director it has been accepted by the H&S Group that latex gloves will continue to be available for surgeons carrying out surgical procedures only. All other clinical gloves to be Nitrile only. • Following consultation with the Deputy Medical Director and the H&S Group it has been recommended that the Trust's Latex Policy is to remain and be updated to reflect current arrangements and best practice covering both staff and patient safety needs.	▪ Recommended vehicular/pedestrian recommendations to be costed up and submitted to CDSG for approval • Review and update of the Trust Latex Policy updated to reflect current arrangements and best practice covering both staff and patient safety needs.	July 2017 (AC & WC) December 2017 (AC, AP, LC and a nominated clinical/medical lead)

Description of Key Objective	2015/16 progress	2016/17 planned actions	Target Date
Further monitoring and review of key safety risk standards to seek assurance of appropriate level of organisation wide compliance (Cont.)	**c. Violence to staff** ▪ Commenced formal support/debrief sessions for staff involved in dealing with violent incidents to help and support them in managing patient with dementia and delirium.	▪ Continue with formal debrief sessions for those staff involved in violent indents relating to dementia and delirium	Ongoing April 2017 to March 2018 (Jim Charlton, June Lawson and Lesley Young)
Overall Health and Safety assurance against HSG 65 (HSE's Management of Health and Safety) and other appropriate health and safety management standards.	• Continued to progress recommendation and agreed actions from H&S Audit Report.	• Key health and safety key objectives for directorates to be specifically set and agreed via the Health and Safety Group. • Deliver Executive Committee Health and Safety Workshop presentation • Liaise with ETC to set up quarterly safety management training compliance reports to H&S Group, DJM's and Heads of Service. • Set up quarterly H&S dashboard compliance report for DM's	June 2017 (CH &AC) September 2017 (CH & AC) July 2017 (AC and Mary Pollard) August 2017(AC)

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

FIRE SAFETY ANNUAL REPORT 2016/17

JULY 2017

EXECUTIVE SUMMARY

The fire safety legislation for NHS Trusts is contained in the Regulatory Reform (Fire Safety Order) 2005 and detailed in the appropriate Hospital Technical Memorandum's (HTM's) which cover all aspects of healthcare fire safety. The overall requirement is that Trusts must be able to demonstrate that fire safety is properly managed in all premises that they own, including any other areas which are to any extent under their control.

The Trust's fire safety performance can be generally measured against the following:

- Number of fires incidents and unwanted fire signals
- Fire drills
- Fire Safety Training
- Fire risk assessments
- Fire safety action plan progress

Fire Safety within a large Acute Hospital such as in CHS remains a constant dynamic challenge in an environment which is in a permanent state of change. We continue to develop our sites with new capital which require the continued review and update of our fire risk assessments and fire safety arrangements.

The overall management of fire safety within the Trust must remain a high priority with the aim of ensuring that we provide a safe environment for all patients, visitors, staff and contractors. We continue to work in close liaison with the Fire Service in meeting our fire safety obligations under the Regulatory Reform (Fire Safety Order) 2005 with the aim of ensuring our fire risk assessments facilitate and support action which deals with any identified significant fire risks.

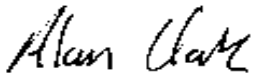
It very encouraging to note this year that we have achieved a significant reduction in our number of unwanted fire signals (uwfs) this year. This is mostly due to all the hard work and effort put in by the RRO Group by taking remedial action in those areas that we have been able to control and influence. We still need to continue to reduce the uwfs in 2017/18 and this continues to be a high priority for the RRO Group.

The report continues to highlight the ongoing pressure that the fire authority are putting on hospitals to adopt a check-first fire alarm strategy. They are still considering enforcing a reduced response to hospitals during the core daytime hours unless we confirm via 999 that a fire or physical sign of fire exists.

Our overall level of compliance with mandatory fire training remains high (90%) and we have continued to provide additional fire warden training as a matter of priority. The report includes an updated draft fire safety training needs which will be taken to the next Mandatory Training Review Group.

RECOMMENDATIONS

Directors are asked to accept the Fire Safety Report for 2016/17 and continue to support the detailed recommendations for 2017/18 contained in this report.



Alan Clark
Principal Safety Advisor

CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST

BOARD OF DIRECTORS

FIRE SAFETY ANNUAL REPORT 2016/17

JULY 2017

INTRODUCTION

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Fire Safety within a large Acute Hospital such as in CHS remains a constant dynamic challenge in an environment which is in a permanent state of change. We continue to develop our sites with new capital schemes which require the continued review and update of our fire risk assessments and fire safety arrangements.

1. FIRE INCIDENTS

Fires

The total number of minor fires (Table 4) has decreased from 11 to 7 this year. Electrical light fittings (1), electrical equipment (4) smoking (1) and an overheating tumble dryer in the mop wash accounted for these incidents.

Table 1 – Sunderland Royal Hospital					
Reported Fires	2012/13	2013/14	2014/15	2015/16	2016/17
Light fitting	3	1	3	3	1
Electrical	0	2	6	4	4
Cooking	0	0	0	0	0
Smoking	0	2	0	0	1
Other		1	2	4	1
Total for Year	**3**	**6**	**11**	**11**	**7**
Table 2 – Sunderland Eye Infirmary					

Reported Fires	2012/13	2013/14	2014/15	2015/16	2016/17
Choke/lighting	0	0	0	0	0
Electrical	0	0	0	1	0
Cooking	0	0	1	0	0
Other	0	0	0	1	0
Total Fires	**0**	**0**	**1**	**2**	**0**

Table 3 – Childrens Centre					
Reported Fires	2012/13	2013/14	2014/15	2015/16	2016/17
Choke/lighting	1	0	0	0	0
Electrical	0	0	0	0	0
Total Fires	1	0	0	0	0

Table 4 – All CHS Sites					
Reported Fires	2012/13	2013/14	2014/15	2015/16	2016/17
Total Fires	4	6	**12**	**13**	**7**

False Alarms (uwfs)

The number of unwanted fire signals (uwfs) has encouragingly decreased this year from 132 in 2015/16 to 89 in 2016/17 (Table 8). Although we have reported a marginal decrease in all uwfs the most significant decrease is in environmental activations (steam, aerosols etc.) from 55 to 32 (17%). Even with this significant decrease we continue to under pressure from the Fire Authority to reduce even further.

The Fire Service like all other public bodies continues to face a reduction in there operating budget which has a direct bearing on their resources. We therefore continue to operate under a threat to of a reduced attendance to our fire calls.

We have continued to fit more robust break glass unit covers in patient areas which include those with a built in sounder/alarm adjacent to ward exit doors. Even though we have only reported a marginal reduction in patient/visitor activations over the past twelve months the majority (14) of these were in the first two quarters of 2016.

Most significant reduction in uwfs is due to environmental (steam and aerosols) causes activating auto fire detectors. We have reported a reduction in 2016/17 of 62%. This is deemed to be attributable to the work carried out by our Estates Engineers in ensuring the detector programming is suitable for the environment so as to not react to steam and cooking fumes.

All unwanted fire signal activations are reported to the Trusts Regulatory Reform (Fire Safety) Group (RRO).

Table 5 – Sunderland Royal Hospital					
Unwanted Fire Signals	2012/13	2013/14	2014/15	2015/16	2016/17
Good Intent	30	30	40	28	21
System Fault	25	19	9	15	13
Accidental	10	3	10	11	1

Patient /Visitor	19	16	16	21	17
Environmental	34	31	42	50	31
Total for Year	**118**	**98**	**117**	**125**	**83**

Table 6 – Sunderland Eye Infirmary					
Unwanted Fire Signals	2012/13	2013/14	2014/15	2015/16	2016/17
Good Intent	2	1	0	0	0
System Fault	0	1	1	0	0
Accidental	1	0	1	0	2
Patient /Visitor	0	0	0	0	1
Environmental	1	2	1	1	1
Total for Year	**4**	**4**	**3**	**1**	**4**

Table 7 – Childrens Centre					
Unwanted Fire Signals	2012/13	2013/14	2014/15	2015/16	2016/17
Good Intent	0	0	0	0	0
System Fault	2	3	0	2	2
Accidental	0	0	0	0	0
Patient /Visitor	0	0	0	0	0
Environmental	0	0	1	4	0
Total for Year	**2**	**3**	**1**	**6**	**2**

Table 8 – All Sites					
Unwanted Fire Signals	2011/12	2012/13	2013/14	2015/16	2016/17
Good Intent	32	31	40	28	21
System Fault	27	23	10	17	15
Accidental	11	2	11	11	3
Patient /Visitor	19	16	16	21	18
Environmental	35	33	44	55	32
Total for Year	**124**	**105**	**121**	**132**	**89**

2. FIRE DRILLS

The Government Healthcare Fire Safety Guide and HTM 05:03 part A (General Fire Safety) recommend that fire drills are carried out at least annually to supplement classroom training and evaluate the effectiveness of our emergency plans.

The Fire Drills carried out at CHS ensures that all areas of the Trust are subjected to an unannounced test of the effectiveness of staff response, both in the 'fire' zone and the support obtained from the assembly point.

Drills carried out 2016/17

Sunderland Royal Hospital 18
Eye Infirmary 2
Children's Centre 2

Observation of our "staff in action" confirms a good understanding of procedures with only minor errors displayed. These are normally attended to at the time of drill debrief. All fire alerts are investigated and attended by a Fire & Safety Officer to ensure that the fire procedures are carried out and reported on a fire report.

3. FIRE TRAINING

Overall compliance with the fire safety mandatory training (annual ½ hour awareness lecture for all staff) of **90%** has been achieved in 2016/17 compared to 90% in 2015/16.

The requirement for all new starters to receive full 1 hour fire lecture at induction remains unchanged.

HTM 05-01 on the Safe Management of Fire Safety places a mandatory requirement for us to ensure that we are capable of dealing with any likely fire situation. It also stipulates clear responsibilities for managers, fire wardens and fire response team members to assist the Trust in the management of fire safety, maintaining and ensuring safe environment as well being able to respond to and deal with any fire situation. This places a requirement on the Trust to provide these staff with suitable training and support to enable them to fulfil their responsibilities. To achieve this we provide Fire Warden training (3 hours maximum) for all ward/department managers and their deputies which covers the full range of fire safety knowledge and skills.

There has been an additional 101 fire wardens trained this year, in summary:

- Since 2010 we have trained a total of 429 fire wardens
- All high dependency areas (i.e ICCU/Theatres/Neo-natal) and SEI, Maternity, Medical Records are compliant via on-going planned bespoke training.
- Priority risk areas for 2017/18 are the in-patient wards from ESR we known that we have 79 out of 192 fire wardens trained in the ward areas.
- It is estimated that each ward should have a minimum 6 (ward managers or deputies) trained to cover 24/7 the Trust has an estimated minimum shortfall of 125 trained ward-based fire wardens (source ESR).

We have completed another review of the fire training provision and have produced an updated recommended fire training needs for consideration (**Appendix 1**), this is to be re-presented to the next available Mandatory Training Review Group meeting.

4. THE REGULATORY REFORM (FIRE SAFETY) ORDER 2005

The Regulatory Reform (Fire Safety) Order 2005 (RRO) places the full responsibility to manage fire safety on the responsible persons, which in our case is the Trust. We have to carry out suitable and sufficient risk assessments and take action to deal with any significant issues identified as part of that process. The Fire Authority has the (responsibility) jurisdiction to enforce and police this legislation through a programme of audits and inspections.

We carried out a full review of the fire risk assessment programme in 2016 and in January 2017 we commenced a new programme of fire risk assessment reviews and fire safety inspections. The RRO clearly states that fire risk assessments must be reviewed by the

responsible person regularly so as to keep it up to date. The Chief Fire Officers Association guidance document on the application of the RRO recommends that an annual review is generally accepted to be best practice.

Based on available resources our new programme sets out to achieve a standard whereby each ward/department/site is subject to a formal annual fire safety visit comprising of a fire risk assessment review every other year and a fire safety inspection in alternative years. This gives us a regular programme of fire risk assessment reviews (2 yearly cycle) supplemented with a fire safety check (2 yearly cycle).

The Fire Authority has also continued with their sample audits and carried out at least 10 visits over a 12 month period. Their audit continues to highlight some ongoing fire safety issues such as storage and wedges. We continue to work closely with all stakeholders concerned to manage these ongoing issues.

Other significant non-compliant areas identified by the Trust's RRO Group as requiring continued review/action/monitoring include:

- The management and storage of waste (Potential fire loading and arson risks).
- Compartmentation (Including fire door maintenance and damage).
- Storage of oxygen cylinders in ward and clinical areas.
- Hazard Rooms (Change of use and ward reconfiguration of, for example, treatment rooms converted to stores or day rooms).
- Fire Warden Training (All ward managers and their deputies are nominated as fire wardens and require additional fire safety training).

We have continued this year to give priority to supporting the capital programme for the new pathology hot lab/endoscopy and the ongoing new Emergency Department, liaising closely with the projects leads to advise on and deal with any fire safety issues identified both at the design stage through the construction and commissioning process.

5. THE RRO FIRE SAFETY MANAGEMENT GROUP

The formal RRO fire safety management group chaired by the Director of CHoICE Facilities Services meets on a monthly basis and reports directly to the Corporate Governance Steering Group. The group oversees and monitors compliance with the Regulatory Reform (Fire Safety) Order 2005 and Health Technical Memorandum (HTM) Firecode on behalf of the Trust, including the development and management the Trust's fire safety risk register and action plan. The action plan includes both short medium and long term actions, for approval by the Corporate Governance Steering Group.

6. FIRE SAFETY OPERATIONAL STRATEGY UPDATE

The current fire safety operational strategy is included in the Operational Fire Safety Policy which was ratified in October 2016. We are currently unable to progress with the full implementation of this Policy due to technical problems with using the 'Confirmer' telecom system. IT have informed us that we will not be able to use 'Confirmer' until a

new upgrade on the telecoms IT platform has been completed. This is hoped to be completed by August/Sept 2017 at which time we will be able to launch and implement the fire safety operational arrangements (for the provision of secondary fire assistance) contained within the policy.

As detailed in last year's report, our current secondary assistance arrangements, which have been in place since the early 1990's, require that all available staff on hearing an intermittent fire alarm make their way to the fire assembly point to be given further instruction by a fire team leader at the assembly point. The use of 'Confirmer allows us to call groups of contacts (all in-patient ward areas) quickly in an emergency situation and deliver a pre-recorded message (i.e. a request for all available staff to assist with a ward evacuation).

7. CHS INTERNAL AUDIT REPORT CHS/2015/18 PROGRESS

CHS Internal Audit was commissioned to undertake a fire safety management audit in 2014/15. Their audit of Fire Safety Management concentrated on the guidance and recommendations contained in the Health Technical Memorandum 05:01: Managing Healthcare Fire Safety (updated in 2013).

The audit findings confirmed that we have a fire safety management structure in place in accordance with the HTM. The following has been actioned in support of the audit recommendations:

- The RRO Group Meeting minutes and action plan continue to be tabled as a standard quarterly agenda item at the Corporate Governance Steering Group

- The draft Operational Fire Policy was ratified by the Policy Committee on the 13 October 2016 subject to some minor changes. *Note: Updated Fire Policy currently on hold until the IT issues regarding the use of 'Confirmer' are resolved.*

- An updated programme of Fire Risk Assessments review and Fire Safety check were implemented by the Fire and Safety Department in January 2017. This will give better assurance that fire safety standards are being maintained and ward/dept managers are carrying their fire safety responsibilities.

- Progress on Fire Warden training and review of Trust fire training detailed in section 4 above.

8. CONCLUSION

The overall management of fire safety within the Trust must remain a high priority with the aim of ensuring that we provide a safe environment for all patients, visitors, staff and contractors. We continue to work in close liaison with the Fire Service in meeting our fire safety obligations under the Regulatory Reform (Fire Safety Order) 2005 with the aim of ensuring our fire risk assessments facilitate and support action which deals with any identified significant fire risks.

It very encouraging to note this year that we have achieved a significant reduction in our number of unwanted fire signals (uwfs) this year. This is mostly due to all the hard work

and effort put in by the RRO Group by taking remedial action in those areas that we have been able to control and influence. We still need to continue to reduce the uwfs in 2017/18 and this continues to be a high priority for the RRO Group.

The report continues to highlight the ongoing pressure that the fire authority are putting on hospitals to adopt a check-first fire alarm strategy. They are still considering enforcing a reduced response to hospitals during the core daytime hours unless we confirm via 999 that a fire or physical sign of fire exists.

Our overall level of compliance with mandatory fire training remains high (90%) and we have continued to provide additional fire warden training as a matter of priority. The report includes an updated draft fire safety training needs which will be taken to the next Mandatory Training Review Group.

9. RECOMMENDATIONS FOR 2017/18

We therefore need to continue with the fire safety initiatives contained in this report by way of the following recommendations:

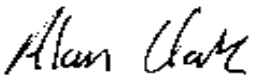
Recommendation 1 – *Continue to progress the RRO 2017/18 action plan in-line with available funding and resources.*

Recommendation 2 *– Continue to further reduce the number of unwanted fire signals at SRH.*

Recommendation 3 *– Present the up-dated model fire training needs, as detailed in appendix 1, to the Mandatory Training Review Group for consideration.*

Recommendation 4 *– Continue with the updated fire risk assessment programme.*

Directors are asked to accept the Fire Safety Report for 2016/17 and to support its recommendations.



Alan Clark
Principal Safety Advisor

APPENDIX 1

DRAFT - CHS Model Fire Training Needs (Applicable to Role)

Administration/office based staff, consultants and medical staff

- Face to face every other year and e-learning in-between

All nursing/support staff in clinical areas not requiring evacuation aide training

- Face to face and e-learning alternate years
- Fire extinguisher training every 3 years (45mins)

In-patient based nursing/support staff requiring evacuation aide training

- Face to face and e-learning alternate years
- Fire extinguisher training every 3 years (45 mins)
- Ski Pad- Bariatric Mat training every 3 years for staff working in Blocks F & H (20 mins)

Matrons, Ward Managers, Junior Sisters and Fire Wardens

- Year one Managers Version of mandatory fire lecture (45 mins). This will provide the training needed to comply with Article 7:28 of HTM 05:01.
- Year two e-learningYear three Mandatory Fire Lecture (45 mins)
- Fire extinguisher training every 3 years (45 mins)
- Ski Pad- Bariatric Mat training every 3 years for staff working in F & H Blocks (20 mins) provided bespoke for the matrons group to facilitate attendance

Theatre, ICCU,NICU, Maternity, Renal and SEI

- Year one Mandatory Fire Lecture (30 mins)
- Year two e-learning
- Year three bespoke ward based training (150 minutes)

Fire Team

- Year one Mandatory Fire Lecture (30 mins)
- Year two e-learning
- Year three Fire Team Training
- Year four e-learning

Note: *ESR will be programmed and set up for all staff groups with their specific fire training requirements based on the above model.*