NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Trust Boards-in-Common (meeting held in Public) to be held on Thursday, 8 August 2024 at 9.00 am to 1.00 pm in the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

No.	Agenda Item	Format	Purpose	Time
1.	**CORE / STANDING BUSINESS ITEMS**			
1.1	**Welcome, Group Chair's Opening Remarks and Apologies for Absence** Sean Lyons, Group Chair	Verbal	Information	**09:00**
1.2	**Patient Story** Amanda Stanford, Group Chief Nurse	Verbal	Discussion / Assurance	
1.3	**Declarations of Interest** Sean Lyons, Group Chair	Verbal	Assurance	
1.4	**Minutes of the Meeting held on Thursday, 13 June 2024** Sean Lyons, Group Chair	BIC(24)133 Attached	Approval	
1.5	**Matters Arising** Sean Lyons, Group Chair	Verbal	Discussion / Assurance	
1.6	**Action Tracker** - **Public** Sean Lyons, Group Chair	BIC(24)134 Attached	Assurance	
1.7	**Group Chief Executive's Briefing** Jonathan Lofthouse, Group Chief Executive	BIC(24)135 Attached	Assurance	**09:25**
2.	**GROUP DEVELOPMENT**			
2.1	**Updates following the Collaboration of Acute Providers meeting** Jonathan Lofthouse, Group Chief Executive	Verbal	Assurance	**09:55**
3.	**BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS**			
3.1	**Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge** Sue Liburd & David Sulch, Non-Executive Directors Committee Chairs	BIC(24)136 Attached	Assurance	**10:00**
3.1.1	**Maternity & Neonatal Safety Champions Overview Assurance / Escalation Reports – NLaG and HUTH** Stuart Hall & Sue Liburd, NED Maternity & Neonatal Safety Champions	BIC(24)137 Attached	Assurance	**10:15**
3.1.2	**Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH** Amanda Stanford, Group Chief Nurse	BIC(24)138 Attached	Assurance	**10:25**
3.1.3	**Audiology Services CQC Response** Dr Kate Wood, Group Chief Medical Officer	BIC(24)139 Attached	Assurance	**10:35**
BREAK – 10:40 – 10:55				

3.2	**Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)140 Attached	Assurance	**10:55**
3.3	**Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge** Tony Curry, Non-Executive Director Committee Chair	BIC(24)141 Attached	Assurance	**11:10**
3.3.1	**Freedom to Speak up Guardian Report - Quarter One – NLaG & HUTH** Liz Houchin & Fran Moverley, FTSUG	BIC(24)142 Attached	Assurance	**11:25**
3.4	**Audit, Risk & Governance Committees-in-Common Highlight / Escalation Report & Board Challenge** Simon Parkes & Jane Hawkard, Non-Executive Directors Committee Chairs	BIC(24)143 Attached	Assurance	**11:35**
3.5	**Capital & Major Projects Committees-in-Common Highlight Report & Board Challenge** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)144 Attached	Assurance	**11:50**
4.	**GOVERNANCE & ASSURANCE**			
4.1	**Board Assurance Framework & Strategic Risk Register – NLaG and HUTH** David Sharif, Group Director of Assurance	BIC(24)145 Attached	Assurance / Approval	**12:05**
5.	**OTHER ITEMS FOR APPROVAL**			
5.1	**Terms of Reference for Committees-in-Common:** • **Workforce, Education & Culture** • **Quality & Safety** • **Performance, Estates & Finance** • **Audit, Risk & Governance** • **Capital & Major Projects**	BIC(24)146 Attached	Approval	**12:10**
5.2	**Modern Slavery Statements – NLaG & HUTH** Simon Nearney, Group Chief People Officer	BIC(24)147 Attached	Approval	
5.3	**Premises Assurance Model (PAM)** Group Director of Estates (Lee Bond)	BIC(24)148 Attached	Approval	
5.4	**Scheme of Delegation & Powers Reserved for the Trust Board** Lee Bond, Group Chief Financial Officer	BIC(24)149 Attached	Approval	
5.5	**Standing Financial Instructions** Lee Bond, Group Chief Financial Officer	BIC(24)150 Attached	Approval	
5.6	**Strategic Framework 2024 – 2029** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(24)153 Attached	Approval	
5.7	**Staff Charter** Simon Nearney, Group Chief People Officer	BIC(24)154 Attached	Approval	
6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**			
6.1	**Items for Information / Supporting Papers (as per Appendix A)** Sean Lyons, Group Chair	Verbal	Information / Assurance	

7.	**ANY OTHER URGENT BUSINESS**			
7.1	**Any Other Urgent Business** Sean Lyons, Group Chair / All	Verbal		**12:45**
8.	**QUESTIONS FROM THE PUBLIC AND GOVERNORS**			
8.1	**Questions from the Public and Governors** Sean Lyons, Group Chair	Verbal	Discussion	**12:50**
9.	**MATTERS FOR REFERRAL TO BOARD COMMITTEES-IN-COMMON**			
9.1	**To agree any matters requiring referral for consideration on behalf of the Trust Boards by any of the Board Committees-in-Common** Sean Lyons, Group Chair / All	Verbal	Discussion	**12:55**
10.	**DATE OF THE NEXT MEETING**			
10.1	**The next meeting of the Boards-in-Common will be held on Thursday, 10 October 2024 at 9.00 am**			

KEY:
HUTH – Hull University Teaching Hospitals NHS Trust
NLaG - Northern Lincolnshire & Goole NHS Foundation Trust

APPENDIX A

6.	**ITEMS FOR INFORMATION / SUPPORTING PAPERS**	
6.1	**Quality & Safety Committees-in-Common**	
6.1.1	**Quality & Safety Committees-in-Common Minutes – May and June 2024** Sue Liburd & David Sulch, Non-Executive Director Committee Chair	BIC(24)155 Attached
6.1.2	**Annual Medicines Optimisation Annual Report** Dr Kate Wood, Group Chief Medical Officer	BIC(24)157 Attached
6.2	**Performance, Estates & Finance Committees-in-Common**	
6.2.1	**Finance & Performance Committees-in-Common Minutes – May and June 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)158 Attached
6.3	**Workforce, Education & Culture Committees in Common**	
6.3.1	**Workforce, Education & Culture Committee-in-Common Minutes – May and June 2024** Tony Curry, Non-Executive Director Committee Chair	BIC(24)159 Attached
6.3.2	**Medical Appraisal & Revalidation Annual Report** Dr Kate Wood, Group Chief Medical Officer	BIC(24)160 Attached
6.4	**Audit, Risk & Governance Committees in Common**	
6.4.1	**Audit, Risk & Governance Committee Minutes – April and June 2024** Lee Bond, Group Chief Financial Officer	BIC(24)176 Attached
6.4.2	**Audit Committee Annual Report - NLaG** Lee Bond, Group Chief Financial Officer	BIC(24)161 Attached
6.4.3	**Audit Committee Annual Report - HUTH** Lee Bond, Group Chief Financial Officer	BIC(24)162 Attached
6.5	**Capital & Major Projects Committees in Common**	
6.5.1	**Capital & Major Projects Committees-in-Common Minutes - February and April 2024** Gill Ponder & Helen Wright, Non-Executive Directors Committee Chairs	BIC(24)164 Attached
6.6	**Other**	
6.6.1	**Integrated Performance Report – NLaG and HUTH** Ivan McConnell, Group Chief Strategy & Partnerships Officer	BIC(24)165 Attached
6.6.2	**Documents Signed Under Seal** David Sharif, Group Director of Assurance	BIC(24)166 Attached
6.6.3	**Trust Boards & Committees Meeting Cycle – 2024 & 2025** David Sharif, Group Director of Assurance	BIC(24)167 Attached
6.6.4	**Health Tree Foundation Annual Report & Accounts** Neil Gammon, Independent Chair of Committee	BIC(24)168 Attached

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

- Any Director wishing to propose an agenda item should send it with 8 clear days' notice before the meeting to the Group Chair, who shall then include this item on the agenda for the meeting. Requests made less than 8 days before a meeting may be included on the agenda at the discretion of the Group Chair.
- Urgent business may be raised provided the Director wishing to raise such business has given notice to the Group Chief Executive not later than the day preceding the meeting or in exceptional circumstances not later than one hour before the meeting.
- Board members wishing to ask any questions relating to those reports listed under 'Items for Information' should raise them with the appropriate Director outside of the Board meeting. If, after speaking to that Director, it is felt that an issue needs to be raised in the Board setting, the appropriate Director should be given advance notice of this intention, in order to enable him/her to arrange for any necessary attendance at the meeting.
- Directors / Board members should contact the Group Chair as soon as an actual or potential conflict is identified. Definition of interests **–** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold." Source: NHSE – Managing Conflicts of Interest in the NHS.
- When staff attend Board meetings to make presentations (having been advised of the time to arrive by the Board Secretary), it is intended to take their item next after completion of the item then being considered. This will avoid keeping such people waiting for long periods.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BOARDS-IN-COMMON MEETING IN PUBLIC

Minutes of the meeting held on Thursday, 13 June 2024 at 9.00 am
in the Boardroom, Hull Royal Infirmary

For the purpose of transacting the business set out below:

Present:

Core Members:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Lee Bond	Group Chief Financial Officer
Paul Bytheway	Group Chief Delivery Officer
Amanda Stanford	Group Chief Nurse
Dr Kate Wood	Group Chief Medical Officer
Tony Curry	Non-Executive Director (HUTH)
Stuart Hall	Vice Chair (HUTH)
Jane Hawkard	Non-Executive Director (HUTH)
Sue Liburd	Non-Executive Director (NLaG)
Gill Ponder	Non-Executive Director (NLaG)
David Sulch	Non-Executive Director (HUTH)
Helen Wright	Non-Executive Director (HUTH)

In Attendance:

Julie Beilby	Associate Non-Executive Director (NLaG)
Rachel Farmer	NHS Liaison
Myles Howell	Group Director of Communications
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Simon Nearney	Group Chief People Officer
Dr Ashok Pathak	Associate Non-Executive Director (HUTH)
Ian Reekie	Lead Governor (NLaG)
David Sharif	Group Director of Assurance
Ammara Sultan	Leadership Fellow (HUTH)
Sarah Meggitt	Executive Assistant to the Group Chair (minute taker)

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome, Group Chair's Opening Remarks and Apologies for Absence

Sean Lyons welcomed board members and observers to the meeting and declared it open at 9.00 am. Sean Lyons introduced Helen Wright the newly appointed Non-Executive Director at HUTH to her first Trust Boards-in-Common

meeting. Paul Bytheway was also introduced as the Interim Group Chief Delivery Officer.

The Trust Boards-in-Common were advised Professor Laura Treadgold would shortly be joining HUTH as a Non-Executive Director (NED) from the Hull University she would replace Una Macleod who had been the previous NED in this role.

Sean Lyons reminded everyone of the pre-election period of purdah. The Group would continue with business during this period, however, all reports to the Trust Boards-in-Common were to keep with purdah requirements.

The following apologies for absence were noted:

Linda Jackson	Vice Chair (NLaG)
Kate Truscott	Non-Executive Director (NLaG)
Simon Parkes	Non-Executive Director (NLaG)

1.2 **Declarations of Interest**

No declarations of interests were received in respect of any of the agenda items.

1.2.1 **Fit & Proper Person Test: Annual Declaration - BIC(24)089**

David Sharif referred to the paper shared and reported that both Trusts maintained its Fit & Proper status.

Sue Liburd referred to the requirement of gaining staff approval to review the digital footprint of social media accounts, they were already in the public domain so she was unsure why this would be required. David Sharif advised that additional guidance had been sought in respect of this issue from NHS England (NHSE). Nothing had been received as yet so there was a proposal to instigate this internally and review what would meet requirements.

Sean Lyons noted the requirement for Board members to sign up to the renewal of Disclosure and Barring Service (DBS) checks, members were asked to ensure this was undertaken.

1.3 **To approve the minutes of the Boards-in-Common meeting held on Thursday, 11 April 2024 – BIC(24)090**

The minutes of the meetings held on the 11 April 2024 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments had been made.

- Dr Kate Wood, referred to page two, item 1.2, Patient Story. The wording should be referenced as Mechanical Thrombosis and not Medical. The procedure was carried out at Hull Royal Infirmary (HRI) and not Castle Hill Hospital (CHH) as referred to in the minutes. The only service at CHH was the proposal regarding the extended rehabilitation to be undertaken there.

- Dr Kate Wood, referred to page eleven, item 4.3. This item referred to a Medical Consultant Strategy, the wording should be changed to say Medical Workforce Strategy.
- Lee Bond, referred to page two, item 1.2. Lee Bond referred to the point regarding Hull being a Stroke Super Centre. This should read that if the two hyper acute stroke units were combined, they would be the second largest and that this was not due to the thrombectomy service being funding.
- Lee Bond, referred to page eleven, item 4.2. This section referred to Lee Bond achieving the financial plan, the wording should be changed to state it was achieved by the Group.

1.4 **Matters Arising**

Sean Lyons invited board members to raise any matters requiring discussion not captured on the agenda, no items were raised.

1.5 **Action Tracker – Public – BIC(24)91**

The following updates to the Action Tracker were noted:

NLaG

- Item 4.5.1, 8 February 2024 – Chair of Health Tree Foundation Trustees' Committee – Extension of Tenure – Foundation Patron Role due to current Patron Standing Down. Sue Liburd advised it was proving difficult to appoint a Patron, however, one person had been asked to fulfil the role and the individual was considering this. Sean Lyons wanted to thank Sir Reginald Sheffield for his services whilst undertaking this role for NLaG.

Trust Boards-in-Common

- Item 1.7, 11 April 2024 – Group Chief Executive's Briefing - Data highlighting a reduced number of Emergency Department (ED) attendances. Jonathan Lofthouse reported the opening of the Urgent Treatment Centre (UTC) had supported a reduction of attendances at ED in HUTH as the service was open for 16 hours a day. A paper providing more detail including trending information would be shared at the Performance, Estates & Finance Committees-in-Common.

1.6 **Group Chief Executive's Briefing – BIC(24)092**

Jonathan Lofthouse shared the paper and asked Dr Kate Wood to provide an update on the National Inquiry into infected blood products. Dr Kate Wood advised the Inquiry had been Chaired by Sir Brian Langstaff and this had affected patients at HUTH. The Inquiry had identified some criticisms which had been accepted and as a result there had been some concerns raised by the public. Following on from this, a helpline had been introduced with several people making contact, with appropriate advice given. Jonathan Lofthouse wanted to formally apologise to those people who had been affected on behalf of the Boards.

David Sharif advised NLaG had been approached to participate in Phase Two of the National Fuller Inquiry which related to NHS Mortuary arrangements. Part of this

included some members of staff being interviewed and documents to be provided in respect of mortuary practice, security, and governance arrangements. Staff due to be interviewed would be supported by the Trust beforehand.

Amanda Stanford advised Donna Ockenden had visited HUTH and had recognised the improvement journey; a further visit would be scheduled in September 2024 with the hope this could be scheduled around a Maternity Conference to enable Donna Ockenden to be a speaker at this. It was reported the Care Quality Commission (CQC) had visited the Emergency Department (ED) at the Diana, Princess of Wales Hospital (DPoWH) this was part of the engagement process. The CQC had provided positive feedback following the visit and had reported the teams had been very positive with them, it was noted this was not a formal inspection.

Jonathan Lofthouse reported that NLaG had received Joint Advisory Group (JAG) Accreditation for Endoscopy at both the DPoWH and Scunthorpe General Hospital (SGH) sites. It was advised that as the Endoscopy construction moved forward at CHH the accreditation would hopefully be achieved there too. Jonathan Lofthouse highlighted the performance update within the report.

Ivan McConnell advised work continued with the Group Strategy with a number of engagement events currently being undertaken with staff which were supported by the Executives and NEDs. External engagement events were also being undertaken.

Jonathan Lofthouse advised that the financial plan would be discussed in the Private Boards-in-Common due to further guidance that now required discussion. It was noted there was nothing of any concern in respect of the discussions.

Lee Bond reported on the current financial position across the Group. One item to note was in respect of agency spend, this had reduced compared to the same period last year. There had been a reduction of circa 40,000 agency hours per week to circa 1,400 hours per week due to a piece of work led by the Workforce and Organisational Development (OD) team. This would make a considerable difference if it continued over the year. Lee Bond advised that one of the concerns (noted in the risk register) was the future financial implications in respect of the replacement of the water and heating system at the SGH site.

Simon Nearney advised that flags had been raised at all sites in respect of Pride month. Several events were being undertaken during the month. It was reported a Group level Equality, Diversity and Inclusion Steering Group was due to be introduced with the first meeting being held in June 2024.

Jonathan Lofthouse referred to the further good news stories that were in the report.

Jonathan Lofthouse advised the Collaborative Acute Provider (CAP) had met recently to review the 2024/25 acute delivery with further meetings planned. It was reported the Executive team also meet with their counterparts from the system to move collaborative working forward. Jonathan Lofthouse referred to a blueprint that Stephen Eames was the custodian of a document that included information for the Integrated Care Board (ICB) including the financial settlement and innovation within the system. There had been a commitment to share this with national colleagues in July 2024 and work continued to meet this deadline. One issue being discussed as

part of this was some level of alliance between Harrogate & District NHS Foundation Trust and York & Scarborough Teaching Hospitals NHS Foundation Trust.

Dr Ashok Pathak queried whether there had been any discussion at the ICB in respect of the issues with workforce within the ICB in respect of General Practitioners (GPs) and Healthcare Practitioners. Jonathan Lofthouse advised that nationally there would be seven ICBs that would be allocated as pilots which would result in 20 practices across the country being given enhanced innovation funding to present how a practice would look in ten years' time and to assess the scale of transformational change. It was hoped that our ICB would be one of the seven that would be allocated this funding. Updates would be provided when available.

Dr Ashok Pathak referred to research and development in respect of patients and queried whether this was being undertaken nationally or if it would be local patients. Dr Kate Wood advised this was predominantly a national programme which the Group dovetailed into. Although there was not a huge amount of research opportunities locally, the Group were looking to the future on how to move away from national programmes to use local programmes in working with local Universities. Sean Lyons referred to the Research Events that had been held previously and encouraged Board members to attend any that were planned in the future.

Stuart Hall referred to dealing with frailty patients and queried whether changes were being made in respect of this. Jonathan Lofthouse explained the frailty model on the South Bank was more developed, however, the provision of consultant specialists for frailty was a challenge at both Trusts. Dr Kate Wood advised the models at both Trusts were different, it was felt that learning could be undertaken as part of developing this from both to ensure best practices were used. It was felt frailty care needed to be improved for patients before they arrived at the "front door". Ivan McConnell advised that as part of the recovery programme there was an integrated programme of work around No Criteria to Reside (NCR) which would include frailty of patients both internally and externally. This would also include the harmonisation of how the Group worked with partners to create a single pathway where appropriate in recognising Place needs.

2. GROUP DEVELOPMENT

2.1 Group Branding Launch

Myles Howell referred to the paper and advised the required changes had been made following the board development session held in May 2024. It was noted the branding work had been undertaken internally by the communications team. A suite of templates had been developed with the flow of the estuary being included in the graphics. The campaign to launch the branding would be in July 2024.

Gill Ponder felt the concept within the branding was positive and queried what support would be provided for staff to embed this. Myles Howell explained that the launch would possibly be part of the Group Chief Executive's briefing asking staff to update email signatures and MS Teams backgrounds. It was recognised the message may need to be repeated over coming weeks to ensure it was embedded. Gill Ponder queried whether some of the implementation could be undertaken

digitally in some areas. It was agreed this would be in place in some areas, particularly around patient template letters.

Myles Howell advised the flow campaign would be launched at the beginning of July 2024. David Sharif explained the Administration Handbook would also support some of this as it was used as a guide to administration staff in terms of template letters.

Tony Curry queried what the guidance would be in terms of when the sovereign name for individual Trusts would be used, particularly when corresponding with the CQC. Myles Howell explained the briefing would be clear as to when the Group branding should be used. Julie Beilby referred to the recruitment advertisement and queried whether this would cause confusion with it being in green rather than the blue as per the other branding documents.

Gill Ponder highlighted that everyone would need to be conscious the new branding was being used as periodically this did not happen. There would also be a need to check posters that were displayed around the Trusts as they should be removed when displaying the old branding.

2.2 **Group Memorandum of Understanding – BIC(24)095**

David Sharif advised the paper referred to the joint working of the Group which required a Memorandum of Understanding (MOU). It was noted this was not a legal binding document, however, legal advice had been sought in respect of this with a review at the Workforce, Education & Culture Committees-in-Common. Also included with the paper was the MOU for the staff shared workforce.

Jane Hawkard referred to page nine, section 6.15, second point, she felt the wording should be changed to say, “ensuring the two organisations continue to be clinically led, managerially enabled”. Julie Beilby felt the document should be shared with senior personnel to ensure they were aware of the process in place. Tony Curry referred to page eight, section 6.12 in particular the reference to the WISHH Foundation. It was felt it should state HUTH Charitable Funds Committee. Tony Curry also queried the reference to costs being shared across the Group and felt this should state “will determine the equitable distribution of costs” rather than will share costs due to this being more complex at times. Sean Lyons requested that the document stated Group Trust Boards-in-Common where required instead of Group Board.

The Trust Boards-in-Common approved the Group Memorandum of Understanding further to the amendments requested being made.

3. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS

3.1 **Quality & Safety Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)096**

David Sulch referred to particular highlights from the report. It was noted the CQC actions continued to be mapped and progress against them continued. A deep dive into concerns regarding mortality had also been undertaken.

Lee Bond queried whether the committee had been satisfied that the actions put in place would improve performance and patient care. Dr Kate Wood advised this was being overseen through the Unplanned Care Board meeting, assurance could not be provided at the moment as it had not been shared.

Sean Lyons felt the Integrated Performance Report (IPR) was developing well with opportunities to learn and share ideas across the Group. Ivan McConnell explained the progression of the report would continue over the next few months.

Dr Kate Wood advised Austin Smithies had been appointed as Associate Chief Medical Officer for Quality & Safety. Dr Kate Wood felt the appointment would support governance processes in this area to provide oversight and assurance.

Dr Kate Wood advised the Boards-in-Common that a never event had occurred at the HUTH site the previous week, details would be shared once available. It was confirmed that the correct processes would be undertaken in terms of investigating and reporting on this.

3.1.1 **Annual Quality Account – HUTH – NLaG - BIC(24)096**

Amanda Stanford referred to the Annual Quality Account and advised it included the NLaG and HUTH paper. The Trust Boards-in-Common were asked to approve both Annual Quality Accounts. Helen Wright queried whether in the past any feedback or comments were received once this was shared more widely. Dr Kate Wood wanted to highlight that engagement was undertaken beforehand to receive comments, however, she was not aware of any feedback being received once it had been published previously.

The NLaG Trust Boards approved the NLaG Annual Quality Account.

The HUTH Trust Boards approved the HUTH Annual Quality Account. It was noted the comments from stakeholders in respect of the HUTH Annual Quality Account would be shared at the Quality & Safety Committees-in-Common meeting in June 2024.

3.1.2 **Maternity & Neonatal Safety Champions' Overview Assurance / Escalation Reports – NLaG and HUTH – BIC(24)098**

Sue Liburd highlighted that NLaG had now exited the Maternity Safety Support Programme (MSSP) the letter to confirm this was expected shortly. In light of this a decision had been made to stand down the Maternity Transformation and Improvement Board at NLaG. It was noted a newly formed meeting of the Maternity Assurance Group would be introduced across the Group and would be chaired by Amanda Stanford. Stuart Hall noted that during a recent visit staff were concerned that the co-ordinators were being used as part of the substantial staffing for the ward rather than being a standalone role.

3.1.3 **Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH – BIC(24)100**

Amanda Stanford referred to the report and introduced Yvonne McGrath, Director of Midwifery to the Trust Boards-in-Common who was in attendance for this item. Rukeya Miah, Head of Midwifery, HUTH was also in attendance for this item.

Amanda Stanford explained three key working groups had now been introduced. One was in respect of the Year Six Maternity & Perinatal Incentive Scheme (MIS) which would be held weekly due to the number of risks still in place with the delivery at HUTH. It was noted this meeting would be chaired by Amanda Stanford. The second was a Three-Year Improvement Group to be chaired by Yvonne McGrath across the Group this would ensure the sharing of learning across both Trusts. Thirdly, a CQC Group had been introduced in respect of the Section 31 Notice received at HUTH, this would be chaired by the Site Director of Nursing, Tracy Campbell. A monthly Maternity Assurance Group was also taking place where ICB colleagues would be in attendance.

Amanda Stanford explained work would also commence to review how the Maternity Safety Champions functioned across the Group.

Amanda Stanford advised a meeting was due to be held later that day to review the diagnostic report for HUTH maternity services.

In respect of the leadership structure at HUTH, Yvonne McGrath would be undertaking a piece of work to put this in place. A request for more information in respect of neonatal deaths at HUTH had been made.

Amanda Stanford referred to the figure regarding the Perinatal Mortality Review Tool (PMRT) as it referred to two figures on the front sheet of the report in respect of eligible baby deaths, during discussion it was confirmed there had been four.

In respect of NLaG PMRT it may be that one case was missed being submitted by one day, this would be confirmed within the report at the August 2024 Board meeting. It was reported work on the maternity dashboard data continued.

Dr Ashok Pathak queried whether issues with the growth scans remained an issue in respect of not being reported or reviewed as previously raised at the Board meeting. Amanda Stanford was aware this had been raised previously, she agreed to review this and report back.

Action: Amanda Stanford to provide further information regarding growth scans being reported

David Sulch referred to the increased numbers of emergency C-sections and queried whether this was in line with national figures or the group. Amanda Stanford explained that from experience it appeared to be a national issue. Rukeya Miah advised this had previously been covered during a separate piece of work so this could be provided if required. Yvonne McGrath agreed this was the general theme across the country. David Sulch asked if the information shared at the Quality & Safety Committees-in-Common could be more streamlined to ensure relevant information was highlighted. Amanda Stanford advised new templates had been circulated to the team to provide what information should be shared so this would mean improvements going forward.

3.2 **Performance, Estates & Finance Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)101**

Gill Ponder drew the Boards' attention to the Group financial plan being met at the end of the financial year. The Boards were advised an urgent care deep dive had been undertaken at one of the recent meetings. The committee had been concerned in respect of frailty as too many elderly patients were being admitted after long waits in ED. The committee had spent time discussing Multi-Agency Discharge Event (MADE) Events as it was felt this was not being embedded as well as they should be. It was reported NLaG were now receiving tiering support from NHS England (NHSE) for 62-day cancer pathways. There was some backlog of inputting information onto patients records at NLaG due to the move to Lorenzo, a recovery plan was in place to resolve this.

In respect of the fire alarm system at the SGH site, it had previously been reported that the risk would reduce, however, due to further testing this would now not reduce until the work had been completed.

It was reported that work to improve effective theatre utilisation to improve productivity was noted by the committee due to the number of cancelled operations on the day and late starts.

Jonathan Lofthouse referred to the tier one cancer issue as this had put NLaG into enhanced monitoring and support with national colleagues. Although, this was not a position NLaG wished to be in it had meant it had opened a substantial support opportunity. As part of this the cabinet had signed off bids for regional assessment support in respect of cancer improvement which should mean improvements over the next quarter. In respect of MADE it was agreed this was not used as it should be. Paul Bytheway agreed there were opportunities to do some learning by putting this in place in a more structure way in the future. Dr Ashok Pathak referred to the cancer breaches and queried whether there were some departments that were more prominent. Jonathan Lofthouse advised this was the case with lung and colorectal being two of them. It was noted that detail of this was in the IPR. Lee Bond added that the Trust had applied for £30 million capital funding to support emergency care, formal notification of this being successful had not yet been received.

3.2.1 **Annual Plan: Operational – BIC(24)102**

Ivan McConnell referred to the paper and highlighted key points. It was reported that the planning guidance was released in March 2024. There were increases in outpatient activity planned through Patient Initiated Follow Ups (PIFU). Whilst there was a 78% national target on ED performance this was based on an acute footprint level within the ICB and not provider level. There were also increases in day case activity and the impact of the new theatre opening at HUTH. This had been through scrutiny internally and at ICB and NHSE level. Ivan McConnell sought the Trust Boards-in-Common approval of the Operational Plan.

Jonathan Lofthouse advised the Group had been instructed not to reflect any Patient Tracking List (PTL) growth within the plan. It was explained that this end of the patch did not have any referral screening; however, the Group partners did have this in place. In agreement with the ICB the Group reduced the likely patient increase over the next 12 months on the basis that the Trusts would have the

screening centre, if this was not in place it was anticipated there would be further growth over the next year.

David Sulch queried whether there were any plans to reduce the over 12 hour waits in ED. Ivan McConnell advised this would be the case. Dr Ashok Pathak queried whether the Group had the required number of clinicians to put in place additional outpatient time or was this to be included by adding additional patients to current clinics; if this was the case had this been discussed with those clinicians. Ivan McConnell explained the clinicians had been engaged with discussions and the planning work. There was also a plan to reduce follow ups which would support those changes.

David Sulch referred to the Same Day Emergency Care (SDEC) activity and queried whether this would impact on mortality rates. Dr Kate Wood advised mortality rates were adjusted nationally and moved up and down dependent on other providers. Once this levelled up this would be worked through.

3.3 **Workforce, Education & Culture Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)103**

Sue Liburd shared the report on behalf of Kate Truscott and highlighted key points. The Boards were advised of NHSE removing funding for resilience HUBS for all NHS Trusts which would have an impact on staff not being able to access mental health services. It was noted HUTH would no longer have a full-time Health & Wellbeing Manager. The committee would continue to oversee this going forward to ensure staff were supported and directed to relevant areas for support they required. There were also two People Promise Managers that would oversee some of this. There had been some concern over the health and wellbeing of staff as they may feel this was being withdrawn. The committee had acknowledged the reduction in agency spend and thanked the teams for the work in achieving this. The plan to be fully established in terms of nursing by November 2024 had also been noted.

Sue Liburd drew the Boards attention to the financial risk in respect of the Band 2/3 Health Care Support Workers (HCSW) duties and job descriptions changing due to the national profile. It was noted the review continued in terms of which roles this would affect. A deep dive had been undertaken in respect of the Consultant Medical vacancy rate; a review was due to be undertaken over the next three months by the care groups. A further update on this would be received by the committee.

David Sulch referred to the point noted in respect of HUTH no longer having Health and Wellbeing Managers and queried whether those roles could be funded internally if this was going to affect staff. Jonathan Lofthouse explained this was a service that had been funded by the system. It was agreed if this was felt beneficial the option to fund internally could be explored, however, the current model would need to be recalibrated.

Dr Ashok Pathak referred to consultant recruitment and explained some Trusts advertised roles in the hope to attract them as they were completing training. It was queried as to whether there was any scope for the Group to put this in place. Simon Nearney explained cabinet had recently signed off a group wide Advisory Appointments Committee (AAC) group selection process which would be implemented. This was a point that was raised as part of this.

Simon Nearney referred to the point raised regarding the HCSWs at band two and three and advised those staff in maternity had been offered two years back dated salary, however, the unions had rejected this and asked members to ballot for strike action. Stuart Hall queried how many staff this would affect. Simon Nearney advised there were 60 HCSWs in maternity, however, across the group this would affect more than 1,000 members of staff.

3.3.1 **Freedom to Speak Up Guardian (FTSUG) Annual Report including Quarter Four – NLaG & HUTH – BIC(24)104**

Fran Moverley referred to the HUTH FTSUG Annual Report and advised that the reported cases had doubled compared to the previous year. Fran Moverley highlighted key points from the report. It was reported 17 members of staff would be trained over coming weeks to enable them to be FTSU Champions. In respect of the action plan, it was noted there were some outstanding actions, an extension had been requested to complete them which had been agreed.

Liz Houchin referred to the NLaG FTSUG Annual Report and advised this was the sixth year where reported concerns had increased. The anonymous concerns had also increased; however, they were still below the national average. Liz Houchin highlighted key points from the report. It was reported 15 FTSU Champions had now been recruited at NLaG over the previous quarter.

It was reported that both the FTSUGs continued to work together to implement improvements, they were also working on a shared Group Strategy that would be introduced. Although group working continued, the individual sovereignty remained for the roles.

Amanda Stanford referred to the concerns reported and queried whether areas where there was no reporting caused any concerns for the guardians. Fran Moverley agreed some areas do not report as much as others and to support this walk arounds have been undertaken to ensure staff are aware of the process which has meant some increases. Amanda Stanford referred to previous discussions around ensuring leaders had the capability to have difficult conversations with some staff when required. Fran Moverley agreed as feedback from some staff was that they found it difficult to raise issues with some leaders if they do not feel supported. Liz Houchin agreed with the point made as feedback received on conversations with leaders was how they had spoken with staff and not necessarily what they had said. It was felt this needed to be considered in respect of investing in compassionate leadership for staff that move into those roles.

Dr Ashok Pathok queried whether there was any data available regarding concerns raised by Black, Asian and Minority Ethnic (BAME) staff. Fran Moverley advised this had recently been discussed and there would now be the opportunity to report on this. Stuart Hall queried whether the two Trusts had any commonality in respect of concerns being raised. Liz Houchin advised that although they were unable to share information on concerns raised, they do share learning and themes. Concerns around behaviour appeared to be higher at NLaG than they did at HUTH. Fran Moverley advised HUTH would also introduce anonymous reporting through the staff app so numbers may increase due to this as this was the case at NLaG.

Julie Beilby queried whether freedom to speak up was a mandatory training requirement, it was agreed this should be discussed further at the Workforce, Education & Cultures Committees-in-Common meeting.

Dr Kate Wood wanted to thank Fran Moverley for the work completed at HUTH as this had traditionally not been as accessible in terms of clinical staff.

Sean Lyons queried whether there was anything the Boards could support with in respect of freedom to speak up. Liz Houchin advised some Trusts did have the speak up modules as mandatory training so further discussion at committee level was welcomed. Some Boards also undertook this as mandatory training at other Trusts. After some discussion it was agreed information on senior leaders training would be circulated to Board members.

Action: Fran Moverley & Liz Houchin to provide information on Senior Leaders training

Simon Nearney advised that the Workforce, Education & Culture Committees-in-Common were looking at one programme for mandatory training across the group so freedom to speak up would be reviewed as part of that work.

3.3.2 **NHS Equality Delivery System 2022 – Submission 2024 – BIC(24)105**

Simon Nearney shared the report and advised this had previously been approved by the Workforce, Education & Culture Committees-in-Common. The process was a national assessment tool where all Trusts had to assess themselves. Both organisations were in the developing stage.

It was noted the Trust Boards would have a scheduled session on Equality, Diversity & Improvement (EDI) this year as part of the development programme. Sean Lyons asked how this fed into the Strategy, Ivan McConnell advised issues were being fed into this to build a solid foundation for improvement.

Gill Ponder referred to the report and highlighted that there was nothing to explain whether there had been any improvements made from the previous year. Simon Nearney explained more BAME staff were being employed. BAME staff were also undertaking coaching and mentoring than they had previously. Gill Ponder felt the Board needed to own this more and should have set targets to achieve. Dr Ashok Pathak recognised improvements were being made, however, this was not reflected in appointments that were being made to particular roles. Sean Lyons agreed that he was acutely aware of this but unfortunately staff in those groups were still not applying for roles which of course determined who would be appointed. Jonathan Lofthouse explained work to progress this was to be undertaken with the Network Chairs, updates would be shared once available. In terms of appraisals, it was reported NEDs would be aligned with Equality, Diversity and Inclusion (EDI) Objectives for this year.

3.4 **Audit, Risk & Governance Committees-in-Common Highlight Report & Board Challenge – BIC(24)106**

Jane Hawkard shared the paper and referred to key highlights from the report. It was noted the Boards were asked to approve the recommendation from the Audit, Risk & Governance Committees-in-Common that the 2023/24 statutory annual

accounts for both Trusts were prepared on a 'Going Concern' basis. The committee had asked that the risks within the Annual Governance Statement (AGS) were enhanced more to show the significance of any risks being raised around quality. The joint Internal Audit Plan for the year had been received, it had been agreed to put in place a single plan from both external auditors. It was reported a process had been put in place to ensure staff completed required information governance (IG) training. Jonathan Lofthouse had written to Simon Parkes and Jane Hawkard following the receipt of the Internal Audit Report to raise concerns around the quality of the report. It was advised the committee would review this.

3.4.1 **HUTH Annual Accounts & Reports 2023/24 formal delegation of authority to Audit, Risk & Governance Committees-in-Common – BIC(24)107**

Lee Bond sought approval from the HUTH Trust Board for the Audit, Risk & Governance Committees-in-Common to have delegated authority to sign off the HUTH Annual Accounts & Reports for 2023/24. Helen Wright queried whether there were any major concerns that the Board needed to be aware of. Lee Bond advised there had been some concerns raised which had been resolved. No other concerns were expected to be raised.

The HUTH Trust Board approved the delegation of authority for the Audit, Risk & Governance Committees-in-Common to sign off the HUTH Annual Accounts at the meeting due to be held on the 21 June 2024.

3.5 **Capital & Major Projects Committees-in-Common Highlight / Escalation Report & Board Challenge – BIC(24)109**

Gill Ponder shared the paper and reported that concerns had been raised that the committees had not had sight of the risk registers for some considerable time. A request was made as to whether there were any gaps that all the Committees-in-Common needed to be aware of due to no report being received.

The delivery date for Badgernet at NLaG had been delayed due to the number of systems that required data cleansing. There were concerns raised around the level of resource in the digital team to support projects. The committee asked for the May 2024 Performance, Estates & Finance Committees-in-Common to consider the lack of data and reporting following the migration to Lorenzo. It appeared the data was available; however, the issue was more around a communication issue and staff being aware of how to obtain the required information. More support was being put in place to support this and address the gaps.

Jane Hawkard referred to the assurance around the risks processes, work was being undertaken around this and a report would be provided at the July 2024 meeting of the committee.

Dr Kate Wood referred to the point raised regarding the digital projects and agreed there had been some issues and the teams were learning from this. It was noted the move to Lorenzo had gone well from a digital perspective, however, there had been some issues in respect of other areas. It was also highlighted that the implementation of Badgernet at NLaG was different to when it had been implemented at HUTH. Dr Kate Wood reported that she had received assurance from the team that they have a "grip" on what was being undertaken.

Ivan McConnell referred to the Community Diagnostics Centre (CDC) and advised that when the committee took place there was not a timescale for the potential delay, however, it was felt this would now be four weeks at Grimsby. However, the senior team were now working with the contractors to claw back. In respect of Scunthorpe this was currently at one to two weeks behind, there was confidence this would complete to schedule. In respect of the HUTH CDC it was reported the contract price had still not been received.

4. GOVERNANCE & ASSURANCE

4.1 Board Assurance Framework (BAF) & Strategic Risk Register – NLaG & HUTH – BIC(24)110

David Sharif shared the BAF and advised this summarised the close of Quarter four. The Trust Boards-in-Common were asked to approve the Quarter four year-end risk ratings for the HUTH and NLaG BAF Risks and to approve the Quarter One Group BAF risks noting further updates would follow. It was noted this had been to relevant Committees-in-Common for review. It was felt the BAF should be shared as a routine item at the Audit, Risk & Governance Committees-in-Common, this option would be reviewed. A piece of work between the BAF and High-Level Risk was due to conclude in July 2024, this would provide assurance around what the Trust had experienced over the previous year and should coincide with the work on the refresh of the Risk Management Strategy and Policy. This should provide more assurance to the Boards.

David Sharif advised that since sharing the report, significant assurance had been received in an internal audit report around risk management processes in place. There were some recommendations made around the BAF and what they thought the future format should be. However, David was aware of the previous process that had been undertaken around the review of the BAF so discussions would take place with internal audit on what recommendations would be taken forward.

Sean Lyons queried whether there was any engagement with the care groups on the assessment of risk. Jonathan Lofthouse advised a cleansing exercise was being undertaken with each care group. He reminded the Boards that an Executive meeting was also held monthly to review the BAF which included Stuart Hall as the NED representative.

Julie Beilby queried whether transformational risks would be included as the BAF developed to achieve the cost improvement plan. Jonathan Lofthouse advised that part of his objectives was to have in place a Group BAF by September 2024.

Jane Hawkard referred to the risk in respect of quality, it was queried whether targets should be reduced to reflect the improvements made going forward instead of them remaining the same.

The Trust Boards-in-Common approved the reports.

5. OTHER ITEMS FOR APPROVAL

5.1 Protocol for Reserving Matters to a Private Board Meeting – BIC(24)111

David Sharif shared the paper with the Trust Boards-in-Common and sought approval.

The Trust Boards-in-Common approved the Protocol for Reserving Matters to a Private Board Meeting

5.2 Division of Responsibilities Between the Group Chair and the Group Chief Executive – BIC(24)112

David Sharif shared the paper with the Trust Boards-in-Common and sought approval.

The Trust Boards-in-Common approved the Division of Responsibilities Between the Group Chair and the Group Chief Executive

5.3 Health & Safety Policy Statement – BIC(24)113

Lee Bond shared the paper with the Trust Boards-in-Common and sought approval. It was explained the new statement introduced was now for the Group.

The Trust Boards-in-Common approved the Health & Safety Policy Statement

6. ITEMS FOR INFORMATION / SUPPORTING PAPERS

6.1 Items for Information / Supporting Papers

- Quality & Safety CiC – March & April 2024
- Performance, Estates & Finance CiC – March & April 2024
- Workforce, Education & Culture CiC – March & April 2024
- Guardian of Safe Working Hours Report – Quarter Four NLaG & HUTH
- Integrated Performance Report (IPR)
- Organ Donation Annual Report
- Trust Boards & Committees Meeting Cycle

Dr Kate Wood wanted to inform the Boards that the Chair of the Organ Donation Committee, Lorraine McLeavy had sadly passed away. Lorraine McLeavy had Chaired the committee at HUTH for over ten years. It was reported she had been given an award for all the hard work she had undertaken during her time Chairing the committee. Dr Kate Wood wanted this to be recognised and to offer condolences on behalf of the Boards to the family during this sad time.

Dr Ashok Pathak queried whether the donating of organs could be promoted more particularly around BAME people. Dr Kate Wood advised work was being undertaken across the Group to promote more widely the donating of organs which included minority groups. Although work was currently undertaken separately, they were looking at how to bring them together going forward.

7. ANY OTHER URGENT BUSINESS

There were no items of any other business raised.

8. QUESTIONS FROM THE PUBLIC AND GOVERNORS

Ian Reekie referred to the approval of the Group Strategy framework and queried whether this could be approved at a Public Board meeting in July 2024. It was agreed that due to timescales this would be approved at a Private Board with it then being ratified at the Public Board in August 2024.

9. MATTERS FOR REFERRAL TO COMMITTEES-IN-COMMON

9.1 There were no matters for referral to any of the other board committees.

10. DATE AND TIME OF THE NEXT MEETING

10.1 **Date and Time of the next Boards in Common meeting:**

Thursday, 8 August 2024 at 9.00 am in the Main Boardroom, Diana, Princess of Wales Hospital.

The meeting closed at 12:28 hrs.

Cumulative Record of Board Director's Attendance 2024/25

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	2	2	Ashok Pathak	2	1
Jonathan Lofthouse	2	2	Simon Parkes	2	1
Julie Beilby	2	2	Gill Ponder	2	2
Lee Bond	2	2	Mike Robson	1	1
Paul Bytheway	1	1	David Sharif	2	2
Tony Curry	2	2	David Sulch	2	2
Stuart Hall	2	2	Shaun Stacey	1	1
Linda Jackson	2	1	Amanda Stanford	1	1
Jane Hawkard	2	2	Kate Truscott	2	1
Sue Liburd	2	2	Kate Wood	2	2
Ivan McConnell	2	2	Helen Wright	1	1
Simon Nearney	2	2			

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

BIC(24)134

BOARDS-IN-COMMON ACTION TRACKER

2024

ACTION TRACKER - CURRENT ACTIONS - 11 APRIL 2024

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
NLaG ACTIONS									
4.5.1	08.02.24	Chair of Health Tree Foundation Trustees' Committee - Extension of Tenure - Foundation Patron Role due to current Patron standing down		Sue Liburd to seek more understanding on what was requried of the Patron role	Sue Liburd	August 2024	It was agreed a further update would be provided at the August 2024 meeting. Update to be provided at the Trust Boards in Common June 2024 meeting.		
Boards-in-Common ACTION									
3.1.3	13.06.24	Maternity & Neonatal Safety Assurance Reports – NLaG and HUTH		Amanda Stanford to provide further information regarding growth scans being reported	Amanda Stanford	August 2024	Update to be provided at the August 2024 meeting.		
3.3.1	13.06.24	Freedom to Speak Up Guardian Annual Report		Fran Moverley & Liz Houchin to provide information on Senior Leaders training	Fran Moverley & Liz Houchin	August 2024	Information was circulated to Board Members		

Key:

Red	Overdue
Amber	On track
Green	Completed - can be closed following meeting

ACTION TRACKER - CLOSED ACTIONS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
HUTH ACTIONS									
09.03	12.09.23	Workforce, Disability Equality Standards Report		Chair of the Disabled Network to attend a Development Session in 2024	Simon Nearney	June 2024	It was agreed a session would be attended, date to be agreed.		April 2024 minutes of the public Board meeting
NLaG ACTIONS									
9.1	05.12.23	Escalation from the Quality & Safety Committee (NLaG) - Lack of equipment		Jonathan Lofthouse to discuss the lack of equipment issue raised in the Infection Prevention Control Annual Report with the Group Cabinet.	Jonathan Lofthouse	April 2024	Update to be provided at the Trust Boards in Common April 2024 meeting. At the February meeting it was reported a wider piece of work was to be completed that would be shared with the Boards.		April 2024 minutes of the public Board meeting
Boards-in-Common ACTION									
9.2	05.12.23	Escalation Report from the Finance & Performance Committee - MADE Events		It was agreed a dicussion would take place outside the meeting regarding next years MADE events.	Shaun Stacey / Jonathan Lofthouse	April 2024	Update to be provided at the Trust Boards in Common April 2024 meeting. At the February meeting it was confirmed the Flow Teams would lead on this piece of work.		April 2024 minutes of the public Board meeting
9.3	05.12.23	Escalation Report from the Workforce Committee - Retention Update		A Retention Update was requested for the next Board meeting.	Simon Nearney	April 2024	Update to be provided at the Trust Boards in Common April 2024 meeting. An update was provided on progress with this item at the February 2024 meeting.		April 2024 minutes of the public Board meeting
9.4	05.12.23	Escalation Report from the Audit, Risk & Governance Committee - Staff working in outside employment		It was agreed a discussion would take place outside the meeting to discuss staff working outside the Trust whilst off sick.	Simon Nearney / Jonathan Lofthouse	April 2024	Update to be provided at the Trust Boards in Common April 2024 meeting. An update was provided on progress with this item at the February 2024 meeting.		April 2024 minutes of the public Board meeting
10.1	05.12.23	Maternity & Neonatal Oversight Report - Maternity Safety Champions Action Log		Actions to be reviewed and completed as required.	Jenny Hinchliffe	April 2024	Update to be provided at the Trust Boards in Common April 2024 meeting. An update was provided on progress with this item at the February 2024 meeting.		April 2024 minutes of the public Board meeting
1.7	11.04.24	Group Chief Executive's Briefing - Data highlighting a reduced number of ED attendances		Shaun Stacey to provide Boards with data highlighting reduced numbers in ED at HUTH due to the opening of the UTC	Paul Bytheway	June 2024	Information was to be shared with the Performance, Estates & Finance Committees-in-Common		

Key:

Green	Completed - can be closed following meeting

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda Item No: BIC(24)135

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 8 August 2024
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer/Author	Jonathan Lofthouse, Group Chief Executive
Title of the Report	Group Chief Executive's briefing
Executive Summary	This report updates the Trust Boards in Common on the outcome of the Humber Acute Services consideration at the ICB public board, recent correspondence from NHS England, and includes updates and the headlines of patient safety, quality, finance and performance.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Group Chief Executive Officer

Briefing to the Trust Boards in Common
Thursday 8 August 2024

1. Introduction

1.1 I would like to start with my heartfelt thanks to our staff. The tragedy in Southport is absolutely shocking and we send our thoughts and condolences to all those families affected. Our NHS colleagues in the north-west acted swiftly to deal with a number of injured patients. It is a stark reminder of the hard work that we all commit to, every day, and I want to send my thanks to our staff who are so focussed on our patients and delivering the best service that we can. I really appreciate talking to staff on my walkarounds and staff reaching out to tell me what they are proud of, and what they want to improve.

1.2 Today is one year plus one day since I joined the organisation. I would like to thank the Trust Boards in Common for everyone's support since starting in post. I have been reflecting on the progress we have made as a new Group organisation in the last 12 months. I am pleased that we have moved at pace and colleagues have placed their trust in us, joining our journey of improvement Group-wide. We have so much potential and collective expertise to offer to our patients and I am determined to bring out the best in the NHS Humber Health Partnership; our patients deserve nothing less than our continued best efforts.

1.3 I would like to thank Chris Hopson, Chief Strategy Officer for NHS England, and Dr Jack Lewis, Consultant in Public Health in our Integrated Care System, for joining me at our senior leadership event on 19 July 2024. Chris joined the Chairman and colleagues for a tour of our capital developments at Castle Hill Hospital and laid a foundation stone at our Centre for Learning and Innovation. Jack's knowledge and expertise on local public health inequalities were eye-opening for our 100 most senior leaders, and was an excellent way to launch our Group Strategic Framework at the event. My sincere thanks to them both.

1.4 My thanks also to Ivan McConnell and to his team, as well as to the communications and organisational development teams, for the development of our Strategic Framework. This has been a significant piece of co-production between the Trust Boards in Common, our staff and our stakeholders, and marks a further milestone in our development as a Group organisation. This is on today's agenda at item BIC(24)153.

1.5 At the time of writing this report, national blood stocks were at amber alert and Trusts, including ours, are taking action to maintain blood stocks and continue to carry out elective and emergency treatments. A huge thank you to our staff and their families who have responded to the national calls for blood donations. If you are able to give blood, I really encourage you to do so.

1.6 I updated the Trust Boards in Common at our last meeting that Northern Lincolnshire and Goole NHS Foundation Trust has been invited to participate in Phase 2 of the Fuller Inquiry, which is a deeper dive into mortuary practice nationally. We have shared a number of documents and we were invited to participate in appreciative enquiry interviews, which took place on 5 August 2024.

1.7 We have now held the next two rounds of Performance and Accountability meetings in our new governance structure. This has meant that the North and South Site Triumvirate teams have entered in to a cycle of formal meetings with each of their 14 Care Group triumvirates, with Site Triumvirate to Cabinet Executive meetings held at the end of each month. I have reflected the relevant updates from these meetings within this report. It would however be fair to reflect this continues to be work evolving.

1.8 As a Cabinet, we received a detailed briefing on the current status of maternity services against national standards and publications, as well as against the Section 31 notice and CQC inspection report, for our north bank service. This reflects a significant amount of work and staff engagement; there are some key next steps have been shared with the Quality Committee, and will be coming to the Trust Boards in Common in the near future.

1.9 I am pleased to inform the Trust Boards in Common that Philippa Russell, Operational Finance Director and Deputy Chief Finance Officer, started with us on Monday 15 July 2024. Philippa comes to us with significant senior NHS finance management experience and we are pleased to welcome her to our Group.

1.10 We welcomed the new junior doctors' rotation on 7 August 2024. We are proud of the training and career development opportunities we offer as a Group organisation, as well as the facilities and supervision from our Medical Education teams and Educational Supervisors from across our clinical teams. Our sincere thanks to our Medical Education teams, Learning and Knowledge services and Communications, HR and OD teams for their hard work to bring on board our new medical staff, and their work to support our medical staff throughout the year.

1.11 I have continued to meet fortnightly with my Cabinet together with the two Site Triumvirate teams as a Financial Improvement Delivery Board. This Board is coordinating the achievement of our Group requirements on waste reduction, staffing and workforce requirements as well as service transformation. We have also considered elective recovery schemes that have been put forward by the Care Groups as to how to improve waiting list times for our patients this financial year using Elective Recovery Funding, and signed of 15 priority schemes, and are considering 25 further schemes.

1.12 Work continues at system level to maximise elective capacity this year and hold providers, including our organisation, to account for bringing on line additional capacity per national funding schemes, most notably our day surgery build at Castle Hill Hospital and our Community Diagnostic Schemes. There are further updates on today's Trust Board in Common agenda on these within the Performance and Finance Committees in Common minutes (agenda item BIC(24)158.

1.13 I am pleased to report that two of the GP practices in our area are taking part in the national pilot hosted by seven selected ICBs, including Humber and North Yorkshire ICB. The pilot is to test ways of working in primary care, to optimise GP practice capacity, and meet increasing demand. The pilots will consider multi-disciplinary team approaches to meeting the needs of patients with complex needs, use of digital tools and population health for anticipatory health interventions in the community, as well as maximising GP practice capacity. The national pilot is being coordinated by Suffolk and North East Essex ICB, with Chief Executive Ed Garratt as programme lead.

2. Patient Safety, Quality Governance and Patient Experience

2.1 I briefed the Trust Boards in Common that our Group was notified on 29 April 2024 that Northern Lincolnshire and Goole NHS Foundation Trust has moved up into Tier 1 in NHS England's Elective Recovery Programme National Tiering Process. We were also notified on this date that Hull University Teaching Hospitals NHS Trust remains in Tier 1.

2.2 We received further correspondence on 26 July 2024 that both of our sovereign organisations remain in Tier 1 for Quarter 2 for cancer.

2.3 Whilst both organisations are showing positive progress against the Faster Diagnosis Standard for cancer, our rounds of Executive Cabinet to Site Triumvirate Performance and Accountability meetings demonstrated that we have some particular issues around: putting pathways in place to achieve this standard in tumour sites where we have not yet achieved the FDS and working with our partner organisations around turnaround times for histopathology. Making improvements in the FDS is crucially important to our patients, and leads to improvement in the 62-day standard, which is the measure used for national tiering. The full data set regarding cancer performance can be found in report BIC(24)165 on today's agenda.

2.4 The May 2024 position for Hull University Teaching Hospitals NHS Trust against the 62-day cancer target was 62.8%.

2.5 The May 2024 position for Northern Lincolnshire and Goole NHS Foundation Trust against the 62-day cancer target was 47.1%.

2.6 The focus within our Site triumvirate to Cabinet meetings on quality, governance and patient safety has specifically centred on: SHMI and mortality rates, including any quality of care issues flagged in Structured Judgement Reviews, VTE compliance, quality of care in the Emergency Department (linked with performance standards), Friends and Family Test feedback and risks.

2.7 A Group-level review of the Risk Management Strategy, risk registers and risk assessment is currently being undertaken by Amanda Stanford and our Quality Governance colleagues. A number of workshops are being undertaken this month to review risk assessments and risk registers, and a Group approach to risk management will be coming to the Trust Boards in Common in due course. This will inform the Board Assurance Framework risk assessment against our new Group Strategic Framework, which will be undertaken as a workshop session at a future Board Development. Further detail will be provided under agenda item BIC(24)145 Board Assurance Framework & Strategic Risk Register – NLaG and HUTH.

3. Urgent and Emergency Care and Elective Care

3.1 The headline data position for each of our Group organisations on ambulance handover and the four-hour Emergency Department standard for June 2024 are set out below.

3.2 The four-hour standard is measured on a 'footprint' basis against the 78% standard set nationally, accounting for all Type 1 and Type 3 activity. The 'footprint' for the north bank is the Emergency Department at Hull Royal Infirmary and the Urgent Treatment Centres in Hull and the East Riding, run by City Health Care Partnership.

3.3 While on a 'footprint' basis, the north bank collective four-hour performance for June 2024 was 69.4% against a plan requirement of 74.1%, we know that the HUTH ED contribution was less than 50% for the month, which is clearly not what we should be achieving for our patients. The Unplanned Care Board has received an updated action plan on the targeted actions that are planned to see improvement in three key metrics: time to first clinician, time in department for non-admitted breaches and total time in department for patients over 65 years of age. This will be subject to scrutiny by the Unplanned Care Board and our next Site triumvirate to Cabinet review meeting.

3.4 The ambulance handover position for the north bank in June 2024 saw the third month of improvement, linked to the delivery of actions to reduce patient volumes in ED, enabling space in the department for ambulance crews to handover.

3.5 The south bank 'footprint' performance in June 2024 for all Type 1 and Type 3 activity, including the UTC in Goole, was 81% against a plan position of 72.3%. The NLaG Type 1 and 3 performance was 69.2%, a slight decrease compared with the previous month.

3.6 The ambulance handover position for the south bank in June 2024 improved as well as initial assessment time for patients. Improvement actions on flow, as well as working towards a zero-tolerance of over 45-minute handovers is planned.

3.7 In respect of elective care, the 65-week position remains under heavy scrutiny. This is an improving position for both sovereign Trusts. Both sovereign organisations are on track to eliminate over 65-week waits by the end September 2024. This is despite new 65-week risks being identified on the south bank in June 2024 from community dentistry and ENT. The focus will remain on ensuring these patients are treated by the end of September 2024.

3.8 The 52-week position is the next area of focus, with waiting list volumes already being scrutinised to understand the monthly caseload that needs to be cleared to meet the 52-week position during next calendar year. We are currently seeing growth in our PTL, particularly on the north bank. This is due to 5.7% increase in referrals from all sources (GPs and other health professionals) needing secondary or tertiary care assessment.

4. Strategy and partnership developments

4.1 Trust Board members will have seen the public announcement from the Integrated Care Board following consideration of the Humber Acute Service Decision Making Business Case at its public board meeting on 10 July 2024. The Decision Making Business Case included detailed feedback from the 14 week public engagement process that was run during the first half of this year. The outcome of the discussion was to approve the proposals contained with the Decision Making Business Case, which have been briefed previously to the Trust Board in Common. Our teams are now coordinating delivery plans to put in place the improvements agreed.

4.2 Our teams have engaged fully in the process; our colleagues have contributed significantly to the public engagement exercise and worked diligently to ensure the Decision Making Business Case was informed through detailed clinical engagement, including an open and transparent risk assessment on the case for change and possible solutions. I pass on my sincere thanks on behalf of our whole organisation for everyone's significant efforts and the improvements to our patients' services that this decision will make.

5. Financial Performance and Estates and Facilities updates

5.1 In respect of the Group financial position, the Month 3 position was reported to the Performance, Estates and Finance Committee on 24 July 2024 and the assurance and escalations report at agenda item BIC(24)140.

5.2 The Month 3 position reflected at the Performance, Estates and Finance Committee on 24 July 2024 is that: the Group's in-month deficit was £12.4m, which was £2.6m adverse to plan. Group Capital spend was £2.1m, which was £3.2m behind plan at month two, largely due to some retrievable slippage on the Community Diagnostic Centres. The Group reported delivery of £9.6m in cost improvements against a year-to-date target of £13.8m, which was £3.8m below plan. Cash balance was rated great at £45.5m and will be monitored closely due to linkage with the Cost Improvement Plan. The Group spent £2.3m less on agency, bank and overtime costs than the same period in 2023/24. This is slightly above the 3.2% target of total pay expenditure, at 3.3%.

5.2 As noted in paragraph 1.9, I am meeting fortnightly with my Cabinet and the site triumvirate teams to provide challenge and robust decision-making on the £84m savings requirement we have for 2024/25 as a Group organisation. We have seen and approved the foundation of a cross-Group transformation plan, which will focus on four key areas: theatre productivity, No Criteria to Reside, outpatients and diagnostics. Alongside this, Care Groups and Cabinet post holders are held to account for the creation and delivery of their own Cost Improvement Plans. The outputs of this work will continue to be reported through the Performance, Estates and Finance Committee.

5.3 Work on our ongoing capital developments continues at pace. I have been able to commit to the Allam Centre for Digestive Diseases at Castle Hill Hospital to receive its first patients from 1 October 2024 following assurance from our Estates team. The Centre for Education and Innovation at Castle Hill Hospital is on scheduled to open on 1 November 2024.

5.4 At agenda item BIC(24)158 (Performance and Finance Committees in Common minutes) there are updates on the capital and revenue plans and delivery of our three hub and one spoke Community Diagnostic Centres. We have started to recruit staff for our CDCs, who will rotate through our acute and community services for to maintain our staff skills sets and give new professional development opportunities. I am delighted for the increased capacity we will have for our patients and our system, and look forward to our first patients being seen in our CDCs from October 2024 onwards.

6. Workforce Update

6.1 We are discussing key workforce metrics in our new Care Group Performance and Accountability meetings. The Care Groups are currently drawing up staff experience improvement plans, picking up on specific points of feedback from the staff survey, the quarterly pulse survey, from exit and stay interviews as well as from other sources of staff feedback, such as our Freedom to Speak Up Guardians. These will set summarised against the NHS People Promise pillars and presented to the Workforce, Education and Culture Committee in the next quarter.

6.2 Our Organisational Development team is currently contracting with the site triumvirate teams, the 14 care group triumvirate teams, as well as to the two support directorates coming under the site triumvirates.

6.3 The Organisational Development team, Recruitment and Communication Teams are launching a new Group induction process, starting next month. This incorporates time for mandatory training and is based on our new Group values, behaviours and flow – how everyone's role is valued and how we can all make a different to our patients by focussing on flow.

7. Equality, Diversity and Inclusion (EDI)

7.1 Our first Group LGBTQIA+ staff conference was held on 12 July 2024 at the University of Hull. I was very disappointed that I could not attend due to pre-arranged annual leave and recorded a message for the conference. The feedback from our staff in attendance is extremely positive. Our keynote speaker, Tony McCaffery, Founder and Chief Executive of Diversity Scotland, shared their life experiences and professional expertise on the topic of "Intersectionality and Inclusiveness in a Healthcare setting". We are really grateful for Tony being open and sharing their experiences, as well as providing detailed answers in the Q&A session, to help our collective understanding of intersectionality.

7.2 The conference agenda was really engaging and gave our staff from the LGBTQIA+ community and staff allies a lot of ideas to discuss. My huge thanks to Tom Rust, Jen Smith and Esther Dame for co-chairing the event, and to our Communications, OD, EDI and Freedom to Speak Up colleagues for helping support a psychologically safe space for the event.

8. Good News Stories and Communications Updates

8.1 Recent good news from across the Group include:

8.2 Vagus Nerve Stimulation

Consultant Neurosurgeon, Mr Adam Razak, and colleagues at Castle Hill Hospital in Cottingham are understood to be among the first in the country to conduct battery changes for vagus nerve stimulators (VNS) in a dedicated day case facility.

Vagus nerve stimulation is a technique used to manage the symptoms of epilepsy and works by implanting a small device under the skin in the chest which is then connected to the left vagus nerve in the neck with a thin wire lead.

Previously, a patient who required their battery device changing would have been admitted to a bed at Hull Royal Infirmary. Now, within the new Day Surgery Unit at Castle Hill Hospital, patients requiring a VNS Therapy battery change can be admitted, operated on and discharged within a couple of hours.

8.3 Nurses Supporting Vulnerable Adults in North Lincolnshire

A new team of nurses are helping to improve vulnerable peoples' health and quality of life by providing vital drop-in care sessions in the community.

The Community Inclusion Team was formed to help those who don't have regular access to health services due to their circumstances, including people sleeping rough, refugees, asylum seekers, those living in temporary accommodation and members of the travelling community.

The Community Inclusion Team are holding clinics in community venues, offering a range of services from health and wellbeing advice and support to managing long term

conditions, to foot and wound care, continence care and immunisations. Staff are seeing around fifty patients a month.

8.4 Flow Campaign Launched

As briefed previously to Trust Board members, we are launching “Flow” to reduce unnecessary hospital stays and admissions.

“Flow” will streamline every stage of a patient’s progress from Emergency Departments until they are well enough to be discharged from any of our hospital sites

Every stage of the patient’s journey will be evaluated to ensure people receive the best treatment in the right place when they need it. The intention is to improve the quality of care for patients, improve performance against waiting time targets and reduce costs.

8.5 Pharmacy Video game Developed by Students

A new video game has been designed to help recruit the next generation of pharmacists to work in our hospitals.

The idea was the brainchild of Rachel Craven, Pharmacy Business, Service and Performance Manager at Northern Lincolnshire and Goole NHS Foundation Trust, who wanted to find a way of inspiring more people to join the team.

After speaking to The Grimsby Institute, students on the BA Game Design course set about making Rachel’s concept a reality. They worked for free over the course of 12 months and came up with the finished product – Pharmacy Rush. It has been launched across our region and received excellent feedback.

8.6 Physiotherapists First to Give Ultrasounds at Bedside

Patients with major injuries and illnesses, including brain injuries and serious heart conditions, can now be given lung ultrasounds without leaving their hospital beds.

Physiotherapists Emily Cockshutt and Aaron Hales have become the first on the north bank of our Group to qualify in a new technique to perform lung ultrasounds by patients’ bedsides, helping people with serious breathing problems.

The technique, endorsed by the Intensive Care Society, allows physiotherapists to assess lung conditions more accurately, enabling them to design effective treatment plans to help patients recover more quickly.

Jonathan Lofthouse
Group Chief Executive
31 July 2024

Committees-in-Common Highlight / Escalation Report to the Trust Boards

	8 August 2024
	Quality and Safety Committees in Common
	27 June 2024 31 July 2024
	Yes for both meetings

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on Thursday 27 June 2024 and Wednesday 31 July 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

27 June 2024

- *Operational pressures*
- *Board Assurance Framework*
- *Annual Quality Account*
- *Integrated Performance Report*
- *CQC Improvement plans – HUTH/HUTH Maternity/NLAG*
- *Maternity and Neonatal Assurance Report*
- *Children and Young People Assurance*
- *PSIRF/Serious Incidents*
- *Quality Impact Assessment (QIA)*
- *Research, Innovation and Development quarterly update*
- *Learning from deaths 203/24 Q4 Report*
- *Audiology Services CQC Response*
- *External Review of Audiology Services*
- *Medicine Management Annual Report*
- *Medication Safety Annual Report*
- *Clinical Audit Annual Report (deferred to July CIC due to time pressures)*

31 July 2024

- *Board Assurance Framework*
- *Integrated Performance Report*
- *Update on Quality IPR Time Out*
- *CQC Oversight update*
- *Nursing Assurance Report*
- *Maternity and Neonatal Assurance Reports*
- *Neonatal Deaths Report*
- *PSIRF/Serious Incidents (Including Duty of Candour and Lessons Learned)*
- *Patient Experience Report (Including Learning from Complaints)*
- *Register of External Agency Visits*
- *Safeguarding including MCA and DOLS*
- *Clinical Effectiveness Report*
- *Clinical Audit Annual Report*
- *EQIA Policy and Terms of Reference*

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

27 June 2024

a) The CIC approved the Quality Accounts following delegated responsibility from the Boards in Common.
b) The CIC received the Audiology CQC submission on behalf of the Trust Board.
c) A Task and Finish Group to be established to review the outstanding CQC actions across the Group. This would be chaired by Jonathan Lofthouse. Progress against actions would continue to be monitored at the CICs.

31 July 2024

a) A Never Event had been declared in July 2024 relating to a nerve block. The duty of candour had been carried out and the event was being investigated appropriately.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

27 June 2024

a) It was reported that there would be a Group IPR time-out in July to review the metrics and the format to ensure ward to board assurance.
b) The C-Difficile position was challenging for the Group with 6 cases reported in May 2024, this was also a national issue.
c) A HUTH Never Event had been declared in June 2024 and the investigation was underway. The outcome of the investigation would be reported back to the CIC.
d) A deep dive into the HUTH IPC outbreaks in NICU was being carried out and the CIC would receive feedback at its next meeting. It was thought that increased demand on the unit could be a factor.
e) HUTH/NLAG CQC Action plans were discussed and more assurance was required relating to completion dates. It was agreed date resets, indications of progress and realistic timescales was required. The CIC were not assured for this item.

f) HUTH CQC Maternity – There were still 11 actions rated as off-track. One of which included the triage out of hours issue. Cabinet would receive a paper in July 2024 detailing the outstanding actions but specifically reviewing the triage out of hours and the training compliance in maternity services. The CIC agreed limited assurance for this item.
g) Group Research and Innovation. A quarterly update was received and reasonable assurance was agreed. There was a caveat that further investment was required to enhance the service.
h) HUTH/NLAG Medicines Management annual reports were received by the CIC. Appropriate processes are in place although there were reported IT issues around the reporting systems. Because of the digital issues the CIC gave limited assurance.
i) Audiology CQC submission was received by the CIC and approved. The submission included IQUIPS accreditation standards, a gap analysis against the standards and the HUTH audiology action tracker. The CIC were assured that appropriate actions had been taken in response to the identification of the concerns relating to the service in terms of investigating and addressing the root causes of the service failings. The CIC had ongoing concerns over the future of the service (while agreeing the direction of travel to a unified service across the Health Group) and over the possibility that other small services may also be struggling without this being widely recognised.
j) The TAVI Report was received for awareness. There was a governance structure in place as well as an action plan for future improvements. NHS England had stood down the single focused meeting to oversee progress related to the service. The CIC requested a 3 month review with progress against identified actions.

31 July 2024

a) SHMI – HUTH. There were still issues relating to Fractured Neck of Femur (FNOR), Sepsis and Secondary Malignancies. Limited assurance was given and further assurance required regarding FNOR. A report to be received in November 2024.
b) Venous Thromboembolism (VTE) performance NLAG. There had been a drop in performance due to mapping and coding changes relating to Lorenzo. The Chief Medical Information Officer was leading on this issue.
c) Infection Prevention Control (IPC) – Group. IPC issues, in particular C.Difficile compliance was raised and limited assurance was given. The CIC agreed to further scrutiny through the IPR and the IPC BAF.
d) Care Quality Commission (CQC) – Reset of actions – Group. The Group Chief Nurse has led a reset of all outstanding CQC actions and this has altered some of the ratings. An updated position would be received by the CIC in October. Limited assurance was given.
e) Maternity Services HUTH – More assurance was requested regarding the level and detail of investment required. The Group CEO and Group CN were leading on this issue. Updates to be received by the CIC and the Boards in Common.
f) Patient Safety Incident Response Framework (PSIRF) – Group. The CIC recognised that there was work ongoing and improvements being made but more emphasis on what had changed within services as a result of the investigations was required. Limited assurance was given.
g) The CIC referred the Domestic Abuse Co-ordinator recruitment to the Workforce, Education and Culture CIC.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The committees considered the areas of the BAFs for which it has oversight and has proposed the following change(s) to the risk rating or entry:

27 June 2024
The committees considered the areas of the BAFs for which it has oversight and no changes were proposed.

31 July 2024
The committees considered the Quality BAF risk ratings and it was agreed that the Chief Medical Officer and the Chief Nurse would carry out a piece of work to review the ratings and bring a proposal back to the October 2024 CIC. The CIC agreed that the risk ratings were too low at 16 for both quality risks and these should be reset.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the issues for reporting in item 3.
- Note the items listed for further assurance and their assurance ratings.

David Sulch and Sue Liburd (Chairs of the Quality and Safety CIC)

27 June 2024

31 July 2024

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Boards-in-Common Front sheet

Agenda Item No: BIC(24)137

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 8 August 2024
Director Lead	N/A
Contact Officer/Author	Sue Liburd, Non-Executive Director Stuart Hall, Non-Executive Director
Title of the Report	**Maternity & Neonatal Safety Champions Report**
Executive Summary	This report sets out the activities undertaken by the Non-Executive Maternity & Neonatal Champions to provide assurance to the Board in the provision of high quality, safe maternity, and neonatal clinical care. The Maternity & Neonatal Safety Champions continue to be proactive in engaging with staff across NLaG and HUTH. This activity is specifically documented in detail in the individual maternity reports produced by the Maternity teams and is summarised in this report. The report sets out matters of risk to escalate which include the instability in some senior leadership roles, but note the positive progress made which has included the appointment of a Group Director of Midwifery who commenced in post in June 2024.
Background Information and/or Supporting Document(s) (if applicable)	The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that the following are in place: • High quality clinical care; • Maternity & neonatal service & facilities; • Workforce numbers; • Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback); and • Effective team working.
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A

Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ✓ Review ☐ Other – please detail below:

Maternity & Neonatal Safety Champion's Report
For June and July 2024

Executive summary:

The role of the Non-Executive Director Maternity & Neonatal Champion is to provide Board level assurance that:

- High quality clinical care;
- Maternity & neonatal service & facilities;
- Workforce numbers;
- Learning & training systems (includes ensuring authentic engagement with service users and ensuring the service acts upon their feedback);
- Effective team working are all in place.

This report has been developed to enable the Maternity & Neonatal Safety Champions for the two trusts to report on and provide assurance to the relevant committees and the boards in respect of the above areas. Where required, the report will include risks & concerns requiring escalation as well as good practice, improvement and innovation.

Activities undertaken this month:

Activities undertaken in April and May have included the standard programme of walk rounds, service level meetings, and meetings with service leaders including the Head of Midwifery for the respective Trusts.

In addition, across both organisations the Champions have attended the following:

HUTH

- 13 June: MSSP Diagnostic Report feedback session with stakeholders.
- 25 June: HNY LMNS Delivery Board
- 3 July: Maternity Assurance visit
- 08 July: QUAD Meeting
- 9 July: Maternity Safety Support Programme
- 18 July: Maternity Transformation and Assurance Committee

NLAG

- 25 June: HNY LMNS Delivery Board
- 26 June: Stakeholder follow on meeting to review HUTH diagnostic report
- 02 July: DPoW Maternity Assurance visit
- 08 July: QUAD Meeting
- 18 July: Maternity Transformation and Assurance Committee
- 24 July: Regional NED Safety Champions Network

Learning Lessons:	Service User Voice Feedback:	Staff Experience & Feedback:
The importance of training our staff to give them the skills to perform their roles safely and to the best of their ability is where there is some variability across the Trusts particularly with regards to safeguarding. The low level 3 safeguarding compliance at NLAG is noted. The Champion for HUTH welcomes the marked improvement in our training compliance above target in majority of specialties and is championing the need for long term planned and sustainable provisions that facilitate staff having enough time to fulfil their responsibilities.	The HUTH Safety Champion met patients within the triage area on 3 July 2024 who were largely positive in respect of their treatment and waiting times. It was noted that some mothers who had previous births at the Trust using paper records were adapting to the digital notes. There were some concerns re the availability of dedicated examination rooms to improve flow. Through the Maternity Assurance and Transformation Committee, the action plans from HUTH and NLAG from the 2023 Maternity Survey (issued in February 2024) have been presented and are being tracked accordingly. It is also positive to see the MNVP representation at the Maternity Assurance Transformation Committee from July 2024 onwards, and to incorporate their highly valued feedback. The Champions were pleased to hear plans for a co-production workshop with the MNVP Leads in September to develop a framework and strategy for co-production and improvements driven by service user feedback. Subsequent outputs will include a communication strategy/plan	The Safety Champion for HUTH reports some mixed response in relation to the BadgerNet role out. Whilst there has been positive commentary on some aspects of the training implementation initially, there appear to be remedial actions to address. Both Safety Champions are pleased that a formal Post Implementation review is being presented to the Maternity Assurance Transformation Committee in August, given some of the feedback from staff, including real-time functionality. It is positive that steps are being taken to learn from our North Bank implementation ahead of roll out across the South Bank in September. There are some concerns that Badgernet is not being used to its full potential and it is understood that a workshop is planned with early adopters to assess functionality and benefits. NLaG safety champion commends the work of the highly engaged and committed team delivering the infant feeding and frenulotomy service on the Southbank.

Good practice, improvements & innovation to share:

The Champions have reported a reduction in midwifery vacancies across the group, although still high, in addition to turnover markedly reducing.

The HUTH Champion has positively noted the additional delivery groups in place at a Group Level to oversee the delivery of MIS Year 6 and remaining HUTH CQC actions. This will allow time for richer

discussion on wider action plans on 3 year delivery plan, MNVP feedback and CQC survey actions at the Maternity Transformation and Assurance Committee (MTAC).

The Champions are pleased to note these delivery groups are cross group and the HUTH and NLaG safety champion is pleased to see that the MTAC will incorporate MNVP participation. This will help address the feedback from ICB membership of the MNVP during May 2024 of the need to increase the timeliness of implementation of 15 steps visit feedback.

The NLAG Champion visited DPOW and was pleased to note the enthusiasm of the staff for providing a high-quality service and their motivation to improve the pool room and active birth environment. Support will be sought from HealthTree Foundation to undertake these improvements.

Risks & concerns to escalate:

The Champions for both Trusts note the Trust's Group Director of Midwifery commenced in post on 10 June 2024 and is bringing leadership across the Group's sites. However, there is a vacancy in place at HUTH for the Head of Midwifery post from 31 July 2024 which is out to recruitment and acting up arrangements in place at NLAG in the Head of Midwifery role. Thus there remain gaps in leadership which has been flagged as a risk at the Quality and Safety Committees-in-Common.

The Champions are conscious that both HUTH and NLAG have attended previous ICB meetings in March and May to review and prioritise planned investments for 2024/25 given the funding pressures. Safety Champions recognised the priorities at HUTH in respect of sustaining triage and leadership, and at NLAG to embed roles funding non-recurrently through Ockenden funding. The Champions note that the Group Director of Midwifery and Group Chief Nurse have completed a paper and presented to Executives setting out the key priorities to be able to address the key risks identified from external support to date. The Champions are supportive of this being presented to Board at the earliest opportunity for necessary review and approval.

Activities planned next month:

The following activities are planned during the month:

HUTH

- 6 August: HNY LMNS PQSAG
- 14 August: HNY LMNS Delivery Board
- 15 August: Maternity Transformation Assurance Committee meeting
- 16 August: Maternity Assurance Visit

NLAG

- 6 August: HNY LMNS PQSAG
- 14 August: HNY LMNS Delivery Board
- 15 August: Maternity Transformation Assurance Committee meeting
- 19 August: QUAD Meeting

The Champions are keen to introduce a joint visit to further the opportunities available to the Group.

Stuart Hall
Non-Executive Director Maternity & Neonatal Safety Champion (HUTH)
31 July 2024

Sue Liburd
Non-Executive Director Maternity & Neonatal Safety Champion (NLAG)

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)138

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**Thursday 8 August 2024**
Director Lead	**Amanda Stanford, Group Chief Nurse**
Contact Officer / Author	**Yvonne McGrath, Group Director of Midwifery**
Title of Report	Maternity & Neonatal Assurance Reports – NLAG & HUTH
Executive Summary	**HUTH** 1. **CNST / MIS Year 6:** Weekly meetings in place- greatest risk is S.A. 5 Midwifery Workforce due to issues with co-ordinator status and that midwifery established does not align to BR+ recommendations. Positive progress on Saving Babies Lives- currently on track- however, continued work needed on Element 4. S.A. 8 remains vulnerable and weekly reviews of training compliance are ongoing. 2. **Maternity Safety Support Programme:** Draft Diagnostic Report shared in June, Awaiting finalised report and agreement of exit criteria 3. **Neonatal Death Review**: Snapshot review did not identify any significant themes. 4. **Neonates:** Neonatal Matron recruited 5. **Workforce*:*** Workforce challenge exacerbated by maternity leave and post return reductions in hours; • Current vacancy is 18.5 WTE. 22.04 WTE Newly qualified midwives have been recruited, however they will be supernumerary until November. • This deficit is affecting care / pathways as intrapartum care, dedicated 24-hr Triage service as the triage service is currently not supported by a funded, midwifery establishment and will remain a risk if further resource is not agreed. • A Position Paper outlining the additional requirements to improve maternity services has gone to Cabinet (inclusive of triage, education and leadership. • Head of Midwifery Post currently out to advert **NLAG** 1. **CNST / MIS Year 6:** Weekly meetings in place-. S.A. 6- capacity and demand review underway by Head of Sonography in view of UTAD capacity. CNST in-depth Progress Report submitted for this meeting. Training is on track. 2. **Infant Feeding:** NLAG will shortly be “Going for Gold” as which recognises that Baby Friendly Initiative Accreditation standards have been maintained. 3. **Level 3 Adult Safeguarding:** currently compliance is very poor at 36% with ongoing actions to rectify. 4. **Neonatal Death Review**: Snapshot review did not identify any significant themes.

	5. **Workforce*:*** Acting Head of Midwifery arrangements now in place in view of the substantive HOM's absence. 12.1 WTE newly qualified midwives recruited.
Background Information and/or Supporting Document(s) (if applicable)	Maternity Incentive Scheme Year 6 Progress Report Perinatal Mortality Review Tool Q1 Report
Prior Approval Process	
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	[insert, if applicable]
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Maternity & Neonatal Safety Assurance Report- Hull University Teaching Hospitals

Yvonne McGrath

July 2024

Contents

Item 1: Executive Summary

The June report on maternity and neonatal services at NHS Humber Health Partnership highlights several key areas of progress and areas needing attention. Ongoing efforts to develop a comprehensive Maternity and Neonatal Safety Improvement Plan and the advancements towards achieving compliance with the CNST Maternity Incentive Scheme's 10 Steps to Safety demonstrate the commitment to enhancing patient safety and care standards.

While challenges remain, particularly concerning the daily co-ordinator supernumerary status at HUTH and the higher preterm birth rates at NLAG, targeted reviews and action plans are in place to address these issues. The implementation of the Saving Babies' Lives Care Bundle V.3 is progressing, with assurances that all reasonable efforts are being made to achieve full compliance.

Staff feedback through listening events has been crucial in identifying concerns related to staffing levels, culture, and safety. These insights will inform future strategies to improve the working environment and patient care outcomes.

Maternity and Neonatal services remain dedicated to continuous improvement and adherence to national standards, ensuring the delivery of high-quality maternity and neonatal services. Through ongoing evaluation, staff engagement, and strategic planning, the Group aims to address current challenges and sustain the positive advancements made.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

Plans are developing to devise an overarching Maternity and Neonatal Safety Improvement Plan that will encompass actions and improvements driven by both local and national drivers. First actions will include the following:

- Review of Three Year Delivery Plan for maternity and neonatal services recommendations and action plans
- Review of ongoing Quality Improvement and Service Transformation projects and eventually the development of a Maternity & Neonatal Quality Improvement library to capture all projects.
- Review of Ockendon actions
- Workshop planned for September to agree co-production strategies and management of action plans with Maternity & Neonatal Voices Partnership

2.2 Maternity Safety Support Programme

- Draft Diagnostic Report received in June. Exit criteria from the MSSP will be agreed once report finalised.
- Maternity Improvement Advisor, Lesley Heelbeck continues to offer on-site support on a weekly basis and provides monthly reports.

2.3 CNST MIS Year 6: 10 Steps to Safety

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					N/A
2 Maternity Services Data Set (MSDS)					Due to the implementation of BadgerNet there has been a risk raised by the digital team regarding the data quality of the external submission for MSDS. The LMNS on the Trust's behalf wrote to NHS Resolution 22 April to explain the concerns with the data quality when implementing BadgerNet. The digital team are planning to continue running test MSDS submissions and will appraise the Trust Board of any risk to delivery safety action 2.
3 Transitional Care Services					Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). Next steps include the arrangement of a multidisciplinary face to face launch event during August 2024.
4 Clinical Workforce Planning					N/A
5 Midwifery Workforce Planning					Issues identified with daily co-ordinator supernumerary status. Midwifery funded establishment does not match BR+ recommendations
6 SBLCB V3					Quality improvement work continues to address areas of non-compliance. Progress made throughout quarter 4 2023/24.
7 Service User Feedback / Co-produced Services					Evidence is to be provided by the LMNS on the NHS Futures Platform. They have advised they will start this in due course.
8 Training					Compliance <90% for certain staff groups. Trajectory indicates targets will be met by 30th November 2024. Recovery plan in place.
9 Floor to Board					Safety champion arrangements to be agreed. Theming and trending work is outstanding. Culture improvement work continues to be undertaken.
10 MNSI / Early Notification Scheme					N/A
Total	**1**	**4**	**5**	**0**	

2.4 Saving Babies Lives Care Bundle (v3)

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24
Assurance review date	13 October 2023	18 December 2023	19 March 2024	10 June 2024
Element 1: Smoking in pregnancy	30%	40%	50%	60%
Element 2: Fetal growth restriction	45%	50%	90%	95%
Element 3: Reduced fetal movements	0%	50%	50%	50%
Element 4: Fetal monitoring in labour	0%	20%	20%	20%
Element 5: Preterm birth	41%	48%	67%	70%
Element 6: Diabetes	17%	17%	83%	83%
TOTAL	34%	43%	69%	73%

During the LMNS assurance meeting, progress made in Q3 was highlighted and improvement work to be undertaken was discussed. It was recognised that significant progress had been made in Elements 2 and 6. There has also been consistent progress made in all the other elements with an increase in the number of interventions now fully implemented. Where Elements 3 and 4 remain at 50% and 20%, it was acknowledged that within the last quarter progress has been made on updating guidance and establishing the audits needed to meet the requirements within each of those elements. A discussion highlighted that engagement with the Digital Midwife and monitoring of the transition to BadgerNet is required to ensure data retrieved from the system can be relied upon for audit data accuracy.

Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. The table below provides the projected targets set by the LMNS.

Element	Mar-24	Interventions fully implemented	Mar-25	Progress required	Interventions fully implemented	Mar-26
Element 1	50%	5/10	80%	3	8/10	100%
Element 2	90%	18/20	95%	1	19/20	100%
Element 3	50%	1/2	100%	1	2/2	100%
Element 4	20%	1/5	80%	3	4/5	100%
Element 5	67%	18/27	85%	5	23/27	100%
Element 6	83%	5/6	100%	1	6/6	100%

2.5 Perinatal Quality Surveillance Model

Data measure	May 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	4 eligible perinatal deaths in Q4 (3 neonatal deaths / 1 antepartum stillbirth). Key points for Learning from PMRT are: • Ensure to offer smoking cessation to all Family members • Ensure CO monitoring is undertaken at ever contact • Reminder to all staff to use Amnisure when SROM is suspected to aid confirmation • Ensure women are offered adequate pain relief in labour regardless of the stage of labour
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	N/A
Findings of review of all cases eligible for referral to MNSI	N/A
Number of incidents graded as moderate or above and what action is being taken	4 Action taken: Initial Incident Repose, After Action Reviews, PMRT, ATAIN reviews
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	To be collated
Service User Voice feedback	Please refer to body of report
Staff feedback from frontline champions and walk-abouts	
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	Yes
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 10	Please refer to body of report

2.6 Maternity and Neonatal Dashboards

Development of a a Maternity and Neonatal Dashboard has commenced and will comprise of the following indicators.

- Activity Indicators
- Maternal Morbidity Indicators
- Neonatal Mortality & Morbidity Indicators
- Workforce Indicators
- Postnatal Indicators
- Risk Management Indicators

These indicators will be underpinned with SPC charts where relevant to support recognition of themes, trends and risk and enable appropriate management and quality improvement.

Item 3: In month developments and updates

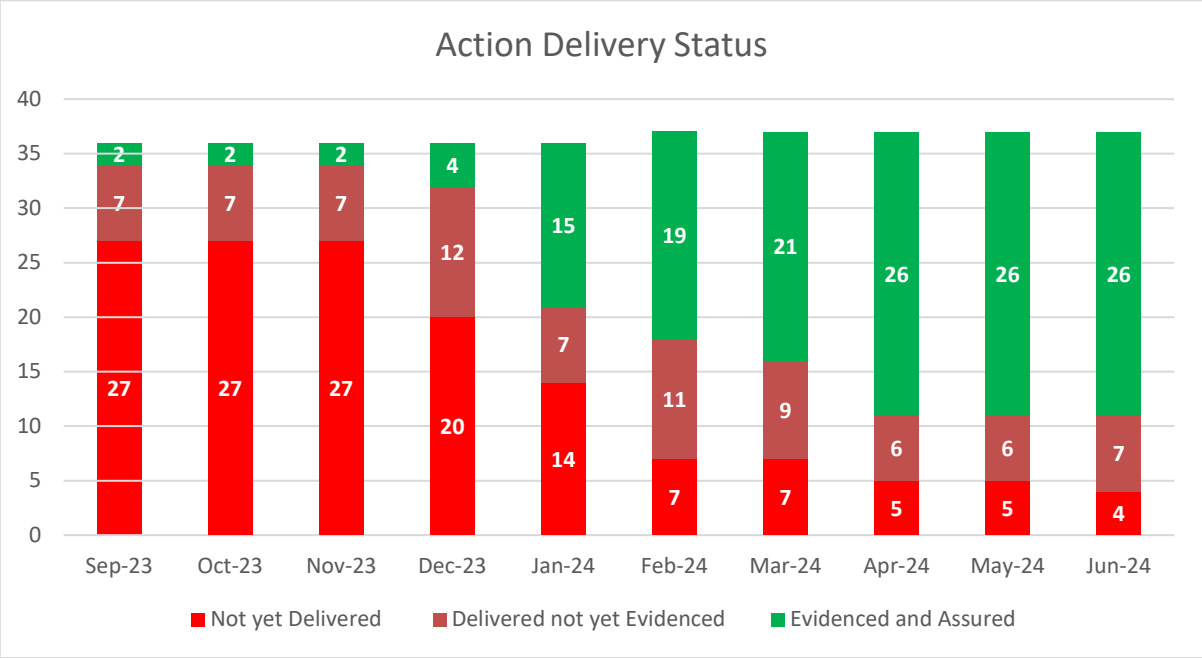
3.1 CQC/Section 31

The purpose of this section is to demonstrate the status of CQC action plans for Maternity services at HUTH, illustrating progression and risks to delivery of the CQC compliance improvement plans across the Group. This plan follows the CQC Maternity inspection in March and April 2023.

There are 37 actions, with an initial scheduled target date delivery between October 2023 and April 2024. The Maternity Service has evidenced full delivery of 26 out of the 37 actions on the action plan. There are 11 actions rated as off-track against ambitions to deliver by the end of April 2024. Good progress against the majority of these actions has been demonstrated but evidenced to varying degrees; however, further embedding is required (in some cases requiring additional investment) to ensure sustainability and for final sign off.

These actions were reviewed at the HUTH CQC and Section 31 Delivery Group on 11.07.24 and although no actions were closed, progress was acknowledged.

For the eleven actions against the CQC plan that remain not fully complete, revised delivery dates were discussed at the most recent delivery group that were considered deliverable. These range between September 2024 (for those remaining actions not requiring additional investment in staff) to December 2024 where additional investment is required to be secured to embed the progress made (e.g., triage) on a sustainable basis without utilising budgeted establishment across other areas. December 2024 delivery would require an imminent decision on priority areas of funding, ahead of revised Birthrate+ assessments.



Antenatal Day Unit/Triage Performance

There has been continued improvement in ADU and Maternity triage. In response to the CQC visit, the service began electronic recording in March 2023.

Planned and unplanned activity was originally seen in the same area and was then separated in September 2023. This has driven the significant improvement since October 2023 to ensure that women attending the hospital are triaged, assessed, and streamlined in a timely manner by appropriately skilled and qualified staff.

The services new Maternity Triage Unit opened in November 2023 and the service started implementation of BadgerNet / BSOTS on 12 March 2024.

The Maternity Triage is staffed and open between 8.00am and 10.00pm seven days a week, including a telephone triage service. The evidence base to demonstrate compliance with the delivery of this action has been achieved between those times; however, the service continues to work on the staffing model to support a 24/7 triage service. Work has commenced to do this, with staffing in place now on the Labour Ward; however, this needs to be a permanent

arrangement and therefore the Maternity Service will not be proposing to close this action until assurance has been received that a 24/7 triage service is in place.

- Average time to be seen – 10 minutes (at the beginning it was 1-hour 30mins)
- Average time in department – less than one hour – this time last year some women were waiting longer than 6 hours (at the beginning the average was 3 hours)
- Current Performance – 93.6% (at the beginning it was last than 60%)

The BSOTS target is 80% compliance for all women attending Maternity Triage to be triaged within 15 minutes of arrival in the department and aligned to the RAG categorisation. Maternity Triage is not staffed appropriately to implement BSOTs in its entirety therefore continues to maintain the Trust performance standards. Both the Trust (time to be seen following triage) and BSOTS KPIs will be reported going forward.
BSOTS w/c 24th June = 80.5% / BSOTS w/c 1st July = 71.7%.

3.2 Maternity updates

Hull University Teaching Hospitals NHS Trust

Infant Feeding Update

The specialist infant feeding clinic in Hull, which is crucial for supporting families and health professionals is primarily run by a Lactation Consultant and is currently facing significant challenges due to a lack of frenotomy practitioners and impending staffing changes. Although there are plans for midwives to begin frenotomy training in January, there will be an 18-month gap before new practitioners are available. Additionally, the clinic's progress towards Unicef BFI Gold status has been stalled due to the postponement of a reassessment and limited team expansion despite previous promises. To address these issues, it is essential to advocate for permanent funding for the four Baby Feeding Practitioners whose temporary contracts end early next year, as they have been instrumental in improving breastfeeding rates and providing support. Immediate actions should include seeking temporary solutions for extending clinic hours and filling the vacant Band 7 hours (0.4 WTE) with a Band 6 Midwife (0.5 WTE). Medium-term efforts should focus on strengthening partnerships with Unicef for the reassessment process and planning for future frenotomy training opportunities, while long-term goals involve developing a sustainable model for these services and expanding support offerings.

3.3 Neonatal updates

- Neonatal Matron appointed at HUTH
- NHS England Assurance Review completed and submitted. Awaiting final update
- Workforce review ongoing
- All nursing and medical workforce recruitment completed in readiness for cot expansion in September
- AHP element of workforce is currently not compliant and will form part of improvement plans going forward.
- Neonatal Voices now in post

Item 4: Maternity dashboard

Date Metric / name	01/01/24	01/02/24	01/03/24	01/04/24	01/05/24	01/06/24
Number of Births per month	405	385	402	376	400	372
Number of Bookings per month	488	421	425	465	462	422
Booking before 10 weeks	88.0%	69.9%	71.3%	73.3%	85.0%	77.9%
Booking over 12 weeks	12.0%	12.5%	11.3%	7.8%	0.5%	3.0%
Caesarean Section	40.1%	44.0%	40.3%	45.7%	47.0%	45.2%
Elective Caesarean Section (grade3 +4)	19.4%	21.4%	19.4%	18.6%	20.8%	16.7%
Emergency Caesarean Section (grade 1 +2)	20.7%	23.0%	20.2%	27.2%	26.3%	28.5%
knife to skin outside criteria						
Instrumental Birth	6.5%	50.0%	7.5%	5.3%	7.8%	5.9%
Normal Birth		56.0%	49.5%	49.2%	46.5%	49.7%
BBA	0	2	5	5	3	4
Home Birth	0.7%	0.5%	1.8%	1.3%	0.3%	0.3%
Induction of Labour	27.2%	29.4%	28.6%	37.8%	37.7%	35.5%
Epidural	33.0%	32.0%	48.5%	47.1%	67.8%	64.0%

4.1 Training compliance

HUTH are on track to achieve the 90% compliance for MIS year six, all managers are informed of any non-attendance and staff cannot be cancelled without the Medical Director being informed (at HUTH).

Safety action 9 (SA8) identifies that 90% attendance in each relevant staff group should attend:

1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal Life Support Training

NOTE: This is an annual rolling total and 90% must be achieved by 30th of November 2024.

Obs consultants & SAS grade doctors	94%
Midwives	92%
TOTAL	**92%**

(Please note HUTHT face to face training only = 87.7%)

Staff Group	**HUTHT**	**Actual non compliant**
Obs consultants & SAS grade doctors	86%	3
Other medical staff on obs rota	88%	3
Midwives & Midwifery Support Workers	91%	
Anaesthetic consultant	88%	1
TOTAL	**90%**	

Neonatal Resuscitation – JUNE 2024	
Staff Group	**HUTHT**
Neonatal/paediatric consultants / SAS grade doctors	54%
Neonatal/paediatric junior doctors	77%
Neonatal nursing staff / senior nurses	81%
Advanced neonatal nurse practitioners	100%
Midwives	81%
TOTAL	**81%**

2 x additional sessions are booked in Sept to ensure delivery against this element

The Neonatal Team are aware of the improvement required for compliance- this equates to 9 doctors attending training

Item 5: Learning lessons

5.1 Maternity & Newborn Safety Investigation cases (ongoing)

MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
MI-036865	Yes	Yes	Yes	Family Factual Accuracy Check

5.2 Detail of incidents graded moderate or above and rapid reviews

Incident number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
W309030 - Manual rotation and NBFD for prolonged second stage. Episiotomy, vaginal tear, button hole deformity admitting 1 finger, 3cm deep inside vaginal introitus. Sutured by consultant, debriefed woman, plan in place.	Obstetric	Moderate harm	DOC and debrief completed. FU arranged in 8 weeks with endoanal USS Discussed at Weekly Patient Safety Summit for senior oversight Woman declined letter with follow up from actions taken
W309263 - Attended community midwife on the 10/6/24 unable to auscultate FH, attended the hospital and IUD confirmed	Obstetric	Fatal	DOC completed Full PMRT investigation initiated Discussed at Weekly Patient Safety Summit for senior oversight
W309496 - Missed antibiotics in labour following a positive GBS swap in pregnancy	Obstetric	Moderate harm	Originally inputted as no harm but uplifted following Maternity Incident Review Meeting. Discussed at Weekly Patient Safety Summit for senior oversight
PSII/2024/5907 - term baby admitted to neonatal unit. Cat 1 section. Thick Meconium. Crash call for Neonatal team to theatre. Baby born in poor condition. Now ventilated on Nitric Oxide and Oscillation and Inotrope support.	Obstetric	Moderate harm - PSII	DOC completed Woman declined letter with follow up from actions taken Joint Maternity and Neonatal initial learning response completed Discussed at Weekly Patient Safety Summit for senior oversight and PSII declated

W309513 - term baby admitted to neonatal unit. Baby born at 41+4 via C-section, meconium at delivery. Emergency transfer out for ECMO due to persistent pulmonary hypertension of the newborn and meconium aspiration syndrome. Baby was intubated, ventilated and on nitric oxide. Was started on the hypotension pathway started on inotropes and supporting medications. The ECMO team came, stabilised and transferred out to Leicester. Dad went with baby and mum was transferred with a midwife.	Obstetric	Moderate harm - AAR	DOC completed Woman declined letter with follow up from actions taken Joint Maternity and Neonatal initial learning response completed Discussed at Weekly Patient Safety Summit for senior oversight and AAR advised

5.3 Key themes & trends

Theme/trend	Additional actions being taken
Hypothermic neonates on the wards (labour ward and postnatal ward)	• Dissemination of learning to managers to cascade to staff • Ongoing oversight of admission temperatures to the postnatal ward for targeted learning • Introduction of teaching session on neonatal study day
Incorrect interpretation of CTG's	• Thematic review jointly with LMNS • Escalation to fetal monitoring team • More targeted teaching • Exploring introduction of fetal monitoring champions on the wards and in community to support staff • Introducing tea trolley teaching sessions
Escalation of a deteriorating baby on CTG's	• Thematic review jointly with LMNS • Escalation to fetal monitoring team • More targeted teaching • Exploring introduction of fetal monitoring champions on the wards and in community to support staff • Introducing tea trolley teaching sessions

5.4 MBRRACE-UK perinatal mortality surveillance UK perinatal deaths of babies born in 2022

The MBRRACE-UK Perinatal Mortality Surveillance Report is in its tenth addition. The report focuses on births from 24 completed weeks of gestational age but also includes information on mortality between 23-23 weeks. Stillbirth rates of babies born to mothers in the least deprived quintile increased and there was a slight decrease in the stillbirth rates to mothers living in the most deprived quintile. Neonatal mortality rates, however, for babies born to mothers from the most deprived areas increased for the second year and now twice that of babies born to mothers from the least deprived areas. A full benchmarking of the report will shortly be undertaken across the group and relevant updates shared.

Key messages

- Extended perinatal mortality rates decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020.
- Compared with rates in 2021, stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
- There were increases in the neonatal mortality rate per 1,000 live births in England and Wales compared with 2021: 1.69 (UK); 1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).
- Stabilised & adjusted stillbirth rates in 2022 showed much more limited variation than in the years 2020 and 2021, with all Trusts and Health Boards having a stabilised & adjusted stillbirth rate within 5% of their comparator group average.
- Stabilised & adjusted neonatal mortality rates continued to show wide variation, with just 21.5% of Trusts and Health Boards falling within 5% of their comparator group average.
- After the exclusion of deaths due to congenital anomalies, 26.8% of Trusts and Health Boards had a stabilised & adjusted neonatal mortality rate within 5% of their comparator group average.

Local Context

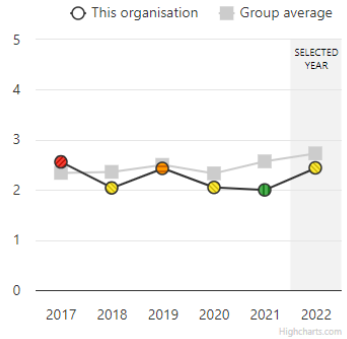
As demonstrated by the graphs below the stillbirth rate (3.77/1000 versus 3.83/1000) for HUTH is within 5% of the respective comparator group (effectively average), however neonatal deaths (2.44/1000 versus 2.73/1000) and extended perinatal mortality(6.19/1000 verus 6.55/1000) are 5-15% lower than comparator organisations.

Hull University Teaching Hospitals NHS Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: Yorkshire & Humber | Region: North East and Yorkshire

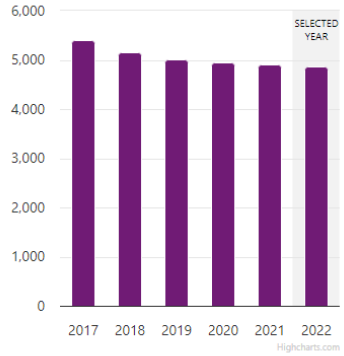
Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



Births, by year

Total number of births

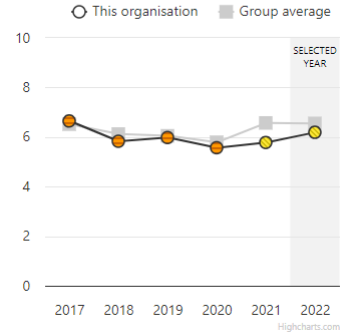


Hull University Teaching Hospitals NHS Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: Yorkshire & Humber | Region: North East and Yorkshire

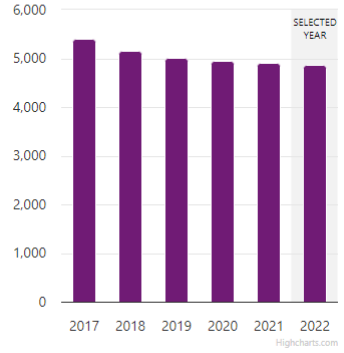
Mortality rates, by year

Stabilised & adjusted extended perinatal mortality rate per 1,000 total births



Births, by year

Total number of births

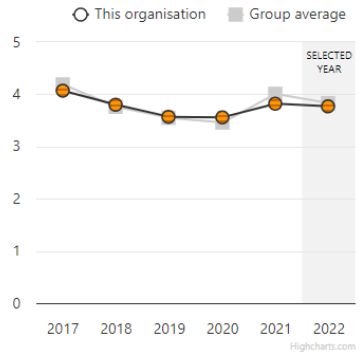


Hull University Teaching Hospitals NHS Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: Yorkshire & Humber | Region: North East and Yorkshire

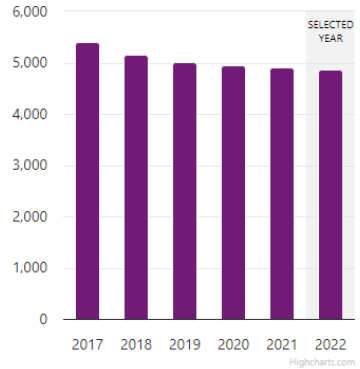
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



Births, by year

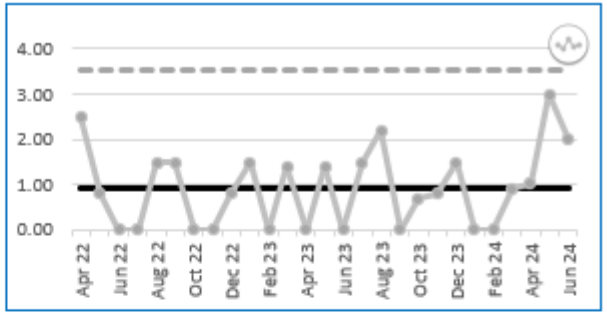
Total number of births



Current Performance

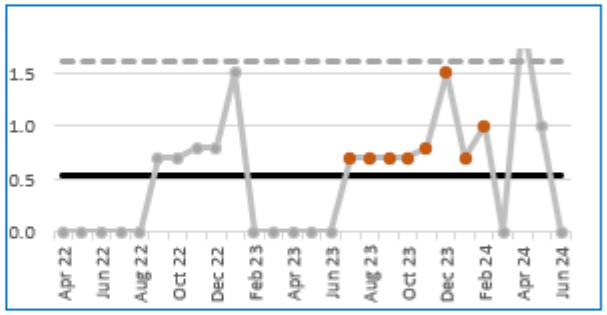
Latest month	01/06/24
Still birth rate/1000	**2.0**

No significant change



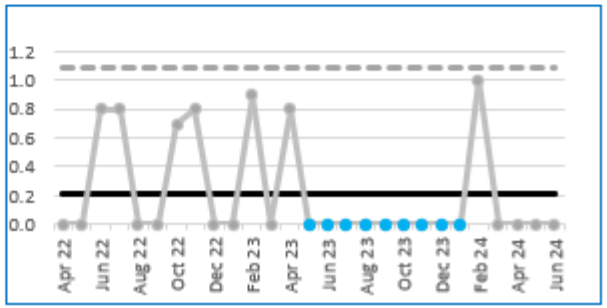
Latest month	01/06/24
Neonatal Death rate/1000	**0.0**

No significant change



Latest month	01/06/24
HIE rate/1000	**0.0**

No significant change



As requested at the last Quality & Safety Committee, a snapshot review of Neonatal deaths from June 2023- June 2024 was completed and is detailed below.

5.5 Neonatal Deaths June 2023- June 2024

15 Neonatal Deaths June 2023-2023

2 met criteria for MNSI referral

5 declared as PSII (inclusive of MSNIs referrals)

3 other cases were graded C or D but have not been declared as PSIIs

- No clear themes identified by this review.
- Points for discussion- grading of care and declaring of PSII- is PMRT sufficient as process within PSIRF framework
- Actions and Learning identified across cases
- Aspirin- issues with prescribing and access. QI project ongoing (2 cases)
- BAPM 7/Periprem not completed- not embedded as a process. Needs work and embedding (2 cases)
- Reduced fetal movements- actioning of reduced movements (2 cases)
- Delay and diagnosis and timing of delivery due to acuity (4 cases)
- MSNI action plans based on cases back to January 2023 across all MSNI referral criteria

Item 6: Listening to our families

6.1 Co-production going forward

A co-production workshop focused on maternity and neonatal care will occur in September to brings together a diverse group of stakeholders, including service users, healthcare providers, community representatives, and policymakers, to collaboratively develop actionable strategies for the governance and management of co-production and feedback. The intended outcome of the workshop is a set of concrete action plans, co-created by the group, that are designed to address identified issues and enhance delivery of the identified improvements. By agreeing a terms of references for the management of these action plans along with a sustained commitment, continuous service-user led improvements can occur.

6.2 Complaints and PALS

Significant delays with complaints and PALS noted and weekly meetings are now in place between the DOM and the Complaints and PALS teams to ensure improvement. Full details and updated position will be shared in the next report.

Item 7: Workforce and Listening to our staff

7.1 Midwifery Workforce-Vacancy

	Midwives
HRI	18.5 WTE 9.4%

18.5 WTE vacancy rate including maternity leave and long-term sickness; over the next quarter several midwives return from maternity leave and 22.04 WTE newly qualified midwives will commence at the Trust in September, however as the triage service remains unfunded and draws on existing established and newly qualified midwives will be supernumerary until November, there will continue to be significant staffing deficits. A paper detailing the necessary resources to support a 24/7 triage service and the leadership structure for midwifery will be taken to cabinet (31st of July 2024).

7.2 Staff Feedback and Initial Actions

A number of listening events for midwifery and obstetric staff have been undertaken at Hull Royal Infirmary in view of staff escalations and concerns about staffing levels, culture and safety. Further listening events are planned across the Group. Key points included:

- Poor workforce models leading to concerns about safe staffing levels in all areas, leading to fear, burnout and exhaustion
- Limited supernumerary time and lack of preceptorship for newly qualified midwives
- Poor mandatory training and education
- Poor communication and engagement between local leaders and staff around service change
- Lack of learning and poor safety culture
- Lack of clear escalation and out of hours support

The feedback received in these initial engagement events triangulates with other feedback and the findings of the draft Maternity Safety Support Programme Diagnostic Report and a number of key actions have commenced, are ongoing or planned:

- Position Paper being prepared for Cabinet outlining the workforce and leadership challenges within the Maternity Services and proposed solutions and investment requirements, including development of a speciality specific 'Manager-on-call' rota
- Daily pan-group safety huddles to facilitate mutual aid commenced on July 1st
- Development of pan-group escalation policy
- 0.49 WTE Labour Ward Co-ordinator vacancy has been offered to the current Labour Ward Co-ordinators who are not full-time which will facilitate two Band 7 Co-ordinators on most shifts, supporting maintenance of a supernumerary shift coordinator
- Maternity Governance structure is currently under review to ensure clear learning forums for actions from incidents.
- Review of Maternity Education and formation of a pan-group Maternity Education Collaborative

7.1 Staff Feedback and Initial Actions

2023 Staff survey results are presented below and indicate areas for improvement. Time is needed to dedicate to a review of the Staff Survey and to develop meaningful actions. Initial ideas are detailed below:

- Engagement sessions capturing the staff survey and the SCORE survey responses
- Promote completion of 2024 Staff Survey
- Quad walkarounds and meet and greets
- Quarterly 'ask the quad'
- High levels of engagement with the workforce form the quad members in new posts.
- Exit interviews are offered to all employees and results collated to learn from trends and themes

Speciality	We are compassionate and inclusive score	We are recognised and rewarded score	We each have a voice that counts score	We are safe and healthy score	We are always learning score	We work flexibly score	We are a team score	Staff Engagement Score	Morale score
Neonatology HUTH	7.7	6.4	7.3	6.6	6.8	7.0	7.2	7.5	6.8
Obstetrics HUTH	6.0	4.7	5.4	4.5	4.1	4.3	5.3	5.7	4.2

7.3 SCORE survey

Initial meetings have commenced with key leaders prior to the SCORE survey feedback.

FAMILY SERVICES DIVISION

Hull University Teaching Hospital

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 6, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 1 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

July 2024

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Hull University Teaching Hospital Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

The following deaths should be reviewed to meet safety action one standards:

- All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- All stillbirths (from 24+0 weeks' gestation)
- Neonatal death (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) (up to 28 days after birth)

2. STANDARDS

A report has been received by the Trust Executive Board each quarter from April 2024 to June 2024 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**Standard**
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**60%**
d) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in 2023-2024 (appendix A)

There has been a total of 11 incidents reported to MBRRACE-UK via the PMRT during MIS year six. 3 in Quarter 4 (01 January – 31 March 2024) in 8 in Quarter 1 (01 April – 30 June 2024). 0 cases were reported to MBRRACE but were for notification only and therefore not eligible for further measurement against CNST standards or review.

2 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 1 (appendix B)

There have been 11 incidents reviewed and published through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during January and March 2024 due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

- 4 cases had no issues identified that would have had an impact on the outcome.
- 5 cases had issues identified that would have had no impact on the outcome
- 2 cases had issues that may have had a difference to the outcome.

<u>Grading of care provided to the mother after the death of the baby</u>

- 11 cases had no issues identified that would have had an impact on the outcome
- 0 cases had issues identified that would not have had an impact on the outcome

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 3.

3.3 CNST Compliance as per MIS Year 6 Standards (Appendix C)

11/11 (100%) are currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of all Eligible Incidents Reported in Q4 and Q1 2023-2024

	Reason for entry to PMRT	Gestation (weeks)	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	Parents involved and updated	MNSI	MBRRACE notified <7 days	Review started < 2mth	Review Publish < 6mth
Q4	Neonatal death	41+1	3240g	HUTH - FABC	HUTH	HUTH	Yes	Yes – MI-	Yes	Yes	Report writing - <6 months
	Neonatal death	33+3	1160g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Met
	Antepartum stillbirth	24+2	154g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Report writing - <6 months
Q1	Neonatal death	37+1	3045g	HUTH	HUTH	HUTH	Yes	Yes – MI-	Yes	Yes	Not yet met – <6 months
	Antepartum stillbirth	25+5	137g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Report writing - <6 months
	Antepartum stillbirth	26+4	975g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Report writing - <6 months
	Neonatal death	34+3	2345g	HUTH	HUTH	Home	Yes	No	Yes	Yes	Not yet met – <6 months
	Antepartum stillbirth	37+1	2775g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months
	Antepartum stillbirth	33+1	1655g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months
	Antepartum stillbirth	29+2	1235g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months
	Antepartum stillbirth	24+2	403g	HUTH	HUTH	HUTH	Yes	No	Yes	Yes	Not yet met – <6 months

Appendix B – Summary of all incidents closed in Q1 of 2023-2024

Case	Cause of Death	Grading of Care	Issues Identified	Actions
90177	• Multiple congenitala nomalies (coarctation of Aorta, Malrotation, hydronephr osi, ectopic hydroureter) • Trisomy 18	**A/A/A**	Ongoing investigations on the neonatal unit were carried out appropriately but were not always timely It is not possible to tell from the notes if the relevant professionals involved in the ongoing care of the parents were informed about the death of their baby	Discussed with genetic lab and they already looked into it and they have got plans to work on Saturdays starting December 2023. Discuss with Martin House in future regarding who completes the notification to other health care professionals
89508	• Acute chorioamnio nitis	**B/A**	This mother had sepsis during her pregnancy and there was a delay in the diagnosis Induction of labour or a caesarean section was indicated but not carried out and it is not clear from the notes why not	Review SOP for checking results and taking appropriate action Review electronic systems to capture results that require action Bereavement Lead to discuss with senior colleagues and develop clear guidance on the policy for confirmation scans for intrauterine deaths out of hours. Reflection to be undertaken with relevant medical staff involved

89885	• Unexplained Stillbirth • Evidence Acute Thymic Involution	**B/A**	This mother smoked during pregnancy but was not offered referral to smoking cessation services This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements This mother presented with reduced fetal movements at >28 weeks and a CTG was not performed At first presentation with reduced fetal movements this mother was not appropriately risk assessed This mother presented with reduced fetal movements and scan was indicated but not carried out This mother presented with reduced fetal movements at >=37 weeks but induction was not discussed This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not carried out This mother has a history of domestic abuse and her antenatal care was not appropriate given this history The confirmed/ suspected delay in this mother's labour was not managed appropriately This mother required oxytocin during her labour, but this was not managed appropriately	Highlight policy to refer all smokers for smoking cessation in PMRT and community newsletters Reminder to all staff via PMRT newsletter that information on fetal movements are provided and this is documented in the records. Providing written information to be included in the new electronic recorded for implementation 2024 Reminder to all staff via PMRT newsletter that woman who report changed fetal movements >28 weeks are advised to attend maternity triage for an assessment and CTG and scan if required Reminder to all staff via the PMRT newsletter that all women who report changed fetal movements >28 weeks to be advised to attend maternity triage fora risk assessment and a discussion on IOL if >=37 weeks Review local guideline to ensure they reflect the national guidance Reminder to staff importance of seeing women alone to ask the domestic violence enquiry question Review bereavement and care in labour guideline to ensure guidance clear on medical review Review of bereavement and care in labour guideline to ensure guidance clear on use of oxytocin to augment labour Reminder to staff the option for postnatal investigations relating to maternal substance misuse

			Although indicated this mother was not offered postnatal investigations relating to maternal substance misuse	Highlight policy to refer all smokers and family members who smoke for smoking cessation in PMRT and Community newsletters. Introduction of Badgernet as opt out now introduced
90354	• acute hypoxic event • large ventricular hemorrhage	**A/A**	No actions	No actions
90628	• Klebsiella Pneumonia • severe chronic lung disease with cystic changes • extreme prematurity, 25 Wks	**B/B/A**	This baby was resuscitated and delayed cord clamping was not instituted although this was indicated line was removed by member of the nursing team during reorientation process before the baby was declared dead	Reminder to neonatal and maternity team and bereavement lead will circulate and make sure the feedback will be circulated to other members of maternity team. Nursing educator will make sure of staff training and competency before assigning to reorientation care.
90698	• hypoplastic aorticarch with tight coarctation • prematurity 32 weeks and IUGR	**D/B/A**	This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons Scribe sheet wasn`t available in the notes	Ongoing quality improvement project to investigate and improve pathway and accessibility of aspirin within the community. Preterm delivery and periprem passport not used. BAPM 7 and periprem passport usage now included on the mandatory training and within the new badgernet system Reminder to all neonatal team to make sure when assigning roles to make sure of a prescriber, so appropriateness of the resuscitation can be reviewed.

90897	• MCCD • Multi organ failure • Septic shock • Necrotizing enterocolitis • prematurity 26 weeks	**D/B/A**	Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate due to organisation issues The ongoing skin care of the baby on the neonatal unit was not appropriate	This was due to high acuity on the ward. Delay occurred but did not impact the outcome. Nursing educator in conjunction with tissue viability has put skin care bundle in place and for continuous education and training for all nursing team.
90359	• Unknown cause of death	**A/A**	During this mothers labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	Reminder to staff in PMRT newsletter. Highlight in bereavement training. Publish bereavement audit findings to highlight
90700	• Unknown cause of death	**A/A**	No actions	No actions
90872	• Severe growth restricted baby	**B/A**	This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements	Highlight in PMRT and Community Midwives Newsletters. Mandatory field on new computer system

GRADING OF CARE

Antenatal loss –

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Neonatal death –

Grading of care of the mother and baby up to the point of birth of the baby:

- ○ A - The review group concluded that there were no issues with care identified up the point that the baby was born
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the baby from birth up to the death of the baby:

- ○ A - The review group concluded that there were no issues with care identified from birth up the point that the baby died
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Grading of care of the mother following the death of her baby:

- ○ A - The review group concluded that there were no issues with care identified for the mother following the death of her baby
- ○ B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
- ○ C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
- ○ D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Appendix C – Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	100%	4/4 (100%)	8/8 (100%)	-	-	
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	4/4 (100%)	8/8 (100%)	-	-	
Multi-disciplinary reviews should be started within two months of the death.	95%	4/4 (100%)	5/5 (100%) - 3 not yet met but within dates	-	-	
Multi-disciplinary reviews should be published within six months of the death.	60%	4/4 (100%)	2/2 (100%) – 6 not yet but within dates	-	-	
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted April 2024	Submitted July 2024	-	-	

NHS Resolution - change to the verification period

The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this was not announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

Appendix D: Learning Points and Key Themes:

Key themes identified from **Q4** and **Q1** cases PMRT reviews are as follows:

- Sepsis pathway started but not completed
- Induction of labour was not performed in a timely manor
- Smoking cessation referrals were not completed
- Routine enquiry not asked at every contact
- The mother's risk status was not assessed at the onset / during the course of labour
- Pre-term perinatal optimisation not sufficient
- Reduced fetal movements guideline not followed

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	0/3 (0%)	2/8 (25%)	-	-	**2/11 (18%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/3 (33%)	0/8 (0%)	-	-	**1/11 (9%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	1/3 (33%)	0/8 (0%)	-	-	**1/11 (9%)**
Element 5.2k	Cases where the prevention, prediction, preparation or perinatal optimization of preterm birth was a relevant issue.	0/3 (0%)	0/8 (0%)	-	-	**0/11 (0%)**

Maternity & Neonatal Safety Assurance Report-

Northern Lincolnshire and Goole NHS Foundation Trust

Yvonne McGrath

July 2024

Contents

Item 1: Executive Summary

The July report on maternity and neonatal services at NHS Humber Health Partnership highlights several key areas of progress and areas needing attention. Ongoing efforts to develop a comprehensive Maternity and Neonatal Safety Improvement Plan and the advancements towards achieving compliance with the CNST Maternity Incentive Scheme's 10 Steps to Safety demonstrate the commitment to enhancing patient safety and care standards.

While challenges remain, particularly concerning the daily co-ordinator supernumerary status at HUTH and the higher preterm birth rates at NLAG, targeted reviews and action plans are in place to address these issues. The implementation of the Saving Babies' Lives Care Bundle V.3 is progressing, with assurances that all reasonable efforts are being made to achieve full compliance.

Staff feedback through listening events has been crucial in identifying concerns related to staffing levels, culture, and safety. These insights will inform future strategies to improve the working environment and patient care outcomes.

Maternity and Neonatal services remain dedicated to continuous improvement and adherence to national standards, ensuring the delivery of high-quality maternity and neonatal services. Through ongoing evaluation, staff engagement, and strategic planning, the Group aims to address current challenges and sustain the positive advancements made.

Item 2: Key highlights

2.1 Maternity and Neonatal Safety Improvement Plan (MatNeoSip)

Plans are developing to devise an overarching Maternity and Neonatal Safety Improvement Plan that will encompass actions and improvements driven by both local and national drivers. First actions will include the following:

- Review of Three Year Delivery Plan for maternity and neonatal services recommendations and action plans
- Review of ongoing Quality Improvement and Service Transformation projects and eventually the development of a Maternity & Neonatal Quality Improvement library to capture all projects.
- Review of Ockendon actions
- Workshop planned for September to agree co-production strategies and management of action plans with Maternity & Neonatal Voices Partnership

2.2 CNST MIS Year 6: 10 Steps to Safety

Safety action	Red	Amber	Green	Blue	Comments/ Actions being taken
1 National Perinatal Mortality Review Tool					N/A
2 Maternity Services Data Set (MSDS)					None Identified for CNST. However, please note the MSDS will be disrupted whilst transitioning to BADGERNET. Support is being provided by the MITS project team across the group alongside collaboration with the Digital Midwife at HUTH.
3 Transitional Care Services					Quality improvement project scoping complete with agreement to undertake joint project as a Group. The project has been registered with the Improvement Team on the AMaT system (as per evidence requirements). Next steps include the arrangement of a multidisciplinary face to face launch event during August 2024.
4 Clinical Workforce Planning					Unable to demonstrate progress made against action plans submitted in year 5 for compensatory rest and BAPM neonatal workforce requirements due to financial restrictions. Evidence of progress is required to allow the Trust to declare compliance. Currently being reviewed
5 Midwifery Workforce Planning					N/A
6 SBLCB V3					There are variations in practice with regards to the timescales for uterine artery doppler (UAD). A capacity/demand review is being undertaken by the head of sonography
7 Service User Feedback / Co-produced Services					Evidence is to be provided by the LMNS on the NHS Futures Platform. They have advised they will start this in due course.
8 Training Plan					Compliance <90% for certain staff groups. Trajectory indicates targets will be met by 30th November 2024. Recovery plan in place.
9 Floor to Board					Safety champion arrangements to be agreed. Theming and trending work is outstanding. Outcome of CULTURE SCORE survey to be reviewed.
10 MNSI / Early Notification Scheme					N/A
Total	**0**	**4**	**6**	**0**	

2.3 Saving Babies Lives Care Bundle (v3)

% of interventions fully implemented (LMNS) validation	Assessment one	Assessment two	Assessment three	Assessment four
Review quarter	Q1 2023/24	Q2 2023/24	Q3 2023/24	Q4 2023/24
Assurance review date	25 October 2023	18 December 2023	20 March 2024	10 June 2024
Element 1: Smoking in pregnancy	10%	70%	70%	70%
Element 2: Fetal growth restriction	55%	70%	90%	90%
Element 3: Reduced fetal movements	50%	100%	100%	100%
Element 4: Fetal monitoring in labour	40%	80%	80%	80%
Element 5: Preterm birth	48%	70%	81%	67%
Element 6: Diabetes	17%	67%	67%	83%
TOTAL	41%	71%	81%	77%

Following peer validation of evidence submitted for quarter 4 2023/24 by the LMNS, a grading of “significant assurance” was assigned with an overall compliance of 77% for all 6 elements. Submission of quarter 1 2024/25 data is on target for the September 2024 deadline.

The division continue to undertake multidisciplinary quality improvement and clinical audit work, with the aim in providing assurance for the partially compliant interventions. At present, work is focused on the following areas where non-compliance has been reported:

Element 1 - Smoking in pregnancy: Documentation issues identified for recording smoking status for pregnant smokers at every antenatal appointment and referring pregnant women to the tobacco dependency treatment service. A sticker has been developed to act as an aide memoire in the case notes until the roll out of Badgernet in September 2024. Smoking fields in Badgernet will be mandatory which will allow the required data to be captured.

Element 2 – Fetal growth restriction: There are variations in practice with regards to the timescales for uterine artery doppler (UAD) – a challenge is the number and availability of sonographers who are trained to undertake UAD and lack of clinician available at the Grimsby site. A meeting has been held with the head of sonography who is currently undertaking a capacity/demand review.

NLaG has a higher rate of babies born over 3rd centile before 39 weeks gestation where FGR is suspected in comparison to national reporting. A deep dive review has been undertaken by the Patient Safety Midwives to determine if women are being induced unnecessarily and results indicate that inductions are being carried out appropriately due to factors such as Oligohydramnious or pre-eclampsia which are not captured in GROW 2.0. The review also highlighted a data inputting error where suspected fetal growth restriction was recorded on GROW incorrectly. This equated to 25 cases from quarter 1 being incorrectly identified and has been fed back to the Perinatal Institute who have agreed to update our figures retrospectively for quarter 1 (reducing the rate from 8.6 to 5.5%) which sits slightly above the LMNS target of 5% but under the national average. Quarter 2 sample has been provided to repeat the process and ensure accurate reporting and a meeting with the maternity managers has been arranged to address the recording issues on GROW.

Element 4 - Fetal monitoring in labour: One non-compliant intervention at SGH regarding the completion of risk assessment documentation at the onset of labour. A test of change has been initiated whereby the intrapartum notes have been prepared with a risk assessment sticker in place to determine the most appropriate method of fetal monitoring and risk status at the onset of labour. The current Q1 audit cycle will evidence whether this change has been successful in improving compliance.

Element 5 – Preterm birth: There has been a decline in the number of perinatal optimisation standards met. This may be attributed to women presenting in advanced labour, leaving insufficient time to optimise care. Given that the preterm birth rate across the trust is higher than the national average, a comprehensive review of preterm deliveries is currently underway to identify any missed opportunities and extract valuable lessons.

Element 6 – Diabetes: 1 intervention outstanding relates to separation of pre-existing and gestational diabetes clinics. A proposal has been drafted and is awaiting approval from the Clinical Leads before implementation.

The table below provides the projected targets set by the LMNS.

Element	Mar-24	Interventions fully implemented	Mar-25	Progress required	Interventions fully implemented	Mar-26
Element 1	70%	7/10	90%	2	9/10	100%
Element 2	90%	18/20	95%	1	19/20	100%
Element 3	100%	2/2	100%	-	2/2	100%
Element 4	80%	4/5	100%	1	5/5	100%
Element 5	81%	22/27	92%	3	25/27	100%
Element 6	67%	4/6	83%	1	5/6	100%

2.5 Perinatal Quality Surveillance Model

Northern Lincolnshire and Goole NHS Foundation Trust

Data measure	May 2024
Findings of review of all perinatal deaths using the real time data monitoring tool	4 eligible perinatal deaths in Q4 (1 neonatal deaths / 1 antepartum stillbirth / 2 unspecified stillbirths). Key points for Learning from PMRT are: • Risk assessments must be completed and documented during antenatal, intrapartum and postnatal periods. • Please follow the cherished pathways to ensure all the investigations are completed. These are necessary to aid with identifying potential causes of IUD. • It is important to document that information regarding RFM has been given. Without this, we cannot be certain this has happened. • All those who have an IUD, regardless of blood group should be offered a Kleihauer test. This aids the investigations to determine potential causes for IUD. • CO monitoring should always be completed and documented at each antenatal appointment. • Assessment for aspirin should be completed for all pregnant people. • When on a scan pathway, scans should be performed 3-4 weekly and this should not be exceeded. • Maternal observations and the partogram should always be completed. • Neonatal alerts should be sent for those on nerve pain medications. • Cherished Care Pathways should always be completed to know exactly what care has been provided.
Number of cases referred to MNSI/ENS	0
Family's informed of referral to MNSI/ENSR	N/A
Findings of review of all cases eligible for referral to MNSI	N/A
Number of incidents graded as moderate or above and what action is being taken	0
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Please refer to body of report

Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover vs actual prospectively	100% - no gaps identified.
Service User Voice feedback	Please refer to body of report
Staff feedback from frontline champions and walk-abouts	Safety Walkabout at DPOW 19/06/24 – concerns raised regarding bank staff shift and lack of CTG equipment on the wards. Action taken: escalated to Matron – update required by 31/07/24 16 open actions on the Safety Champion Improvement Plan – main themes relate to: • Staffing • Capacity & demand • Estates
MNSI/NHSR/CQC or other organisations with a concern or request for action made directly with the Trust	Yes
Coroner Reg 28 made directly to the Trust	0
Progress in achievement of CNST 10	Please refer to body of report

2.5 Maternity and Neonatal Dashboards

Development of a Maternity and Neonatal Dashboard has commenced and will comprise of the following indicators.

- Activity Indicators
- Maternal Morbidity Indicators
- Neonatal Mortality & Morbidity Indicators
- Workforce Indicators
- Postnatal Indicators
- Risk Management Indicators

These indicators will be underpinned with SPC charts where relevant to support recognition of themes, trends and risk and enable appropriate management and quality improvement.

Item 3: In month developments and updates

3.1 Maternity updates

Infant Feeding Update

Frenulotomy Service

The frenulotomy service has been successfully launched at both Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPOW), with five midwives having completed their training and practical assessments. This development means that local women now have reduced waiting times and shorter travel distances compared to the previous requirement to go to Sheffield for appointments. While the service is still new, established pathways and referral processes are proving effective, and positive feedback from women and their families is already being received. Moving forward, there are plans to track the continuation rates of breastfeeding following this intervention to further assess its impact.

Going for Gold

Following the successful attainment of Level 3 Accreditation for the Baby Friendly Initiative (BFI) in 2022, Maternity Services are now working towards the "Going for Gold" Award, scheduled for assessment in October 2024. This award aims to sustain the high standards already achieved and ensure that the progress made over the years is maintained and protected. The "Going for Gold" assessment will evaluate leadership, culture, monitoring, and the long-term sustainability of the service. The evaluation will be a collaborative effort with Health Visitor Services from both North and North East Lincolnshire, focusing on both Maternity and Health Visiting services to ensure comprehensive and high-quality care for future service users.

Other updates:

- Acting up arrangement for the HOM role in place in view of substantive HOM absence
- Triage Task & Finish Group initiated.
- Digital Midwife currently absent work- support obtained from HUTH Digital Midwife and the Project Team prior to Badgernet launch in September 2024.

3.2 Neonatal updates

- AHP element of workforce is currently not compliant and will form part of improvement plans going forward.
- Neonatal Voices now in post

Item 4: Maternity dashboard

Trustwide Maternity Dashboard

Indicator	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
Midwife to Birth Ratio	23.0	23.1	23.3	22.8	22.7	20.8	21.8		19.6			
Red Flags	25.0	2.0	7.0	14.0	3.0	14.0	9.0	7.0	8.0	18.0	10.0	6.0
(a) Delayed or cancelled time critical activity (delay in IOL >24 hours, Emer or El LSCS, delay in ARM >24 hr, delay in aug of SROM >30 hours)	2.0	0.0	0.0	3.0	1.0	3.0	1.0	1.0	1.0	3.0	2.0	1.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	0.0	0.0	3.0	3.0	1.0	2.0	2.0	1.0	3.0	2.0	2.0	3.0
(c) Missed medication during an admission to hospital	2.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	0.0	2.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	1.0	0.0	1.0	1.0	0.0	0.0	1.0	1.0	0.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0
(f) Full clinical examination not carried out when presenting in labour	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(g) Delay of 2 hours or more between admission for induction and beginning of process	5.0	0.0	1.0	1.0	1.0	0.0	1.0	0.0	0.0	1.0	1.0	0.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	0.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	2.0	0.0
(j) Community staff have been called in to work on the unit.	16.0	2.0	2.0	5.0	0.0	8.0	3.0	5.0	2.0	7.0	1.0	2.0
Continuity of Carer %												
In Receipt of %												
CoC In Receipt of %												
Continuity Team Caseload												
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	94.8	94.2	92.8	94.5	93.9	98.5	94.3	96.9	101.0			
Labour Co-ordinator Supernumerary Status %	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1:1 Care in Labour %	100.0	100.0	100.0	99.5	99.0	99.4	99.5	99.5	100.0	100.0	100.0	100.0
Vacancies	14.5	14.9	15.5	15.4	27.9	29.4	28.4	22.8	22.5	21.1	26.1	25.6
Vacancies - Registered	18.0	17.6	19.1	15.9	27.5	23.0	22.4	16.9	16.9	17.8	16.5	15.2
Vacancies - Unregistered	-3.5	-2.7	-3.6	-0.4	0.4	6.4	5.9	5.9	5.5	3.3	9.6	10.4
Serious Incidents	1.0	1.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Complaints	0.0	3.0	1.0	3.0	0.0	1.0	0.0	2.0	2.0	2.0	2.0	1.0
PALS	6.0	6.0	4.0	5.0	4.0	3.0	3.0	6.0	2.0	8.0	4.0	5.0
Sickness Absence (Division) %	5.2	5.5	5.7	5.4	5.8	5.4	5.7	5.7	4.8	4.6	5.0	5.0

4.1 Training compliance

NLAG is on track to achieve the 90% compliance for MIS year six, all managers are informed of any non-attendance.

Safety action 8 (SA8) identifies that 90% attendance in each relevant staff group should attend:

1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal Life Support Training

NOTE: This is an annual rolling total and 90% must be achieved by 30th of November 2024.

Fetal Monitoring – JUNE 2024 (Incorporating K2 Competency Assessments - Intelligent Intermittent Auscultation, Antenatal CTG Intrapartum CTG, Human factors).			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	100%	88%	94%
Other medical staff on obs rota	94%	87%	91%
Midwives	94%	97%	95%
TOTAL	**95%**		

PROMPT – JUNE 2024 To include Live Skills Drills (Shoulder Dystocia, cord prolapse, APH, PPH, Eclampsia, vaginal breech), Sepsis, Deteriorating Patient.			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Obs consultants & SAS grade doctors	100%	88%	94%
Other medical staff on obs rota	88%	80%	84%
Midwives	98%	93%	96%
Midwifery Support Workers	94%	78%	88%
Anaesthetic consultant	92%	100%	96%
Anaesthetic staff on Obs rota	100%	83%	91%
TOTAL	**93%**		

Neonatal Resuscitation – JUNE 2024			
Staff Group	**DPOW**	**SGH**	**Trustwide**
Neonatal/paediatric consultants / SAS grade doctors	78%	100%	88%
Neonatal/paediatric junior doctors	83%	100%	93%
Neonatal nursing staff / senior nurses	71%	95%	80%
Advanced neonatal nurse practitioners	-	-	100%
Midwives	98%	94%	96%
TOTAL	**93%**		

Safeguarding Adults Training Compliance

The CQC review of maternity services at Goole Hospital identified that midwives were not compliant with the requirement for Level 3 Safeguarding Adults training. October 2024 is the target for 100% compliance. As the table below demonstrates there are currently very low levels of compliance with Level 3 Safeguarding Adults training due to the increase numbers of staff required to complete this training.

	% of Midwives July 2024
Level 2	86.18%
Level 3	36%

The predicted trajectory if compliance by November is currently 70% which falls short of the October due date.

Actions:

- Review staff booked to attend the two sessions in September. Offer additional hours to complete outside of contracted time.
- Identify opportunities for October training dates and urgently allocate staff before roster completion.
- Opportunity to complete e-learning and a workbook to achieve compliance is being explore, which again staff will be requested to do as paid additional hours outside of contracted time.
- Agenda item on weekly manager's meeting.
- Report item monthly to Maternity Assurance Group for oversight.

Item 5: Learning lessons

5.1 Maternity & Newborn Safety Investigation cases

MNSI number	Qualify for EN? If Yes, include reference	Have the family received notification of role of MNSI/EN?	Compliant with Duty of candour?	Details/update
None open				

5.2 Detail of incidents graded moderate or above and rapid reviews

No moderate or above in June, however one rapid review with learning identified.

Incident number and detail	Obstetric/ Neonatal	Grading (Moderate or above, cases considered at PSRP, AARs, PSII)	Learning/action taken/update
322974-Meconium aspiration, thin meconium until delivery. Baby transferred out however baby quickly returned to the unit with no intervention	Both	Low	Having epidural at the time of the ward round therefore did not get reviewed at the time and did not return to review. Learning on the safety huddles Hyperstimulation not recognised and actioned – CTG workshop using this case for learning

5.3 Key themes and trends

Theme/trend	Additional actions being taken
In utero transfers	IUT policy being embedded into practice. Proforma now being used which will be discussed and analysed by matrons to identify and potential missed opportunities for acceptance. Some incidents received for incomplete or no handover from other units. Those have been sent for their investigation and feedback

5.4 MBRRACE-UK perinatal mortality surveillance UK perinatal deaths of babies born in 2022

The MBRRACE-UK Perinatal Mortality Surveillance Report is in its tenth addition. The report focuses on births from 24 completed weeks of gestational age but also includes information on mortality between 23-23 weeks. Stillbirth rates of babies born to mothers in the least deprived quintile increased and there was a slight decrease in the stillbirth rates to mothers living in the most deprived quintile. Neonatal mortality rates, however, for babies born to mothers from the most deprived areas increased for the second year and now twice that of babies born to mothers from the least deprived areas. A full bench-marking of the report will shortly be undertaken across the group and relevant updates shared.

Key messages

- Extended perinatal mortality rates decreased across the UK in 2022 (UK extended perinatal mortality rate: 5.04 per 1,000 total births) after a rise in 2021, although rates remain higher than both 2019 and 2020.
- Compared with rates in 2021, stillbirth rates per 1,000 total births in 2022 were lower across all the devolved nations except Scotland, where there was a small increase: 3.35 (UK); 3.33 (England); 3.31 (Scotland); 3.63 (Wales); and 3.49 (Northern Ireland).
- There were increases in the neonatal mortality rate per 1,000 live births in England and Wales compared with 2021: 1.69 (UK); 1.67 (England); 1.59 (Scotland); 1.91 (Wales); and 2.29 (Northern Ireland).
- Stabilised & adjusted stillbirth rates in 2022 showed much more limited variation than in the years 2020 and 2021, with all Trusts and Health Boards having a stabilised & adjusted stillbirth rate within 5% of their comparator group average.
- Stabilised & adjusted neonatal mortality rates continued to show wide variation, with just 21.5% of Trusts and Health Boards falling within 5% of their comparator group average.
- After the exclusion of deaths due to congenital anomalies, 26.8% of Trusts and Health Boards had a stabilised & adjusted neonatal mortality rate within 5% of their comparator group average.

Local Context

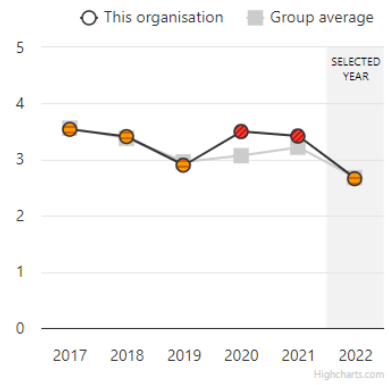
As demonstrated by the graphs below the stillbirth rate (2.66/1000 versus 2.88%) for NLAG is within 5% of the respective comparator group (effectively average), however neonatal deaths (1.24/1000 versus 1.05/1000)) and extended perinatal mortality is (3.94/1000 versus 3.73/1000) over 5% higher than comparator organisations.

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Comparator group: 2,000-3,999 births | Country: England | Neonatal network: Yorkshire & Humber | Region: North East and Yorkshire

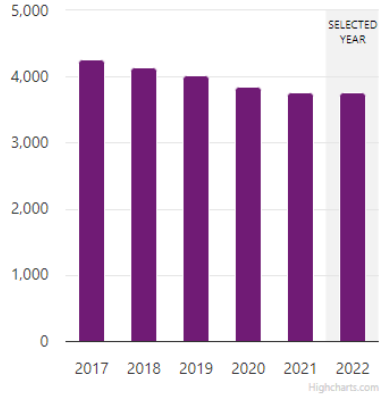
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



Births, by year

Total number of births

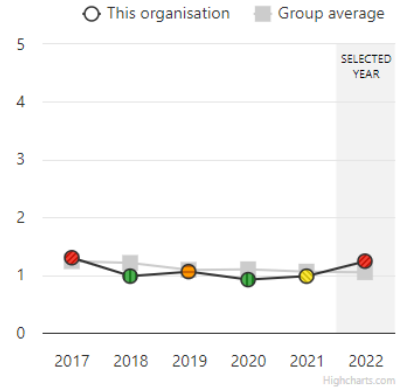


Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Comparator group: 2,000-3,999 births | Country: England | Neonatal network: Yorkshire & Humber | Region: North East and Yorkshire

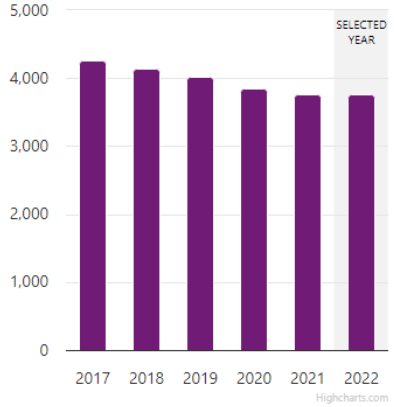
Mortality rates, by year

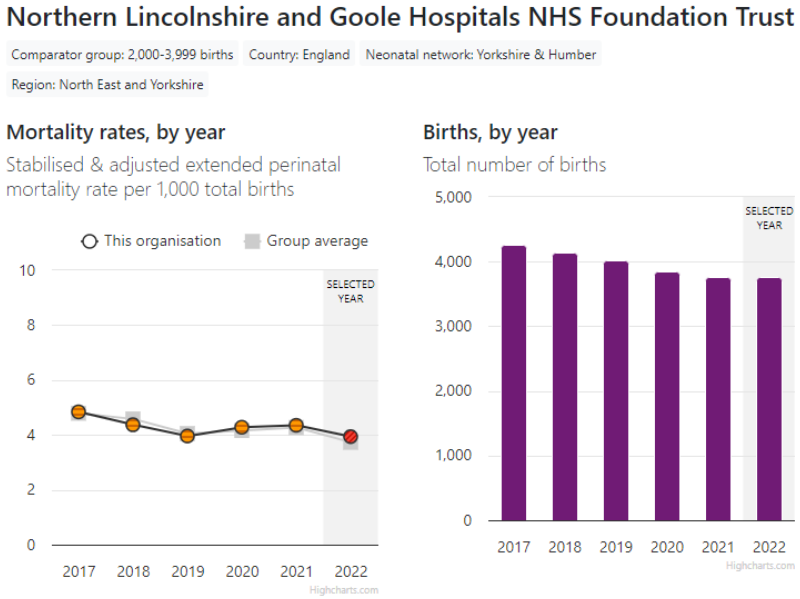
Stabilised & adjusted neonatal mortality rate per 1,000 live births



Births, by year

Total number of births





Current Performance

To allow up to date monitoring of current performance and outcomes the tables have been developed and provide a breakdown of stillbirths and neonatal deaths among the 3,653 babies born within the Trust and for each hospital (SGH and DPOW) between June 2023 to May 2024.

The calculations below are determined by using the MBRRACE-UK formaulae (detailed in the table below) used in national reporting.

Formulae applied	Current performance

*No. of stillbirth deaths / total live births x 1000	4.4
**No. of neonatal deaths / total live births x 1000	2.7
***No. of perinatal deaths / total live births x 1000	6.8

Aligned to review of Neonatal deaths requested at the last Quality & Safety Committee and in view of the findings of this report, a snapshot review of Neonatal deaths from June 2023- June 2024 was completed and is detailed below.

Neonatal Deaths June 2023- 2024

8 Neonatal Deaths identified

None met criteria for MNSI referral

2 were declared as After Action Reviews

None were declared as PSIIs.

- Significant learning identified with the care of an extremely premature neonate. (Case 91144)
- Identification and escalation of high-risk pregnancies from triage to the Labour Ward. This was a twin pregnancy with a preterm SROM. (Case 91196)
- BAPM 7/Periprem not completed- confusion with respect of the care of the extremely premature neonate - not embedded as a process at the time of the two incidents in January (2 cases)
- Labour progress not documented on a partogram (2 cases)
- Poor documentation by the neonatal team (2 cases)
- of the 8 cases are related to abnormality included one concealed pregnancy

Item 6: Listening to our families

6.1 Co-production going forward

A co-production workshop focused on maternity and neonatal care will occur in September to brings together a diverse group of stakeholders, including service users, healthcare providers, community representatives, and policymakers, to collaboratively develop actionable strategies for the governance and management of co-production and feedback. The intended outcome of the workshop is a set of concrete action plans, co-created by the group, that are designed to address identified issues and enhance delivery of the identified improvements. By agreeing a terms of references for the management of these action plans along with a sustained commitment, continuous service-user led improvements can occur.

Item 7:Workforce and Listening to our staff

7.1 Workforce

Vacancy Rate

Site	Midwives
DPOW	9.1 WTE 10%
SGH	8.5 WTE 12.9%

12.1 WTE newly qualified are due to commence in post in the Autumn which will leave a vacancy rate of 5.5 WTE cross-site.

7.2 Staff Feedback and Initial Actions

2023 Staff survey results are presented below and indicate areas for improvement. Time is needed to dedicate to a review of the Staff Survey and to develop meaningful actions. Initial ideas are detailed below:

- Engagement sessions capturing the staff survey and the SCORE survey responses
- Promote completion of 2024 Staff Survey
- Quad walkarounds and meet and greets
- Quarterly ‘ask the quad’
- High levels of engagement with the workforce form the quad members in new posts.
- Exit interviews are offered to all employees and results collated to learn from trends and themes

Speciality	We are compassionate and inclusive score	We are recognised and rewarded score	We each have a voice that counts score	We are safe and healthy score	We are always learning score	We work flexibly score	We are a team score	Staff Engagement Score	Morale score
208 L4 DPOW Maternity	7.3	5.5	6.7	5.4	5.8	5.2	6.5	6.9	5.5
208 L4 DPOW Neonatal Care	7.1	5.2	6.6	5.4	5.5	4.5	6.7	6.7	5.2
208 L4 S&G Maternity	7.1	5.7	6.0	5.0	5.0	5.2	6.7	6.2	4.9
208 L4 SGH Neonatal Care	7.7	6.1	7.1	6.7	5.7	5.6	6.9	7.2	6.3
208 L4 Women & Childrens Services Central	7.0	6.1	7.0	5.8	5.7	6.1	6.2	7.4	5.7

7.3 SCORE survey

Initial meetings have commenced with key leaders prior to the SCORE survey feedback.

NHS
Humber Health
Partnership

FAMILY SERVICES DIVISION

Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - MIS Year 6, Safety Action 1

National Perinatal Mortality Review Tool (PMRT) Quarterly Report (Quarter 1 2024/25)

Yvonne McGrath
Group Director of Midwifery– Family Services Care Group

July 2024

Working in partnership:
Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

United by Compassion:
Driving for Excellence

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Trust Board and Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

1.2 MIS YEAR 6 NOTIFCATION REQUIREMENTS:

The following deaths should be reviewed to meet safety action one standards:

- All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- All stillbirths (from 24+0 weeks' gestation)
- Neonatal death (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available) (up to 28 days after birth)

2. STANDARDS

A report has been received by the Trust Executive Board each quarter from XX that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	**Standard**
a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	**100%**
b) All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**95%**
c.i) Multi-disciplinary PMRT reviews should be started within two months of the death.	**95%**
c.ii) A multidisciplinary PMRT should be completed within six months of the death of a baby.	**60%**
d) Quarterly reports should be submitted to the Trust Board to include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

3. SUMMARY

3.1 Eligible Incidents in MIS Year Six (Appendix A)

There has been a total of 12 incidents reported to MBRRACE-UK via the PMRT during MIS year six. 5 in Quarter 4 (01 January – 31 March 2024) in 7 in Quarter 1 (01 April – 30 June 2024). 5 cases were reported to MBRRACE but were for notification only and therefore not eligible for further measurement against CNST standards or review.

0 cases have met the threshold for referral to the Maternity and Neonatal Safety Investigation (MNSI).

No concerns have been raised with the notification submission and the current reporting process is to continue.

3.2 Summary of all incidents reviewed through PMRT in Quarter 1 2024/25 (Appendix B)

There have been 5 incident reviewed through the PMRT process. This is broken down into the care provided to the mother before the death of the baby and the care of the mother after the death of the baby. However, it should be acknowledged that reporting relates to incidents that occurred during January and March 2024 due to the lag in the review and reporting process.

<u>Grading of care provided to the mother before the death of the baby</u>

- 0 cases had no issues identified that would have had an impact on the outcome.
- 3 cases had issues identified that would have had no impact on the outcome
- 2 cases had issues that may have had a difference to the outcome.

<u>Grading of care provided to the mother after the death of the baby</u>

- 2 cases had no issues identified that would have had an impact on the outcome
- 3 cases had issues identified that would not have had an impact on the outcome

3.3 CNST Compliance as per MIS Year 6 Standards (Appendix C)

12/12 (100%) are currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning Points and Key Themes (Appendix D)

Learning and progress against actions are included in appendix D.

4. Saving Babies' Lives (Appendix E)

To comply with safety action 6 of the MIS the Trust must demonstrate implementation of all elements of the Saving Babies' Lives Care Bundle Version Three by the 01 March 2024. The care bundle was published in July 2023 with the overall aim of providing evidence-based best practice for providers across England to reduce perinatal mortality rates. To declare compliance, the PMRT tool should be used to calculate the percentage of cases where the following were identified as a relevant issue:

- Identification and management of fetal growth restriction (FGR) was a relevant issue
- Issues associated with reduced fetal movement (RFM) management
- Identification of cases of severe brain injury where issues were associated with failures of intrapartum monitoring as a contributory factor
- The prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.

Details of the cases that meet the above criteria are provided in appendix E.

Appendix A – Summary of all Eligible Incidents Reported in MIS Year 6 (n=12)

	Reason for entry to PMRT	Gestation (weeks)	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q1	Neonatal death	29+0	2100	Unbooked	DPOW	DPOW	Yet to be sought	No	Yes	Yes	N/A – post qualifying date
	Antepartum stillbirth	29+2	560	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	N/A – post qualifying date
	Neonatal death	36+2	2300	SGH	SGH	SGH	Yet to be sought	No	Yes	Yes	Not yet met
	Antepartum stillbirth	30+0	1900	Unbooked	DPOW	DPOW	Yet to be sought	No	Yes	Yes	Not yet met
	Antepartum stillbirth	25+2	1290	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet met
	Neonatal death	23+3	532	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Not yet met
	Antepartum stillbirth	39+4	3112	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	Neonatal death	27+4	1230	SGH	SGH	SGH	Yes	No	Yes	No	Met
	Antepartum stillbirth	22+3	558	DPOW	DPOW	DPOW	Yes	No	Yes	Yes	Met
	Antepartum stillbirth	25+0	1790	SGH	SGH	SGH	Yes	No	Yes	Yes	Met

	Reason for entry to PMRT	Gestation (weeks)	Weight (g)	Location of booking	Location of Delivery	Location of Death	Parents involved	MNSI Case	MBRRACE notified < 7 days	Review started < 2mth	Review Publish < 6mth
Q1	Neonatal death	26+4	910	SGH	SGH	SGH	Yes	No	Yes	Yes	Met
	Neonatal death	22+5	510	SGH	SGH	SGH	Yes	No	Yes	Yes	Met

Appendix B – Summary of all incidents reviewed in Q1 of 2024/2025

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91639 Antepartum stillbirth 25 weeks	Complex cardiac anomaly, ventriculomegaly. Contributory factor of pre-eclampsia, possible marginal abruption.	The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	Mother had poor/no English and arrangements other than an interpreter were made during her labour and birth. Chromosome analysis of the baby was not carried out. Infection screening of the mother and baby was not carried out. This mother only had partial investigations for underlying metabolic and/or haematological Abnormalities.	For discussion of this case at Coordinators meeting about appropriate allocation and support for agency midwives. For discussion at managers meeting, quarterly PMRT meeting and for inclusion on PMRT Newsletter.
91144 Neonatal death 22+5 weeks	Extreme prematurity.	Up to birth: the review group identified care issues which they considered may have made a difference to the outcome for the baby. From birth to death: the review group identified care issues which they considered may have made a difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	This mother was in preterm labour/threatened preterm labour but was not offered: • antenatal steroids when indicated. • antibiotics when indicated. • magnesium sulphate for fetal neuroprotection when indicated. This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately. Senior staff were needed at the time this mother was giving birth, they were called but didn't arrive. The fetal heart monitoring in established labour was not carried out correctly.	Conflict of Opinion Guideline to be redistributed and communicated to staff. Neonatal Lead to provide further training and roles/responsibilities regarding care of extreme prematurity. Further training to be given with regards DCG303 Care of the Extreme Premature Neonate. Care of the Extreme Premature Neonate Guideline to be updated. Learning to be included on the PMRT Newsletter. Spot checks for completion of equipment checklists.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91144 Neonatal death 22+5 weeks			The interpretation of the fetal heart rate monitoring in established labour was not correct. Neonatal staff were predicted to be required but all staff of an appropriate seniority did not attend. During the resuscitation of the baby positive pressure respiratory support was required but it was not administered appropriately. The notes relating to the resuscitation of the baby were inadequate and so it is not possible to fully assess the quality of the resuscitation. Positive pressure respiratory support ir oxygen was required but a saturation monitor was not used to assess the baby's oxygen saturation. It is not possible to assess from the notes whether surfactant was indicated and given appropriately during the resuscitation of the baby. It is not possible to assess from the notes whether chest compressions were indicated and administered appropriately during the resuscitation of the baby. During the stabilisation of the baby the stabilisation/support was not carried out appropriately. The baby should have been admitted to the neonatal unit sooner.	

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91144 Neonatal death 22+5 weeks			The respiratory management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate. The management of pain and sedation of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate. The decision to offer re-orientation of care for the baby could have been considered sooner. It is not possible to assess from the notes whether appropriately trained staff were involved in moving the baby to the neonatal unit. Not all the equipment needed to move the baby to the neonatal unit was available. Although indicated this mother was not offered further postnatal investigations for herself and/or her baby. It is not possible to tell from the notes if the parents were provided with written support information around emotional issue before they left hospital.	

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91196 Neonatal death 26 weeks	Extreme prematurity, RDS bilateral IVH, traumatic birth with associated bruising.	Up to birth: the review group identified care issues which they considered may have made a difference to the outcome for the baby. From birth to death: the review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group concluded there were no issues with care identified for the mother following the death of her baby.	This mother had preterm labour or had preterm pre-labour rupture of membranes during her pregnancy which was not managed according to national or local guidelines. This mother's risk status during labour was not assessed during her labour. This mother had pregnancy complications but they were not recognised as requiring specific birth planning advice. This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs. This mother was in preterm labour/threatened preterm labour but was not offered: • antenatal steroids when indicated. • antibiotics when indicated. • magnesium sulphate for fetal neuroprotection when indicated. Type of fetal monitoring in labour was not appropriate. The fetal heart monitoring in the latent phase of labour was not carried out correctly. It was not possible to tell from the documentation if the interpretation of the fetal heart rate monitoring in the latent phase of labour was correct. The interpretation of the fetal heart rate monitoring in established labour was not correct.	For presentation at PMRT Quarterly and Safety Bulletin to focus on IUT criteria. All triage documentation, Antenatal CTG and PROM Guidelines to be updated to include need for CTG from 26 weeks gestation. For inclusion on the PMRT Newsletter.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
91196 Neonatal death 26 weeks			During this mothers' labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out. This mother's progress in labour was not monitored on a partogram.	
92441 Antepartum stillbirth 37 weeks	Acute hypoxic ischaemic mode of demise, secondary to pathological small placenta	The review group identified care issues which they considered would have made no difference to the outcome for the baby. The review group identified care issues which they considered would have made no difference to the outcome for the mother.	There is no evidence in the notes that this mother was asked about domestic abuse at booking. Although indicated this mother was not offered a Kleihauer test.	Statistics to be shared at the Managers meeting and Community meetings. For inclusion on this week's huddle and for discussion with coordinators at each shift.
92515 Neonatal death 27 weeks	Anencephaly	Up to birth: the review group identified care issues which they considered may have made no difference to the outcome for the baby. From birth to death: the review group that there were no issues with care identified from birth up to the point that the baby died. The review group concluded there were no issues with care identified for the mother following the death of her baby.	This mother lives with family members who smoke but they were not offered referral to smoking cessation services. Induction or elective delivery was indicated but the timing of the induction/elective delivery was not appropriate for 'other' reasons. This mother had had a caesarean section previously but her birth options for this pregnancy were not discussed with her during the antenatal period. This mother had an operative delivery but this was not carried out with appropriate urgency.	For inclusion on the PMRT newsletter and to explore inclusion on Badgernet for the future. For discussion at the quarterly PMRT meeting. Update the Neonatal Death Cherished Pathway.

Case	Cause of Death	Grading of Care	Issues Identified	Actions
92515 Neonatal death 27 weeks			It is not possible to assess from the notes whether options for organ donation were considered and discussed with the parents as part of the end of life care for their baby.	

Appendix C – Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days.	100%	6/6 (100%)	6/6 (100%)	-	-	
All parents have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	6/6 (100%)	2/2 (100%) 4 – not yet met (in process)	-	-	
Multi-disciplinary reviews should be started within two months of the death.	95%	*5/6 (83%)	6/6 (100%)	-	-	
Multi-disciplinary reviews should be published within six months of the death.	60%	6/6 (100%)	6 – not yet met (first deadline 17/10/24)	-	-	
Quarterly reports should be submitted to the Trust Executive Board.	100%	Submitted May 2024	Submitted August 2024	-	-	

NHS Resolution - change to the verification period

The year 6 scheme in relation to SA1 is for deaths from the 8th of December 2023 but this was not announced until the 2nd of April 2024 and the supporting downloadable reports were not fully available until mid-May. In view of this, the verification of Safety Action 1 will exclude notifications, SA1a), and the review started standard under SA1 c) for deaths between the 8th of December 2023 and the 1st of April 2024.

*Due to the above change the non-compliant case detailed in Q4 will not affect overall compliance due to the death occurring in March 2024.

Appendix D: Learning Points and Key Themes:

The following key learning points from **Q4** PMRT reviews have been shared with staff via safety bulletins:

- Risk assessments must be completed and documented during antenatal, intrapartum and postnatal periods.
- Please follow the cherished pathways to ensure all the investigations are completed. These are necessary to aid with identifying potential causes of IUD.
- It is important to document that information regarding RFM has been given. Without this, we cannot be certain this has happened.
- All those who have an IUD, regardless of blood group should be offered a Kleihauer test. This aids the investigations to determine potential causes for IUD.
- CO monitoring should always be completed and documented at each antenatal appointment.
- Assessment for aspirin should be completed for all pregnant people.
- When on a scan pathway, scans should be performed 3-4 weekly and this should not be exceeded.
- Maternal observations and the partogram should always be completed.
- Neonatal alerts should be sent for those on nerve pain medications.
- Cherished Care Pathways should always be completed to know exactly what care has been provided.

Key themes identified from **Q1** cases PMRT reviews are as follows:

- The mother's risk status was not assessed at the onset / during the course of labour
- Mother's progress not monitored on a partogram
- Pre-term perinatal optimisation not sufficient.

Action to be taken in response to the issues identified are detailed in appendix C.

Appendix E: Summary of Saving Babies' Lives Interventions:

SBL intervention	Indicator / contributing factors	Number of cases identified				
		Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 July – Sep 24	Q3 Oct – Dec 24	Total
Element 2.8	Stillbirths which had issues associated with fetal growth restriction management.	1/4 (25%)	0/5 (0%)	-	-	**1/9 (11%)**
Element 3.2c	Stillbirths which had issues associated with reduced fetal movement management.	1/4 (25%)	0/5 (0%)	-	-	**1/9 (11%)**
Element 4.3d	Stillbirths, early neonatal deaths and cases of severe brain injury which had issues associated with failures of intrapartum monitoring identified as a contributory factor.	0/4 (0%)	0/5 (0%)	-	-	**0/9 (0%)**
Element 5.2k	cases where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0/4 (0%)	2/5 (40%)	-	-	**2/9 (22%)**

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)139

Name of the Meeting	Trust Boards-in-Common (meeting held in Public)
Date of the Meeting	08 August 2024
Director Lead	Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Neil Rogers, Site Managing Director (North bank)
Title of the Report	Audiology Services CQC Response
Executive Summary	The Care Quality Commission (CQC) have written to all Trusts that provide Audiology services seeking answers to five key areas of enquiry: • Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made. • Whether you are working towards IQIPS accreditation. • What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about. • The expected timeline for gaining accreditation. • The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support. The response and supporting information has been reported to the Group Cabinet, and will be reported through Trust Board following this Quality and Safety Committees-in-common report and their consideration. The NLAG Paediatric Audiology service has been the subject of a serious incident cluster of cases where children have been identified with delayed diagnosis of hearing loss and sub-optimal management, through both the audiology and community paediatric hearing services. The British Academy of Audiology have undertaken a service review and external support from specialist audiologists continue to support the head of department since they were appointed 9 months ago. The HUTH Audiology team are IQIPS accredited and have a responsive action plan to the national NHS England review of paediatric audiology services, referred to by the CQC in their request. Both North and South bank teams are part of the Head and Neck Care Group as part of the new operational management structure. The papers provided for this paper include the Group response to the lines of enquiry and the following appendices: a. Improving Quality in Physiological Sciences (IQIPS) Gap analysis for NLAG b. IQIPS standards for accreditation c. HUTH Action tracker for Audiology Performance & Governance Group ○ HUTH Action tracker embedded documents (for reference) d. NLAG Action plan in response to the British Academy of Audiology Review.

	The Committee is asked to review the response to the CQC with supporting information for assurance on the management and governance of the audiology departments.
Background Information and/or Supporting Document(s) (if applicable)	The report also provides information about the NLAG Serious Incident investigation, external review and proposed group approach to audiology moving forward.
Prior Approval Process	Group Cabinet and Quality and Safety Committees-in-Common meeting on 27 June 2024.
Financial implication(s) (if applicable)	None currently
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

NHS Humber Health Partnership

Head and Neck Care Group

Audiology Services CQC Response - Briefing Paper

1. Purpose of Paper

The purpose of this paper is to provide an update for the Exec Cabinet in relation to Audiology services at Hull University Teaching Hospitals NHS Trust (HUTH) and North Lincolnshire and Goole NHS Foundation Trust (NLAG) and their progress in relation to achieving the UKAS Improving Quality in Physiological Services Accreditation (IQIPs).

2. Background

In December 2021 an expert review undertaken by NHS Lothian in Scotland found multiple failings in the standard of Paediatric Audiology services that resulted in delayed identification and missed treatment of children with hearing loss, which resulted in permanent avoidable deafness for some children.

As a result of the NHS Lothian review, similar reviews were undertaken which found four Hospital Trusts in England had similar failings, one of which was NLAG. As a result of these findings and wider concerns in relation to the quality of Paediatric Hearing Services an Improvement Programme has been established by NHS England to support providers and Integrated Care Boards (ICBs) to improve the quality of these services.

As part of this work the Care Quality Commission (CQC) are working closely with NHS England to help understand the current situation across the country regarding the level of assurance Trust boards have in relation to the quality of hearing services for children that they commission or provide.

3. Care Quality Commission - Key Lines of Enquiry

The section below details the five key lines of enquiry that were specifically mentioned in the letter received from the CQC by the Trust on the 8th April 2024 and sets out the position for Audiology services at both NLAG and HUTH.

3.1 Whether you have achieved IQIPs accreditation, including whether there were any improvement recommendations made:

NLAG - Audiology services at NLAG are not currently IQIPs accredited for either Adult or Paediatric Audiology.

HUTH - Audiology services at HUTH are IQIPs accredited for Adult Audiology but not for Paediatric Audiology.

The Adult component of the hearing aid service at HUTH successfully achieved IQIPs accreditation in 2017. This accreditation has been maintained over subsequent years, this includes being one of the first services in the country to successfully transition to the new standard (IQIPS Standard v2, 2020).

3.2 Whether you are working towards IQIPs accreditation:
NLAG **-** Yes, the Audiology service at NLAG is currently working towards achieving IQIPs accreditation for both Adult and Paediatric services.

HUTH - Yes, the Audiology service at HUTH is currently working towards achieving IQIPs accreditation for Paediatric services.

3.3 What stage that work has reached and the assurance the board has about paediatric audiology using the IQIPS standards as a guidance for the areas to tell us about:
NLAG **-** The Audiology service at NLAG have completed the IQIPS gap analysis tool and this assessment is attached at Appendix A. The results from this gap analysis assessment demonstrate the following level of progress against the 178 elements contained within the domains that are needed to achieve IQIPs accreditation. Currently the service believes it is: -

Compliant with 66 elements (green)
Partially meet 39 elements (amber)
Does not meet 69 elements (red)
With a further 4 elements not applicable to the service

HUTH - The Audiology service at HUTH has not completed a gap analysis tool assessment because it has already achieved the standards required for Adult Audiology services. However, the service has assessed its current position in relation to required standards to achieve accreditation for the Paediatric element of the service.

IQIPs standard v2 includes five domains which are used for quality assurance, these are attached at Appendix B for information. The existing quality management system (QMS) within the HUTH service will need to be augmented to include all functions of Paediatric Audiology referenced against the British Audiology Academy (BAA) Quality Standards in Paediatric Audiology, 2022. This work will also need to be documented within the departmental Audiology Quality Manual. The service has the advantage of being able to submit this information within a well-defined pre-existing structure.

Domains
1. Leadership and Management domain
Most of the systems needed to demonstrate compliance are documented by the service, although further paediatric pathways and documents will need to be added. A departmental Audit plan needs to be agreed and delivered and informatics will need to report DM01 for paediatrics. The service currently has an unmanageable cohort of over 300 diagnostic breaches and it is highly likely that this position would prohibit successful IQIPs accreditation and will need to be addressed.

2. Clinical domain
Clinical documentation needs to be strengthened, this includes SOPs, pathways into and out of Paediatric Audiology to be agreed and embedded within the team and with stakeholders.

3. Patient/Client Experience domain
An annual user survey needs to be completed together with a Paediatric family friendly test. Many of the systems needed for this domain are already used by the Adult service and can be

replicated relatively easily for Paediatrics.

4. Safety and Risk Management domain
Systems are already in place to cover this domain, although a number of these will need to be documented for Paediatrics within the service's quality manual.

5. Facilities and Resources domain
Whilst present facilities are regarded as appropriate, they are not available in sufficient volume for the number of clinics required and in addition to this the Hull location is not central which affects attendance and prevents/limits equitable access to the service. It will not be possible to achieve FR1 (The healthcare provider must manage facilities and environment to support service delivery) of the IQIPs standard without resolving the lack of accommodation needed to deliver a timely Paediatric service. In addition to this robust workforce plans are needed to assure succession for retirements expected in 2025 along with the associated funding. Equipment and calibration is covered by quality systems shared with the Adult service and should therefore present no challenges.

3.4 The expected timeline for gaining accreditation:
NLAG **-** The service forecasts that it will take 2-3 years in order to complete the necessary actions to gain IQIPs accreditation for both Adult and Paediatric services.

HUTH - The service forecasts that it will take between 1-2 years in order to complete the necessary actions to gain IQIPs accreditation for Paediatric services.

3.5 The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support:
NLAG **-** 64 children have been identified as suffering detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support. These cases were identified as part of a nationally declared incident and are being managed as such. Unfortunately, it is likely that this number could increase further as more children are reviewed as part of the on-going investigation. 28 of these cases were due to babies not being corrected correctly with Auditory Brainstem Response (ABR) testing within the Audiology department. The remaining 36 cases were from the community paediatrician led service where hearing loss was not diagnosed correctly, not managed or treated correctly or a combination of both in some cases.

HUTH **-** Diagnostic and follow up care waiting lists are reviewed on a weekly basis by the senior Audiologists within the service. Waiting lists are prioritised to enable children where there is a high level of concern regarding hearing to be seen sooner. In addition to this, waiting lists are also prioritised so that younger children (0-5 years of age) receive formative adjustments to their hearing aids to promote speech and language development. Despite the best efforts of the service a number of children within this category have missed their review by 3-6 months. This is not an oversight by the service but an inability to provide the necessary capacity to see all children in a timely manner due to difficulties in recruiting appropriately trained staff and a lack of access to the appropriate accommodation needed to test this age group. The level of detriment is difficult to quantify but from an Audiologist and parental perspective it is a concern and remains a high level risk for the service.

4. Barriers to achieving IQIPs accreditation

In order for the Audiology services at both HUTH and NLAG to be able to deliver services with the necessary standards to achieve IQIPs accreditation two key (and long standing) issues need to be addressed. In order to address both issues, the services require support from both the Group Executive and ICB level to drive the required change across the system.

A summary of these two challenges are as follows: -

4.1 Accommodation

By far the greatest risk to achievement of IQIPs accreditation for both NLAG and HUTH is the poor quality of the physical environment that the Audiology services have at their disposal to see Paediatric patients.

At NLAG there are multiple issues relating to the environment including inadequate sound proofing, inadequate ventilation, a lack of facilities for children with additional needs and no suitable facilities to undertake ABR testing properly.

At HUTH access for Paediatric patients is severely limited by a lack of appropriate specialist accommodation which stems back to the loss of the Paediatric Audiology suite at the Children's Centre on Walker Street in Hull following the floods in 2013. The issue was further compounded by the loss of what was deemed 'appropriate' accommodation at HRI in 2020. This has left the service short of specialist accommodation for 5.5 clinical sessions each week which has contributed to growing waiting lists and challenges meeting the required time frames for patient reviews. Multiple efforts to secure alternative accommodation and funding have proved fruitless and there is currently no accommodation plan to avoid the continued service failure or the prospect of being able to successfully achieve IQIPs accreditation.

The pressing need for remedial accommodation options for both services needs to be urgently recognised, agreed and resourced by the Group, the ICB and local health communities in order to deliver the necessary standard of accommodation to meet the levels required for IQIPs accreditation.

4.2 Workforce

Nationally, recruitment of specially trained Paediatric Audiologists is extremely challenging. Trying to attract the highly skilled staff to Hull, the East Riding of Yorkshire and North Lincolnshire to deliver the required level of service with its geographical isolation and cultural demography is a tall order and despite multiple attempts both services find this a barrier to securing accreditation.

Robust workforce plans are being developed, including plans for pending retirements and 'growing our own' workforce internally. However, these plans need to be supported with the necessary funding that enables the services to right size capacity in order to meet current demand. This will mean that the services are able to deliver on the nationally set timescales for patient reviews and therefore achieve delivery of a safe service.

5. Next Steps

Both services are developing action plans aligned to the key domains required for securing IQIPs accreditation. HUTH have developed a Paediatric specific action plan which is attached at

Appendix C. This action plan is currently in draft format and will be endorsed at the next specialty governance meeting in June. NLAG are utilising the gap analysis tool (Appendix C) and the BAA recommendations following an external review as part of the serious incident process and this is attached at Appendix D. The key actions from these two documents will be combined to create one overarching action plan that the service is signed up to and committed to delivering.

The focus over the next 18 months or so will be securing positive progress against delivery of these actions supported by the Head and Neck Care Group triumvirate and the British Academy of Audiology (BAA). These action plans will form part of the core business of the departments going forward and will be both internally and externally challenged to ensure compliance with the necessary standards. A robust governance process will be critical in achieving a successful outcome with any accreditation applications.

The clinical leads for both departments are committed to driving forward the necessary changes in order to delivery IQIPs accreditation for Adult and Paediatric Services across the Group. Opportunities exist to work on this together sharing documentation, pathways, best practice and resources with the aim of delivering unified high quality services. With the establishment of the new Head and Neck Care Group this is something that the services are keen to build on which can only result in stronger services going forward and ultimately achievement of accreditation for both Paediatrics and Adult Audiology services within the next two years.

A number of organisations who have successfully delivered IQIPs accreditation have recruited a dedicated Quality Manager to support the clinical leads in delivery of the sizable workload. It would be worth considering a fixed term joint post across HUTH and NLAG to support the on-going IQIPs work programme.

As detailed in section 4 above, throughout this process support will be required from the organisation, the Group Executive team and the wider ICB. Support in unlocking the long standing specialist accommodation issues is a vital part of this process and cannot be understated. Alongside this there will be the need for financial investment in staffing and equipment to ensure that the services are fit for purpose and able to deal with the ever increasing demands. Without this support the services along will only be able to progress the accreditation process so far.

May 2024

IQIPS v 2.1 2023 GAP ANALYSIS REQUIREMENTS

1. Introduction

Any Physiological Sciences Service(s) wishing to gain UKAS accreditation will need to demonstrate compliance against the requirements of the Improving Quality in Physiological Sciences (IQIPS) Standard:2023.

The accreditation standard is split into domains, which cover leadership and management, clinical, facilities, resource and workforce, safety and risk and patient experience requirements. If an organisation is looking to cover multiple disciplines the majority of management system requirements will be the same and can be managed centrally.

A copy of the IQIPS Standard:2023 v2.1 is available on the UKAS website.

2. Objective

This document is aimed at providing all potential UKAS applicants for the IQIPS scheme with a mechanism to identify gaps between their current documented management system and supporting evidence against the standard requirements.

3. UKAS requirements for applicant IQIPS organisations

Please complete this Gap Analysis form and confirm compliance with each clause. If you are currently compliant, please indicate where in your management system the clause is addressed. If your management system is currently non-compliant please detail what actions you plan to take to address the gap and the associated timescale for completion.

Annex 1

Gap Analysis and Transition Plan

Name of Organisation	Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
Technical Discipline	Audiology
Date of Submission	**20 May 2024**

GAP ANALYSIS

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONSPLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
Leadership & Management					The healthcare provider is or must be part of a legal entity	
Legal entity	LM1				The healthcare provider for specific clinical services can be either autonomous or part of a larger parent organisation. It must where applicable:	
	1.1				Be part of an entity that can be held legally responsible for its activities.	Part of a NHS Trust.
	1.2				Be licensed to operate according to relevant international and UK regulatory frameworks.	Trust will be licensed healthcare organization?
	1.3				Where applicable, be clearly recognised in the published organisational structure of the parent organization.	Now within the Head and Neck care group? Are we named in structure? May need to develop own department evidence.
	1.4				Have clearly documented processes in place to inform	Trust has core values, Audiology does not

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONSPLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
					users, staff, and stakeholders of its purpose and core values (culture). This is normally defined and published as a mission, vision and values statement.	have a mission statement/values, one needs to be developed.
Governance including Roles & Responsibilities	LM2				The healthcare provider must deliver clearly defined clinical service(s) to meet the needs of the target population, whether at static, mobile and/or domiciliary settings. System(s) must ensure, where applicable:	
	2.1				A leadership and management team consisting of individual(s) with defined responsibilities and accountabilities for clinical and professional leadership, advice, budget control and risk management.	Audiology lead and lead for ABR service, site lead for each site in place. Need an adult audiology lead and paediatric audiology lead. Audiology lead has budget responsibility and risk management responsibility within audiology and senior management above have oversight. Will be linked into governance structure of Head & Neck care group.
	2.2				A leadership and management team that is visible, approachable and available to staff.	Audiology Lead and site leads all visible and approachable and staff know how to contact if not on their site.
	2.3				The leadership team identify and document details of individuals with specific roles and responsibilities across the Quality Management System (QMS).	Needs development.
	2.4				All staff have: • An agreed contract of employment; • A current job description/job plan that specifies his/her role, responsibilities, authorities and relationships.	All staff should have a copy of their job description and contract, stating who they report to and are responsible to.
	2.5				All staff understand their specific role and responsibilities, authorities and relationships.	All staff should be aware of the specific role and responsibilities and who to escalate things to or obtain advise.
	2.6				All staff understand the processes in place to manage	Trust HF process/policy. Not sure staff

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONSPLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
					conflicts of interest.	understand this as some staff have in the past recommended a former audiologist to patient as wax removal service.
	2.7				All staff understand how to differentiate and manage feedback and complaints.	Trust has policies on this PALS for example, and records compliments and gifts to the department as per trust policy. For example thankyou card/biscuits/chocolates from a patient.
	2.8				All staff can give feedback and raise matters of concern, in confidence, and without fear of recrimination.	Trust has the speak up guardian, staff are aware of this information is displayed within the departments. They can also speak to a site/lead or Audiology lead if needed.
Quality Policy & Objectives	LM3				The healthcare provider must operate within its quality policy and monitor performance. against measurable quality objectives System(s) must ensure, where applicable:	
	3.1				The leadership team develop, and publish an appropriate quality policy and measurable quality objectives that are regularly reviewed;	Needs to be developed.
	3.2				Agreed local targets and key performance indicators/outcomes for service activities and clinical procedures, in line with local and national targets e.g. outcomes of objectives, equipment breakdown times, staff retention rates, patient/client satisfaction rates, workloads etc;	Needs to be developed.
	3.3				Consistency in performance across the provider's activities with internal and external benchmarking.	Once 3.2 has been developed, will need to record performance inline with what is developed.
QMS	LM4				The healthcare provider must establish, implement, and	

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONSPLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
					maintain a quality management system (QMS) The healthcare provider must establish an appropriate QMS to integrate all agreed processes, monitor their effectiveness and ensure continuous improvement of its service(s). The QMS will:	
	4.1				Be described in a quality manual.	Needs to be developed.
	4.2				Be sufficiently robust to ensure that staff only have access to the latest and current versions of documents.	Some documents need to be written and developed, trust has a process where all current documents are on the Hub for staff to access and it only hold the latest versions. Emails are sent out when documents are getting ready to be updated if no national guidance hasn't been released to update the documents.
	4.3				Ensure availability of supporting documentation to include, but not be limited to: • Processes (ways of working) for all activities; • Pathways and clinical protocols; • Records of resources (staffing, equipment etc) available to support delivery; • Forms in use; • Internal audits; • Publications;	Needs to be developed and written.
	4.4				Be subjected to regular management reviews, at least annually, to include at least the following: • Quality improvement initiatives to include business planning; • Periodic review of referrals received; • Results and outcomes from user feedback and complaints; • Staff and stakeholder consultation and feedback; • Results and outcomes from internal audits;	User feedback is obtained through questionnaires and results discussed in the clinical sciences governance meetings. Internal audits are feedback in department staff meetings. Some equipment is on the risk register and it is

SECTION	CLAUSE	COMPLIANT			EVIDENCE WHICH SUPPORTS COMPLIANCE STATEMENT (e.g. Reference to Procedure/Clause, Reference Material, Reports, agreements, minutes of meetings)	ACTIONSPLANNED TO ADDRESS ANY GAPS (e.g. Update specific Procedure, develop Work Instruction, design/implement quality checks)
		YES	NO	N/A		
					• Risk management reports, and update of risk register; • Reviews conducted by external organisations; • Objectives aligned to local and national performance targets with outcomes of interservice comparison programmes/benchmarking; • Performance of suppliers; • Identification and control of non-conformities; • Follow-up actions from previous management reviews; • Changes to the volume and scope of work including capacity and demand, staffing, premises, equipment consumables and resources;	updated regularly inline with trust guidance. ABR tests are all sent out for extenral peer review. Regional Healthcare Scientist is setting up a process where staff get externally peer reviewed on testing. ABR service monitored nationally through NHSP. Staff levels are inadequate and have not been increased for the transfer of the community paediatric audiology clinics. Inadequate number of rooms at both main sites.
Document control	LM5				The healthcare provider must ensure that documents and records (including clinical records) are controlled System(s) must ensure, where applicable:	
	5.1				Agreed format and media for documents and records.	Trust standard for document layout. Report templates for clinic letters within auditbase.
	5.2				Data is processed, handled, maintained and secured in line with applicable regulation and professional guidance.	Trust guidance followed (IG policy).
	5.3				All documents and records supporting delivery of services are current, reviewed, approved and available.	All documents require review and some writing.
	5.4				All documents and records created and revised contain: • A title; • Unique identifier on each page; • Date of current edition, review, edition number; • Page number to total number of pages; • Authority for issue;	Any documents submitted to the hub after governance approval comply with this. The documents on the hub comply, still a large number of documents need to be written and approved.

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		YES	NO	N/A		
	5.5				Appropriate controls for the identification, collection, indexing, access, storage, maintenance, and amendments of current and obsolete records and documents.	Not sure what happens with out-of-date documents on the hub. Could possibly keep at a department level.
	5.6				Documents and records are protected from unauthorised alterations and where necessary kept confidential.	Documents on the hub cannot be changed. When Documents require review, they are sent to the document owner.
Subcontracting	LM6				**The healthcare provider must establish and review agreements for any outsourcing /subcontracting clinical services. System(s) must ensure, where applicable:**	
	6.1				Specification of the minimum information needed for different types of agreements;	No subcontracting, locum agencies have specific contracts in place.
	6.2				Timely review of all agreements;	These are reviewed before any are renewed.
	6.3				Assurance that the selected sub-contractor is competent to perform the activity for which it has been selected. If not accredited the healthcare provider will need to demonstrate how competency has been established and what criteria were used;	Only using accredited locum agency staff that have been approved to be supplies to the NHS, staff used are all registered and have been vetted by the British Academy of Audiology external review team and the Regional Lead Healthcare Scientist.
	6.4				Maintenance of patient/client confidentiality;	Trust policies are followed and this would be put into any contracts.
	6.5				Monitoring and review of performance against contract requirements, including remedial actions;	Activity of locum staff is monitored with regular meetings held to discuss any issues that arise.
	6.6				Transparency of outsourcing/subcontracting to users and in clinical service outputs	Most recent contract was put out nationaly for the agreed timeframe for other competitors to come forward and express their interest. Not sure this has been communicated to patients.

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		YES	NO	N/A		
						ICB are aware of locum agencies being used for the recall patients.
Advisory Services	LM7				**The healthcare provider must provide competent advisory services System(s) must ensure, where applicable**	
	7.1				Communication to users and stakeholders on the range and choice of clinical procedures currently available, and on emergent practice.	NLAG Audiology website will need updating to show all services we now provide. Any emerging practice developments if of benefit to patients would be communicated to as necessary.
	7.2				Communication on clinical, professional and logistical matters.	Communication to who?
	7.3				Users and stakeholders can access advice on interpretation of results.	Need to develop additional written information to go in with clinic letters, which explains what the tests are and what the results mean.
	7.4				Sufficient capacity for staff to attend multidisciplinary meetings with users/ stakeholders about patient/client management.	MDT meetings need to be set with ENT and Paediatrics as a minimum, possibly may need to include education services for Teacher of the Deaf input on patients.
Non-conformity management	LM8				**The healthcare provider must identify, manage, eliminate and prevent non-conformities by taking preventative and corrective actions System(s) must ensure, where applicable:**	
	8.1				Designated responsibilities for non-conformities and non-conformity prevention.	This needs to be developed.
	8.2				Training for staff to detect and record non-conformities.	Needs development.
	8.3				Review of data/information to determine where future non-conformities could occur (e.g.as part of clinical review	Needs to be developed.

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		YES	NO	N/A		
					meetings such as 'Discrepancy' or 'Morbidity and Mortality').	
	8.4				Immediate actions are taken to mitigate the effect of non-conformities.	Needs to be developed.
	8.5				Determine and document the root cause/s and extent of the non-conformity or potential non-conformity.	Needs to be developed.
	8.6				Further actions are taken to remove the root cause and prevent reoccurrence of the nonconformity.	Need to be developed.
	8.7				The need for preventative action is evaluated and implemented when required.	Needs to be developed as part of non-conformities.
	8.8				Mechanism(s) for recording non-conformities and resultant changes in practice.	Needs to be developed.
	8.9				Mechanisms for communicating non-conformities and resultant changes in practice to relevant users, staff and stakeholders.	Needs to be developed.
	8.10				Regular review of non-conformities to identify trends.	Need to be developed.
	8.11				Results and effectiveness of preventative actions are reviewed and documented.	Needs to be developed.
	8.12				Criteria are available to determine the following in the case of a clinical non- conformity: • Whether clinical activities should be halted; • Whether reports should be withheld; • Who authorises the recommencement of any halted clinical activities; The need for previously released results to be recalled; • The medical significance of a non-conformity to patient/client management; • Responsibilities for reporting the non-conformity to the relevant referrer, users, staff	Need to be developed.

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		YES	NO	N/A		
					and for escalating to the regulatory authority and/or equipment manufacturer as appropriate.	
Internal audit	LM9				**The healthcare provider must evaluate and audit the effectiveness of their QMS including clinical activities System(s) must ensure, where applicable**	
	9.1				The QMS including clinical activities is evaluated and assured with a regular audit cycle. This would usually be annually.	Annual department audit cycle needs to be developed.
	9.2				Use of different audit methods (vertical, horizontal and/or witnessing) to comprehensively cover the requirements of this standard.	Needs to be developed.
	9.3				The scope, criteria, methodology and frequency of audits are defined, documented and reported in an agreed format.	Needs to be developed and decided.
	9.4				That the service assures appropriate training in audit.	Needs to be designed/developed.
Major Incidents	LM10				**The healthcare provider must manage internal and external major incidents System(s) must ensure, where applicable.**	
	10.1				Availability of an agreed, published and up to date business continuity plan.	Needs to be developed.
	10.2				That staff are aware of their roles and responsibilities in the event of a major incident and are provided with accessible up-to-date contact details, key action prompts and appropriate training.	Needs to be developed.
	10.3				Management of the return to routine service following the incident, including management of any backlog.	Needs to be developed.

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		YES	NO	N/A		
	10.4				Accessibility of counselling and support services.	Is this for staff or patients? Either way needs developing.
	10.5				Analysis and review of performance following a major incident.	Needs to be developed.
	10.6				Regular review and communication of any changes to major incident procedures and action Plans.	Need to be developed.
Clinical						
Pathways	CL1				**The healthcare provider must define and deliver its services from referral to discharge or further management. System(s) must ensure, where applicable.**	
	1.1				Publication of the diagnostic and interventional service(s) description, range of clinical activities offered, and their locations.	Needs to be developed.
	1.2				Publication of evidence-based agreed pathways developed with stakeholder involvement.	Paediatric assessment and management pathway developed and Directory of Service updated. Adult pathways need to be developed.
	1.3				Agreement and publication of metrics and key performance indicators for monitoring the patient pathway e.g. Did Not Attend (DNA), Referral to Treatment (RTT). These could be based on a review of relevant guidelines, clinical pathways, quality standards and benchmark data.	Needs to be developed.
	1.4				Performance is communicated to users and stakeholders, as appropriate.	Needs to be developed.
Referrals	CL2				**The healthcare provider must manage referrals and prepare patients/clients for their clinical activity System(s) must ensure, where applicable.**	

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		YES	NO	N/A		
	2.1				Mechanisms for the referral process are clearly communicated.	Paediatric service DOS updated, new referral form sent out to GPs, Health visitors, Speech therapy and School nurse. Adult needs to be developed.
	2.2				Requests are vetted in advance of the appointment.	All referrals are triaged. Paediatric referrals are risk rated using NHS England guidance.
	2.3				Request forms seek appropriate information including: Patient/client identification details; • Name and contact details of the person making the request (who must be authorised to sign and request the specific clinical activity); • The clinical activity being requested including the specific anatomic site, where relevant; • Clinically relevant information pertaining to the requested activity; • Date of the request; • Requirements for specified equipment, drugs, radioactive medicinal products and/or reagents if relevant; • Additional information to support patient/client needs e.g. need for wheelchair access, interpreter, infection status and any known allergies.	Standard on referral forms.
Technical Quality	CL3				**The healthcare provider must assure the technical quality of clinical activities System(s) must ensure, where applicable.**	
	3.1				Patients/clients are correctly identified, and appropriate consent is obtained.	Consent is obtained in all appointments and documented in patient's notes.
	3.2				Equipment has been calibrated, serviced and is fit for purpose.	All equipment is annually calibrated at a minimum, and serviced if faults arise.

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		YES	NO	N/A		
						Calibration certificates issued by companies and kept as records. Equipment PAT tested as per trust guidelines from estates.
	3.3				Availability of appropriate positioning and supporting devices to ensure the integrity and quality of the clinical activity.	Equipment positioned in appropriate places, due to small room sizes they make it difficult for staff to perform real ear measures.
	3.4				Availability of protocols for each clinical activity. Protocols must: V2.1 2023 Page 9 of 18 • Be evidence-based and appropriate; • Fully describe the critical procedural steps; • Include diagnostic criteria and measurement uncertainty, as appropriate; • Include arrangements for safe sedation, analgesia and or anaesthesia where necessary; • Include health and safety considerations, contraindications and infection control; • Include guidance for onward referral, management of incidental or clinically urgent findings, and post-procedure care.	All need to be written.
	3.5				Regular review of protocols, communication of protocol changes to relevant staff, and training on the changes where necessary.	Needs to be developed.
	3.6				Competent and appropriate supervision of staff.	Clinical staff currently undergoing paediatric training.
	3.7				Quality control measures are in place to ensure that the intended outcome of the testing/measurement/assessment stage is achieved, and that if there is a problem with quality, data is not released for reporting before the	Happens in practice needs the protocols to be written. For example if results are though to be not accurate further testing is arranged.

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		YES	NO	N/A		
					patient/client is discharged from the service.	
	3.8				Results are reported in an appropriate time frame.	Reports are written at the end of each appointment.
Quality of records & results	CL4				**The healthcare provider must ensure the clinical and technical quality of records, interpretations and reports System(s) must ensure, where applicable.**	
	4.1				Defined responsibilities for reporting clinical activities. If certain clinical activities are not reported then an agreement for transferring responsibility for the evaluation must be in place.	Needs to be developed.
	4.2				Adequate numbers of competent reporting staff are available and documented.	Insufficient number of clinical staff to manage paediatric referrals.
	4.3				Reporting formats are agreed with referrers and stakeholders.	Reporting formats are not agreed, they are pre-defined by our audiology management system.
	4.4				Availability of locally agreed reporting structures/templates to reporting staff, including those external to the healthcare provider.	Report formats ad templates are set in auditbase, new templates can be produced/updated as needed.
	4.5				Clear identification of the report issuer. This is particularly relevant where outsourcing arrangements are used.	Reports are issued with the Audiologists name, no out sourcing used.
	4.6				Reports include, as appropriate: • Referral information • Date and time of clinical activity • The clinical activity performed • Relevant findings/observations, including unexpected findings; • A conclusion and/or diagnosis; • How certain the conclusion is, and advice on further	compliant

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		YES	NO	N/A		
					diagnostic tests; • Signature(s) with the name(s) of the reporter(s) and their position(s).	
	4.7				Mechanisms for auditing reports and processes for feedback and remedial actions.	Reports not audited.
	4.8				Access to a second opinion, where appropriate.	Not clearly defined, but can refer to another centre for a second opinion.
	4.9				Deviations from the reporting requirements are justified, documented and communicated to referrers.	Should be infrequent, need written protocol.
Release of reports	CL5				**The healthcare provider must manage the release of reports** **System(s) must ensure, where applicable.**	
	5.1				Reports are issued by staff who are authorised to do so.	Reports only written by qualified Audiologists.
	5.2				Definition of local agreed reporting timescales/turnaround times for each type of clinical procedure particularly those with critical, urgent or unexpected findings.	Reports are written at the end of an appointment, no written protocol in place.
	5.3				Locally agreed mechanisms are in place for communication of reports. Communication mechanisms must be secure and monitored.	Reports are sent to the GP and copied to the patient. No
	5.4				Records are maintained of all reports including those transmitted by telephone.	All reports are saved to patients file on Auditbase.
	5.5				Where an interim report is issued it is clearly identified as such and a final report is issued according to locally agreed timescales.	Interim reports are not issued.
	5.6				Timely identification of reporting backlogs/delays and associated patient/client risks with escalation to the highest level within the parent organization.	Needs a protocol developing, but in theory should not happen.

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		YES	NO	N/A		
	5.7				Where amendments are made to an issued report, that the changes are authorised and dated. The revised report must be communicated to the referrer with a clear explanation of the reason for the amendment and the implications for the management of the patient/client including any necessary urgent actions and lessons learnt.	Needs development of written protocol.
Clinical Information Systems	CL6				**The healthcare provider must manage clinical information systems System(s) must ensure, where applicable.**	
	6.1				Confidentiality of patient/client data in compliance with national requirements for data protection.	Trust IG and IT policies are followed for patient confidentiality and data storage.
	6.2				Validation of any clinical information system(s) for the collection, processing, recording, reporting, storage and retrieval of data.	Not sure how we would develop this/prove this.
	6.3				Any changes to the clinical information system(s) are authorised, documented and verified prior to implementation. Where applicable, this includes checking the proper functioning of interfaces with other information systems, instrumentation and administrative systems used to deliver patient/client services.	Auditbase is not integrated with any other systems. Any updates come from the manufacturer and are rigorously tested before being released to the NHS.
	6.4				Secure transmission of data.	No data is transmitted from Auditbase. Test results and reports are printed.
	6.5				Availability of documentation (e.g. user guides), to support day-to day functioning of clinical information system(s).	Need to be developed.
	6.6				Protection from unauthorised access, safeguards against tampering and data loss, investigation of non-compliances, and remedial action after non-compliances.	Only Audiology staff can access auditbase and each member of staff is given a user name to sign in to the system. Auditbase can only be access from signing on to a trust computer.

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		YES	NO	N/A		
	6.7				Non-computerised systems should have safeguards against errors of manual recording and transcription.	Do not have any non-computerised systes.
	6.8				Information systems are operated in compliance with supplier specifications.	This happens but need documentation to evidence.
	6.9				Recording, investigation, correction and reporting of breaches of data integrity or system failures.	This should not happen, but if it did, this would be classed an incident and the trust's policy on incident reporting should be followed.
	6.10				Compliance with the requirements of this standard where information system(s) are managed and maintained off-site or sub-contracted.	Server is managed by Trust's IT department.
Patient experience						
Patient/client focused care	PE1				**The healthcare provider must ensure that care is patient/client focused.** **System(s) must ensure, where applicable.**	
	1.1				Equality of access.	Small testing rooms are difficult to position wheelchairs, Soundproof booths at DPOW have steps and no ramp access.
	1.2				Privacy, respect, dignity and compassion regardless of age, gender, religion, culture, language, disability, circumstances or any other factors.	
	1.3				Patient/Client identity is confirmed throughout their contact with the service.	This happens in appointments and is documented in patient's notes.
	1.4				Chaperone provision.	No Audiology staff available for this. Patient's can bring a relative/friend/carer into appointment if they wish.
	1.5				Appropriate clinical management adapting to individual needs.	This happens in appointments, eg referring to another specialist if needed, testing techniques adapted or changed to most appropriate for

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		YES	NO	N/A		
						patient. Need a written protocol/evidence of this.
	1.6				Counselling for those who become distressed during their contact with the provider, for example following bad news.	
	1.7				Streamlined scheduling of appointments.	Admin book appointments from waiting lists. Clinic rota is 6 weeks ahead for them to book into.
	1.8				Opportunities to provide feedback.	Friend and family testing used in both departments and periodic service user surveys sent out to patients to obtain patient feedback.
Information for users & stakeholders	PE2				**The healthcare provider must ensure that information is available for users and stakeholders. System(s) must ensure, where applicable.**	
	2.1				Development of patient/client-friendly information.	There is some information sheets/booklets. These need to be reviewed and improved and new ones developed. Task passed on to band 5 audiologist to start working on this several months ago.
	2.2				Lay involvement in the development and review of information.	When new documents are written developed they need to go through several stages before they are approved, which involves patients in the process.
	2.3				Availability of location-specific information including but not limited to: • address; • list of available activities; • opening hours; • contact details; • parking arrangements.	Services available at multiple sites. Work needs to be developed on list of activities.

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		YES	NO	N/A		
	2.4				Information is accessible in a range of formats and media and in various languages relevant to the population.	Letters can be printed in larger text if requested. Have the ability to have letters translated if required. Need a clear written protocol on this on how to do this for patients if requested.
	2.5				Information addresses specific patient/client care aspects such as: Explanation of the procedure to include preparation, side-effects and or risks; Preventative measures to minimise risk e.g. infection, fasting requirements; How long the appointment is likely to take; Who is performing the examination/treatment/intervention; Access to interpretation and chaperones, if required; On arrival, the length of any known delay to appointments; Aftercare and return to normal activity; Communication of results and awareness of second opinions; Peer/self-help support information.	Partly met, needs more work on this.
	2.6				Communication to users in regards their responsibilities to: • Notify the provider of appointment changes and cancellations; • Providing feedback where expectations are not being met; • Abiding by any behavioural codes of conduct.	Information is put in appointment letters on how to contact us and change appointments if needed.
Consent	PE3				**The healthcare provider must ensure that consent is obtained** **Procedure(s) must ensure, where applicable.**	
	3.1				Valid informed consent for the specific clinical activity.	Verbal consent is obtained and documented in patient's notes.
	3.2				Sufficient information is provided for valid consent, including information about risks.	No written information given appointment. Needs to be developed.

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		YES	NO	N/A		
	3.3				Appropriate arrangements where the patient/client lacks the capacity to consent, for example, children and young people, vulnerable adults and users with intellectual disabilities.	Not sure how to evidence this, with children we document that parents have consented and we also where children are old enough they will allow us to examine their ears etc.
	3.4				Consent is documented in the patient/client's record where relevant.	
	3.5				Acknowledgment of the patient/client's right to withhold or withdraw consent.	
	3.6				Gaining consent when data is likely to be used for training or research purposes and/or if it will be shared electronically within or outside of the provider organization.	Patients would be informed if they were going to have some or part of their care performed by trainee/students. It would also be documented in notes if seen by a student.
Feedback & complaints	PE4				**The healthcare provider must manage feedback and complaints System(s) must ensure, where applicable:**	
	4.1				Feedback/complaints procedures and materials are available in a variety of formats and media.	FFT forms are available, information can be provided to patients on how to contact PALS.
	4.2				Confidentiality for those giving feedback and/or making a complaint.	Names of people completing FFT is not published, information is anonymous.
	4.3				Regular review of feedback and complaints with collation, analysis, actions and dissemination to all relevant parties.	This needs to be incorporated in to staff meetings.
	4.4				Involvement of users in the development and review of feedback and complaints materials, where relevant.	Needs to be developed if trust does not have a standard for this.
Safety & Risk Management						
All service risks	SR1				**The healthcare provider must manage all service risks. Systems must ensure, where applicable.**	

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		YES	NO	N/A		
	1.1				An overall health and safety and risk management strategy that has been developed in collaboration with the parent organization.	As part of the BAA review it was recommended to the managers overseeing audiology in July 2023 to undertake this. No evidence this has taken place or hasn't' taken place.
	1.2				Risk assessments to identify: • Risks associated with clinical activities e.g. infection control; • Non-clinical risks e.g. COSHH, moving and handling, violence and aggression etc.	Staff have moving and handling training. Risk assessments need to be written for each procedure/activity. Staff that haven't completed training will need to complete.
	1.3				Maintenance of a comprehensive and up-to-date risk register to document, escalate and report risks, as necessary.	Trust risk register is in place, Audiology has items listed on this.
	1.4				Tools are in place to record, report, investigate and manage adverse incidents and near misses within specified timescales.	Trust has an incident reporting system.
	1.5				Management of patient safety alerts, and appropriate actions.	These are managed as and when they are published, for example tamperproof battery draws on hearing aids for children to stop them accessing batteries.
	1.6				Regular health and safety training for all staff.	All staff must be compliant with trust's mandatory training.
	1.7				Readily available, well-maintained health and safety and risk-reduction equipment and devices.	Eye protection in place for using mechanical grinders for adjusting ear moulds. Raised as a risk by BAA as the grinders should be in an extraction chamber to extract dust particles from a confined space. Estates have been slow to respond.
Facilities, Resource & Workforce						

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		YES	NO	N/A		
Facilities & Environment	FR1				**The healthcare provider must manage facilities and environment to support service delivery. System(s) must ensure, where applicable.**	
	1.1				Sufficient suitable space to deliver all aspects of the service.	Ventilation in DPOW soundproof rooms not working, this causes the rooms to get excessively hot, which will on occasions may affect the accuracy of hearing assessments as the patient's complain of getting too hot during their assessment. As an extreme example this could lead to a consultant making a surgical decision on an inaccurate test result. Two other rooms at DPOW are too noisy and are not sound treated and noise levels exceed the international standards, such as toilets can be heard flushing and water draining into pipes. Insufficient paediatric Audiologists to manage the paediatric service which has been moved to Audiology from the community paediatricians. No blinds in the clinic rooms to help keep them cool. DPOW Large paediatric room condemned and deemed not to be big enough for testing young children in. No room within the department for performing ABR testing. Insufficient numbers of room to manage clinical demands on both DPOW and SGH sites.

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		YES	NO	N/A		
						The observation room at SGH requires blinds for when using the observation window for paediatric testing as the room needs to be in darkness, at present this cannot be achieved.
	1.2				Enough suitable facilities for patient/client confidentiality and privacy and dignity.	When in the clinic rooms at DPWO, you can hear conversations that patient's have in the waiting room, so there is a chance they may hear what is said in the consulting rooms.
	1.3				Appropriate access for users and staff who use wheelchairs, trolleys/beds, have impaired vision, hearing, or have other needs.	Soundproof rooms at DPOW do not have access for wheel chairs to access easily and heavy ramps have to be manually put in place. Small sound proof at DPOW difficult to position wheelchairs correctly due to the room size. Soundproof rooms at SGH too small to get wheelchairs in for Real Ear Measures to be performed accurately.
	1.4				Management and monitoring of the condition of facilities and environment including cleaning and maintenance.	Environment issues reported to estates. Ventilation issues reported to estates multiple times and needs to be added to risk register as they are unable to repair the ventilation in the rooms as they have run cables in the ceiling space prevent access to the ventilation systems that do not work. *Not sure why air conditioning units cannot be fitted into the rooms like they were at SGH to meet air quality for a confined space during COVID, unsure why this was only delivered at one site.*
	1.5				Display of relevant signage to notify users, staff and visitors of access and specific hazards.	No signs, staff have to advise patients to mind steps etc.
	1.6				Facilities and environment are fit for their intended purpose,	Soundproofing is failing on all the rooms due

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		YES	NO	N/A		
					in particular.	to their age and requires refurbishment, as the rooms are not soundproof enough as you can hear people outside of them.
	1.6.1				Clinical facilities • Records relating to environmental conditions that allow for correct performance (assure quality and integrity) of the clinical activity concerned e.g. noise reduction, ventilation, variable lighting and temperature, equipment performance; • Appropriate facilities for decontamination of equipment and consumables.	Ventilation and temperature of rooms have been repeatedly reported to estates, rooms are not compliant to meet IQIPS.
	1.6.2				Reception, waiting and changing facilities • Sufficient and appropriate seating facilities for all patients/clients including space for those waiting in wheelchairs, needing bariatric support, waiting for hospital transport, as appropriate; • Appropriate waiting areas for children, vulnerable adults and their carers and those waiting on trolleys; • Screened areas for patients/clients dressed in gowns or those waiting on trolleys or in beds; • Secure storage facilities for patient's/clients' valuables.	Childre and adults wait in the same areas at SGH and DPOW. Very small waiting room at DPOW no bariatric chairs.
	1.6.3				Staff facilities • Sufficient and appropriate changing facilities for staff including those with disabilities; • Access to safe storage for personal items; • Access to toilet facilities and drinking water; • Storage of personal protective equipment.	Staff have staff toilet and lockers.
External	FR2				**The healthcare provider must have systems in place for**	

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		YES	NO	N/A		
service/suppliers selection					**the selection of external services and suppliers for equipment, reagents, drugs (includes contrast media), radioactive medicinal products and consumables. System(s) must ensure, where applicable.**	
	2.1				Maintenance of an approved list of suppliers.	Do not keep a list of approved suppliers.
	2.2				Availability of purchasing criteria that clearly describe the requirements for the product(s)and or service(s) to be purchased.	Need to follow trust guidance, but documentation needs to be developed.
	2.3				Review of budgets/funding for equipment, reagents, gases, drugs, radioactive medicinal products and consumables, at least annually, and where appropriate managed in conjunction with the parent organization.	Budgets managed in line with trust policies.
	2.4				Regular monitoring of all purchases to ensure consistency with specified criteria.	Purchases are checked to ensure they meet the requirements of what was ordered, documentation will need to be written to support this.
Storage of reagents, drugs, medicinal products & consumables	FR3				**The healthcare provider must receive, store and manage equipment, reagents, drugs (includes contrast media), radioactive medicinal products and consumables. System(s) must ensure, where applicable.**	
	3.1				Verification that the receiving location/facility has adequate storage and handling capabilities to maintain the purchased items in a manner that prevents damage and Deterioration.	Hearing aids and batteries are stored safely within each department.
	3.2				Verification of the performance of any new batch or shipment before use in clinical procedures.	Stock is not verified.
	3.3				Maintenance and routine implementation of an inventory	Hearing aid serial numbers are inputted into

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		YES	NO	N/A		
					control system.	the Audiology Patient management system and hearing aids are issued to a patient within the system.
	3.4				Appropriate instructions for use for all items are readily available.	SOPs need to be written.
	3.5				Investigation and reporting of any adverse incidents or accidents that can be attributed directly to use of an item.	Would be reported on the trusts incident reporting system.
	3.6				Maintenance of records for each item that contributes to the performance of clinical procedures.	Equipment annually calibrated. Daily and weekly checks are recorded.
Procurement & installation of equipment	FR4				**The healthcare provider must manage procurement, installation and replacement of all Equipment. System(s) must ensure, where applicable.**	
	4.1				Any equipment used (including that on loan to patients/clients for use outside of the healthcare provider) meets the specific requirements of the clinical activities offered and the target population concerned (e.g. weight, age, disability etc.	Hearing aids are on loan to patients from the NHS and meet the patient's requirements.
	4.2				Maintenance of an equipment inventory and rolling replacement programme Including software, upgrades (including diagnostic software) and accessory devices (e.g. couches, chairs etc).	There does not appear to be anything like this in place. Audiology has equipment on the risk register which requires replacement, due to its age and no longer being supported by the manufacturers.
	4.3				Regular review of equipment budget, at least annually, and where appropriate managed in conjunction with the parent organization.	
	4.4				Acceptance testing upon installation and before use.	Staff would complete manufacturer training on any new equipment before they use it on patients.

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		YES	NO	N/A		
	4.5				Maintenance of training and authorisation records for staff to operate specific equipment.	No records have been kept on staff training for equipment.
	4.6				Agreed minimum information is maintained for any equipment that contributes to the performance of clinical activity. The expectation is that records will include: • Identity of the equipment; • Manufacture's name, model and serial number or their unique identification; • Contact information for the supplier or the manufacturer; • Date of receiving and date of entering use within the service. Location of the equipment; • Condition when received (new, used or reconditioned); • Manufacturer's instruction manual; • Confirmation of acceptability for use; • Maintenance carried out and the schedule for preventative maintenance; • Performance records (reports/calibration certificates) that confirms ongoing acceptability for use; • Record of any damage to, malfunctions, modification and or repairs.	Needs to be developed.
Calibrate & maintain equipment	FR5				**The healthcare provider must calibrate and maintain equipment.** **System(s) must ensure, where applicable.**	
	5.1				Use of an authorised/accredited body to conduct calibration.	Equipment calibrated inline with IQIPS standards.
	5.2				That calibration and maintenance takes account of conditions of use and manufacturer's instructions.	Staff trained to use equipment, equipment is calibrated as recommended by manufacturers and repairs are performed either by medical engineering or sent to the manufacturers.

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		YES	NO	N/A		
	5.3				Traceability between the equipment and the calibrated reference standard.	This information should be on the equipment calibration certificates.
	5.4				Verification of the measurement accuracy at defined measurement intervals.	This information should be on the equipment calibration certificates.
	5.5				Timely and accurate updating of correction factors as necessary.	Correction factors will be updated as part of the calibration.
	5.6				Safeguards to prevent adjustments or tampering that might invalidate clinical results.	All software is password protected for calibration settings, of which only calibration providers have access to.
	5.7				Reporting of faults and management of equipment breakdowns and repairs, in line with legislation, manufacturer's guidelines and organisational policy.	Faulty equipment reported as per trust policy to medical engineering who will either repair or arrange for repair with manufacturer.
	5.8				Mechanisms to communicate health and safety warnings and alerts to staff, which are formally acknowledged, and acted on within specified timescales.	No written policy for this, but does take place.
	5.9				Regular review of electrical safety, emergency stop devices (where relevant).	Equipment PAT tested by estates inline with their time frames. Emergency stop not required.
	5.10				Regular cleaning and decontamination of all equipment, including ancillary equipment following direct contact with patients/clients.	All equipment cleaned after each patient in line with trust's infection control procedures.
	5.11				Maintenance of training and authorisation records for staff who calibrate, clean and decontaminate equipment.	No records kept of this will need to be developed.
	5.12				Timely Investigation and reporting of adverse incidents and accidents caused by defective equipment to manufacturers and relevant authorities.	Procedure protocol needs to be developed. Any incidents are reported on the trusts incident system.

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		YES	NO	N/A		
	5.13				Labelling and removal from service of any equipment found to be defective.	Faulty equipment is removed from clinical rooms so it cannot be used and would then be collected by medical engineering.
Recruitment, training & competence	FR6				**The healthcare provider must recruit, select and train staff to assure competence. System(s) must ensure, where applicable.**	
	6.1				Recruitment and selection criteria for each staff group in line with professional registration requirements.	Staff that are employed must have the relevant qualifications and registration for their post.
	6.2				Completion of pre-employment checks.	Completed by HR.
	6.3				Verification that each member of staff including locum staff is qualified, trained and authorised (registered where necessary) to perform their intended functions and this is reflected in job description / job plan.	Qualifications and registration is checked.
	6.4				Tailored induction training and supervision programmes are available specific to each role, circumstance and/or environment. For example, staff taking on new roles, temporary staff, those returning to work following extended leave and students.	Staff will complete Trust's induction, departmental induction needs to be developed as there was nothing in place when I started recently.
	6.5				Collaboration with education institutions for education and training support to meet current and predicted staffing needs of the service.	No collaboration as far as I am aware, we have accessed funding to train staff for apprenticeships.
	6.6				Maintenance of records of staff training activities, professional qualifications, professional registration status, induction and refresher training courses attended, and certificates of competence with authorisation to carry out specific tasks.	Staff have to be compliant with mandatory training and maintain a CPD record for their registration. Do not keep records of this, needs to be developed.
	6.7				Regular review of performance and assessment of competence for all staff.	Review of clinical performance needs to be developed for all clinicians. Currently ABR testing is externally peer

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		YES	NO	N/A		
						reviewed.
	6.8				Protected time for staff to engage in continuous professional development activities and to undertake improvement initiatives.	Regular time needs to be built into the clinic schedules for staff to maintain their CPD and development.
	6.9				Defined mandatory training is specified, available and completed for all staff.	This is set and maintained by HR through the ESR system.
	6.10				Systematic monitoring of staff retention and succession planning.	Succession planning needs to be developed, lack of interest from the NHS as a whole for a profession that has a shortage of professionals, with many choosing to leave the NHS. NLAG has been affected by this 2 staff leaving in the last 12 months and more applying for jobs external to the trust..

IQIPS Standard v2, 2020

Introduction

This Improving Quality In Physiological Services (IQIPS) standard is based upon IQIPS standard v1 2012, revised to map to ISO15189, BS70000, QSIv3 and CQC Key Lines of Inquiry.

The purpose of this standard is to ensure that healthcare providers deliver physiological services that are accurate, effective, safe, efficient, responsive, accessible and sustainable. Achieving these goals requires:

- An effective leadership and management structure (clinical and administrative) including an appropriately designed quality management system;
- Administrative and clinical practices appropriate to the patient/client population including children
- Review of existing and new clinical practice to develop and improve the service;
- Provision of appropriate information and support for patients/clients and carers with due regard to differences in socio-economic characteristics, including effective feedback systems for patients and carers;
- Effective management of risks and emergencies;
- Appropriate and adequate facilities, equipment and consumables;
- Motivated and competent staff;
- The integration of sound business planning principles.

The healthcare provider must develop and maintain systems that are grounded in best practice, in line with professional guidance, and statutory and commissioning requirements. The healthcare provider must review its systems regularly, make corrections, and log changes. The provider must learn and take appropriate actions from its reviews and disseminate findings to support wider service improvement. Where necessary this standard will be supplemented by additional discipline-specific guidance from the relevant professional body.

Scope

This standard specifies the requirements for quality and competence in Audiology, Clinical Neurophysiology, Cardiac Physiology, Respiratory & Sleep Physiology, Vascular Science, Ophthalmic & Vision Science, Gastrointestinal Physiology and Urodynamics. The standard may also be useful in other disciplines.

Terms and definitions

Advisory Services – Services that provide information relating to diagnosis, management, and patient support.

Clinical activity – this includes:

- Preparations conducted before a procedure;
- A test/measurement/assessment/examination that is performed on a patient/client;
- Methods for capturing data relating to a patient/client;
- Reporting the findings from an interaction with a patient/client;
- Any onward management which may include interventional/rehabilitation activity and monitoring of the outcome of the activity

Corrective action - Action taken to remove the root cause of a problem causing a nonconformity

Diagnostic criteria - clinical decision values / clinical reference ranges

Healthcare Provider – organisation that provides clinical services(s)

Manager(s) – Person(s) with overall responsibility for providing clinical services(s)

Measurement of uncertainty – the degree of doubt about a value. Uncertainty is usually expressed as the range within which the true value can be said to lie with a specified level of confidence. For example, if a person's height is given with 95% confidence as 160.0 +/- 0.5 cm this means there is a 5% chance it is more than 160.5 cm or less than 159.5 cm.

Non-conformity – Failure to fulfil a requirement

Preventative action - Action taken to eliminate the cause of potential nonconformities to prevent their occurrence

Quality Management System – A formalised system that documents processes, procedures and responsibilities for achieving quality policies and objectives. This helps coordinate and direct an organisations activities to meet user, stakeholder and regulatory requirements and assure continual improvement

Quality policy – A short document published by management that establishes what quality means to the organisation

Quality manual - document that states the organisation's intentions for operating within the quality management system

Referral – the entry point to service pathway which may include both self-referral and stakeholder referral

Stakeholders – includes commissioning bodies, professional bodies, clinicians, patient representative groups, patients and others, where appropriate

System – an agreed way of doing things that is documented, consistently implemented and regularly monitored

Users – patients/clients, their carers and referrers

Leadership and Management domain

The purpose of the Leadership and Management domain is to ensure appropriate leadership and managerial controls to support the healthcare provider's staff to deliver clinical services. This is achieved through an effective leadership and management structure (clinical and administrative).

LM1 The healthcare provider is or must be part of a legal entity	
The healthcare provider for specific clinical services can be either autonomous or part of a larger parent organisation. It must:	
LM1.1.	Be part of an entity that can be held legally responsible for its activities;
LM1.2.	Be licensed to operate according to relevant international and UK regulatory frameworks;
LM1.3.	Where applicable, be clearly recognised in the published organisational structure of the parent organisation;
LM1.4.	Have clearly documented processes in place to inform users, staff, and stakeholders of its purpose and core values (culture). This is normally defined and published as a mission, vision and values statement.

LM2 The healthcare provider must define, document and communicate governance arrangements including leadership, roles, responsibilities and accountabilities	
The healthcare provider must deliver clearly defined clinical service(s) to meet the needs of the target population, whether at static, mobile and/or domiciliary settings. System(s) must ensure, where applicable:	
LM2.1.	A leadership and management team consisting of individual(s) with defined responsibilities and accountabilities for clinical and professional leadership, advice, budget control and risk management.
LM2.2.	A leadership and management team that is visible, approachable and available to staff;
LM2.3.	The leadership team identify and document details of individuals with specific roles and responsibilities across the Quality Management System (QMS)
LM2.4.	All staff have: • An agreed contract of employment; • A current job description/job plan that specifies his/her role, responsibilities, authorities and relationships;
LM2.5.	All staff understand their specific role and responsibilities, authorities and relationships;
LM2.6.	All staff understand the processes in place to manage conflicts of interest;
LM2.7.	All staff understand how to differentiate and manage feedback and complaints;
LM2.8.	All staff can give feedback and raise matters of concern, in confidence, and without fear of recrimination.

LM3 The healthcare provider must operate within its quality policy and monitor performance against measurable quality objectives System(s) must ensure, where applicable:	
LM3.1.	The leadership team develop, and publish an appropriate quality policy and measurable quality objectives that are regularly reviewed;
LM3.2.	Agreed local targets and key performance indicators/outcomes for service activities and clinical procedures, in line with local and national targets e.g. waiting times, report turnaround times, Do Not Attend rates, equipment breakdown times, staff retention rates, patient/client satisfaction rates, workloads etc;
LM3.3.	Consistency in performance across the provider's activities with internal and external benchmarking.

LM4 The healthcare provider must establish, implement, and maintain a quality management system (QMS) The healthcare provider must establish an appropriate QMS to integrate all agreed processes, monitor their effectiveness and ensure continuous improvement of its service(s). The QMS will:	
LM4.1.	Be described in a quality manual;
LM4.2.	Be sufficiently robust to ensure that staff only have access to the latest and current versions of documents;
LM4.3.	Ensure availability of supporting documentation to include, but not be limited to: • Processes (ways of working) for all activities; • Pathways and clinical protocols; • Records of resources (staffing, equipment etc) available to support delivery; • Forms in use; • Internal audits; • Publications;
LM4.4.	Be subjected to regular management reviews, at least annually, to include at least the following: • Quality improvement initiatives to include business planning; • Periodic review of referrals received; • Results and outcomes from user feedback and complaints; • Periodic review of referrals received; • Results and outcomes from user feedback and complaints; • Staff and stakeholder consultation and feedback; • Results and outcomes from internal audits; • Risk management reports, and update of risk register; • Reviews conducted by external organisations; • Objectives aligned to local and national performance targets with outcomes of inter-service comparison programmes/benchmarking; • Performance of suppliers; • Identification and control of non-conformities; • Follow-up actions from previous management reviews; • Changes to the volume and scope of work including capacity and demand, staffing, premises, equipment consumables and resources;

Where the healthcare provider is required to follow the QMS of a parent organisation, they must demonstrate that the parent organisation's system is appropriately implemented and where necessary the management review output is taken forward to the parent organisation.

LM5 The healthcare provider must ensure that documents and records (including clinical records) are controlled System(s) must ensure, where applicable:	
LM5.1.	Agreed format and media for documents and records;
LM5.2.	Data is processed, handled, maintained and secured in line with applicable regulation and professional guidance;
LM5.3.	All documents and records supporting delivery of services are current, reviewed, approved and available;
LM5.4.	All documents and records created and revised contain: • A title; • Unique identifier on each page; • Date of current edition, review, edition number; • Page number to total number of pages; • Authority for issue;
LM5.5.	Appropriate controls for the identification, collection, indexing, access, storage, maintenance, and amendments of current and obsolete records and documents;
LM5.6.	Documents and records are protected from unauthorised alterations and where necessary kept confidential.

LM6 The healthcare provider must establish and review agreements for any outsourcing /subcontracting clinical services. System(s) must ensure, where applicable:	
LM6.1.	Specification of the minimum information needed for different types of agreements;
LM6.2.	Timely review of all agreements;
LM6.3.	Assurance that the selected sub-contractor is competent to perform the activity for which it has been selected. If not accredited the healthcare provider will need to demonstrate how competency has been established and what criteria were used;
LM6.4.	Maintenance of patient/client confidentiality;
LM6.5.	Monitoring and review of performance against contract requirements, including remedial actions;
LM6.6.	Transparency of outsourcing/subcontracting to users and in clinical service outputs.

LM7 The healthcare provider must provide competent advisory services System(s) must ensure, where applicable:	
LM7.1.	Communication to users and stakeholders on the range and choice of clinical procedures currently available, and on emergent practice;
LM7.2.	Communication on clinical, professional and logistical matters;
LM7.3.	Users and stakeholders can access advice on interpretation of results;
LM7.4.	Sufficient capacity for staff to attend multidisciplinary meetings with users/ stakeholders about patient/client management.

LM8 The healthcare provider must identify, manage, and eliminate non-conformities by taking corrective actions	
System(s) must ensure, where applicable:	
LM8.1.	Designated responsibilities for non-conformities;
LM8.2.	Training for staff to detect and record non-conformities;
LM8.3.	Immediate actions are taken to mitigate the effect of non-conformities;
LM8.4.	Root cause analysis to determine the reasons for and extent of the non-conformity;
LM8.5.	Actions are taken to remove the root cause and prevent reoccurrence of the non-conformity;
LM8.6.	Mechanism(s) for recording non-conformities and resultant changes in practice
LM8.7.	Mechanisms for communicating non-conformities and resultant changes in practice to relevant users, staff and stakeholders;
LM8.8.	Regular review of non-conformities to identify trends;
LM8.9.	Criteria are available to determine the following in the case of a clinical non- conformity: • Whether clinical activities should be halted; • Whether reports should be withheld; • Who authorises the recommencement of any halted clinical activities; The need for previously released results to be recalled; • The medical significance of a non-conformity to patient/client management; • Responsibilities for reporting the non-conformity to the relevant referrer, users, staff and for escalating to the regulatory authority and/or equipment manufacturer as appropriate.

LM9 The healthcare provider must seek and eliminate the cause(s) of potential future non-conformities by taking preventative actions	
System(s) must ensure, where applicable:	
LM9.1.	Designated responsibility for non-conformity prevention;
LM9.2.	Review of data/information to determine where future non-conformities could occur (e.g. as part of clinical review meetings such as 'Discrepancy' or 'Morbidity and Mortality');
LM9.3.	Root cause(s) of potential non-conformities are sought;
LM9.4.	The need for preventative action is evaluated
LM9.5.	Preventative action occurs when it is required;
LM9.6.	Results and effectiveness of preventative action are reviewed and documented.

LM10 The healthcare provider must evaluate and audit the effectiveness of their QMS including clinical activities	
System(s) must ensure, where applicable:	
LM10.1.	The QMS including clinical activities is evaluated and assured with a regular audit cycle. This would usually be annually;
LM10.2.	Use of different audit methods (vertical, horizontal and/or witnessing) to comprehensively cover the requirements of this standard;
LM10.3.	The scope, criteria, methodology and frequency of audits are defined, documented and reported in an agreed format;
LM10.4.	That staff involved in the audit process have appropriate training.

LM11 The healthcare provider must manage internal and external major incidents System(s) must ensure, where applicable:	
LM11.1.	Availability of an agreed, published and up to date business continuity plan;
LM11.2.	That staff are aware of their roles and responsibilities in the event of a major incident and are provided with accessible up-to-date contact details, key action prompts and appropriate training;
LM11.3.	Management of the return to routine service following the incident, including management of any backlog;
LM11.4.	Accessibility of counselling and support services;
LM11.5.	Analysis and review of performance following a major incident;
LM11.6.	Regular review and communication of any changes to major incident procedures and action plans.

Clinical domain

The purpose of the Clinical domain is to promote timely, accurate and effective diagnosis and treatment. These are achieved by ensuring that administrative and clinical practices are appropriate to the patient/client population, that risk management is effective, and that the service develops and improves itself by reviewing existing and new clinical practices.

CL1. The healthcare provider must define and deliver its services from referral to discharge or further management System(s) must ensure, where applicable:	
CL1.1	Publication of the diagnostic and interventional service(s) description, range of clinical activities offered, and their locations;
CL1.2	Publication of evidence-based agreed pathways developed with stakeholder involvement;
CL1.3	Agreement and publication of metrics and key performance indicators for monitoring and verifying the effectiveness of the service e.g. Did Not Attend (DNA), Referral to Treatment (RTT) and report turnaround. These could be based on a review of relevant guidelines, clinical pathways, quality standards and benchmark data;
CL1.4	Performance is communicated to users and stakeholders, as appropriate;
CL1.5	Information on how to access second opinions is provided.

CL2. The healthcare provider must manage referrals and prepare patients/clients for their clinical activity System(s) must ensure, where applicable:	
CL2.1	Mechanisms for the referral process are clearly communicated
CL2.2	Requests are vetted in advance of the appointment;
CL2.3	Request forms seek appropriate information including: Patient/client identification details; • Name and contact details of the person making the request (who must be authorised to sign and request the specific clinical activity); • The clinical activity being requested including the specific anatomic site, where relevant; • Clinically relevant information pertaining to the requested activity; • Date of the request; • Requirements for specified equipment, drugs, radioactive medicinal products and/or reagents if relevant; • Additional information to support patient/client needs e.g. need for wheelchair access, interpreter, infection status and any known allergies.

CL3 The healthcare provider must assure the technical quality of clinical activities System(s) must ensure, where applicable:	
CL3.1	Patients/clients are correctly identified, and appropriate consent is obtained;
CL3.2	Equipment has been calibrated and is fit for purpose;
CL3.3	Availability of appropriate positioning and supporting devices to ensure the integrity and quality of the clinical activity;
CL3.4	Availability of protocols for each clinical activity. Protocols must: • Be evidence-based and appropriate; • Fully describe the critical procedural steps; • Include diagnostic criteria and measurements of uncertainty, as appropriate; • Include arrangements for safe sedation, analgesia and or anaesthesia where necessary; • Include health and safety considerations, contraindications and infection control; • Include guidance for onward referral, management of incidental or clinically urgent findings, and post-procedure care.
CL3.5	Regular review of protocols, communication of protocol changes to relevant staff, and training on the changes where necessary;
CL3.6	Competent and appropriate supervision of staff;
CL3.7	Quality control measures are in place to ensure that the intended outcome of the testing/measurement/assessment stage is achieved, and that if there is a problem with quality, data is not released for reporting before the patient/client is discharged from the service;
CL3.8	Results are reported in an appropriate time frame.

CL4 The healthcare provider must ensure the clinical and technical quality of records, interpretations and reports. System(s) must ensure, where applicable:	
CL4.1	Defined responsibilities for reporting clinical activities. If certain clinical activities are not reported then an agreement for transferring responsibility for the evaluation must be in place;
CL4.2	Adequate numbers of competent reporting staff are available and documented;
CL4.3	Reporting formats are agreed with referrers and stakeholders;
CL4.4	Availability of locally agreed reporting structures/templates to reporting staff, including those external to the healthcare provider;
CL4.5	Clear identification of the report issuer. This is particularly relevant where outsourcing arrangements are used;
CL4.6	Reports include, as appropriate: • Referral information • Date and time of clinical activity • The clinical activity performed • Relevant findings/observations, including unexpected findings; • A conclusion and/or diagnosis; • How certain the conclusion is, and advice on further diagnostic tests; • Signature(s) with the name(s) of the reporter(s) and their position(s);
CL4.7	Mechanisms for auditing reports and processes for feedback and remedial actions;
CL4.8	Access to a second opinion, where appropriate;
CL4.9	Deviations from the reporting requirements are justified, documented and communicated to referrers.

CL5 The healthcare provider must manage the release of reports System(s) must ensure, where applicable:	
CL5.1	Reports are issued by staff who are authorised to do so;
CL5.2	Definition of local agreed reporting timescales/turnaround times for each type of clinical procedure particularly those with critical, urgent or unexpected findings
CL5.3	Locally agreed mechanisms are in place for communication of reports. Communication mechanisms must be secure and monitored;
CL5.4	Records are maintained of all reports including those transmitted by telephone;
CL5.5	Where an interim report is issued it is clearly identified as such and a final report is issued according to locally agreed timescales;
CL5.6	Referrers have ready access to a second opinion;
CL5.7	Timely identification of reporting backlogs/delays and associated patient/client risks with escalation to the highest level within the parent organisation;
CL5.8	Where amendments are made to an issued report, that the changes are authorised and dated. The revised report must be communicated to the referrer with a clear explanation of the reason for the amendment and the implications for the management of the patient/client including any necessary urgent actions and lessons learnt.

CL6 The healthcare provider must manage clinical information systems System(s) must ensure, where applicable:	
CL6.1	Confidentiality of patient/client data in compliance with national requirements for data protection;
CL6.2	Validation of any clinical information system(s) for the collection, processing, recording, reporting, storage and retrieval of data;
CL6.3	Any changes to the clinical information system(s) are authorised, documented and verified prior to implementation. Where applicable, this includes checking the proper functioning of interfaces with other information systems, instrumentation and administrative systems used to deliver patient/client services;
CL6.4	Secure transmission of data
CL6.5	Availability of documentation (e.g. user guides), to support day-to day functioning of clinical information system(s);
CL6.6	Protection from unauthorised access, safeguards against tampering and data loss, investigation of non-compliances, and remedial action after non-compliances;
CL6.7	Non-computerised systems should have safeguards against errors of manual recording and transcription;
CL6.8	Information systems are operated in compliance with supplier specifications;
CL6.9	Recording, investigation, correction and reporting of breaches of data integrity or system failures;
CL6.10	Compliance with the requirements of this standard where information system(s) are managed and maintained off-site or sub-contracted;

Patient/Client Experience domain

The purpose of the Patient/Client Experience domain is to ensure that the Service is patient-focused. This is achieved through respect for individuals and their specific requirements, and through effective mechanisms for feedback from service-users. A patient-focussed Service provides information and support that are appropriate for patients, clients and carers taking account of differences in culture, religion, age and other factors.

PE1 The healthcare provider must ensure that care is patient/client focused System(s) must ensure, where applicable:	
PE1.1.	Equality of access;
PE1.2.	Privacy, respect, dignity and compassion regardless of age, gender, religion, culture, language, disability, circumstances or any other factors;
PE1.3.	Patient/Client identity is confirmed throughout their contact with the service;
PE1.4.	Chaperone provision;
PE1.5.	Appropriate clinical management adapting to individual needs;
PE1.6.	Counselling for those who become distressed during their contact with the provider, for example following bad news;
PE1.7.	Streamlined scheduling of appointments;
PE1.8.	Opportunities to provide feedback.

PE2 The healthcare provider must ensure that information is available for users and stakeholders System(s) must ensure, where applicable:	
PE2.1.	Development of patient/client-friendly information;
PE2.2.	Lay involvement in the development and review of information;
PE2.3.	Availability of location-specific information including but not limited to: • Address; • list of available activities; • opening hours; • contact details; • parking arrangements;
PE2.4.	Information is accessible in a range of formats and media and in various languages relevant to the population;
PE2.5.	Information addresses specific patient/client care aspects such as: Explanation of the procedure to include preparation, side-effects and or risks; Preventative measures to minimise risk e.g. infection, fasting requirements; How long the appointment is likely to take; Who is performing the examination/treatment/intervention; Access to interpretation and chaperones, if required; On arrival, the length of any known delay to appointments; Aftercare and return to normal activity; Communication of results and awareness of second opinions; Peer/self-help support information;
PE2.6.	Communication to users in regards their responsibilities to: • Notify the provider of appointment changes and cancellations;

	• Providing feedback where expectations are not being met; • Abiding by any behavioural codes of conduct.

PE3 The healthcare provider must ensure that consent is obtained Procedure(s) must ensure, where applicable:	
PE3.1.	Valid informed consent for the specific clinical activity;
PE3.2.	Sufficient information is provided for valid consent, including information about risks;
PE3.3.	Appropriate arrangements where the patient/client lacks the capacity to consent, for example, children and young people, vulnerable adults and users with intellectual disabilities;
PE3.4.	Consent is documented in the patient/client's record where relevant;
PE3.5.	Acknowledgment of the patient/client's right to withhold or withdraw consent;
PE3.6.	Gaining consent when data is likely to be used for training or research purposes and/or if it will be shared electronically within or outside of the provider organisation.

PE4 The healthcare provider must manage feedback and complaints System(s) must ensure, where applicable:	
PE4.1.	Feedback/complaints procedures and materials are available in a variety of formats and media;
PE4.2.	Confidentiality for those giving feedback and/or making a complaint;
PE4.3.	Regular review of feedback and complaints with collation, analysis, actions and dissemination to all relevant parties;
PE4.4.	Involvement of users in the development and review of feedback and complaints materials, where relevant.

Safety and Risk Management Domain

The purpose of the Safety and Risk domain is to ensure that the healthcare provider delivers the highest level of safety for all users. This is achieved through assessment and management of the risks associated with delivery of its services.

SR1 The healthcare provider must manage all service risks Systems must ensure, where applicable:	
SR1.1.	An overall risk management strategy that has been developed in collaboration with the parent organisation;
SR1.2.	Risk assessments to identify: • Risks associated with clinical activities e.g. infection control; • Non-clinical risks e.g. COSHH, moving and handling, violence and aggression etc;
SR1.3.	Maintenance of a comprehensive and up-to-date risk register to document, escalate and report risks, as necessary;
SR1.4.	Tools are in place to record, report, investigate and manage adverse incidents and near misses within specified timescales
SR1.5.	Management of patient safety alerts, and appropriate actions;
SR1.6.	Regular health and safety training for all staff;
SR1.7.	Readily available, well-maintained health and safety and risk-reduction equipment and devices;

Facilities and Resources domain

The purpose of the Facilities, Resources and Workforce domain is to ensure that the healthcare provider's resources are used effectively to provide safe, efficient, comfortable and accessible services. This is achieved through appropriate and adequate facilities (rooms and equipment); motivated and competent staff; and the integration of sound business planning principles.

FR1 The healthcare provider must manage facilities and environment to support service delivery. System(s) must ensure, where applicable:	
FR1.1.	Sufficient suitable space to deliver all aspects of the service;
FR1.2.	Enough suitable facilities for patient/client confidentiality and privacy and dignity;
FR1.3.	Appropriate access for users and staff who use wheelchairs, trolleys/beds, have impaired vision, hearing, or have other needs;
FR1.4.	Management and monitoring of the condition of facilities and environment including cleaning and maintenance;
FR1.5.	Display of relevant signage to notify users, staff and visitors of access and specific hazards.
FR1.6.	Facilities and environment are fit for their intended purpose, in particular:
FR1.6.1	**Clinical facilities** • Records relating to environmental conditions that allow for correct performance (assure quality and integrity) of the clinical activity concerned e.g. noise reduction, ventilation, variable lighting and temperature, equipment performance; • Appropriate facilities for decontamination of equipment and consumables
FR1.6.2	**Reception, waiting and changing facilities** • Sufficient and appropriate seating facilities for all patients/clients including space for those waiting in wheelchairs, needing bariatric support, waiting for hospital transport, as appropriate; • Appropriate waiting areas for children, vulnerable adults and their carers and those waiting on trolleys; • Screened areas for patients/clients dressed in gowns or those waiting on trolleys or in beds; • Secure storage facilities for patient's/clients' valuables;
FR1.6.3	**Staff facilities** • Sufficient and appropriate changing facilities for staff including those with disabilities; • Access to safe storage for personal items; • Access to toilet facilities and drinking water; • Storage of personal protective equipment.

FR2 The healthcare provider must have systems in place for the selection of external services and suppliers for equipment, reagents, drugs (includes contrast media), radioactive medicinal products and consumables	
System(s) must ensure, where applicable:	
FR2.1.	Maintenance of an approved list of suppliers;
FR2.2.	Availability of purchasing criteria that clearly describe the requirements for the product(s) and or service(s) to be purchased;
FR2.3.	Review of budgets/funding for equipment, reagents, gases, drugs, radioactive medicinal products and consumables, at least annually, and where appropriate managed in conjunction with the parent organisation;
FR2.4.	Regular monitoring of all purchases to ensure consistency with specified criteria.

FR3 The healthcare provider must receive, store and manage equipment, reagents, drugs (includes contrast media), radioactive medicinal products and consumables.	
System(s) must ensure, where applicable:	
FR3.1.	Verification that the receiving location/facility has adequate storage and handling capabilities to maintain the purchased items in a manner that prevents damage and deterioration;
FR3.2.	Verification of the performance of any new batch or shipment before use in clinical procedures;
FR3.3.	Maintenance and routine implementation of an inventory control system;
FR3.4.	Appropriate instructions for use for all items are readily available;
FR3.5.	Investigation and reporting of any adverse incidents or accidents that can be attributed directly to use of an item;
FR3.6.	Maintenance of records for each item that contributes to the performance of clinical procedures.

FR4 The healthcare provider must manage procurement, installation and replacement of all equipment	
System(s) must ensure, where applicable:	
FR4.1.	Any equipment used (including that on loan to patients/clients for use outside of the healthcare provider) meets the specific requirements of the clinical activities offered and the target population concerned (e.g. weight, age, disability etc);
FR4.2.	Maintenance of an equipment inventory and rolling replacement programme Including software, upgrades (including diagnostic software) and accessory devices (e.g. couches, chairs etc);
FR4.3.	Regular review of equipment budget, at least annually, and where appropriate managed in conjunction with the parent organisation;
FR4.4.	Acceptance testing upon installation and before use;
FR4.5.	Maintenance of training and authorisation records for staff to operate specific equipment;
FR4.6.	Agreed minimum information is maintained for any equipment that contributes to the performance of clinical activity. The expectation is that records will include: • Identity of the equipment; • Manufacture's name, model and serial number or their unique identification; • Contact information for the supplier or the manufacturer;

	• Date of receiving and date of entering use within the service; • Location of the equipment; • Condition when received (new, used or reconditioned); • Manufacturer's instruction manual; • Confirmation of acceptability for use; • Maintenance carried out and the schedule for preventative maintenance; • Performance records (reports/calibration certificates) that confirms ongoing acceptability for use; • Record of any damage to, malfunctions, modification and or repairs.

FR5 The healthcare provider must calibrate and maintain equipment System(s) must ensure, where applicable:	
FR5.1.	Use of an authorised/accredited body to conduct calibration;
FR5.2.	That calibration and maintenance takes account of conditions of use and manufacturer's instructions;
FR5.3.	Traceability between the equipment and the calibrated reference standard;
FR5.4.	Verification of the measurement accuracy at defined measurement intervals;
FR5.5.	Timely and accurate updating of correction factors as necessary;
FR5.6.	Safeguards to prevent adjustments or tampering that might invalidate clinical results;
FR5.7.	Reporting of faults and management of equipment breakdowns and repairs, in line with legislation, manufacturer's guidelines and organisational policy;
FR5.8.	Mechanisms to communicate health and safety warnings and alerts to staff, which are formally acknowledged, and acted on within specified timescales;
FR5.9.	Regular review of electrical safety, emergency stop devices (where relevant);
FR5.10.	Regular cleaning and decontamination of all equipment, including ancillary equipment following direct contact with patients/clients;
FR5.11.	Maintenance of training and authorisation records for staff who calibrate, clean and decontaminate equipment;
FR5.12.	Timely Investigation and reporting of adverse incidents and accidents caused by defective equipment to manufacturers and relevant authorities;
FR5.13.	Labelling and removal from service of any equipment found to be defective.

FR6 The healthcare provider must recruit, select and train staff to assure competence System(s) must ensure, where applicable:	
FR6.1.	Recruitment and selection criteria for each staff group in line with professional registration requirements;
FR6.2.	Completion of pre-employment checks;
FR6.3.	Verification that each member of staff including locum staff is qualified, trained and authorised (registered where necessary) to perform their intended functions and this is reflected in job description / job plan;
FR6.4.	Tailored induction training and supervision programmes are available specific to each role, circumstance and/or environment. For example, staff taking on new roles, temporary staff, those returning to work following extended leave and students;
FR6.5.	Collaboration with education institutions for education and training support to meet current and predicted staffing needs of the service;
FR6.6.	Maintenance of records of staff training activities, professional qualifications, professional registration status, induction and refresher training courses attended, and certificates of competence with authorisation to carry out specific tasks;
FR6.7.	Regular review of performance and assessment of competence for all staff;
FR6.8.	Protected time for staff to engage in continuous professional development activities and to undertake improvement initiatives;
FR6.9.	Defined mandatory training is specified, available and completed for all staff;
FR6.10.	Systematic monitoring of staff retention and succession planning.

Revised IQIPS Standard (mapped to IQIPS v1)

Leadership and Management	IQIPS v1 2012
LM1. The healthcare provider is or must be part of a legal entity	AY1, AY2
LM2. The healthcare provider must define, document and communicate governance arrangements including leadership, roles, responsibilities and accountabilities	C1 all domains across standard, FR3
LM3. The healthcare provider must operate within its quality policy and monitor performance against measurable quality objectives	FR5, FR6C5, CL1C2
LM4. The healthcare provider must establish, implement, and maintain a quality management system, QMS	Whole standard
LM5. The healthcare provider must ensure that documents and records (including clinical records) are controlled	Extra, plus , CL7
LM6. The healthcare provider must establish and review agreements for any outsourcing /subcontracting clinical services	FR6C5
LM7. The healthcare provider must provide competent advisory services	CL1C3, CL3C5, PE1C6, PE4C6
LM8. The healthcare provider must identify, manage, and eliminate non-conformities by taking corrective actions	Extra plus SA1C6,SA2C7,SA3C5, SA4C4,SA5C7,CL6C5,
LM9. The healthcare provider must seek and eliminate the cause(s) of potential future non-conformities by taking preventative actions	Extra plus SA1C6,SA2C7,SA3C5,SA4C4,SA5C7,CL6C5,
LM10. The healthcare provider must evaluate and audit the effectiveness of their QMS including clinical activities	CL8
LM11. The healthcare provider must manage internal and external major incidents	Extra plus SA5C3,C7, CL6C3,C5
Clinical	
CL1. The healthcare provider must define and deliver its services from referral to discharge or further management	CL1C2,C3, , FR5C2
CL2. The healthcare provider must manage referrals and prepare patients/clients for clinical procedure(s)	CL1C4,C5,C6, CL5C4, PE4C5
CL3. The healthcare provider must assure the technical quality of clinical procedures	CL2C2,C3,C4,CL4C3,C4,C5, PE4C5, FR2C3, FR4C3, CL3C5
CL4. The healthcare provider must assure the clinical and technical quality of records, interpretations and reports	CL3
CL5. The healthcare provider must manage the release of reports	CL1C7, CL3C5,C6,CL7C4, PE1C5

CL6. The healthcare provider must manage clinical information systems	CL7
Patient/Client Experience	
PE1. The healthcare provider must ensure that care is patient/client focussed	PE4,PE2
PE2. The healthcare provider must ensure that information is available for users and stakeholders	PE1, CL9C6(Aud)
PE3. The healthcare provider must ensure that consent is obtained	PE3, CL6C4
PE4. The healthcare provider must manage feedback and complaints	PE5, FR7
Safety and Risk Management	
SR1. The healthcare provider must manage all service risks	SA1, SA2, SA3, SA4, SA5, ,CL4C2,CL5C3, CL6,CL9(Aud/Neuro/Uro/RS/Vas)
Facilities and Resource	
FR1. The healthcare provider must manage facilities and environment to support service delivery	FR1, PE2C3,C4, SA5C6
FR2 The healthcare provider must have systems in place for the selection of external services and suppliers for equipment, reagents, gases, drugs (includes contrast media), radioactive medicinal products and consumables	FR2C2, CL5C2
FR3. The healthcare provider must receive, store and manage equipment, reagents, gases, drugs (includes contrast media), radioactive medicinal products and consumables	FR2C5, CL5C6, CL6C3,SA2C3, SA5C6, CL9C6(Aud)
FR4. The healthcare provider must manage procurement, installation and replacement of all equipment	SA2C4, SA3C3, FR2C2,C3,C4,C5,C6,C7, CL9C2(A/N/U),
FR5. The healthcare provider must calibrate and maintain equipment	SA5C5, FR2C3,C5,C6,C7, CL6C3, SA2C6, SA1C5
FR6. The healthcare provider must recruit, select and train staff to assure competence	SA5C4, FR3C2, C3,C4,C5,C6,C7,PE2C2 FR4C2,C3,C4,C5,C6,C7,C8, FR5C4,C5,C6, FR6C2,C3,C4,C6

Department of Audiology – Standard Operating Procedure SOP200

Title	Paediatric Audiology Behavioural Assessment: Pre-school Children		
Date First Published	April 2021	Review Date	01/07/2026
Current Version Published		Version Number	1.3
Document Managed by	Tracy Kemp	Reviewed By	Rachel Feirn

Due to the frequent changes to government guidance regarding COVID-19 precautions, SOP042 ("Control and Prevention of COVID-19 in the Department of GI Physiology for Staff, Patients and Visitors") should be followed

a	Purpose of this Standard Operating Procedure
	This SOP describes the agreed local departmental approach, taking into account national recommended procedures and guidelines. It is designed to ensure consistency of approach between individual Audiologists.
b	Process for distribution and dissemination
	Disseminated by email to Paediatric Audiology team and discussed at team meetings. SOP saved to Audiology Y: drive.
c	Which patients/staff members is this Standard Operating Procedure applicable to
	All Audiologists involved in Paediatric Behavioural Assessment. SOP saved to Audiology Y: drive. Updated SOPs disseminated by email to Paediatric Audiology team and discussed at team meetings.
d	Appendices
	British Society of Audiology Practice Guidance: The Acoustics of Sound Field Audiometry in Clinical Audiological Applications, 2019 https://www.thebsa.org.uk/wp-content/uploads/2022/02/OD104-79-BSA-Practice-Guidance-Acoustics-of-Sound-Field-Audiometry-March-2019_.pdf British Society of Audiology Recommended Procedure: Visual Reinforcement Audiometry, June 2014 (revision in process 2023) https://www.thebsa.org.uk/wp-content/uploads/2014/06/OD104-37-Recommended-Procedure-Visual-Reinforcement-Audiometry-2014-1.pdf British Society of Audiology Practice Guidance: Assessment Guidelines for the Distraction Test of Hearing, 2018 https://www.thebsa.org.uk/wp-content/uploads/2018/12/OD104-86-Practice-Guidance-Distraction-Test-for-Hearing-Final-copy-August-2018.pdf British Society of Audiology Recommended Procedure: Tympanometry, 2014 https://www.thebsa.org.uk/wp-content/uploads/2013/04/OD104-35-Recommended-Procedure-Tympanometry-.pdf British Society of Audiology Recommended Procedure: Ear examination, 2022 https://www.thebsa.org.uk/wp-content/uploads/2022/02/OD104-54-BSA-Recommended-Procedure-Ear-Examiniation-February-2022.pdf
E	Standard Operating Procedure

Scope:
This document is a standard operating procedure for performing behavioural hearing assessments on pre-school children at the Hull University Teaching Hospitals NHS Trust.

Testing to be carried out by two audiologists/clinical scientists experienced in paediatric testing, with the lead graded Band 6 or higher. All testing should be performed according to British Society of Audiology (BSA) recommended procedures.

Testing to be performed in a sound treated room conforming to BSA guidelines for soundfield audiometry.

Room preparation:

At the start of each day, carry out Stage A checks on all equipment.
Check that the room is clean and tidy and there is an adequate supply of consumables. Complete the room checklist. All surfaces, transducers, transducer leads and toys to be wiped down with Clinell or alcohol wipes before and after seeing each patient.

Patient arrival:

Introduce yourself and any colleagues and observers. Confirm the child's details and the relationship of the accompanying adult/s to the child (ie. parent, grandparent, foster carer etc). Explain the reason for the appointment and how the session will proceed.

History:

A full history should normally be taken prior to commencing testing. However, if a young child is becoming restless, it may be appropriate to proceed to testing and complete the history afterwards, in order to use the best window of opportunity for testing the child.

History to include the following: (questions modified to be age-appropriate)

- Parental / professional concern about hearing or speech & language development
- Birth history, newborn hearing screen result, and any significant medical history
- History of ear infections and other ENT symptoms
- General developmental progress, understanding and social interaction
- Involvement of any other professionals
- The child's state of health on the day of testing.

Otoscopy:

For this age group, otoscopy is generally best conducted after testing, because of the risk of upsetting the child. However, otoscopy must be conducted prior to inserting insert earphones into the ears for ear-specific testing.

Testing:

1. **Behavioural hearing assessment**

Behavioural hearing testing should be performed at a range of frequencies important for speech.
The choice of test will depend on the age and developmental stage of the child, and the amount of information obtained will depend on the child's co-operation and attention span. As a general guide:

i) From 6-8 months developmental age:

a) Visual Reinforcement Audiometry: the test of choice for this age group.

- Measure minimal response levels in sound field dBHL at 0.5, 1 and 4kHz; additionally 2kHz where possible.

- The default stimulus is FM warble tones. However, if the child is unresponsive to warble tones, FRESH noise may be used. FRESH noise may also be useful for initial conditioning prior to reverting to warble tones.
- Repeatable responses down to 25 dBHL can be taken as satisfactory hearing.
- If sound field thresholds are raised, attempt not-masked bone conduction testing where possible.
- If satisfactory sound field responses are obtained, localisation may be checked using FRESH noise. Check localisation to both left and right using 60 dBHL FRESH noise at 1kHz.
- Consider ear-specific testing using insert earphones. Note that:
    - Ear-specific testing is particularly important in some circumstances – see 'Management' section below
    - Otoscopy must be carried out before inserting earphones, to check for contraindications such as obstructive wax.

  With insert earphones, 20 dBHL is generally taken as satisfactory hearing. Consider correction factors at lower for young infants – see BSA VRA recommended procedure for further information.

b) Distraction testing:

- For some children, including very young infants not yet able to sit unsupported and children with additional disabilities or complex needs, it may not be possible to obtain successful conditioning to VRA.
- Measure minimal response levels for a range of low, mid and high frequency sounds.
- Responses at 30 dBA are consistent with satisfactory hearing.

ii) <u>2-3 years developmental age:</u>

a) For some children in this age group, VRA will still be the most appropriate test.

b) Other children in this age group can be successfully conditioned to carry out sound field performance testing using FM warble tones:

- Wherever possible, stimuli should be presented through the sound field speaker, enabling accurate calibration of the signal. A hand-held warbler can be a useful alternative, particularly for initial conditioning.
- Frequencies tested and minimal response levels to test down for are as for VRA.
- As with VRA, proceed to bone conduction and/or ear-specific testing (using insert earphones or TDH39 headphones) as appropriate.

iii) <u>From 3 years developmental age:</u>

- Aim to condition the child for play audiometry. This may need to commence with sound field performance testing, with the aim to move to ear-specific testing using TDH39 headphones whenever possible.
- Test at 0.5, 1 and 4kHz, and 2kHz if possible. Pure tones should be used whenever possible; however FM warble tones may be a more interesting alternative for some children.
- Thresholds should be obtained whenever possible, but screening at 20dBHL can be used for children with limited concentration span.
- If thresholds are raised bilaterally, perform not-masked bone conduction testing.
- With co-operative children, masking may be possible. If masking is needed and not performed, be sure to indicate this when recording and reporting results.

2. <u>Tympanometry</u>

Perform 226Hz tympanometry on both ears, unless contraindicated.

3. Additional tests

Depending on the individual case, the following tests may be useful:

a) Age-appropriate speech discrimination tests – to support other test results and/or demonstrate hearing levels to the parent/carer

b) Otoacoustic emissions – to screen for normal cochlear function – useful particularly if child finds it difficult to co-operate with accurate behavioural testing

Management and de-briefing:

Explain the results to the parent/carer, including the implications for hearing speech sounds.

i) Satisfactory hearing levels and mobile tympanograms

Where there are no contraindications in the history, young children may be discharged on the basis of sound field testing at the discretion of the clinician. Make clear in de-briefing and reporting that the results only reflect the hearing in the better-hearing ear.

Ear-specific testing must be obtained in the following circumstances:

- Newborn diagnostic testing suggested possible unilateral or bilateral hearing loss (PCHI or temporary conductive)
- Risk factors for progressive or acquired hearing loss – eg. Bacterial meningitis, congenital CMV
- Reported concerns about unilateral hearing loss
- Missed newborn hearing screen

Some groups of children require ongoing audiological monitoring. These include children with:

- Down's syndrome
- Cleft palate
- Congenital CMV infection (pre-school children)
- Other syndromes associated with persistent conductive or progressive hearing loss.

Refer to departmental protocols for frequency of monitoring.

Children should not normally be discharged on the basis of a distraction test alone. However, this may sometimes be appropriate at the discretion of the clinician, for example in children with additional and complex needs.

ii) Raised hearing thresholds / abnormal tympanograms

Discuss the results and management options with the parent / carer. Management will depend on the degree and type of hearing loss, duration of loss, degree of concern reported in the history, and parental wishes.

Options include:

- Discharge - for cases of mild middle ear fluid with normal hearing and no reported concerns
- Paediatric audiology review:
    - Mild temporary conductive hearing losses: usually review in 3 months
    - Mild previously-diagnosed PCHI not requiring aiding: usually monitor 6-monthly for pre-school children. (See school-age SOP for frequency of monitoring beyond age 5)

- ENT referral - for more significant or persistent conductive losses, or cases with other significant ENT symptoms such as frequent recurrent ear infections. (Young children referred to ENT who are not yet able to easily co-operate with reliable pure tone audiometry may also be kept under Paediatric Audiology review at the clinician's discretion if there is substantial concern about their hearing. Other cases should be discharged from Paediatric Audiology to await further request from ENT.)
- Hearing aid assessment – for cases of significant PCHI, and significant persistent temporary conductive losses where there is substantial concern about the child's progress or where parents do not wish to have medical management
- Review on complex needs clinic – for difficult-to-assess cases.

Suspected or confirmed new cases of PCHI, and other cases where management is difficult to determine, should be discussed with the Lead Paediatric Audiologist.

Reporting:

- Ensure that all test results are saved in Otosuite / Auditbase.
- Document the history, results and management in an Auditbase journal, using the appropriate journal template, and set the outcome.
- Standard letters may be used for HV/SALT/GP referrals when appropriate. For children referred by a paediatrician, ENT or other professional, or where there is no appropriate standard letter available, a letter should be written. For children under a paediatrician the letter should be uploaded to Lorenzo.

Department of Audiology – Standard Operating Procedure SOP201

Title	Paediatric Audiology Behavioural Assessment: School Age Children		
Date First Published	April 2021	Review Date	01/07/2025
Current Version Published		Version Number	1.3
Document Managed by	Tracy Kemp	Reviewed By	Rachel Feirn

Due to the frequent changes to government guidance regarding COVID-19 precautions, SOP042 ("Control and Prevention of COVID-19 in the Department of GI Physiology for Staff, Patients and Visitors") should be followed

a	Purpose of this Standard Operating Procedure
	This SOP describes the agreed local departmental approach, taking into account national recommended procedures and guidelines. It is designed to ensure consistency of approach between individual Audiologists.
b	Process for distribution and dissemination
	Disseminated by email to Paediatric Audiology team and discussed at team meetings. SOP saved to Audiology Y: drive.
c	Which patients/staff members is this Standard Operating Procedure applicable to
	All Audiologists carrying out hearing assessments with school-age children. SOP saved to Audiology Y: drive. Updated SOPs disseminated by email to Paediatric Audiology team and discussed at team meetings.
d	Appendices
	British Society of Audiology Recommended Procedure: pure-tone air-conduction and bone-conduction threshold audiometry with and without masking, 2018 https://www.thebsa.org.uk/wp-content/uploads/2018/11/OD104-32-Recommended-Procedure-Pure-Tone-Audiometry-August-2018-FINAL-1.pdf British Society of Audiology Recommended Procedure: Tympanometry, 2014 https://www.thebsa.org.uk/wp-content/uploads/2013/04/OD104-35-Recommended-Procedure-Tympanometry-.pdf British Society of Audiology Recommended Procedure: Ear examination, 2022 https://www.thebsa.org.uk/wp-content/uploads/2022/02/OD104-54-BSA-Recommended-Procedure-Ear-Examiniation-February-2022.pdf
E	Standard Operating Procedure

Scope:

This document is a standard operating procedure for performing diagnostic hearing assessments on school-age children at the Hull University Teaching Hospitals NHS Trust.

Testing to be carried out by an audiologist /clinical scientist experienced in paediatric testing, graded Band 6 or higher. All testing should be performed according to British Society of Audiology (BSA) recommended procedures.

Testing to be performed in a sound treated room conforming to BSA guidelines.

Room preparation:

At the start of each day, carry out Stage A checks on all equipment.
Check that the room is clean and tidy and there is an adequate supply of consumables. Complete the room checklist. All surfaces, transducers, transducer leads and toys to be wiped down with Clinell or alcohol wipes before and after seeing each patient.

Patient arrival:

Introduce yourself and any colleagues and observers. Confirm the child's details and the relationship of the accompanying adult/s to the child (ie. parent, grandparent, foster carer etc). Explain the reason for the appointment and how the session will proceed.

History:

A full history should normally be taken prior to commencing testing. If the child becomes very restless, it may be appropriate to proceed with testing and go back to complete the history afterwards.

History to include the following:

- Parent / carer concern about hearing / speech / educational progress
- Teacher / school concern about hearing / speech / educational progress
- Child's own concerns about ears and hearing (depending on age)
- History of ear infections and other ENT symptoms
- Birth history, newborn hearing screen result, family history of PCHI, and any significant medical history
- Involvement of any other professionals
- The child's state of health on the day of testing.

Otoscopy:

Otoscopy should normally be conducted prior to commencing testing. With young or anxious children, it may be more helpful to carry out testing first and complete otoscopy afterwards.

Testing:

1. **<u>Pure tone audiometry</u>**

PTA should be performed based on the BSA recommended procedure, with modifications as necessary depending on the child's age, co-operation and attention span. For younger children and those with limited attention span, concentrate on obtaining reliable information at a few key frequencies first. It is usually wise to swap back and forth between the ears, rather than testing several frequencies in one ear before any have been tested in the second ear.

- Pure tones should normally be used as the stimulus, rather than FM warble tones, unless the child is having difficulty responding reliably to the pure tone stimulus.
- As a minimum, aim to measure thresholds at 0.5, 1, 2 and 4kHz, with additional frequencies where possible.
- Measure thresholds whenever possible. However, young children with limited attention span can be screened at 20 dBHL if it proves difficult to obtain accurate thresholds.
- Where appropriate, perform bone conduction testing at 0.5, 1 and 2kHz.
- If masking is needed but has not been performed (due to the child's age/ability/concentration span) be sure to indicate this clearly when reporting results.
- Young children may need to be conditioned for the test using sound field warble tones prior to introducing the headphones. If the child is unable to co-operate with reliable audiometry using headphones, measure

sound field FM warble tone thresholds. This should preferably be done using the sound field speakers to present the stimulus, as the calibration is more accurate than with the handheld warbler.

2. <u>Tympanometry</u>

Perform 226Hz tympanometry on both ears, unless contraindicated. For older children this can be done prior to audiometry.
If pure tone thresholds are within normal limits in both ears and there are no relevant concerns in the history, tympanometry can be omitted.

3. <u>Additional tests</u>

Depending on the individual case, the following tests may be useful:

a) Age-appropriate speech discrimination tests:
- to support other test results
- to demonstrate hearing levels to the parent/carer
- to gain an indication of true hearing ability if non-organic hearing loss is suspected
- to give an indication of speech discrimination ability in cases of auditory neuropathy spectrum disorder or auditory processing disorder.

b) Otoacoustic emissions:
- screen for normal cochlear function, when middle ear function is normal
- useful for cases of possible non-organic hearing loss
- note that significant wax, middle ear fluid or negative middle ear pressure will often prevent OAEs being recorded.

Management and de-briefing:

Explain the results to the parent/carer, including the implications for hearing speech sounds.

i) <u>Hearing within normal limits and mobile tympanograms</u>

Where there are no contraindications in the history, children can be discharged.

Ear-specific thresholds should normally be obtained for this age group. For young children with short attention span, it is acceptable to discharge the child based on screening at 20 dBHL.

Some groups of children require ongoing audiological monitoring. These include children with:
- Down's syndrome
- Cleft palate
- Other syndromes associated with persistent conductive or progressive hearing loss.
- Unilateral PCHI

Refer to departmental protocols for frequency of monitoring.

ii) <u>Raised hearing thresholds / abnormal tympanograms</u>

Discuss the results and management options with the parent / carer. Management will depend on the degree and type of hearing loss, duration of loss, degree of concern reported in the history, and parental wishes.

Options include:

- Discharge - for cases of mild middle ear fluid with normal hearing, or minimal hearing loss at low frequencies, and no reported concerns

- Paediatric audiology review:
    - Mild temporary conductive hearing losses: usually review in 3 months
    - Mild previously-diagnosed PCHI not requiring aiding: if hearing is stable, monitor annually until age 10 and then discharge (for review on request). Monitoring can continue beyond age 10 at the clinician's discretion.

- ENT referral - for more significant or persistent conductive losses, or cases with other significant ENT symptoms such as frequent recurrent ear infections. These children should normally be discharged from Paediatric Audiology review, to await further request from ENT.

- Hearing aid assessment – for cases of significant PCHI, and significant persistent temporary conductive losses where there is substantial concern about the child's progress or where parents do not wish to have medical management

- Review on complex needs clinic – for difficult-to-assess cases.

Suspected new cases of PCHI, and other cases where management is difficult to determine, should be discussed with the Lead Paediatric Audiologist.

iii) <u>Occlusive wax</u>

If hearing levels are normal, the child can be discharged.
If hearing levels are raised, advise use of wax softening drops (unless contraindicated by the history) and review for re-test, usually in 3 months.
If wax is persistent and there is a significant hearing loss, children can be referred to the ENT nurses for microsuction.

Reporting:

- Ensure that all test results are saved in Otosuite / Auditbase.
- Document the history, results and management in an Auditbase journal, using the appropriate journal template, and set the outcome.
- Standard letters may be used for HV/SALT/GP referrals when appropriate. For children referred by a paediatrician, ENT or other professional, or where there is no appropriate standard letter available, a letter should be written. For children under a paediatrician the letter should be uploaded to Lorenzo.

Department of Audiology – Standard Operating Procedure SOP###

Title			
Date First Published		Review Date	
Current Version Published		Version Number	
Document Managed by		Reviewed By	

a	Purpose of this Standard Operating Procedure
	Purpose of the document, including rationale for having a policy/procedural document in this area
b	Process for distribution and dissemination
	Self-explanatory
c	Which patients/staff members is this Standard Operating Procedure applicable to
	Detail where documents are stored and monitored (i.e. Document Store with dates, etc.) *How patients/staff are updated when changes take place*
d	Appendices
	Hyperlinks to relevant documents where appropriate (i.e. to Consent SOP/Covid SOP, etc.)
e	Standard Operating Procedure

Main body of the document (flow charts or diagrams can be used where possible to simplify the process)

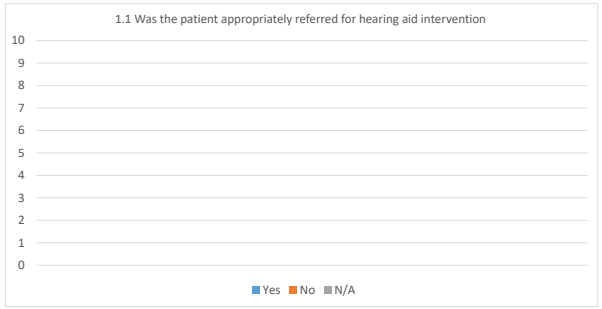
Local Protocol/SOP	Review due date	Comments
SOP001 - Standard SOP template	Mar-25	
SOP002 - Adult Audiology direct referral SOP	Mar-25	Discontinued
SOP003 - H&S use of lathe	Feb-25	
SOP004 - H&S use of sharps	Feb-25	
SOP005 - H&S use of drill	Feb-25	
SOP006 - H&S use of superglue	Feb-25	
SOP007 - Adult Audiology direct referral guidelines	Mar-25	
SOP008 - Holiday request guidelines	Mar-25	
SOP009 - ABR Protocol	Dec-23	Emailed Carl re updated version
SOP010 - Otoneurological ABR protocol	Dec-23	Discontinued
SOP011 - Transport patient guidance	Oct-24	
SOP012 - Acoustic reflex threshold protocol	Mar-25	
SOP013 - Hearing aid repair SOP	Mar-25	
SOP014 - Guidelines for testing infectious patients	Sep-26	
SOP015 - In the ear hearing aid candidacy guidelines	Mar-25	
SOP016 - Real ear to couple difference guideline	Mar-25	
SOP017 - Hear to Help IG policy	Mar-25	
SOP018 - Equipment fault reporting SOP	Mar-25	
SOP019 - Sudden hearing loss	Jun-25	
SOP020 - Performing Competency Assessments & Observations	Oct-25	
SOP021 - Management of Asymmetrical Sensorineural Hearing Loss and Tinnitus	Dec-23	SB & PV to update 01/03/2024
SOP900 - Audit SOP Guideline	Oct-25	
SOP901 - Document Protection v1	Nov-25	
SOP902 - How to complete non-comformity log	Nov-23	Discontinued
SOP903 - Department annual operational review meeting	Nov-24	

1. Was the patient appropriately referred for hearing aid intervention

Patient	1.1 Was the patient appropriately referred (Yes / No)							
	Referral source	Type of hearing loss	DoB (--/--/--)	Issue date (--/--/--)	Age	Gender	Yes/No/N/A	Comment
Paed-HA-01								
Paed-HA-02								
Paed-HA-03								
Paed-HA-04								
Paed-HA-05								
Paed-HA-06								
Paed-HA-07								
Paed-HA-08								
Paed-HA-09								
Paed-HA-10								

1.1 Was the patient appropriately referred

Yes	0
No	0
N/A	0



Guidance for appropriate referral:-

1. Were hearing levels on average below 30dBHL across the known speech frequencies
2. Was the hearing loss long term (i.e. more than 6 months)
3. Was there significant concerns about speech development

2. Were governance checks completed (Refer to Auditbase journal)

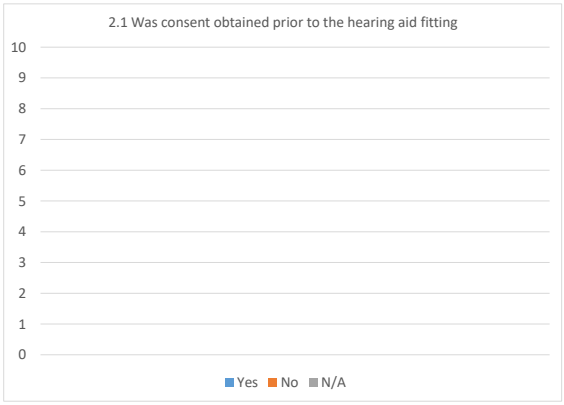
Patient	2.1 Was consent obtained prior to the hearing aid fitting (Yes / No)	
	Yes/No/N/A	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	2.2 Was the patients ID and address confirmed (Yes / No)	
	Yes/No/N/A	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	2.3 Was consent obtained to share information with education (SaPTs / IPaSS) (Yes / no)	
	Yes/No/N/A	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

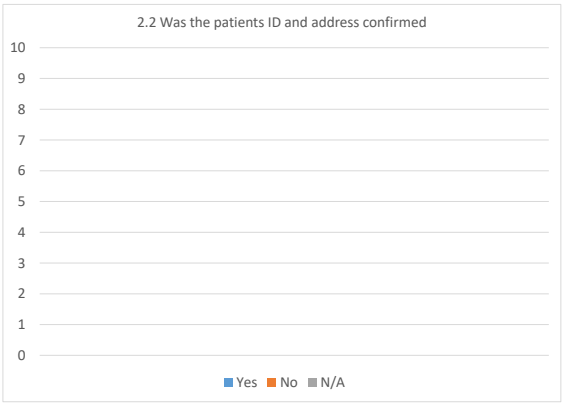
2.1 Was consent obtained prior to the hearing aid fitting

Yes	0
No	0
N/A	0



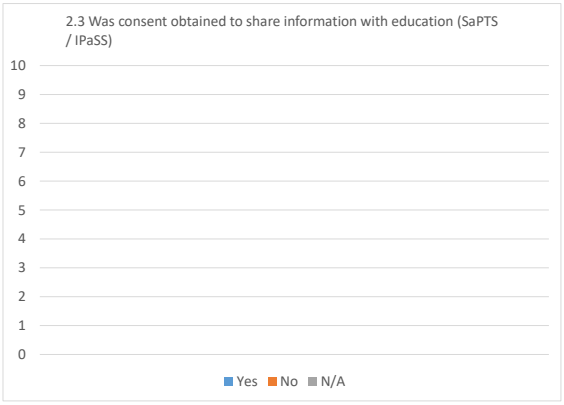
2.2 Was the patients ID and address confirmed

Yes	0
No	0
N/A	0



2.3 Was consent obtained to share information with education (SaPTs / IPaSS)

Yes	0
No	0
N/A	0



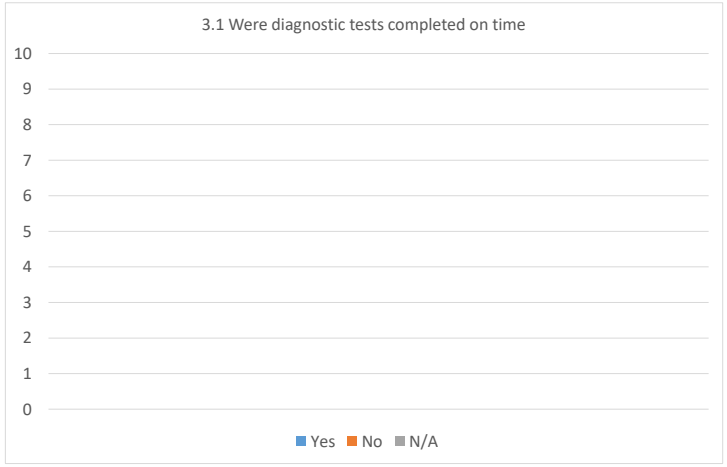
3. Were performance indicators (KPIs) achieved (Check Auditbase journal to establish time line)

Patient	3.1 Were diagnostic tests completed on time (NHSP 4 wks other 6 wks) (Yes / No)		
	Yes/No/N/A	Wks over / under KPI	Comment
Paed-HA-01			
Paed-HA-02			
Paed-HA-03			
Paed-HA-04			
Paed-HA-05			
Paed-HA-06			
Paed-HA-07			
Paed-HA-08			
Paed-HA-09			
Paed-HA-10			

Patient	3.2 Were hearing aid(s) fitted within 4 weeks from identification of need		
	Yes/No/N/A	Wks over / under KPI	Comment
Paed-HA-01			
Paed-HA-02			
Paed-HA-03			
Paed-HA-04			
Paed-HA-05			
Paed-HA-06			
Paed-HA-07			
Paed-HA-08			
Paed-HA-09			
Paed-HA-10			

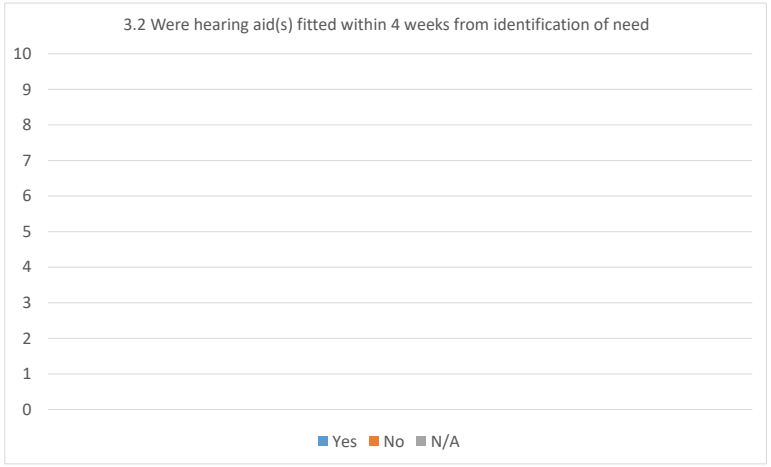
3.1 Were diagnostic tests completed on time (NHSP 4

Yes	0
No	0
N/A	0



3.2 Were hearing aid(s) fitted within 4 weeks from

Yes	0
No	0
N/A	0



4. Was the hearing aid prescription, earmould(s) and hearing aid type appropriate

Patient	4.1 Was the hearing aid prescription selected appropriate (DSLv5) (Yes / No)	
	Yes/No	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

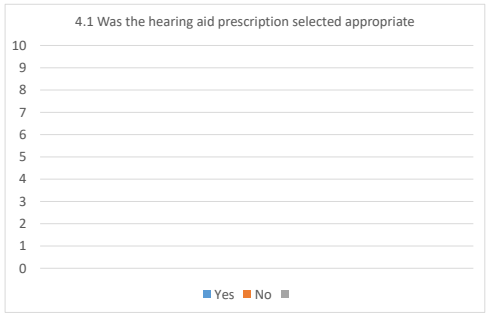
Patient	4.2 Was the most appropriate compression selected (linear / non linear) (Yes / No) As a guide conductive losses set to linear & S/N losses set to non-linear		
	Type set	Yes/No	Comment
Paed-HA-01			
Paed-HA-02			
Paed-HA-03			
Paed-HA-04			
Paed-HA-05			
Paed-HA-06			
Paed-HA-07			
Paed-HA-08			
Paed-HA-09			
Paed-HA-10			

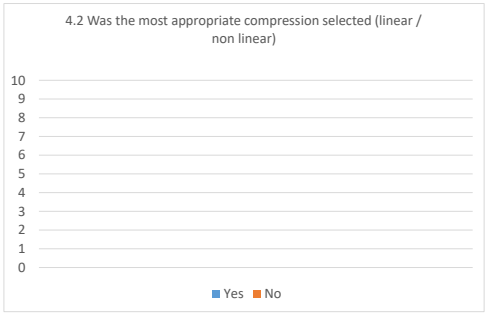
4.1 Was the hearing aid prescription selected appropriate (DSLv5)

Yes	0
No	0

4.2 Was the most appropriate compression

Yes	0
No	0





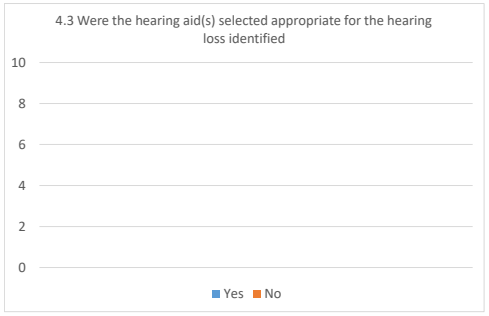
Patient	4.3 Were the hearing aid(s) selected appropriate for the hearing loss identified (Yes / No) Did power output match hearing levels	
	Yes/No	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	4.4 Were the earmould(s) appropriate and a good fit (Yes / No) Check material and acoustic properties	
	Yes/No	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	4.5 If indicated was a tamperproof elbow and battery drawer fitted (Yes / No) Check age of child and siblings	
	Yes/No/N/A	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

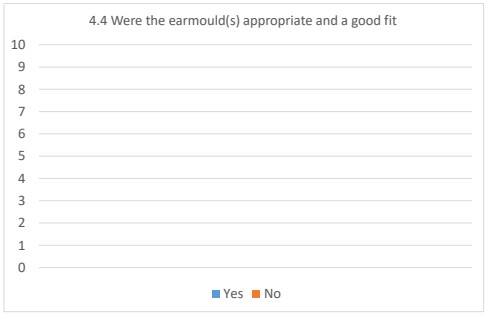
4.3 Were the hearing aid(s) selected appropriate for the hearing loss identified

Yes	0
No	0



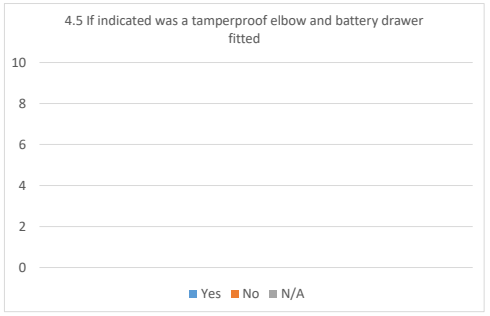
4.4 Were the earmould(s) appropriate and a good fit

Yes	0
No	0



4.5 If indicated was a tamperproof elbow and battery drawer fitted

Yes	0
No	0
N/A	0



5. Were validation checks completed according to BSA

Patient	5.1 RECD measurement taken (Yes / No / other) Check journal and Otosuite	
	Yes/No/other	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	5.2 Were REMs completed within tolerance (Yes / No) Check otosuite	
	Yes/No/N/A	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	5.3 Was a functional check completed to confirm the absence of loudness discomfort (Yes / No) Check journal	
	Yes/No	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

5.1 RECD measurement taken

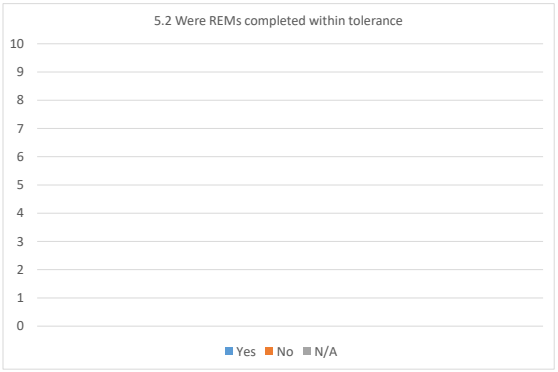
Yes	0
No	0
Excessive wax	0
Non compliance	0
Atresia	0

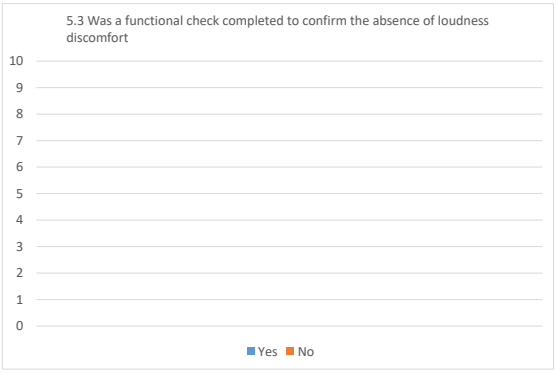
5.2 Were REMs completed within tolerance

Yes	0
No	0
N/A	0

5.3 Was a functional check completed to confirm the absence of loudness discomfort

Yes	0
No	0





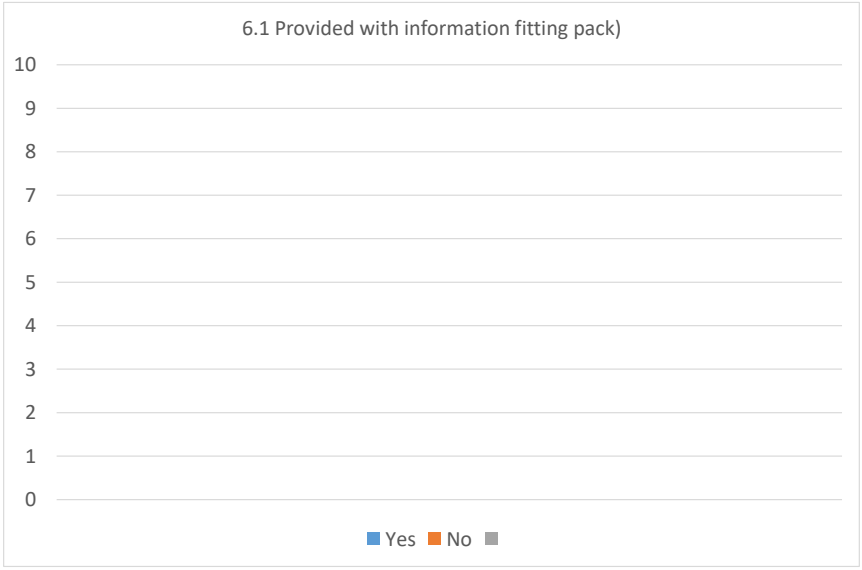
6. Was patient information provided

Patient	6.1 Provided with information fitting pack (Yes / No) Check journal	
	Yes/No	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

Patient	6.2 Provided with Oliver care kit / tubing puffer (Yes / No) Check journal	
	Yes/No/N/A	Comment
Paed-HA-01		
Paed-HA-02		
Paed-HA-03		
Paed-HA-04		
Paed-HA-05		
Paed-HA-06		
Paed-HA-07		
Paed-HA-08		
Paed-HA-09		
Paed-HA-10		

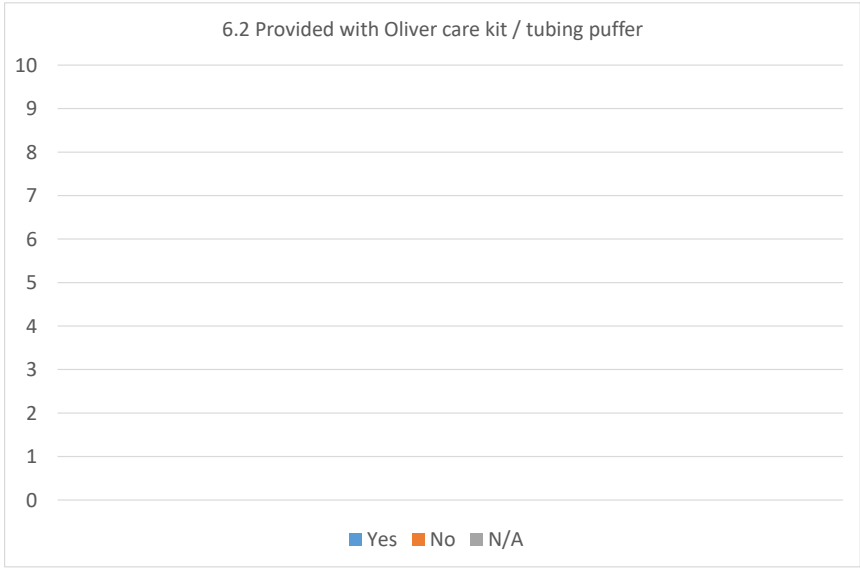
6.1 Provided with information fitting pack

Yes	0
No	0



6.2 Provided with Oliver care kit / tubing puffer

Yes	0
No	0
N/A	0

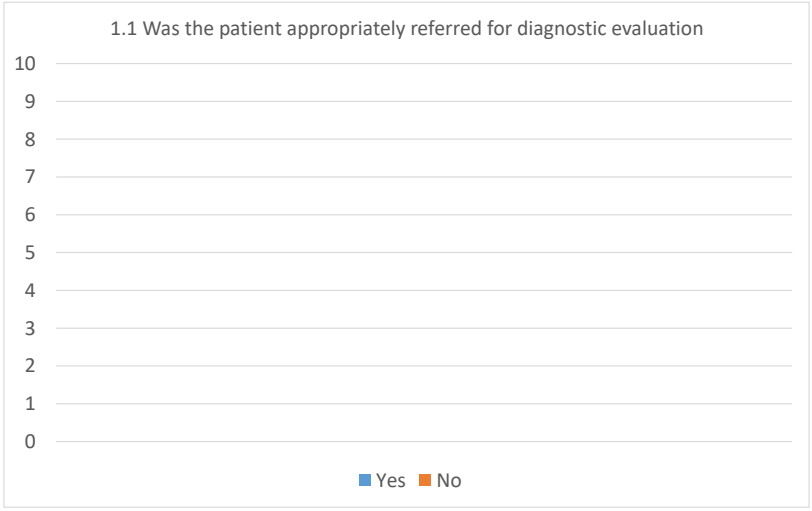


1. Was the patient appropriately referred for diagnostic evaluation (refer to triage SOP)

Patient	1.1 Was the patient appropriately referred (Yes / No)						
	Referral source	DoB (--/--/--)	Referral date (--/--/--)	Age	Gender	Yes/No	Comment
Ref-01							
Ref-02							
Ref-03							
Ref-04							
Ref-05							
Ref-06							
Ref-07							
Ref-08							
Ref-09							
Ref-010							

1.1 Was the patient appropriately referred

Yes	0
No	0



2. Were governance checks completed (refer to Auditbase journal)

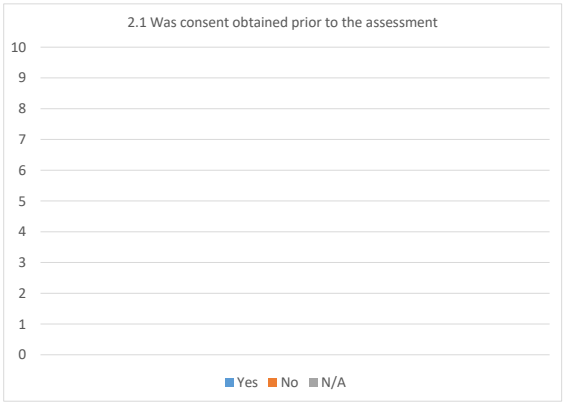
Patient	2.1 Was consent obtained prior to assessment (Yes / No)	
	Yes/No/N/A	Comment
Ref-01		
Ref-02		
Ref-03		
Ref-04		
Ref-05		
Ref-06		
Ref-07		
Ref-08		
Ref-09		
Ref-010		

Patient	2.2 Was the patients ID and address confirmed (Yes / No)	
	Yes/No/N/A	Comment
Ref-01		
Ref-02		
Ref-03		
Ref-04		
Ref-05		
Ref-06		
Ref-07		
Ref-08		
Ref-09		
Ref-010		

Patient	2.3 Was the guardians / carers relationship to the patient confirmed (Yes / No)	
	Yes/No/N/A	Comment
Ref-01		
Ref-02		
Ref-03		
Ref-04		
Ref-05		
Ref-06		
Ref-07		
Ref-08		
Ref-09		
Ref-010		

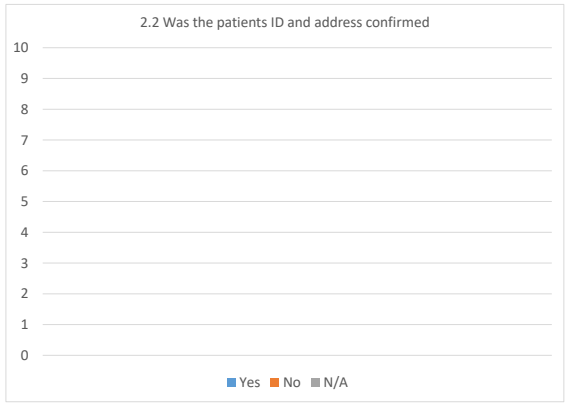
2.1 Was consent obtained prior to the assessment

Yes	0
No	0
N/A	0



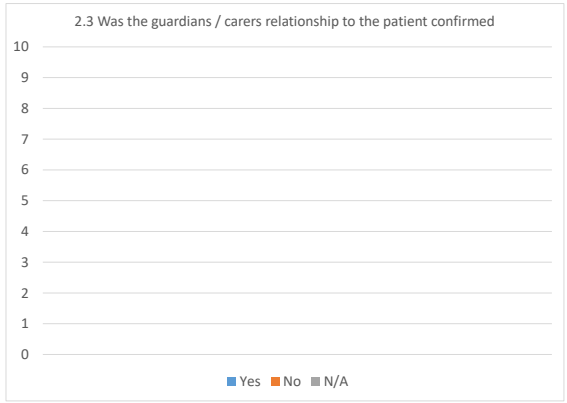
2.2 Was the patients ID and address confirmed

Yes	0
No	0
N/A	0



2.3 Was the guardians / carers relationship to the patient confirmed

Yes	0
No	0
N/A	0

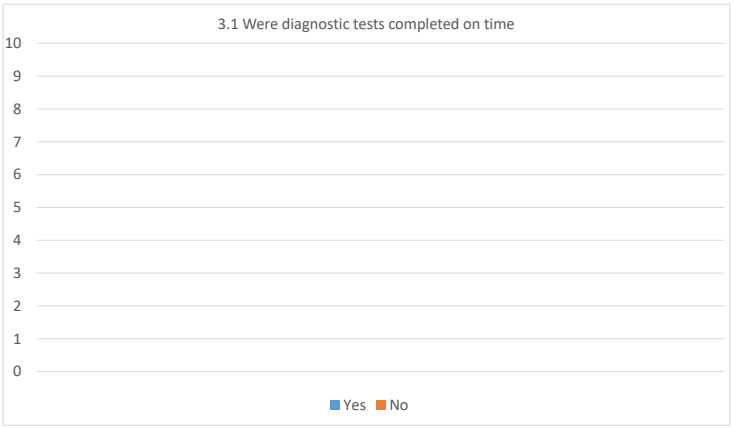


3. Were performance indicators (KPIs) achieved (check Auditbase journal to establish time line)

Patient	3.1 Were diagnostic tests completed on time (NHSP 4 wks other 6 wks) (Yes / No)					
	Date of test	Wait (wks)	KPI (4wks/6wks)	Wks over / under KPI	Yes/No	Comment
Ref-01						
Ref-02						
Ref-03						
Ref-04						
Ref-05						
Ref-06						
Ref-07						
Ref-08						
Ref-09						
Ref-010						

3.1 Were diagnostic tests completed on time (NHSP 4 wks other 6 wks)

Yes	0
No	0

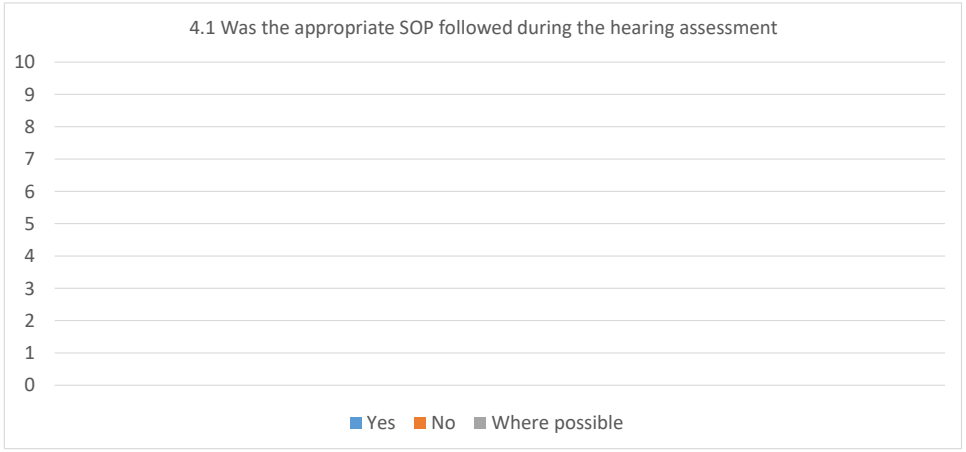


4. Were SOPs followed during the assessment process (check Auditbase journal)

Patient	4.1 Was the appropriate SOP followed during the hearing assessment (Yes / No)		
	SOP reference	Yes/No/Where possible	Comment
Ref-01			
Ref-02			
Ref-03			
Ref-04			
Ref-05			
Ref-06			
Ref-07			
Ref-08			
Ref-09			
Ref-010			

4.1 Was the appropriate SOP followed during the hearing assessment

Yes	0
No	0
Where possible	0



SOP reference key

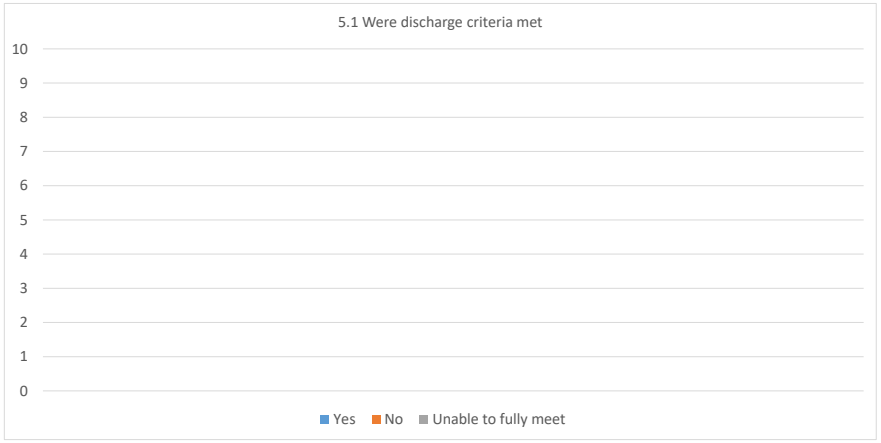
- SOP201 - Paediatric Audiology Behavioural School Age Clinic_final
- SOP200 - Paediatric Behavioural Pre-School Clinic_final

5. Was the regional discharge criteria followed

Patient	5.1 Were discharge criteria met (Yes / No)				
	Preschool / School age	Test type	Discharge criteria (1,2,3 or 4)	Discharge criteria met (Yes / No / Unable to fully meet)	Comment
Ref-01					
Ref-02					
Ref-03					
Ref-04					
Ref-05					
Ref-06					
Ref-07					
Ref-08					
Ref-09					
Ref-010					

5.1 Were discharge criteria met

Yes	0
No	0
Unable to fully meet	0



Minimum Discharge Criteria

1) Auditory Brain stem clinics (ABR):
- Discharge from NHSP well baby no risks no concerns
- OAE minimum 3 band[1] greater than 75% reproducibility discharge, SNR >=6dB BSA OAE standard
- ABR <= 30dBeHL bilaterally at 4kHz
- Discharge from NHSP with risk factors e.g. bacterial meningitis
- <=20eHL 1 and 4 kHz

2) VRA
- Sound-field: =25 dBHL. Minimum of 3 frequencies (500 Hz, 1 or 2 k Hz & 4 kHz)

Risk factors e.g. as per Surveillance-and-audiological-referral-guidelines
- Inserts: 20 dB-HL bilaterally - Minimum of 2 frequencies (1 & 4 kHz)
- If soundfield has not been conducted then 3 frequencies must be obtained (500 Hz, 1 or 2 k Hz & 4 kHz)

3) Performance (sound-field)
- 25 dB-HL. Minimum 3 frequencies (500 Hz, 1 or 2 k Hz & 4 kHz)

Risk factors e.g. as per Surveillance-and-audiological-referral-guidelines
- Inserts: 20 dB-HL bilaterally - Minimum of 2 frequencies (1 & 4 kHz)
- If soundfield has not been conducted then 3 frequencies must be obtained (500 Hz, 1 or 2 k Hz & 4 kHz)

4) Play and PTA
- Headphones ≤20 dBHL. Minimum 3 frequencies (500 Hz 1 or 2 k Hz & 4 kHz)

1. Were the ABR traces internally peer reviewed according to department protocol

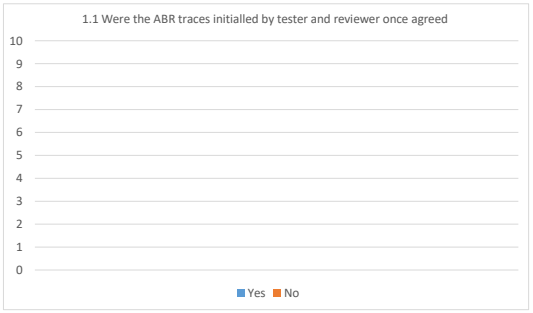
Patient	1.1 Were the ABR traces initialled by tester and reviewer once agreed (Yes / No)			
	Initialled T1	Initialled T2	Yes/No	Comment
ABR T1-01				
ABR T1-02				
ABR T1-03				
ABR T1-04				
ABR T1-05				
ABR T2-01				
ABR T2-02				
ABR T2-03				
ABR T2-04				
ABR T2-05				

Patient	1.2 Is there an internal review spreadsheet (Yes / No)	
	Yes/No	Comment
ABR T1-01		
ABR T1-02		
ABR T1-03		
ABR T1-04		
ABR T1-05		
ABR T2-01		
ABR T2-02		
ABR T2-03		
ABR T2-04		
ABR T2-05		

Patient	1.3 Were the internal reviews completed within 5 working days (Yes / No)	
	Yes/No	Comment
ABR T1-01		
ABR T1-02		
ABR T1-03		
ABR T1-04		
ABR T1-05		
ABR T2-01		
ABR T2-02		
ABR T2-03		
ABR T2-04		
ABR T2-05		

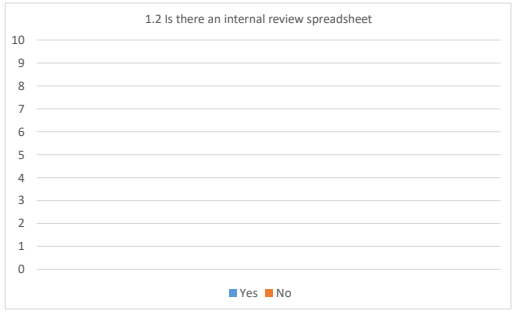
1.1 Were the ABR traces initialled by tester and reviewer once agreed

Yes	0
No	0



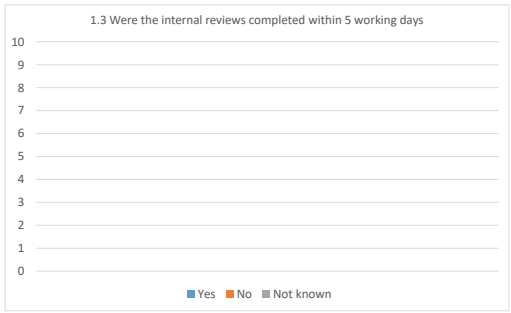
1.2 Is there an internal review spreadsheet

Yes	0
No	0



1.3 Were the internal reviews completed within 5 working days

Yes	0
No	0
Not known	0



Additional notes:-

Internal review process 2023 - internal peer review info/details not logged except that results were agreed - this is someone we're doing from 2024
Date sent for internal peer review (not logged) -, Raw data sent to Internal Reviewer Y drive To do file , saves raw data to Y drive raw data folder. If disagree, discussion with Tester and levels agreed together, traces/actions amended as agreed

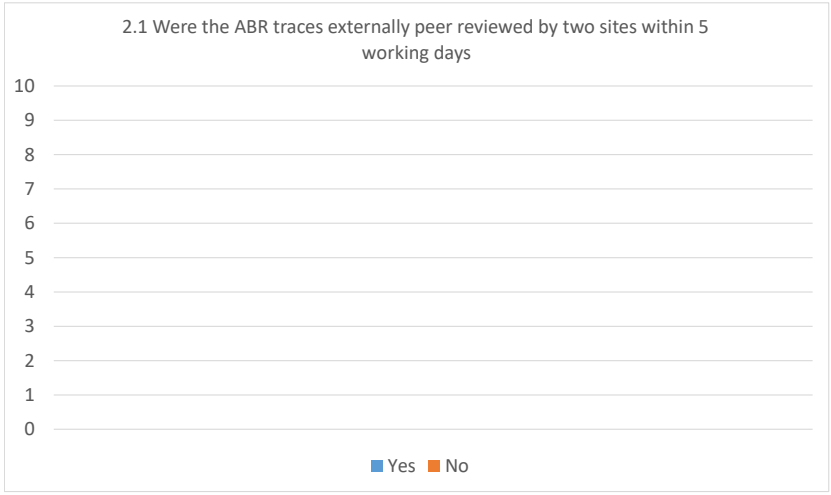
internal peer review
1. Internal Reviewer checks traces, if ok adds initials to each trace labelled Y/N, If N why?
2. Reviewer ID, date reviewed, whether results agreed, improvement indicators entered in ABR peer review log (spreadsheet) - only logged since Jan 2024
3. Any queries/improvement indicators acknowledged, justification, reasoning or amendments dated and detailed in spreadsheet in Comments/Actions - only logged since Jan 2024

2. Were the ABR traces externally peer reviewed according to regional protocol

Patient	2.1 Were the ABR traces externally peer reviewed by two sites within 5 working days (Yes / No) Check early diagnostic file for dates (Y:\AA - Paediatrics\Early Diagnostic\AANBIG\Peer Review\Anonymous PDF ABRs)						
	Date sent for review	Date received (site 1)	No work days (Site 1)	Date received (site 2)	No work days (Site 2)	Yes/No	Comment
ABR T1-01							
ABR T1-02							
ABR T1-03							
ABR T1-04							
ABR T1-05							
ABR T2-01							
ABR T2-02							
ABR T2-03							
ABR T2-04							
ABR T2-05							

2.1 Were the ABR traces externally peer reviewed by two sites within 5 working days

Yes	0
No	0



3. What did we do with the information

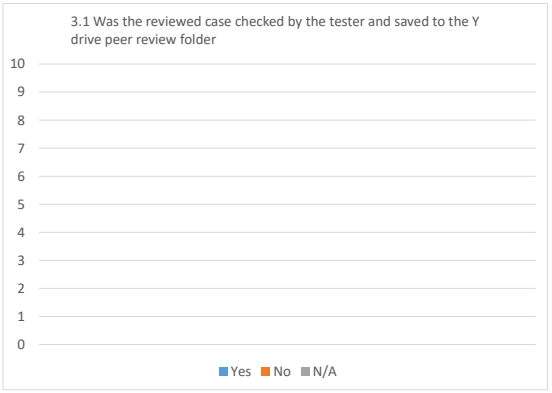
Patient	3.1 Was the reviewed case checked by the tester and saved to the Y drive peer review folder (Yes / No)	
	Yes/No/N/A	Comment
ABR T1-01		
ABR T1-02		
ABR T1-03		
ABR T1-04		
ABR T1-05		
ABR T2-01		
ABR T2-02		
ABR T2-03		
ABR T2-04		
ABR T2-05		

Patient	3.2 Was the peer review spreadsheet fully updated (Yes / No)	
	Yes/No	Comment
ABR T1-01		
ABR T1-02		
ABR T1-03		
ABR T1-04		
ABR T1-05		
ABR T2-01		
ABR T2-02		
ABR T2-03		
ABR T2-04		
ABR T2-05		

Patient	3.3 Were peer review recommended actions considered and responded to appropriately (Yes / No)	
	Yes/No	Comment
ABR T1-01		
ABR T1-02		
ABR T1-03		
ABR T1-04		
ABR T1-05		
ABR T2-01		
ABR T2-02		
ABR T2-03		
ABR T2-04		
ABR T2-05		

3.1 Was the reviewed case checked by the tester and saved to the Y drive peer review folder

Yes	0
No	0
N/A	0



3.2 Was the peer review spreadsheet fully updated

Yes	0
No	0

3.3 Were peer review recommended actions considered and responded to appropriately

Yes	0
No	0

Paediatric Audits

See corresponding worksheet listed on the tabs below reference **(PA1 -PA5)** for copy of proforma used to manage audit. **Includes rationale, standard(s), method and dissemination process**

Project reference	Project title	Project lead	Frequency	Next Audit Due Date	Audit period	Minimum sample	Date last completed
PA1	Hearing aid pathway	Philip Vokes / Tracy Kemp	Once only	N/A	1 January 2023 - 1 January 2024	10 randomly selected	11 January 2024
PA2	New diagnostic referrals – case note audit	Tracy Kemp / Rachel Feirn	Once only	N/A	TBC	10 randomly selected	
PA3	ABR peer review – each tester	Tracy Kemp / Carl Davy	Once only	N/A	TBC	10 randomly selected	
PA4	ID & address verified confirmed - new HA fittings	TBC	Once only	N/A	Sample Q2 2024-25	All fittings completed within quarter	
PA5	RECD completed / where contra-indicated documented	TBC	Once only	N/A	Sample Q2 2024-25	All fittings completed within quarter	

Key:-
No longer required
In date
Out of date
New audit

CLINICAL·AUDIT·OUTCOMES·FORM¶

PLEASE·ENSURE·THAT·ALL·FIELDS·ARE·COMPLETE·AND·THAT·THE·GOVERNANCE,·AUDIT·OR·CLINICAL·LEAD·FOR·THE·SERVICE·HAS·READ·AND·SIGNED·THIS·FORM¶

Project·No.¤	PA1¤	**Health·Group·and·Speciality:¤**	Clinical·Support/Paediatric·Audiology¤
Project·Title¤	Paediatric·hearing·aid·provision·—·Pathway·process·verification¤	**Date·Completed¤**	¤
Project·Lead¤	PV,·TK¤	**Collaborating·specialties/departments¤**	Audiology¤

Issue·or·problem·addressed¤	A·process·evaluation·utilizing·vertical·audit·to·provide·an·assurance·all·components·of·the·paediatric·hearing·aid·pathway·are·being·performed·according·to·department·protocol¤
Rationale·for·audit¤	To·identify·potential·areas·for·improvement·in·the·patient·care·pathway·for·children·identified·as·hearing·impaired·and·in·need·of·hearing·aid·provision.¤
Standards¤	Quality·Standards·in·Paediatric·Audiology,·British·Academy·of·Audiology,·July·2022¶ ¶ Guidance·on·the·verification·of·hearing·devices·using·probe·microphone·measurements,·British·Society·of·Audiology,·May·2018¤
Method¤	Ten·new·paediatric·hearing·aid·fittings·will·be·randomly·selected·using·a·random·number·generator·tool·(https://www.textfixer.com/numbers/random-number-generator.php)·from·babies,·infants·and·older·children·issued·with·hearing·aid(s)·between·1st·January·2023·and·1st·January·2024.··To·preserve·anonymity·each·selection·will·be·numbered·Paed-HA-01·to·Paed-HA-10.··In·the·event·of·a·non-conformity·being·identified·this·will·be·fully·investigated·and·recorded·using·the·non-conformity·tool.¶ ¶ Six·principal·components·of·the·paediatric·hearing·aid·fitting·pathway·will·be·included·within·the·audit;¶ ¶ 1.→Was·the·patient·appropriately·referred·for·hearing·aid·intervention¶ 2.→Were·governance·checks·completed¶ 3.→Were·performance·indicators·(KPIs)·achieved¶ 4.→Was·the·hearing·aid·prescription,·earmould(s)·and·hearing·aid·type·appropriate¶ 5.→Were·validation·checks·completed·according·to·BSA¶ 6.→Was·patient·information·provided¶ ¶ Each·element·of·study·will·be·scrutinized·using·fixed·Yes·or·No·questions·to·provide·an·assurance.··Answers·will·be·transferred·to·excel·for·analysis.··Free·text·is·available·to·provide·narrative·for·non-conformities·or·other·significant·findings.¶ ¶ A·spreadsheet·tool·has·been·prepared·to·guide·and·analyse·results.··Good·practice·and·areas·that·are·found·to·require·improvement·will·be·reported·to·the·audiology·team·via·email·and·quarterly·paediatric·department·meeting(s).··Areas·requiring·improvement·will·be·actioned·following·agreement·by·the·senior·paediatric·team·(TK,·SB·&·PV).¶ ¶ Additional·training·and·follow-up·audit·will·be·actioned·if·there·are·significant·areas·that·require·further·improvement.¤
Results¤	¶ **Please·use·the·headings·below·to·present·the·results·(as·requested·by·the·CQC):-¶** ¶ **Key·Successes¶** ¶ **Question·1.1)¶** **Question·2.1)¶** **Question·2.2)¶**

March·2017¶

	Question·2.3)¶ Question·3.1)¶ Question·3.2)¶ Question·4.1)¶ Question·4.2)¶ Question·4.3)¶ Question·4.4)¶ Question·4.5)¶ Question·5.1)¶ Question·5.2)¶ Question·5.3)¶ Question·6.1)¶ Question·6.2)¶ ¶ Key·Concerns¶ ¶ ¤
Dissemination·of·results¤	Paediatric·Team·(email·and·team·meeting)¤
Recommendations¤	¤
Do·you·give·permission·for·your·report·/·presentation·to·be·made·available·on·the·clinical·audit·intranet·site?····Yes·☐·No·☐¤	
If·you·would·like·this·to·appear·on·the·clinical·audit·intranet·site,·please·add·some·keywords·to·facilitate·searching:¤	

Actions·(including·re-audit*)·¶

If·no·action·is·required·as·the·standards·were·met,·please·state·'no·further·action·required'·on·line·1¶

Please·note·that·a·CG1·form·will·need·to·be·completed·and·submitted·for·approval·before·any·re-audit·data·is·collected.¤

¤	State·action¤	Lead¤	Grade·of·action·(see·table·below)¤	Date·to·be·completed·by¤
1.¤	¤	¤	1·/·2·/·3¤	¤
2.¤	¤	¤	1·/·2·/·3¤	¤

The·level·of·importance·of·actions·is·as·follows:·¶

1·=·Fundamental → 2·=·Significant·····3·=·Requires·Attention¶

Examples:···1·-·urgent·staff·training → 2·-·a·guideline/protocol → 3·-·review·of·guideline·at·renewal·date¤

Please·state·the·route·of·escalation·if·difficulties·are·encountered·in·implementing·the·action·plan·(ie.·clinical·lead,·specialty·governance·meeting):·¤	AP&GG¤
Is·this·a·re-audit?¤	¶ No¤
If·yes,·have·the·results·improved·significantly·enough·to·enable·the·audit·to·be·closed?··¤	¶ ¶ Yes··/··No····· If·no,·please·ensure·further·actions·have·been·identified·and·a·re-audit·planned¶ ¶ ¶ ¶ ¤
Please·state·how·practice·has·changed·as·a·result·of·this·audit·and·any·lessons·	¤

¶

that have been learned¶	

Signature of Governance, Audit or Clinical Lead for the Service	Name (printed)	Date

CLINICAL AUDIT OUTCOMES FORM

PLEASE ENSURE THAT ALL FIELDS ARE COMPLETE AND THAT THE GOVERNANCE, AUDIT OR CLINICAL LEAD FOR THE SERVICE HAS READ AND SIGNED THIS FORM

Project No.	PA2	**Health Group and Speciality:**	Clinical Support/Paediatric Audiology
Project Title	New diagnostic referral case note audit – Pathway process verification	**Date Completed**	
Project Lead	RF, TK	**Collaborating specialties/departments**	Audiology

Issue or problem addressed	A process evaluation utilizing vertical audit to provide an assurance all components of the diagnostic referral to discharge pathway are being performed according to department protocol.
Rationale for audit	To identify potential areas for improvement in the patient care pathway for children referred with potential hearing impairment requiring diagnostic assessment.
Standards	Quality Standards in Paediatric Audiology, British Academy of Audiology, July 2022
Method	Ten diagnostic referrals will be randomly selected using a random number generator tool (https://www.textfixer.com/numbers/random-number-generator.php) from new referrals requiring diagnostic assessment. The cohort will include babies, infants and older children referred from NHSP and health care professionals within community and acute health between 1st January 2023 and 1st January 2024[1]. To preserve anonymity each selection will be numbered Ref-01 to Ref-10. In the event of a non-conformity being identified this will be fully investigated and recorded using the non-conformity tool. *Ref: 1 – Note sample size was revised (1st January 2024 to 30th June 2024) to account for long W/L to ensure pathway of care completed.* Six regionally agreed components of the diagnostic referral to discharge pathway will be included within the audit; 1. Was the patient appropriately referred for diagnostic evaluation 2. Were governance checks completed 3. Were performance indicators (KPIs) achieved 4. Were SOPs followed during the assessment process 5. Was the regional discharge criteria followed Each element of study will be scrutinized using fixed Yes or No questions to provide an assurance. Answers will be transferred to excel for analysis. Free text is available to provide narrative for non-conformities or other significant findings. A spreadsheet tool has been prepared to guide and analyse results. Good practice and areas that are found to require improvement will be reported to the audiology team via email and quarterly paediatric department meeting(s). Areas requiring improvement will be actioned following agreement by the senior paediatric team (TK, SB & PV). Additional training and follow-up audit will be actioned if there are significant areas that require further improvement.
Results	**Please use the headings below to present the results (as requested by the CQC):-** **Key Successes** **Question 1.1)** **Question 2.1)** **Question 2.2)**

	Question·2.3)¶ Question·3.1)¶ Question·4.1)¶ Question·5.1)¶ ¶ Key·Concerns¶ ¶ ¤
Dissemination·of·results¤	Paediatric·Team·(email·and·team·meeting)¤
Recommendations¤	¤
Do·you·give·permission·for·your·report·/·presentation·to·be·made·available·on·the·clinical·audit·intranet·site?····Yes·☐·No·☐¤	
If·you·would·like·this·to·appear·on·the·clinical·audit·intranet·site,·please·add·some·keywords·to·facilitate·searching:¤	

Actions·(including·re-audit*)·¶

If·no·action·is·required·as·the·standards·were·met,·please·state·'no·further·action·required'·on·line·1¶
Please·note·that·a·CG1·form·will·need·to·be·completed·and·submitted·for·approval·before·any·re-audit·data·is·collected.¤

¤	State·action¤	Lead¤	Grade·of·action·(see·table·below)¤	Date·to·be·completed·by¤
1.¤	¤	¤	1·/·2·/·3¤	¤
2.¤	¤	¤	1·/·2·/·3¤	¤

The·level·of·importance·of·actions·is·as·follows:-¶

1·=·Fundamental → 2·=·Significant·····3·=·Requires·Attention¶

Examples:···1·-·urgent·staff·training → 2·-·a·guideline/protocol → 3·-·review·of·guideline·at·renewal·date¤

Please·state·the·route·of·escalation·if·difficulties·are·encountered·in·implementing·the·action·plan·(ie.·clinical·lead,·specialty·governance·meeting):-¤	AP&GG¤
Is·this·a·re-audit?¤	¶ No¤
If·yes,·have·the·results·improved·significantly·enough·to·enable·the·audit·to·be·closed?··¤	¶ ¶ Yes··/··No····· If·no,·please·ensure·further·actions·have·been·identified·and·a·re-audit·planned¶ ¶ ¶ ¶ ¤
Please·state·how·practice·has·changed·as·a·result·of·this·audit·and·any·lessons·that·have·been·learned¶ ¤	¤

¤	¤	¤	¤
Signature·of·Governance,·Audit·or·Clinical·Lead·for·the·Service¤	¤	Name·(printed)¤	¤ Date¤

¶

¶ ¶

HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST

Review: Audiology Performance & Governance Group (APGG) meetings

ICB AUDIT ACTION TRACKING LIST – 19/04/2024

Authors: Tracy Kemp (TK) & Philip Vokes (PV)

Head of Audiology (PV), Paediatric Service Manager (TK)

ITEM	Domain	DESCRIPTION OF OPEN ISSUE	LATEST PROGRESS ON OPEN ACTIONS	LEAD	REVIEW DATE	STATUS
1	Documentation	Triage protocol	***Action: Complete triage protocol for paediatric audiology referrals*** Started, but incomplete draft triage SOP currently used as working document by team to prioritise and allocate new referrals. Based on template shared by York & Scarborough Audiology service who recently underwent IQIPs accreditation. Time needed to complete amendments to reflect HUTH Paediatric Audiology service in correct format and finalise document.	TK	23/06/2024	Action ongoing
2	Documentation	Assessment protocol	***Action: Ensure assessment SOP/protocol completed for all areas of paediatric assessment*** Early diagnostic assessment Preschool assessment – completed – attach document School age assessment – completed – attach document Hearing assessment for children with complex needs Hearing aid assessment Aetiology referral  SOP200 - Paediatric Behavioural Pre-Sch  SOP201 - Paediatric Audiology Behaviou	TK		Action ongoing
3	Documentation	Management protocol	***Action: Ensure management of cases requiring ongoing review including treatment and habilitation*** Paediatric Hearing Aid Initial Fitting SOP Paediatric Hearing Aid Review Appointment SOP	TK		Action ongoing
4	Documentation	All documents have a version control	***Action: All paediatric documents to be controlled using standard templates*** Paediatric SOPs to be formatted using the IQIPs template  Protocol Template.docx All new and reviewed paediatric documents to be added to the document tracker	TK		Action ongoing

			Document Tracker.xls			
5	**Documentation**	**National guidelines referenced**	***Action: Protocols and audit are referenced against the relevant national standard*** Completed audits are referenced against BAA quality standards - see audits Completed protocols are referenced against relevant national standard – see protocols	**TK**		**Action ongoing**
6	**Documentation**	**Local deviations from national standards described**	***Action: These need to be identified by the local team, in agreement with regional practice and documented***	**TK**		**Action ongoing**
7	**Documentation**	**Management options for specific conditions described**	***Action: Local protocol references national guidance where available and/or in agreement with regional practice***	**TK**		**Action ongoing**
8	**Documentation**	**Clear indications of what is an urgent referral**	***Action: Ensure the triage protocol includes fast tracking for urgent referrals*** Identify and document clinical criteria that qualify for fast track Ensure the triage protocol includes a fast track process – see triage protocol	**TK**		**Action ongoing**
9	**Audit**	**Audit plan gives assurance for whole pathway**	***Action: Audit plan includes tools to assess principal functions of the service*** Hearing aid pathway PA1 - Paediatric HA pathway vertical auc New diagnostic referrals – case note audit PA2 - New diagnostic referrals ABR peer review – each tester audit PA3 - ABR peer review vertical audit Annual Audit plan to be agreed at AP & GG annual management review meeting	**TK**	**October 2024**	**Action ongoing**
10	**Audit**	**Audit plan mentions BAA Quality Standards**	***Action: All audits reference the relevant quality standard*** Audit plan includes standard for each audit – see audit plan Paediatric Audits.xls	**TK**		**Action ongoing**
11	**Audit**	**Identified completion dates**	***Action: Audit plan includes completion dates*** Audit plan includes completion and due dates – see audit plan (above)	**TK**		**Action ongoing**

12	**ABR**	**Issues with interpretation that did not affect outcome**	***Action:* Assurance of consistency of ABR test interpretation** Discussed actions required with Regional CSO. Issues seen reflected across region, addressed by regional CSO providing 2 x led ABR peer review training workshops for sites outlining best practice for ABR (March and June 2024). March workshop (Part 1) attended by all 4 ABR Audiologists from Hull, commitment to all attend June workshop (Part 2) to complete requirement. Hull continues to peer review internally and externally following NE&Y ABR Peer Review Group TOR and regularly attends NE&Y ABR PR group meetings.	**TK**	**21/06/2024**	**Action ongoing**

Status	Item	Description	Start	End	Comments
	Workstream	**Audiology Facilities at DPOW for Adults & Peadiatrics**			
On-going	Action	Audiology Booth	08/05/23	01/09/24	Once ophthal move out to move into the clinic room between ENT and Audiology
Complete	Action	Risk Assessment of all rooms at both sites	08/05/23	Completed	Completed
Complete	Action	Locked door at Reception	08/05/23	Completed	New door fitted with hatch
Complete	Action	Move round of Audiology Suite to meet soundproofing standards	08/05/23	Completed	Unneccasry equipment removed from rooms, calibration completed.
Complete	Action	Stop distraction testing at Wheelsby view with immediate effect	08/05/23	Completed	Complete
Complete	Action	Health & safety assessments in all external locations to be undertaken	08/05/23	Ccompleted	Completed as not fit for purpose.
Complete	Action	Range of toys for VRA engagement & Play Audit Audiometry needs improvement and updating	08/05/23	Completed	complete
On-going	Action	VRA testing - Aurical tick sheet must be completed & stored for each test	08/05/23	31/07/23	AS part of paediatirc training and is built into the software on the clinical Astera Audiometers.
Complete	Action	SGH Paeds booth to be reconfigured - extensions installed and re-calibrated before testing can recommence	08/05/23	Completed	Calibrated by Acoustic metrology
	Workstream	**Paediatric Assessment Service**			
Complete	Action	DPOW Service unsafe with current Staff Grade & Band 3 assistance	08/05/23	Completed	Service stopped
Complete	Action	Poor training of medical staff	08/05/23	Stopped	Service Stopped, medics no longer invloved
Complete	Action	Set-up and Calibration of rooms is not appropriate	08/05/23	Completed	Calibrated by Acoustic metrology
Complete	Action	Poor practice in VRA Testing	08/05/23	Stopped	Complete
Complete	Action	For all Community Paeds Clinics - Qualified Audiolgist must be present and lead the testing	08/05/23	Stopped	Clinics suspended moved to Audiology
	Milestone	**Protocols and Documentation**			
On-going	Action	Evidence of poor decision making	08/05/23	31/11/2024	As part of paeddiatric training
Complete	Action	Lack of protocols and pathways in all areas	08/05/23	Completed	New SOP on all elemetns of audiology
Not-started	Action	Notes not visible at all	08/05/23	31/11/2024	To review and discuss - ENT now request paper notes but need to have MDT meeting to discuss pts together.
On-going	Action	Poor practice of documenting VRA responses	08/05/23	31/07/24	As part of paeddiatric training
Complete	Action	Relevant protocols, pathways and SOP's incl onward referals to be reviewed and agreed Trustwide	08/05/23	Completed	Completed
	Milestone	**Appointment Time not satisfactory**			
Complete	Action	1 hour slot for adult re-assessment	08/05/23	Complete	Complete
Complete	Action	1.5 hour slot for Pead re-assessment	08/05/23	Complete	Complete
Complete	Action	1.5 hour slot for hearing aid reviews	08/05/23	Complete	Complete
Complete	Action	1 hour slot for Tinnitus	08/05/23	Complete	Complete
Complete	Action	1 clinic for 1 purpose only	08/05/23	Complete	Complete
Complete	Action	Post clinic time 15 mins	08/05/23	Complete	Complete
Complete	Action	Pre clinic time 15 mins	08/05/23	Complete	Complete
	Milestone	**Training and Development**			

	Action	NATUS training for fitting and REM	08/05/23	On-going	REM audited, online training booked, one triqaning session completed 2nd booked and awaiting dates from Natus.
	Action	NATUS training for sound recovery verification	08/05/23	on-going	As above
	Action	NATUS training for speech	08/05/23	01/09/24	As above
Abandoned	Action	ABR Training at Sheffield Teaching Hospital	08/05/23	Stopped	No longer required
Complete	Action	OAE assessments by BAA	08/05/23	Complete	Programmed in for next 4 weeks
On-going	Action	Etological assessments by Paediatrics to continue	08/05/23	Complete	PCHI cases referred as and when diagnosed
On-going	Action	Support from BAA in decision making for ENT and Paeds	08/05/23	31/07/24	Meeting underttaken and to continue until MDT meetings commnce
On-going	Action	IG Training on safe record keeping to be re-submitted	08/05/23	31/07/24	On-going as part of MT
Complete	Action	Lone worker policy to be evoked	08/05/23	Completed	Policy shared and updated via Aaron on any actions required
Complete	Action	Mobile phones to be purchased	08/05/23	Completed	Both sites have a mobile
Complete	Action	Lack of awareness of Incident & risk assessment - training to be undertaken	08/05/23	31/07/24	Training confirmed and then reaffirmed at weekly meetings
On-going	Action	**Poor appraisal practice with no tangible outcomes for the staff**	08/05/23	31/07/24	Appraisals booked for all DPOW staff
	Action	Deaf awareness training for all admin staff	08/05/23	Completed	Training confirmed
	Milestone	**Communication**			
Complete	Action	Set up regular meetings trustwide with both depts	08/05/23	Completed	regular staff meetings are now taking place.
Complete	Action	Poor quality of Paeds reports therefore onward reporting	08/05/23	Completed	Report templates now in Auditbase for staff to use.
Complete	Action	Conflict between Clinical input to booking rules - to discuss with admin teams	08/05/23	Completed	
Complete	Action	Lack of protected time for Clinical Leaders at both sites - to be reviewed	08/05/23	31/07/23	New starter training pack being commenced
On-going	Action	Poor communication with ENT - no evidence of joined up working or pathways	08/05/23	31/07/24	Audiology lead now attending ENT business meetings and doing some collaborative workingwith both departments.
	Milestone	**Medium to Long Term**			
Complete	Action	Departments need scientific lead with Paed Audiology background	01/09/23	Completed	Audiology Lead Employed 2/10/23
On-going	Action	Agreed protocols and pathways developed across site inc ENT and Paeds	01/09/23	31/07/24	first document agreed with ENT - agreed and working across commiunity andf ENT
On-going	Action	Registration for all relevant clinic staff to be mandated	01/09/23	31/07/24	Only 1 staff member to register
Complete	Action	Appointment times and booking rules agreed cross site	01/09/23	Completed	
Complete	Action	Hot keys for all clinic noting and reports agreed	01/09/23	31/03/24	Hot keys set up in Auditbase
Not-started	Action	Equivalency of roles in training agreed cross site	01/09/23	31/07/24	
On-track	Action	Appraisal training delivered and protected time given to staff to complete objectives	01/09/23	31/07/24	
Not-started	Action	Key clinical staff complete health care notes on trial training	01/09/23	31/07/24	NHS note taking to be accessed via e-learning

Status	Item	Description	Start	End	Comments
On-going	Action	Consider higher specialist training for key staff	01/09/23	31/11/2024	Paediatric training commenced, BAA HTS modules discussed in appriasals with relevant staff.
On-going	Action	Consider upgrading audit base inc the ability to upload docs to webV	01/09/23	31/11/2024	Awaiting for PDF attachment license to be approved, second request submitted, first request rejected in 2023.
On-going	Action	Refresher training for all ages of hearing aids	01/09/23	31/11/2024	DSF funding appproved for course, for paqediatric staff
Not-started	Action	Use of BAA Paeds quality standards as a benchmark for improvements	01/09/23	31/03/24	
Complete	Action	Regular team meetings inc whole team	01/09/23	Completed	Clinical staff from both sites meeting regularly, meeting admin managers and business manager weekly.
On-going	Action	Introduce case review discussions for all staff	01/09/23	31/03/24	Used a case study as part of recent REM audit to demonstrate to staff importance of of
On-going	Action	Annual leave and lone working policies to be invoked	01/09/23	On-going	
Complete	Action	Introduce regular audit of clinical audit, patient out comes and staff competencies	01/09/23	Completed	Some audits have been done, more to be looked at and embedded into a regualr audit cycle for service.
On-going	Action	Both sites require formal governance meetings	01/09/23	31/07/24	Attend clinical science governance meetings, need to now join Head and Neck Governance meetings.
Not-started	Action	Both site require regular meetings with ENT, Community & admin	01/09/23	31/07/24	To envoke MDT meetings

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24) 140

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Gill Ponder, Helen Wright – Chairs of CIC
Contact Officer / Author	Gill Ponder, Helen Wright
Title of Report	Performance, Estates and Finance CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting(s) held on Wednesday 26 June 2024 and Wednesday 24 July 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Group financial position • Cancer performance **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	Financial implications are included in the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

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Committees-in-Common Highlight / Escalation Report to the Trust Boards

	8 August 2024
	Performance, Estates and Finance Committees in Common
	26 June 2024 24 July 2024
	26 June 2024 - Yes, until 11am when Paul Bytheway and Kate Wood left the meeting. 24 July 2024 - Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance, Estates and Finance Committees-in-Common at their meeting(s) held on Wednesday 26 June 2024 and Wednesday 24 July 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

26 June 2024

- Board Assurance Framework
- Risk Register Reports for HUTH/NLAG
- CQC Actions Report – Group
- Financial Report – Month 2
- Group Integrated Performance Report
- Deep Dive – Patient Administration
- Estates and Facilities – General Update
- North Bank Site Report
- South Bank Site Report
- Planned Care Board meeting minutes
- Unplanned Care Board meeting minutes

24 July 2024

- Group Board Assurance Framework including High Level Risks
- CQC Actions Report – Group
- Financial Report Month 3
- National Cost Submission
- Group Integrated Performance Report
- Estates and Facilities – Building Investments
- Premises Assurance Model
- Contract Approvals – Routine Radiology
- North Bank Site Report
- South Bank Site Report

- Care Groups Transitional Arrangements
- Deep Dive – Urgent Care
- Unplanned Care Board meeting minutes

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

Finance – Limited Assurance
The Group financial position was £12m deficit in Month 3, £2.6m adverse to plan. Year to date the deficit was £25.1m (£6.5m adverse). The most significant driver of the overall adverse performance is due to under-delivery year to date of the overall annual cost improvement plan of £85m. Nurse agency expenditure had continued to reduce which was positively adding to the NLaG cost improvement programme (CIP). There remain issues regarding medical staffing.
The Group cash position was improving, but this was heavily reliant on delivery of the planned CIP programme.

A recent letter from NHS England had given the Humber and North Yorkshire Integrated Care Board an oversight framework score of 3+, due to the system run rate and deficit being £7.8m more than plan. As a result, all Provider organisations had been asked to submit a bridge plan by the end of the week showing the actions that would be taken to get back on plan. Grant Thornton had been engaged by NHSE to review system and organisational financial grip and control, pay spend and plans in place and CIP programmes. Whilst the Committees noted that there were plans in place to improve the financial position, controls, accountability and productivity, he CIC agreed limited assurance until an improvement in the financial position was reported and detailed CIP plans were agreed and allocated.

Performance – Assurance levels were variable and detailed in each section below.

Urgent and Emergency Care - There were continued concerns about ED Performance and the performance of the Urgent Treatment Centres at HUTH, including concerns about the lower volumes of patients being seen since the UTC moved to the Hull Royal Infirmary site. A deep dive took place at the July CIC and the Committees were assured that detailed monitoring was taking place and improvement plans were starting to result in some improvements in the critical enablers of performance:

- time to see a clinician
- reducing the time non-admitted patients spend in ED
- improving the assessment, decision making and flow through ED of frail patients over 65 years of age.

There were signs that staff engagement had increased, as they were starting to believe that improvement was achievable if they focused on these 3 metrics. .

The CIC were reasonably assured that there were robust plans in place that were starting to have an impact on the critical enablers

Diagnostics - There was positive progress on overall Diagnostics performance, which was ahead of the planned improvement trajectory.

The CIC were reasonably assured due to the sustained improvements being reported.

Cancer – Pathway improvements and plans were in place for every modality to increase performance against the Faster Diagnosis standard at NLaG and the 62 day standard across the Group. These included improving the 7 day diagnostic turnaround as well as patients having treatment plans in place by day 38, as that was a critical enabler to achieving the 62 day standard. The focus is on sustainability of improvement plans across all modalities.

The CIC gave limited assurance regarding cancer performance as there were multi-factorial issues across all of the pathways which included; theatre capacity, specific tumour site workforce challenges and administration issues. The Cancer Improvement Programme was in place to address these issues and their focus was on days 28-62 of the pathways, as some improvements had already been made in the activities in the first 28 days of the pathways. The Committee asked for the next Deep Dive on Cancer to PEF to include progress against previously agreed plans with the Cancer Alliance.

Elective Activity - The 78ww (week wait) target of zero had been achieved for June 2024 and the Group were on track to deliver the 65ww target in September 2024. Referral to Treatment targets were not yet being achieved but Improvement plans were in place, focused on refreshing pathways, reducing follow-up appointments to create additional capacity for new referrals and improving theatre productivity, including understanding the time lost due to late starts and the reasons for the delays. The CIC had limited assurance as the RTT improvement plans had not yet resulted in sustained improvements in performance and reduction of waiting lists.

Outpatient Administration - A deep dive was carried out in June into improvements planned, including Patient Initiated Follow-Up (PIFU) by default, validation of patients on waiting lists, reduction in follow-up appointments, virtual appointments, new pathways, reduction in Did Not Attend rates and financial savings from the use of digital letters. Staffing issues were challenging, but vacancies included recruitment of 10 additional staff for validation purposes. Funding to rollout Connected Health Network further had not yet been secured. As the paper presented had not been to the Executive Cabinet before the CIC meeting, the Committee received it outside the agreed process. The paper was therefore referred back to the Cabinet for review.

Estates and Facilities –Reasonable Assurance

The Committees wanted to highlight the acquisition of 46 good quality Council accommodation units in Elizabeth Row in Scunthorpe which would assist with recruitment.

A grant of £20.6m over 2 years had been obtained from the Public Sector Decarbonisation Fund to improve heating, roofing, glazing and the Building Management System at Scunthorpe Hospital, which would reduce the estates risks on that site in addition to reducing the carbon footprint. The Group had to contribute £7m to complete the work, which was due for completion by March 2026.

A planned review and harmonization of Group parking policies, catering, patient bedhead services and cleaning provisions was reported to the Committees, with further details being brought to the Committees as these reviews are completed.

The Committees approved the Premises Assurance Model for submission to the Board for sign off. There were 3 main areas of non-compliance which were:

- safety and security in leased premises where it had not been possible to get documentary evidence that all PAM criteria had been met
- transport policy still under review
- anti-ligature compliance, where it was not possible to evidence compliance because fixtures that fall off during testing, as designed, have to be reinstalled, at which point the new installation cannot be proven to have been tested

There were no immediate concerns regarding these areas and work was ongoing to improve compliance in the future.

Procurement Initiatives – Agreement of process

The Group wide approach to procurement will form part of the overall cost improvement plans. A paper was presented proposing the alignment of rates for radiology reports across the trusts with a potential saving of upwards of £650k.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

a) There was still work to do regarding the Risk Register report particularly regarding mitigations but more detail was appended with the Board Assurance Framework showing the high level risks relevant to the CIC.

b) CQC actions NLAG – The CIC received the monthly updates and discussed the complexity of the actions that remained and the timescales for closure. End of Life data was no longer being provided by the Quality Improvement team. As the CQC had stated that this data was needed to understand performance, make decisions and improvements, it was agreed that the provision of the data was essential. The CIC would receive an update on this at the next meeting. Reasonable assurance was received.

A report was also received showing the HUTH CQC update and the outstanding actions for the PEF CIC were; the Ground Floor model, pathway zero and maternity triage. Maternity triage times had reduced from 90 minutes to 10 minutes for patients to be triaged. This has been facilitated through pulling staffing from existing ward establishments. A funding business case is required to ensure sustainability of this improved position. Reasonable assurance was received.

c) The CIC supported the development of a Costing Steering Group to resolve the numerous data issues that meant that the Group's mandatory costing submissions could not be made without substantial amounts of manual intervention and workarounds. Reports from these submissions enable the Group to compare costs with other organisations and identify opportunities to reduce costs. It was agreed that the PEF CIC would monitor progress and escalate any issues to the Board.

d) NLAG day surgery case rates were discussed due to them dropping 516 cases below plan, which was under investigation. An updated position was requested for the August 2024 meeting.

e) Further detail on late theatre starts will be brought to the next CIC meeting, including time lost and reasons for delays.

f) The CIC requested assurance that retail catering at HUTH would break even in future years following a full review of the service.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

The committees considered the areas of the BAFs for which they have oversight and no changes are proposed. Business continuity and cyber risks are to be reviewed by the Audit Risk & Governance CIC.

There was a detailed discussion around the Finance Risk being rated 25, which was higher than the Quality and Safety risk score. The CIC agreed that patient safety was equally or more important. There was a proposal supported by some members of the CIC to reduce the score to 20, as it was felt that a likelihood of 5 in Quarter 1 was too high, given all the work taking place to improve the financial position. There was an alternative view that the score should remain at 25 in view of the recent letter from NHSE and the current financial position. It was agreed to review the score again once the requested bridging plan was available and the confidence levels of achieving each action could be considered. The BAF will be subject to a refresh in August 2024 at the Executive session to review it alongside the new strategy framework.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the issues highlighted in item 3 and their assurance ratings.
- Note the items listed for further assurance and their assurance ratings.

Gill Ponder, Chair of Performance, Estates and Finance CIC NLaG
Helen Wright, Chair of Performance, Estates and Finance CIC HUTH
26 June/24 July 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24) 141

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	8 August 2024
Director Lead	Tony Curry – Chair of CIC
Contact Officer / Author	Tony Curry – Chair of CIC
Title of Report	Workforce, Education and Culture CIC Escalation Report
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on Thursday 27 June 2024 and 25 July 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards. The CIC gave limited assurance to the following items and details are included in the escalation report: • Required Learning - Group • CQC Actions – Group **The Board in Common are asked to** • Note the issues highlighted in item 3 and their assurance ratings. • Note the items listed for further assurance and their assurance ratings.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	None
Financial Implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ✓ Review ✓ Assurance ☐ Other – please detail below:

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Committees-in-Common Highlight / Escalation Report to the Trust Boards

Report for meeting of the Trust Boards to be held on:	8 August 2024
Report from:	Workforce, Education and Culture Committees in Common
Report from meeting(s) held on:	27 June 2024 25 July 2024
Quoracy requirements met:	27 June 2024 – Yes 25 July 2024 – Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on Thursday 27 June 2024 and 25 July 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

27 June 2024

- *Board Assurance Framework*
- *NLAG/HUTH CQC Actions Progress Report*
- *Integrated Performance Report*
- *Modern Slavery Statement HUTH/NLAG*
- *Undergraduate Medical Education HUTH/NLAG*
- *Deep Dive – Group required learning*
- *Deep Dive – Group Training Space*
- *Medical Engagement Update (Monthly)*
- *Nursing Band 2/3 Options*

25 July 2024

- *Board Assurance Framework*
- *NLAG/HUTH CQC Actions Progress Report*
- *Integrated Performance Report*
- *Update on Consultants without CCT*
- *Update on CDC Recruitment*
- *Registered Nurse and Midwifery Staffing HUTH/NLAG*
- *Freedom to Speak Up Quarterly Reports HUTH/NLAG*
- *Medical Revalidation/Responsible Officer*
- *Deep Dive – Staff culture, engagement and values*
- *Group Leadership Programme*
- *Medical Engagement and Leadership Strategy*

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

27 June 2024

a) The quarterly Pulse survey results were discussed by the CIC and it was agreed that revisiting the Barratt values suggested by staff as part of the Group Values sessions would be useful. The CIC also agreed to review the BAF Culture risk rating at the same time.

25 July 2024

a) The committee received a paper in which concerns were raised regarding the Group culture and staff experience. The paper included feedback form the Q1 staff pulse survey and the findings from the Barratt values work that has been undertaken. The paper identified the reduction in staff satisfaction levels in the Q1 pulse survey, especially at NLAG – which was also supported with concerns about the impact of the group changes and the impact on morale in the NLAG FTSU Guardians report. The Barrett values work found a high level of limiting values which were impeding the Group in achieving their goals which require urgent attention. As a result of these concerns this agenda item was given a no assurance rating and escalation to the Boards in common for discussion.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

27 June 2024

a) NLAG and HUTH CQC Actions. The CIC discussed the timescales of the actions and how realistic they were. It was agreed that a full review of all the outstanding actions would take place, led by the Chief Nurse, and refreshed timeframes would be submitted to the CICs. **The CICs were not assured.**

b) NLAG reported that the trajectory to reduce nursing agency spend to zero by 1st July 2024 was on track. NLAG medical agency usage was reducing but was still challenged.

c) The CIC discussed sickness and the main reason staff were off work was due to stress. This would be impacted further by the loss of the Wellbeing Manager. **Further assurance was required and would be monitored monthly through the IPR.**

d) The CIC received a deep dive into mandatory training/required learning. It was reported that a Required Learning Steering Group had been established to review the gaps and find ways to make training accessible for all. New starters would now be required to complete their mandatory training on day 1 of joining the organisation. **The CICs gave limited assurance because of the existing gaps and compliance.**

e) Reports from North and South relating to Undergraduate Medical Education were received. **The CICs gave significant assurance due to the processes and initiatives in place.**

f) The CIC received another deep dive into the training space facilities across the Group. A review of all rooms had been undertaken and there was now a clear view of training demand and what availability of rooms was required. A further report would be presented in November 2024 detailing the plans for 2025.

g) The Medical Engagement and Leadership Strategy was being developed and

the CIC agreed to receive oversight in July 2024.

h) The CIC received a verbal update regarding the Band 2/3 issues and the potential financial impact. A Task and Finish group had been established and the CIC would receive regular updates regarding decisions and outcomes.

25 July 2024

a) Further assurance was required regarding the High Level Risks and the ongoing work with the new Care Groups. This would be developed further and presented with the BAF report at each meeting.

b) CQC Actions NLAG – Goole Hospital had been inspected by the CQC and one of the actions was to increase compliance relating to midwives completing their Level 3 Safeguarding training. The Compliance had decreased due to the cohort numbers increasing. The training department and maternity team were working this through and the Required Learning Group were monitoring all nursing and midwifery mandatory training.

CQC Actions HUTH – staffing issues in the Maternity services was raised and the action had been changed from amber to red. A business case for funding was being developed.
ED Security staff training was also raised as an issue.

Limited assurance was agreed for HUTH/NLAG as there was a full review of outstanding actions being undertaken.

c) The CIC discussed the Acute Medicine Care Group and the vacancy issues. The CIC asked how the Group were supporting with recruitment and managing any leavers.

d) Freedom to Speak UP – NLAG The CIC were concerned regarding the 32 out of 110 cases relating to the impact of the new Group and Care Group restructuring. **Reasonable assurance was received for the processes and management of the cases and the 32 cases would be monitored as part of the Cultural Board Development.**

e) Revalidation HUTH – there are a lack of appraisers on the North Bank and this was impacting on the medical staffing body and the volume of appraisals to be undertaken. Work was ongoing to rectify this and the processes were being aligned across the Group. **Reasonable assurance was given for HUTH.**

f) NLAG received significant assurance for their revalidation processes.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The committees considered the areas of the BAFs for which it has oversight and has proposed the following change(s) to the risk rating or entry:

The committees considered the areas of the BAFs for which it has oversight and no changes are proposed.

The high level risks linked to workforce and culture have been added to the July 2024 report.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the issues for reporting in item 3.
- Note the items listed for further assurance and their assurance ratings.

Tony Curry/Kate Truscott

27 June 2024

25 July 2024

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)142

Name of the Meeting	Trust Boards-in-Common
Date of the Meeting	8th August 2024
Director Lead	Simon Nearney, Chief People Officer
Contact Officer/Author	NLAG – Liz Houchin, Freedom to Speak Up Guardian HUTH – Fran Moverley, Freedom to Speak Up Guardian
Title of the Report	**Freedom to Speak Up (FTSU) Guardian 2024/2025 Quarterly Report (Quarter 1) - HUTH** **Freedom to Speak Up (FTSU) Guardian 2024/2025 Quarterly Report (Quarter 1) – NLAG**
Executive Summary	Each report provides the Q1 2024/2025 for NLAG and HUTH respectively. Each report gives an update including an overview of the number of concerns raised, national and regional updates and the proactive work undertaken by each Freedom to Speak Up Guardian.
Background Information and/or Supporting Document(s) (if applicable)	Not applicable
Prior Approval Process	Both NLAG and HUTH reports have been submitted to the Workforce, Education and Culture Committee in Common on 25th July 2024.
Financial implication(s) (if applicable)	Not applicable
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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Freedom to Speak Up Guardian
Quarter 1 Report
April to December 2024

Fran Moverley
July 2024

Hull University Teaching Hospitals NHS Trust

Freedom to Speak Up Guardian Report Quarter 1 2024/2025

1. Executive Summary

1.1 This paper provides an update regarding the Hull University Teaching Hospitals NHS Trust (HUTH) Freedom to Speak Up Guardian (FTSUG) activity during quarter one (Q1) of the 2024/2025 reporting year. The paper includes details of relevant regional and national updates for comparison and context. An overview of Group working as the NHS Humber Health Partnership is also provided.

1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

2. Strategic Objectives, Strategic Plan and Trust Priorities

2.1 This paper contributes to the current Trust Strategic Objectives of ‘Great Staff’ and ‘Great Care’.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff.

2.3 Freedom to speak up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

3. Introduction / Background

3.1 All organisations that provide services under the NHS Standard Contract are required to appoint a FTSUG. There are a number of processes at HUTH in place that allow staff to raise concerns, including, but not limited to:

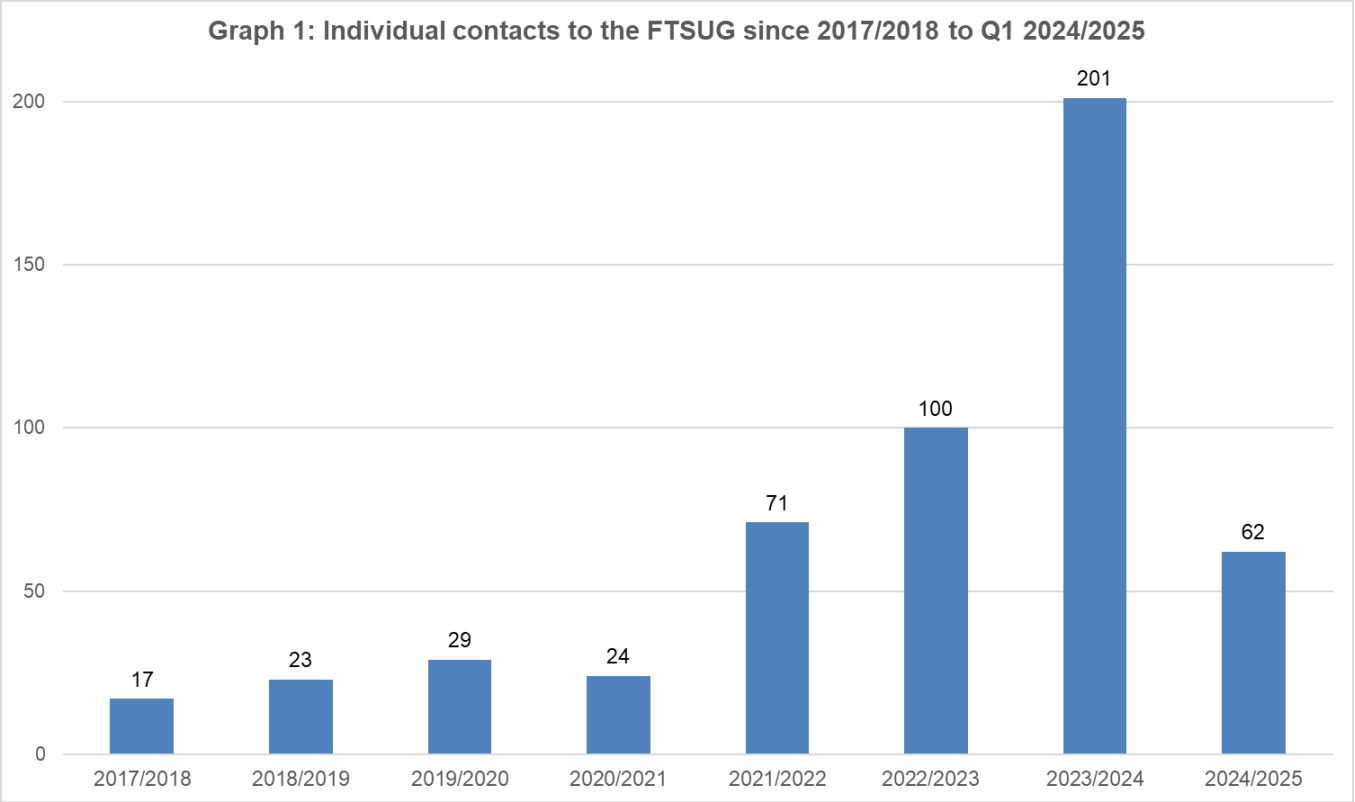
- Line manager or senior manager
- FTSUG
- Counter Fraud Plus (CFP) Team
- Raising Concerns at Work (whistleblowing) policy (CP169)
- Freedom to Speak Up Policy for the NHS (CP451)
- Staff Conflict Resolution and Professionalism in the Workplace Policy (CP269)
- Grievance Policy (CP036)

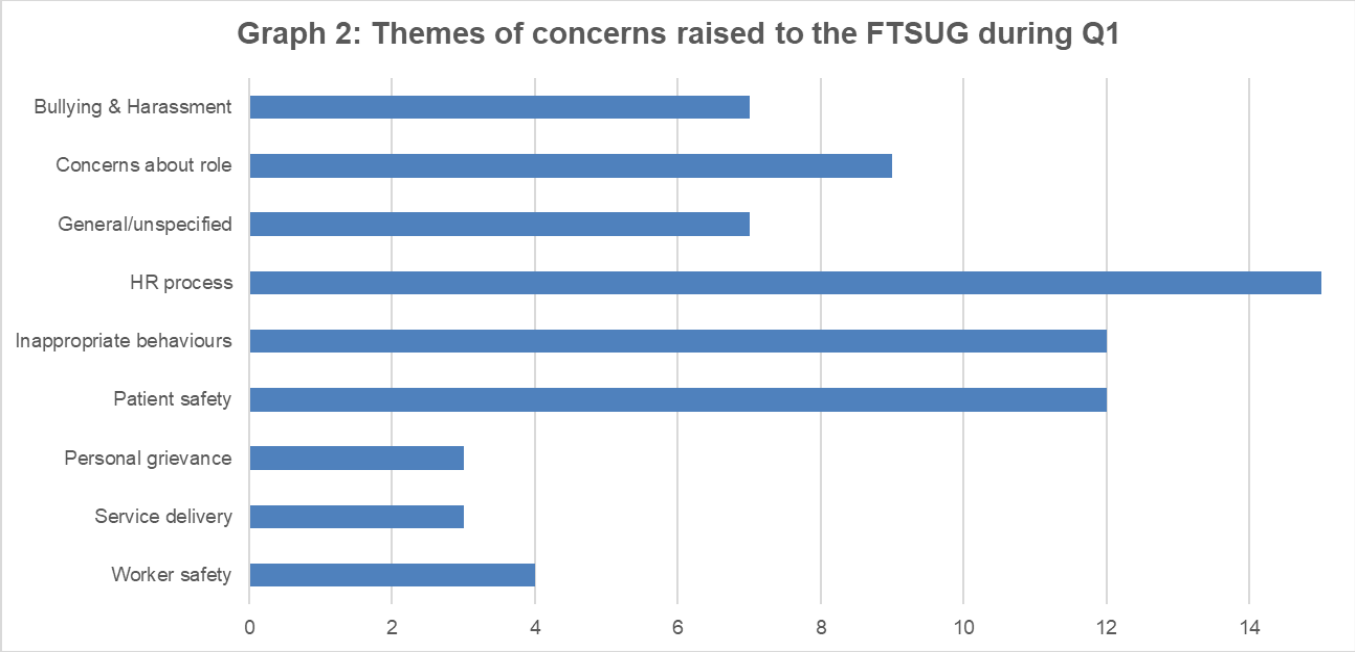
3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

4. FTSU concerns raised during 1st April 2024 to 30th June 2024 (Q1) – data, comments and assessment

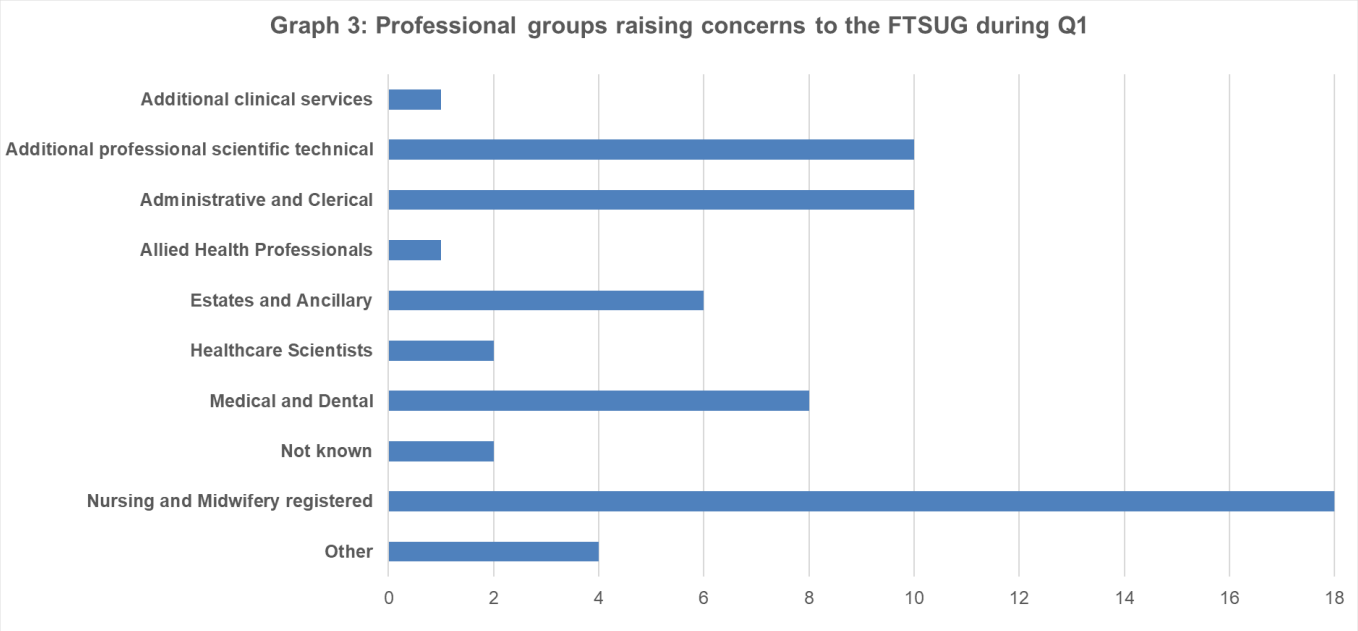
4.1 The FTSUG reports on the numbers and themes of the individual contacts received from members of staff, students, trainees and volunteers. The FTSUG reports to Group committees and to the National Guardian Office.

4.2 Graphs 1, 2 and 3 summarise the Q1 data:





*** NB. Please note some concerns may have more than one element.**



4.3 Observation and comments:

- In Q1 2024/2025, 62 concerns were received. This is the highest number of concerns received than previous quarters, with the exception of the previous reporting period - Q4 2023/2024 when 89 records were received.
- 3% (2) concerns were raised anonymously in Q1; where the FTSUG did not know the identity of the individual.
- At 15.07.24. 29 concerns remain open and 33 are closed.
- 19.4% (12) individuals requested to be anonymous throughout the speaking up process; where the FTSUG knew the identity of the individuals.
- 45% (28) of concerns were appropriate for an individual's line manager to assist in resolution, of which 79% (22) of individuals had already spoken to their line manager, before approaching the FTSUG.
- From Q1 onwards there have been minor changes to the concern codes (in graph 2) due to the HUTH FTSUG and NLAG FTSUG aligning their reporting to ensure that the new Care Groups in the Group can be compared and senior leaders have oversight.
- The highest number of reasons for staff approaching the FTSUG were concerns about involvement in HR processes (15) followed by jointly concerns about patient safety (12) and inappropriate behaviours (12).
- Concerns about inappropriate behaviours, HR processes and bullying and harassment had all increased in comparison to Q4 2023/2024.
- During Q1 the most common individuals raising concerns were the nursing and midwifery professional group (18); this is consistent with Q4 2023/2024. The second most common professional groups were jointly additional professional scientific and technical (10) and administrative and clerical (10).
- 4.8% (3) staff members reported being subject to detriment and/or inappropriate behaviours after speaking up.

4.4 The HUTH and NLAG FTSUGs are working together to produce a consistent way of producing quarterly reports for the new Care Groups to ensure the FTSU information can be used to triangulate with other data (for example, HR metrics) to ensure trends and themes can be identified.

4.5 FTSU Guardian Feedback/Evaluation:

The feedback survey has now been developed and updated by the FTSUG and Communications Team. The FTSUG has commenced sending out feedback forms and will start to present the results in this report from the next meeting onwards.

4.6 Case Study

The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The freedom to speak up guardian received a concern from a colleague with a disability, who felt unsupported and very upset that they had asked for a reasonable adjustment and this was denied by their line manager. The reasonable adjustment was a recommendation from the Occupational Health department and for a temporary period of time to support the staff member.

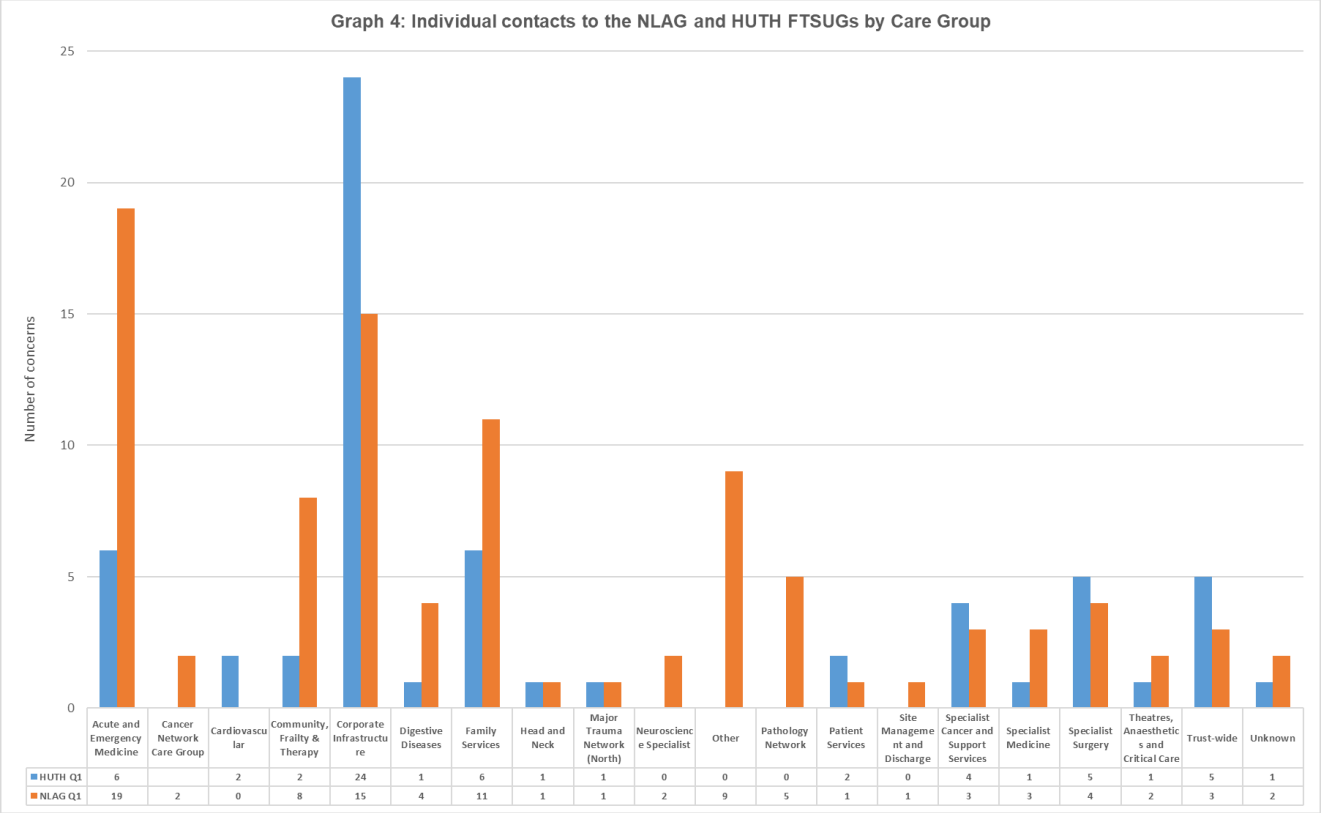
The freedom to speak up guardian supported the staff member talking through the concerns and encouraged them to speak further with their line manager and senior manager to explain how the adjustment could work in practice and to explain the personal impact on their disability of not having the adjustment. The staff member later updated the guardian that they had had the meeting, had felt listened to by their senior manager and was happy that the reasonable adjustment had been agreed. The guardian also gained consent from the colleague to speak confidentially with the HR Advisor for the department to make them aware of the staff member's experience for learning and awareness as part of their support to the management team.

The staff member was thankful for the help of the guardian and commented: "I just wish that I hadn't had to fight for the right to have the adjustments while trying to recover".

4.7 Care Groups – concerns combined

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 4 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.

The highest number of concerns was received regarding departments within the corporate infrastructure followed by the Acute and Emergency department Care Group.



5. FTSUG activities and proactive work during Q1

5.1 A high level summary of the activities are detailed below:

- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan. A progress report against the improvement and strengths action plan is included as Appendix 1 to this report.
- Contributed to the HUTH Quality Accounts through writing the Freedom to Speak Up and Whistleblowing sections.
- Continued monthly 121s with the Group CEO.
- Attendance at the Group leadership conference.
- New dedicated communications support, extending the support already provided to NLAG FTSUG.
- Introductory meetings with new South Medical Director, Specialist Surgery triumvirate meeting and the new Interim Chief Nurse.
- Continued monthly support sessions to the leadership teams of the staff networks.
- Continued to support the Group development of the NHS England sexual safety charter.
- Introductory meeting with the GMC regional advisor to discuss partnership working.
- A further two Speak Up Champions were trained; increasing the total number of trained Champions to 28. Led the Speak Up Champion peer support and development session, including inviting the local counter fraud specialist as a guest speaker to increase fraud awareness in the champions.

- Presented the annual FTSUG report to the JNCC, LNC and Group HR Advisory meeting to share high level detail and learning.
- Discussion with the NHS England speaking up team and NLAG FTSUG, to discuss Group arrangements in respect of the Board self-reflection process.
- Presented at the Professional Nurse Advocate (PNA) meeting to promote speaking up and working in partnership with the PNA network.
- Conducted a joint walk around with the Group Chairman and escalated several learning points.
- Attended bereavement conference to strengthen support provided to staff.
- Met with the new People Promise Manager and contributed to the Trust assessment process.
- Supported the HR team in the review and ratification of the updated Raising Concerns at Work (whistleblowing) policy (CP169).
- Further away day with NLAG FTSUG to discuss and agree consistent ways of working and the initial planning of the Group FTSU strategy.
- Initial discussion with the Power BI team to plan for future data available to Care Group triumvirates.

5.2 Future plans:

- Exploring the possible introduction of a FTSU reporting function on a Staff App to mirror NLAG.
- Delivery of additional Speak Up Champion training to further expand the Speak Up Champion Network.
- Initial work on the new Group FTSU strategy in partnership with the NLAG FTSUG.

6. Regional and National Information and Data

6.1 Regional update

The FTSUG attends, where possible, the Yorkshire and the Humber and North East regional meetings to discuss best practice and contribute to active discussions.

6.2 National update

The FTSUG participated in a national round table meeting to discuss Group arrangements for FTSUGs and contribute to the potential new national guidance.

The FTSUG was contacted by two FTSUGs at other acute trusts across the UK to discuss how the HUTH and NLAG FTSUGs have developed working practices and Group arrangements.

The FTSUG successfully completed the equality, diversity and inclusion mandatory training required by the National Guardian Office. This has enabled the HUTH FTSUG to remain on the national register of FTSUGs.

The National Guardian Office strategy will be published in July, this has been delayed due to the general election. The FTSUGs will use this and the Group Strategy to shape the future Group FTSUG Strategy.

6.3 National Guardian Office annual report

On 18th July 2024 the National Guardian Office annual report was released, collating the 2023/2024 speaking up data from all FTSUGs nationally. The report can be read on the National Guardian Office website.

The key highlights of the report have included nationally 32,167 cases were raised with FTSUGs – an increase of 27.6% on the previous year. In comparison, HUTH saw a 100% in cases during 2023/2024.

Nationally 19.8% of cases reported bullying or harassment (HUTH 8%), 38.5% cases related to inappropriate behaviours (HUTH 10.4%) and 19.4% cases related to patient safety (HUTH 16.4%).

Dr Jayne Chidgey-Clarke, the National Guardian, has urged all leaders to use the information in the report as a springboard for asking curious questions, including:

- *What are people coming to your FTSUG about?*
- *What are you doing about what they are hearing?*
- *How can you better address workers' concerns?*
- *How does this data compare with your staff survey and other speaking up data?*
- *How can you improve confidence in speaking up through all available routes and your response to it?*
- *Who are you not hearing form and what more can you do to ensure that you do?*
- *Does your FTSUG have the time, resources and support they need?*

7. Conclusion

7.1 The Trust has continued to support the important FTSUG role and staff continue to contact the FTSUG for support and assistance in speaking up.

7.2 The FTSUG has continued to be active in promoting speaking up and creating partnerships with internal and external stakeholders.

7.3 The Group arrangements continue to develop, with the HUTH and NLAG FTSUGs working closely together to develop consistent reporting processes and contributing to conversations at a national level.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Frances Moverley
July 2024

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

ACTIONS IN PROGRESS			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 3: Continually review the speak up champion network, to promote champions within different staffing groups and at different levels across the Trust.	31/12/24	FTSUG	**Action in progress** • Bimonthly training dates booked until end of 2023. • Bimonthly training dates for 2024 are in place. • The Speak Up Champion Network has been expanded to 27 trained Speak Up Champions. Trust-wide email sent April 2024 promoting the training. Further 14 places booked on training in July 2024 and September 2024. Additional training date in November 2024 planned and advertised. • Speak Up Champions have been mapped per Care Group and there are minor gaps with some Care Groups with no Champions. FM to discuss with senior management to recruit as widely as possible across the Trust. At 16/07/24: • The total number of Speak Up Champions trained is 34; with further 8 trainees booked for training in September and November 2024.
Action 5: Launch the feedback survey for staff who have spoken up to the FTSUG. To include: • Consideration will be given to including a question regarding whether they experienced positives behaviours that encouraged them to speak up. • Include in the feedback survey for staff members approaching the FTSUG, a question asking how the staff member knew about the FTSUG role. Review this data and identify any improvements to widen the awareness of the role and speaking up. • Monitor the feedback survey responses for information on staff subject to detriment and where possible, to understand the circumstances.	30/09/24	FTSUG	**Action in progress** • Question about whether the individual had experienced positive behaviours when speaking up considered and included in the feedback survey. • Question about referral route and awareness of the FTSUG role included in the feedback survey. • Free text box included in the survey to include permission to share stories of speaking up. • Final amendments to the feedback survey to be made – Digital Communications team confirmed in work plan. • Questions related to protected characteristics approved by Equality, Diversity and Inclusion Committee 18.01.24. Final checks in progress and feedback survey will commence. • Delay in survey due to further changes required (as per the National Guardian Office change in guidance), currently with the Communications

• A free text box if respondents are comfortable feeding back their experiences. Review the answers from the feedback survey, and include any appropriate case studies (with consent of the staff member) in future Board reports.			Team to progress using Encapsulate to satisfy data protection requirements. Aim to launch the survey in Q2. At 16/07/24: • Feedback survey completed and live. FTSUG has commenced circulating links to staff who have spoken up since April 2024. • Questions included asking about how well the staff member felt listened to, supported and whether their concern was resolved. National mandatory question included. • FTSUG to report on results at the next Board meeting.
Action 6: Review our programmes of delivery to ensure that the FTSUG process and person is clear/explicit. This would be done with better involvement of FTSUG operationally in content creation. This is alongside being explicit how Just Culture and Compassionate Leadership approaches are married together and should be used in a symbiotic way as a leader.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss incorporating existing Health Education England e-learning into line manager development. • PACT embedded into all of the leadership programmes and how to speak up. Programmes will be reviewed with the move to the group leadership model but speaking up with remain with any new/revamped programmed. • January 2024 - Head of Learning and Organisational Development confirmed looking at opportunities to include speaking up content in future leadership training. Requested an extension to the target date. • FTSUG met with OD Facilitator to discuss including a bespoke speaking up module within the new Inclusion Academy. • Bitesized programmes are due to begin again in end of June 2024 and full programmed activity will begin end of October 2024 – FTUG content will be included.
Action 7: Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an “internal consultant” to bring expertise into bespoke work design.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • The Maternity reporting tool is now live and Cardiology is currently in progress. • FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised. • Cardiology incivility reporting tool launched on 10th November 2023. • FTSUG continues to be involved in the monthly circle groups.
Action 8: Creating an organisational wide Circle group approach to better use FTSUG intelligence and other cultural indicators.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • Initial discussion held between Head of Organisational Development and FTSUG to discuss what indicators and data could be appropriately used for a Trust wide group. • This action needs further thought as more reporting tools are made live. Zero tolerance to ableism launched October 2023 in addition to the existing zero tolerance to racism. • LGBTQ+ framework and circle group are due to go live February 2024.

			• Group Director of Learning and Organisational Development have identified a potential support/supervision need for staff network leadership teams – informal meeting to discuss further the scope of this work in February 2024. • Head of OD (South) now in post and has EDI and Cultural Transformation as part of their portfolio. Target date of 31st August 2024 for roll out of Zero Tolerance tools Groupwide.
Action 9: Development of a Trust wide Professionalism and Kindness programme that supports just and speaking up culture.	30/11/24	Group Director of Learning & Organisational Development	**Action in progress** • PACT "Professionalism and Civility Training" launched from late August 2023 onwards, alongside a marketing campaign to allow us to reflect on how "Bad Behaviour Doesn't Work – Time to Change". • PACT has been delivered to approximately 150 leaders and is currently on hold for a group roll out as needed. PACT is also delivered in the new format to all new starters and this includes a FTSUG contacts and how to report concerns. • Currently on hold subject to the Group leadership structure. • New Values and Staff Charter now in place. Head of OD (South) has been tasked with creating the following Group Programme: o Civility and Respect Campaign refresh and relaunch (bad behavior doesn't work) o Required Learning for Leaders inc PACT o "What's it like to be managed by me?" and "What's it like to work with me?" style content o Cultural Ambassadors (NLAG have currently and scoping out group roll out) o Cultural Dashboard – People metrics triangulated to give an overall picture of culture in a care group or department
Action 13: Review what triangulation of data is possible including what data can be obtained e.g. patient safety, staff survey. Link with action 8 above.	31/12/24	FTSUG	**Action in progress** • FTSUG conducted a breakdown per Health Group of the staff survey 2022 results. Presented information within the Health Group Governance briefing reports. • January 2024 – initial discussion with NLAG FTSUG to discuss best practice and different ideas for triangulation. • March 2024 commenced reviewing 2023 staff survey results in relation to the four speaking up questions. Trust-wide results communicated to each Health Group in the governance briefing reports. • Ongoing discussions with the Workforce Intelligence team to provide data to Care Group triumvirates, in conjunction with other relevant workforce data.

			At 16/07/24: • BI spreadsheet in development with assistance from the Workforce Intelligence team, to develop reporting data for Care Groups.
Action 14: Create a freedom to speak up strategy. To include: • Inclusion of this improvement plan created by the Board self-reflection and planning tool. • Regularly review the freedom to speak up strategy and improvement plan and report on progress updates to the Trust Board on a regular basis.	31/12/24	FTSUG	**Action in progress** • Initial work underway to develop a draft strategy; including reviewing other Trust's strategies. • January 2024 – discussed with NLAG FTSUG to propose a joint Group. NLAG current strategy due for renewal August 2024. • In February 2024 the Board agreed to the creation of a joint Group FTSU strategy. NLAG and HUTH FTSUGs have commenced the early stages of developing a strategy. Development day planned in June 2024. At 16/07/24: • HUTH and NLAG FTSUGs have commenced the early planning of a Group wide strategy. Awaiting publication of the Group Strategy and National Guardian Office Strategy.

ACTIONS COMPLETED			
Development areas to address in the next 6–12 months	**Target date**	**Action owner**	**Progress update**
Action 1: Scheduled assessments and review of associated improvement programmes of speaking up arrangements.	30/06/23	Executive Lead	**Action completed** • Repeat self-assessment of the Board self-reflection will be scheduled no longer than two years from the previous assessment (February 2023). Executive Lead committed to ensuring this has been completed.
Action 2: Continue to grow contacts via the champions and promotion to identify themes for learning and improvement programmes.	31/03/24	FTSUG	**Action completed** • 6 further Speak Up Champions recruited and trained during March, April, May, June and July 2023. • List of local Speak Up Champions continually updated on staff intranet Pattie and bimonthly network meetings for all Champions providing peer support and development are in place. • Private workspace on Pattie set up for Champions to provide a central resource for key updates and resources. • Recruitment to being a Speak Up Champion continues to be promoted at local induction events e.g. internationally educated nurses, junior doctors. • At 29.01.24. 24 active Speak Up Champions trained and further 4 are booked on training. At 03/06/24: • The Speak Up Champion Network has been expanded. Currently 27 Speak Up Champions trained, with 13 further places booked on training in July 2024 and September 2024.
Action 4: Update the 2023 speaking up communications plan. To include: • Clear messages that detriment will not be accepted or tolerated at HUTH. • Communication of the new national speak up policy once ratified. • Further reminders about the availability of the e-learning modules as self-managed learning. • Incorporate, where possible, positive stories of speaking up.	31/12/23	FTSUG Request communications from senior leaders.	**Action completed** • New national speak up policy has been personalised and circulated to stakeholders. The Workforce Transformation Committee on 20th July 2023 was cancelled – currently seeking ratification through email approval to progress the policy. • Joint drop in session with the York and Scarborough NHS Teaching Hospitals NHS Trust held for SHYPS staff took place 27th July 2023. Further dates will be scheduled to provide further opportunities to speaking up. • The new Group CEO circulated communications in reflection of the recent national media coverage into the conviction of a neonatal nurse and the importance of speaking up in the NHS. • Joint drop in session with the FTSUG and Chief Nurse scheduled for 31st August 2023.

			• Attendance planned to provide a market stall to raise awareness of speaking up at the Staff Disability Network conference in October 2023. • Repeated communications and bulletins from the Group CEO promoting a speaking up culture at HUTH and the FTSUG role. • During speak up awareness month in October 2023, a timetable of activities was promoted across the Trust including joint drop in sessions and walk arounds with the Interim Chief Nurse and FTSUG. • Ad hoc communications e.g. Daily Update linked to speaking up, circulated Trust-wide. • Future - 2024 Communications Plan to be developed, where possible in conjunction with the NLAG FTSUG.
Action 7: Bring clear speak up processes into our bespoke cultural transformation pieces e.g. Maternity and Cardiology and ensuring the FTSUG is used as an "internal consultant" to bring expertise into bespoke work design.	31/03/24	Group Director of Learning & Organisational Development	**Action completed** • The Maternity reporting tool is now live and Cardiology is currently in progress. • FTSUG a member of the new Circle Group for Maternity and is actively part of triaging and discussing any concerns raised. • Cardiology incivility reporting tool launched on 10th November. • FTSUG continues to be involved in the monthly circle groups.
Action 10: Implementation of the new NHS England speaking up policy. To include: • Implement the new NHS England speaking-up policy before January 2024. This is also an action recorded from an audit of the speaking up service conducted during December 2022. • Review the new national speak up policy template and include reference to the processes if a staff member feels subject to detriment.	31/12/23	FTSUG	**Action completed** • National policy transferred into HUTH template and personalised. • Policy could not be ratified due to Workforce Transformation Committee on 20th July 2023 being cancelled. Approval sought via email approval. • Approval via email confirmed. Policy now published live on Pattie (reference CP451).
Action 11: Involve key stakeholders (e.g. Staff Support Networks) in the consultation process of the policy.	31/03/23	FTSUG	**Action completed** • Draft policy sent to internal stakeholders for information/comment. Including Executive Lead, Director of Workforce, Head of Workforce, Head of HR, Disability Staff Network Chair, BAME Staff Network Chair, LGBTQ+ Staff Network Chair, JNCC Chair, LNC Chair, Equality Diversity & Inclusion Trust Lead.
Action 12: Review with the Organisational Development Team whether it is appropriate for speak up training to be incorporated into any of the programmes of delivery.	31/05/23	FTSUG	**Action completed** • Discussed with Head of Organisational Development the inclusion of the speak up e-learning into existing leadership development courses and future line manager training.
Action 13: Review the self-reflection and planning tool outputs from at least two	31/12/23	FTSUG	**Action completed** • Self-reflection and planning tool reviewed and shared with NLAG FTSUG.

other Trusts. Identify any best practice applicable to HUTH and incorporate into the Freedom to Speak Up improvement plan.			• HUTH FTSUG has contacted other FTSUGs working in similar sized acute Trust's across the region to discuss sharing. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • HUTH results compared to NLAG. Copies of improvement plans requested from two other acute NHS trusts for comparison. • Contact made with Mid Yorkshire Teaching NHS Trust and Group (Kettering General Hospital and Northampton General Hospital). At 03/06/24: • Reviewed the self-reflection and improvement tool from Cambridge Community Trust, previously rated as the highest in the FTSU Index.
Action 14: Implement requesting for feedback from senior nursing staff when concerns are escalated directly by the FTSUG, as per the request of the Chief Nurse.	31/03/23	FTSUG	**Action completed** • Ongoing feedback requested as appropriate

Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	**Target date**	**Action owner**	**Progress update**
1. Share speak up arrangements with other Trusts. To include: recruitment and ring fenced time for the role, locally agreed absence arrangements, creation of the speak up champions network, involvement with other services across the Trust and being an ally of each staff network.	30/09/23	FTSUG	**Action completed** • Self-reflection and planning tool reviewed and shared with Northern Lincolnshire and Goole NHS Foundation Trust. • Documentation created by the FTSUG in the development of the Speak Up Champion Network has been shared regionally on request with all FTSUGs across Yorkshire and Humber. • FTSUGs at three other Trust's across the region have requested observing the training the HUTH FTSUG provides to Speak Up Champions to gather best practice ideas. • HUTH FTSUG to present training videos produced at the Trust by the FTSUG at the next regional FTSUG meeting due to interest from other Trusts. • Additional update at 16/07/24: FTSUG being approached by FTSUGs at other trusts with requests to discuss the Group arrangements with NLAG. HUTH and NLAG FTSUGs involved in national discussions regarding the arrangements.

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Quarter 1 Report April to June 2024

Liz Houchin
15th July 2024

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up Guardian Report Quarter 1 2024/2025

1. Executive Summary

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1.2 The paper is presented in line with the suggested information FTSUGs should provide in the ‘’Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts’’ published by NHS England and Improvement.

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2.1 This paper satisfies the Trust Strategic Objective of ‘Being a good employer’ and is aligned to the Trust priorities of: Leadership and Culture, Workforce and Quality and Safety.

2.2 The report aims to provide assurance to the Group Board on promoting a ‘speaking up’ culture at the Trust for staff. Freedom to Speak Up is directly linked to the CQC Well-led quality statement *‘We foster a positive culture where people feel that they can speak up and that their voice will be heard’.*

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- Grievance Policy (DCP084)

3.2 The FTSUG role is an additional route for speaking up and the role acts impartially and independently.

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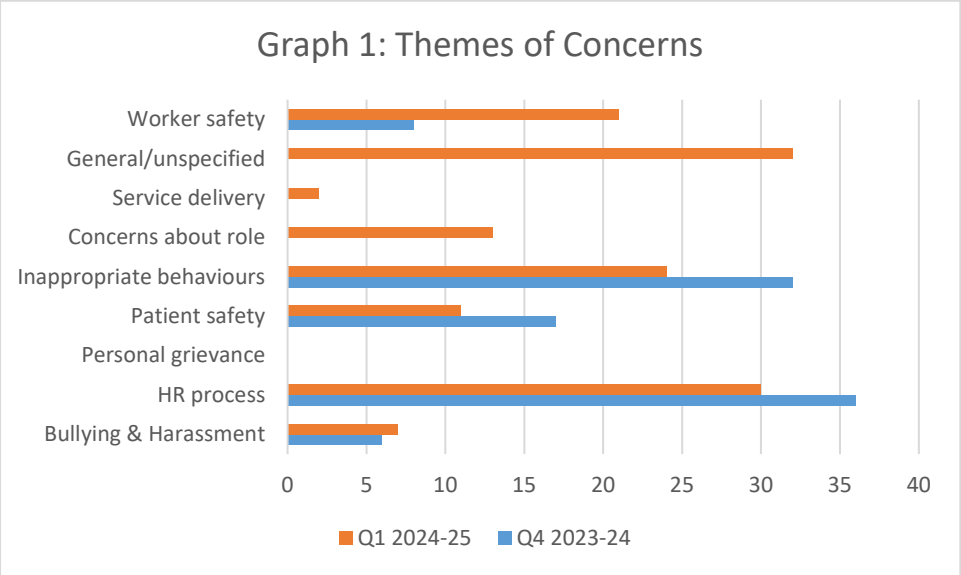
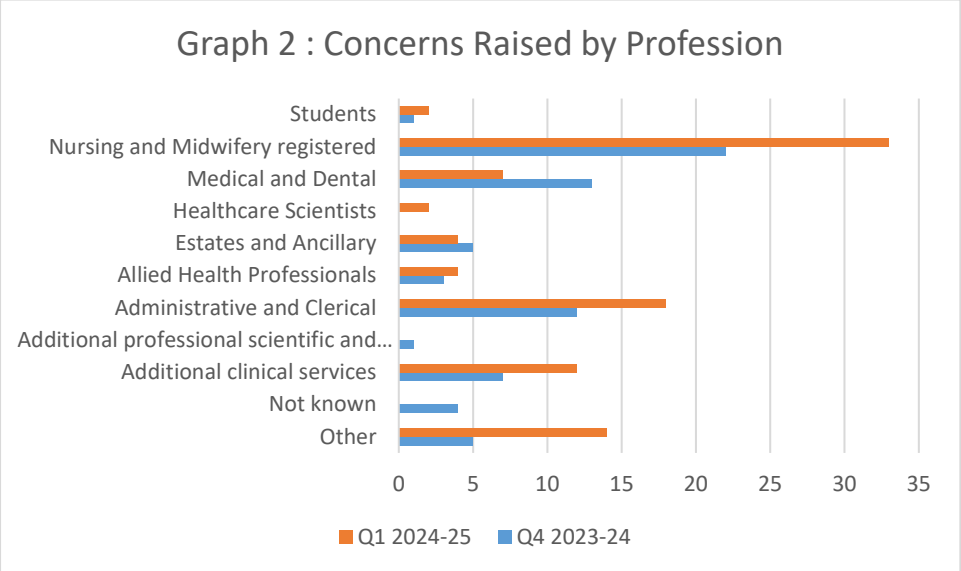




4.3 In Q1 2024-25, 96 concerns were received. 35% of these were closed on the same day after giving advice or signposting.

- 3 concerns were raised anonymously in Q1. Two of these through the Staff App.
- In Q1 11 concerns involved an element of patient safety. This puts the Trust in the mid quartile nationally, the peer figure being 11 (figures accessed from Model Hospital data July 2024).
- In Q1 7 concerns involved an element of bullying and harassment which puts the Trust in the mid quartile nationally, the peer median figure being 6.

4.2 The Q1 figure of 96 is significantly higher than Q1 in 2023-24 which was 68. The main themes raised were around behaviours, HR process and general concerns.

4.4 Most concerns were acknowledged either the same day or next working day by the FTSU Guardian and the majority were managed and closed within 10 weeks. Any outstanding concerns are discussed monthly with the CEO /CPO for awareness and support if required.

4.5 FTSU Guardian continues to produce quarterly reports to ensure that the FTSU information is used to triangulate with other data i.e., Human Resources (HR) information (grievances, disciplines, staff sickness rates and information from exit interviews), so that hotspot areas can be identified, and interventions put in place where needed. Quarterly Meetings are being set up with the Managing Directors, Medical Directors and Directors of Nursing for both Teams North and South for their oversight and awareness.

4.6 **FTSU Guardian Feedback/Evaluations received:**

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The feedback provided by staff that have spoken up has been predominantly positive.

Quarter 2023-24	Feedback received	Would you speak up again? Yes
Q1	6	6

Data analysis of the completed evaluation forms indicate colleagues aged between 25-70 accessing the FTSUG. Regarding ethnicity, colleagues from Asian, Asian British and White backgrounds accessed the FTSUG in Q1.

Within the feedback received, the following are extracts of qualitative feedback received:

I am very grateful for the support offered and the FTSUG was kind, compassionate and nonjudgmental when managing the issues I raised. Thank you.

Liz has been supportive and sensitive throughout

I think she did all she humanly could to find information and relay that back to me. She acted promptly and arranged a meeting with the right people which subsequently offered me some reassurances.

4.7 Case Study

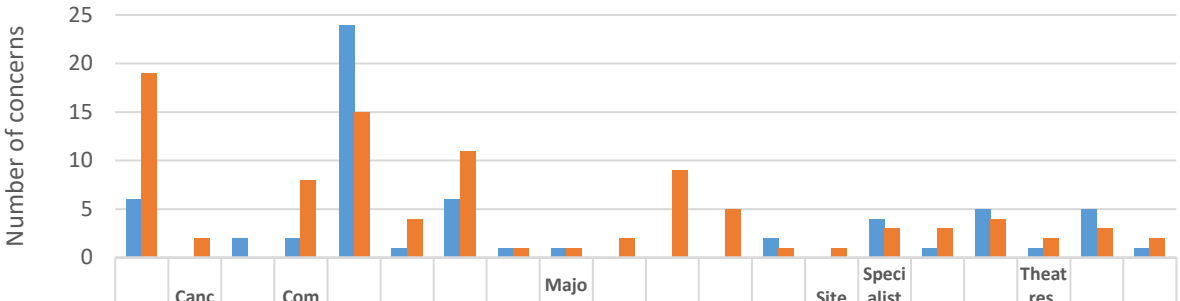
The inclusion of a case study illustrates and highlights the value of FTSU Guardians in organisations, the positive impact that 'speaking up' can have for staff and the subsequent benefits to patient care and experience.

The FTSU Guardian received a concern from a colleague who was leaving the organisation. They asked for some information from his personnel file, which could not be found. They contacted the FTSUG who asked the Data Protection Officer to investigate this. Subsequent searches failed to locate the file, and due to a potential data breach, the case has been raised with the Information Commissioners Office. The Data Protection Lead is going to use this as a case study for learning which may result in changes to information governance processes.

4.8 Care Groups – Concerns Combined:

The FTSUGs at NLAG and HUTH support staff at each Trust respectively. Graph 3 provides a Group overview of the concerns raised to the sovereign HUTH and NLAG FTSUGs combined.

Graph 4: Individual contacts to the NLAG and HUTH FTSUGs by Care Group



	Acute and Emergency Medicine	Cancer Network Care Group	Cardiovascular	Community, Frailty & Therapy	Corporate Infrastructure	Digestive Diseases	Family Services	Head and Neck	Major Trauma Network (North)	Neuroscience Specialist	Other	Pathology Network	Patient Services	Site Management and Discharge	Specialist Cancer and Support Services	Specialist Medicine	Specialist Surgery	Theatres, Anaesthetics and Critical Care	Trust-wide	Unknown
HUTH Q1	6		2	2	24	1	6	1	1	0	0	0	2	0	4	1	5	1	5	1
NLAG Q1	19	2	0	8	15	4	11	1	1	2	9	5	1	1	3	3	4	2	3	2

5. FTSUG activities and proactive work during Q1

5.1 A high level summary of the activities are detailed below:

- Continued work in support of the NHS England Board Self-Reflection and planning tool action plan. A progress report against the improvement and strengths action plan is included as Appendix 1 to this report.
- Successful completion of Annual Training for FTSUGs
- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at all Trust inductions and Top 100 Leaders Event
- Attendance at Junior Doctors Forum

5.2 Future plans:

- Continue to work with HUTH FTSUG to develop FTSU Group Strategy
- Continue to recruit and train FTSU Champions
- Work with Care Groups to ensure that learning from concerns is embedded into practice.
- Attendance at all relevant meetings

6. Regional and National Information and Data

6.1 Regional update

The FTSUG continues to attend regional meetings virtually. Discussions included the development of the Sexual Safety policy and the role of the FTSUG in this, whether organisations have mandated the NGO/HEE FTSU training and presentations by GMC representatives.

6.2 National update

The National Guardian Office Strategy will be published in July (delayed due to the General Election).
The Group FTSUGs will use this and the new Group Strategy to shape the FTSU Strategy which will be developed in the coming months.
Both FTSUGs have been part of a round table discussion with the National Guardians Office on how FTSUGs operate in Group structures. FTSUG has also been contacted by other FTSUGs to discuss Group arrangements.

7. Conclusion

7.1 The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

8.1 The Group Trusts Boards-in-Common are asked to receive and accept this update, and to confirm whether there is sufficient assurance on the Trust's Freedom to Speak Up Guardian arrangements.

8.2 The Group Trusts Boards-in-Common are asked to feedback any observations on how further to develop the Freedom to Speak Up Guardian role and speaking up arrangements in the Trust.

Liz Houchin
15th July 2024

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

Development areas to address in the next 6-12 months	Target date	Action owner	Progress Update
1. Board development session to get all Board members to agree a vision for Speaking Up (including role modelling values of the organisation) and to commit to it	June 2023	HRD/Vice Chair	Board development session to be planned once new Group Executive team in post in 2024/25
2. Discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course	June 2023	HRD/Vice Chair	Will form part of the board development session in 2024/25
3. Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme) – Review FTSU input after 12 months delivery	January 2024	OD/FTSU Guardian	All leaders undertaking the leadership development course complete 'listen up' training. Leadership training being looked at for the Group
4. Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board- review in 6 months	June 2023	HRD/CIO	FTSU information sent to divisional management teams quarterly and will now share with the new Care Groups
5. Update and Communicate new policy to staff			Action Completed
6. Develop ways of measuring the effectiveness of the communications strategy for FTSU	June 2023	FTSU Guardian/Comms	Bi-monthly meetings held with Comms
7 Ensure FTSU	March 2023	FTSU	FTSU listed on

information on local induction check list		Guardian/People Directorate	Induction Checklist for New Starter (DCM716) Action Completed
8 Further work needed on how we can encourage managers including targeted support through cultural transformation work to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale.	October 2023	OD/HRD	FTSU information included in the Manager's monthly email FTSU Guardian part of the Cultural Transformation Working Group FTSU Guardian presented at OMG away day – October 2023 FTSU Guardian held Manager Drop-In sessions during October

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)143

Name of the Meeting	Trust Boards-in-Common - Public
Date of the Meeting	8 August 2024
Director Lead	Tony Curry, Non-Executive Director / Member of HUTH Audit, Risk and Governance Committee and Chair for the June 2024 meeting. Simon Parkes & Jane Hawkard – Non-Executive Directors / Chairs of Audit, Risk and Governance Committees-in-Common.
Contact Officer/Author	Tony Curry
Title of the Report	**HUTH Audit, Risk and Governance Committee Highlight / Escalation Report – June 2024 & Audit, Risk and Governance Committees-in-Common Highlight / Escalation Report – July 2024.**
Executive Summary	The attached highlight / escalation reports summarise the key matters presented to and discussed by the meeting of the Hull University Teaching Hospitals NHS Trust (HUTH) Audit, Risk and Governance (ARG) Committee on 21 June 2024 and also the Audit, Risk and Governance Committees-in-Common meeting on 25 July 2024. Year end items of business were considered by the HUTH ARG Committee at its June 2024 meeting, under formal delegated authority from the Trust Board to review and approve the year end financial statements and associated reports on its behalf. The Group Chair and Group Chief Executive were in attendance at the June 2024 HUTH ARG Committee meeting. The Trust Boards are asked to note: • the highlight report from the June 2024 HUTH Audit, Risk and Governance Committee; and • the highlight report from the July 2024 Audit, Risk and Governance Committees-in-Common.
Background Information and/or Supporting Document(s) (if applicable)	HUTH ARG Committee Agenda Papers – 21 June 2024 ARG CiC Agenda Papers – 25 July 2024
Prior Approval Process	-
Financial implication(s) (if applicable)	-
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

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Committees-in-Common Highlight / Escalation Report to the Trust Boards

	8 August 2024 - Public
	Audit, Risk and Governance Committees-in-Common (ARG CiC)
	21 June 2024 – HUTH ARG Committee 25 July 2024 – ARG CiC
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by:

- the Hull University Teaching Hospitals NHS Trust (HUTH) Audit, Risk and Governance (ARG) Committee at its meeting on 21 June 2024, and;
- the Audit, Risk and Governance Committees-in-Common (ARG CiC) at their meeting held on 25 July 2024, including those matters which the Committees specifically wish to escalate to either or both Trust Boards.

1.2 The Group Chair and the Group Chief Executive Officer had been invited to the HUTH ARG Committee meeting on 21 June 2024 and were in attendance.

2.0 Matters considered by the committees

2.1 The HUTH ARG Committee considered the following items of business, under delegated authority from the Trust Board (given at its meeting on 13 June 2024) to review and approve the year-end financial statements and reports on its behalf at its meeting on **21 June 2024**:

- HUTH Audited Annual Accounts 2023/24
- HUTH Audit Completion Report inc. Letter of Representation, Audit Opinion and Consistency Opinion 2023/24
- HUTH Annual Governance Statement 2023/24
- HUTH Annual Internal Audit Report and Head of Internal Audit Opinion 2023/24
- HUTH Trust Annual Report 2023/24
- HUTH ARG Committee Annual Report to the Trust Board 2023/24

2.2 The ARG CiC considered the following items of business at its meeting on **25 July 2024**:

- HUTH Auditors Annual Report 2023/24
- Annual Claims Report 2023/24 – Group

- HUTH External Audit Recommendations Action Plan
- Internal Audit Progress Report / Overdue recommendations – HUTH, NLAG & Group
- Group LCFS Update
- Group Annual LCFS Report 2023/24
- Annual Review of Adequacy & Effectiveness of System for Devising / Monitoring the BAF – Group
- Annual Review of Adequacy & Effectiveness of System for the Management / Monitoring of Risk – Group
- Annual Review of Risk Management Strategy – Group
- Review of Legal Fees & External Consultancy Fees - Group
- Annual EPRR & Business Continuity Report 2023/24 - Group
- Group Information Governance (IG) Highlight Report inc. Annual IG Toolkit Returns
- Position Statement on Expired Contracts
- Draft Group Standing Financial Instructions*
- Draft Group Scheme of Delegation & Powers Reserved for the Trust Board*
- NLAG ARG Committee Annual Report to Trust Board 23/24*
- NLAG & HUTH ARG CiC Terms of Reference Changes
- Internal Audit Contracts for NLAG and HUTH – Future Service Provision

*[*Items marked with an asterisk are on the boards' agenda as a standalone item in accordance with the board reporting framework – as applicable]*

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The **HUTH ARG Committee meeting on 21 June 2024** agreed the following matters for reporting / escalation to the HUTH Trust Board:

a) **HUTH Audited Annual Accounts** – The draft accounts were previously reviewed in detail by the Committee at its April 2024 meeting. The Assistant Director of Finance – Planning and Control provided a written list of the limited number of changes made to the draft accounts, noting that the overall financial position had not changed. Following discussion, the Committee approved the Trust's Annual Accounts for 2023/24 for submission to NHS England on 28 June 2024 on behalf of the Trust Board under formal delegated authority, subject to any final adjustments identified by the External Auditor's internal quality review currently taking place.

b) **HUTH Audit Completion Report inc. Letter of Representation, Audit Opinion and Consistency Opinion 2023/24** – The Trust's External Auditor gave an unqualified opinion, without modification, for the 2023/24 annual accounts. The Committee discussed two unadjusted misstatements, but these were not material items. A number of recommendations had been made in relation to inventory items and accruals and management actions agreed to address these. In respect of the Trust's value for money (VFM) arrangements, the External Auditor continues to report one significant weakness in relation to the outcome of the Care Quality Commission (CQC) Report in 2022. The External Auditor advised that work had been undertaken in this area and no further weaknesses identified, however given that the CQC had not returned to perform a re-inspection the existing significant weakness would remain in their report. The Committee endorsed the signing of the Management Letter of Representation 2023/24.

The Committee was also advised that Mazars was forming a new global network with Forvis and following a re-branding exercise was now known as Forvis Mazars LLP effective 1 June 2024.

c) **HUTH Annual Governance Statement (AGS) 2023/24** – The Committee received and approved the AGS subject to a limited number of minor adjustments agreed following discussion during the meeting.

d) **HUTH Annual Internal Audit Report including Head of Internal Audit Opinion (HoIAO) 2023/24** – The Committee received the final version of the HoIAO, although the Annual Internal Audit Report remained as draft pending the conclusion of their final piece of audit work. The HoIAO remained unchanged from the draft version received at the April 2024 ARG Committee meeting, namely a positive opinion (adequate and effective framework for risk management, governance and internal control, with further enhancements identified to ensure it remains so).

e) **HUTH Trust Annual Report 2023/24 -** The Trust's Annual Report 2023/24 was received by the Committee. The Group Director of Assurance advised that the document was substantially complete subject to a few typographical errors identified since it was circulated, and these would be adjusted as necessary before being branded and published. The Committee approved the Trust's Annual Report 2023/24 subject to final amendments.

f) **HUTH ARG Committee Annual Report to the Trust Board 2023/24** – The Committee reviewed and approved its annual report outlining its oversight activities in the previous 12 months for note to the HUTH Trust Board. This is submitted to the Board as a separate item for information.

3.2 The **ARG CiC meeting on 25 July 2024** agreed the following matters for reporting / escalation to the Trust Boards:

a) HUTH External Audit Recommendations Action Plan – Four internal control deficiencies were raised as part of the External Auditors audit of the HUTH annual accounts for 2023/24, which were discussed at the June 2024 HUTH ARC Committee meeting, including an issue leading to an unadjusted misstatement item relating to stock prices (£59k, and £6.2m when extrapolated). The Committee received an action plan at the July 2024 meeting setting out the actions taken / being taken to address these four items and the current position with each. Implementation of these actions should ensure that there is no repeat of these deficiencies in future year audits.

b) **Annual Emergency Preparedness, Resilience and Response (EPRR) 2023/24 & Business Continuity Report inc. Medical Gas Testing Oversight – Group** - The ARG CiC received the Group report and discussed the reduced 2023/24 compliance rates against the NHS England (NHSE) Core Standards for EPRR, with HUTH at 18% and NLAG at 40% compliance. The 2023/24 submission process was changed for the North East and involved a more rigorous baseline assessment with expanded requirements, which significantly negatively impacted the compliance rates for all NHS providers in the area. The 2023/24 submissions, including the compliance rates, were received and approved by the respective Trust Boards in November and December 2023. The ARG CiC requested an update at its meeting on 1 October 2024 to provide the Committees with assurance that the action plans, developed to address the

areas of non-compliance at each Trust and reduce any potential risks, were progressing and to ensure improvement in meeting the standards in 2024/25. The Committee noted that both Trusts had undertaken a number of EPRR test events and real events throughout 2024/25. The 2024/25 core standards submission is due in December following approval by the Boards-in-Common at their December 2024 meeting. It was noted that the core standards were changing again to be more in line with 22/23 standards. It was also noted that the Trusts had received positive EPRR internal audit reports.

c) **Position Statement on Expired Contracts** – Following concerns raised by the Non-Executive Directors involving the number of contracts being extended and the value for money aspect of any delayed contract renewals, the Group Chief Financial Officer requested the Director of Procurement provide a paper to the ARG CiC setting out the background, current position, issues and solutions to the problem – a problem being experienced by many other Trusts following the Covid pandemic during which time Trusts focused on securing supplies and not renewing contracts. As at July 2024, 18% of all group contracts held had expired, and 15% renewals were in progress of which some would have also expired. The group have a total of 1,568 contracts. Assurance was provided that there were no commercial to the Trusts of this situation particularly as inflation has been running at circa 10%. The Procurement team are working diligently to address the issue although they have an 18% vacancy rate at present, but it was acknowledged that this would take significant time and resource to achieve. The Procurement team highlighted that maintenance contracts were often separate to the capital equipment contract and that combining the two would result in a significant reduction in the number of contracts to maintain. The ARG CiC noted there was no timescale for the recovery plan and acknowledged that it would not be resolved quickly, but requested a timetable be prepared and brought back to the ARG CiC.

d) **Annual Review of Adequacy and Effectiveness of System for Devising and Monitoring the Board Assurance Framework (BAF) – Group** – Following discussion of the work undertaken thus far on reviewing sovereign organisation risks and developing a Group BAF, the Committees were not wholly assured that the organisations high level risk register and the BAF connected sufficiently at the present time. The Group Director of Assurance is continuing work to review all risk registers and risks and make further progress to ensure alignment of risks into the BAF. The Committee took some assurance from the meetings that were now taking place with the Care Group triumvirates where risks were being discussed. The ARC CiC discussed their responsibility to be confident in this regard, to be cognisant of the organisations major risks and be assured that they were being managed appropriately. Further updates will be bought back to the ARG at future meetings.

e) **NLAG ARG Committee Annual Report to the Trust Board 2023/24** – The NLAG ARG Committee reviewed and approved its annual report outlining its oversight activities in the previous twelve months for note to the NLAG Trust Board and the Council of Governors. This is submitted to the NLAG Board as a separate item for information.

f) **Draft Group Standing Financial Instructions and Draft Group Scheme of Delegation and Powers Reserved for the Trust Board** – These draft documents were approved by the ARG CiC and are submitted to the Boards-in-Common as separate items for approval.

g) **NLAG and HUTH ARG CiC Membership and Terms of Reference (ToR) Changes** – The ARG CiC approved the proposed amendments to the existing ToR. They are submitted as separate items to the Boards-in-Common for approval.

h) **Internal Audit Contracts – NLAG and HUTH** – The Committees considered the position with the existing Internal Audit contracts, both of which are in their final scheduled year of contracted activity (2024/25). Although each contract has an extension year option for 2025/26, given the Group status and that the existing Internal Audit providers have collaborated to produce a Group plan as far as possible for this year, it was considered an appropriate time to conduct a procurement exercise for a single Group Internal Audit provider. The ARG CiC therefore approved the proposal to go out to tender with a view to having a single service for the two organisations from April 2025. Members of the ARG Committee will contribute to the tender evaluation process with members of the Executive team.

4.0 Matters on which the committees have requested additional assurance:

4.1 At the June 2024 HUTH ARG Committee meeting a number of recommendations were made by the External Auditor in relation to inventory items and accruals, and the Committee requested updates on the implementation of these at the July 2024 meeting of the Committee.

4.2 The ARG CiC requested additional assurance in relation to items b, c, and d from its 25 July 2024 meeting in section 3.2 above.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The Board Assurance Framework (BAF) was not received at the June 2024 HUTH ARG Committee meeting.

5.2 The BAF was not specifically received at the July 2024 ARG CiC meeting, but the Committees did receive a report on the Annual Review of Adequacy and Effectiveness of System for Devising and Monitoring the BAF. The Committees also agreed to a proposal for the BAF to be received at each full meeting going forward.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the highlight report from the HUTH Audit, Risk and Governance Committee meeting on 21 June 2024, and:
- Note the highlight report from the Audit, Risk and Governance Committees-in-Common meeting on 25 July 2024.

Tony Curry **HUTH NED / Chair of June ARG Committee meeting**	**Simon Parkes** **NLAG ARG CiC Chair / NED**	**Jane Hawkard** **HUTH ARG CiC Chair / NED**
21 June 2024	**25 July 2024**	**25 July 2024**

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Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)144

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	**8 August 2024**
Director Lead	Gill Ponder/Helen Wright, Non-Executive Director Committees Chairs
Contact Officer / Author	Rebecca Thompson, Deputy Director of Assurance
Title of Report	**Capital & Major Projects Committees-in-Common Minutes Highlight Report & Board Challenge**
Executive Summary	The attached highlight / escalation report provides an overview of the key matters presented to, discussed and escalated at the Capital & Major Projects Committees-in□Common meeting held on 25 June 2024
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	The report has been approved by the Committee Chairs
Financial Implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Committees-in-Common Highlight / Escalation Report to the Trust Boards

	Thursday 8th August 2024
	Gill Ponder, Chair Capital and Major Projects CIC
	25 June 2024
	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Capital and Major Projects Committees-in-Common at their meeting(s) held on Tuesday 25 June 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- Terms of Reference
- Board Assurance Framework
- Risk Register Report
- Capital Funding update
- Group Capital Plan Delivery – expenditure against plan
- Update on New Build at HRI
- Public Sector Decarbonisation Scheme – NLAG
- Electronic Patient Record (EPR) draft Outline Business Case (OBC)
- Urgent Care Building Works - HRI
- Humber Acute Services Review
- Community Diagnostic Centre Programme (CDC)
- Digital Plan Delivery – Bi-monthly update and EPR business case
- Group Capital Committee meeting minutes

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting to the Trust Boards:

a) The Cyber Security risk rating was discussed and the Committees agreed that there was Limited Assurance, as there were concerns raised regarding the risk target and whether it would be met. This item will be discussed at the Board

Development session in July 2024 and it was agreed that a report would be brought back to the Committees after that to provide assurance on the mitigations of the impact in place if an attack occurred.

b) EPR outline business case was presented to the CIC. The Group is required to follow Treasury and NHS E processes and investment appraisal techniques when producing the OBC to obtain the funding needed to .replace 32 existing clinical systems with a single, modern platform. The Committee were Reasonably Assured by the Cost Benefit ratio, but were pleased to note that an independent benefit review session was planned before the full business case was produced in Quarter 1 of 2025/26. The CIC approved the OBC for presentation to the Boards in Common in July 2024.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

a) Risk Register report to be received by the CIC in August 2024 as this was still under development. The Committees agreed to allow sufficient time on the agenda to fully review the report at that meeting.
b) De-carbonisation programme for Scunthorpe Hospital was presented and the Committee was Reasonably Assured, but further assurance was requested around how this impacts on the Net Zero strategy. A report to be received in October 2024.
c) The HASR programme had been given substantial assurance by the system but as there were still risks with the delivery of the programme and delays due to Purdah the CIC gave it Limited Assurance.
d) The Community Diagnostics Centre programme was given Limited Assurance due to the continued external changes to requirements, delays with the Grimsby CDC which were considered to be recoverable and difficulty in recruiting radiologists.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The committees considered the areas of the BAFs for which they have oversight and no changes were proposed. It was noted that the BAF would be updated once the Group Strategy had been agreed and that the revised BAF would be discussed in detail at the next Board Development session in July 2024.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the issues for reporting in item 3 and approve the actions being taken.
- Note the items listed for further assurance and their assurance ratings.

Gill Ponder, Co-Chair Capital and Major Projects CIC

Helen Wright, Co-Chair Capital and Major Projects CIC

25 June 2024

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Trust Boards in Common

Agenda Item No: BIC (24) 145

Name of the Meeting	**Trust Boards in Common**
Date of the Meeting	8 August 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Group Board Assurance Framework – July 2024
Executive Summary	The attached report now includes the July 2024 position for: • Group BAF risks for Workforce, Leadership, Finance, Estates, Digital, Performance and Strategy • HUTH/NLAG Quality risks • High level risks for each Committee in Common There have been no changes to any of the risk ratings since Q1 2024/25. Work has been carried out with the Executive leads to ensure the BAF risk ratings are current and that the controls and gaps in controls are up to date. The Committee is asked to: • note that there have been no changes to the risk ratings since June 2024 • note the High Level risks are now included in the CIC BAF Reports
Background Information and/or Supporting Document(s) (if applicable)	The full Board Assurance Framework is attached at Appendix 1.
Prior Approval Process	Group Cabinet Risk and Assurance Committee, Committees in Common.
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance ☐ Information ✓ Review ☐ Other – please detail below:

Group Board Assurance Framework
July 2024

1. Purpose of the Report

The purpose of the report is to update the BIC regarding the July 2024 Board Assurance Framework which now includes merged risks for workforce, leadership, finance, performance, estates, digital and strategy.

2. Background

The Board Assurance Frameworks for both Trust's (HUTH/NLAG) have now been merged into one document and will remain so until the Group strategic objectives are set in July and the BAF risks reviewed again. This is with the exception of the Quality and Safety risks which are being reviewed by the Chief Nurse/Chief Medical Officer and the interim Group Director of Quality Governance.

3. Board Assurance Framework Development

The risk ratings for July 2024 are shown in the table below. The table shows the will show risk movement from Q1 2024/25. There has been no changes to any of the risk ratings since Q1 2024/25. The detailed BAF is attached at Appendix 1.

No	Description of Risk	Lead	Committees in Common	Current Risk Rating	Movement since last Qtr	Target Risk Rating
Group						
1	**Group Workforce** – The Group does not effectively manage its risks around staffing levels, both quantitative and qualitative and does not provide quality of care to its patients	Group Chief People Officer	Workforce, Education and Culture Committees in Common	16 4 x 4	↔	12 3 x 4
2	**Group Culture and Leadership** – The Group does not make progress towards further improving a positive working culture this year and must have leadership capacity to develop an outstanding working environment	Group Chief People Officer	Workforce, Education and Culture Committees in Common	16 4 x 4	↔	12 3 x 4
3	**Group Finance** – There is a risk that the Group does not achieve delivery of the in-year financial plans or manage the underlying position appropriately	Group Chief Financial Officer	Performance, Estates and Finance Committees in Common	25 5 x 5	↔	5 1 x 5
4	**Group Estates** - The risk that the Group's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action)	Group Chief Financial Officer	Performance, Estates and Finance Committees in Common	20 4 x 5	↔	15 3 x 5
5	**Group Digital (IT Failure)** – There is a risk that the Group will suffer a major failure of its digital systems, leading to loss of life, finance and reputation through inability to maintain business continuity	Group Chief Medical Officer	Capital and Major Projects Committees in Common	15 3 x 5	↔	10 2 x 5
6	**Group Digital (Cyber Security) –** There is a risk that the Group will suffer a Cyber-Attack, leading to loss of life, finance and reputation through inability to maintain business continuity	Group Chief Medical Officer	Capital and Major Projects Committees in Common	15 3 x 5	↔	10 2 x 5
7	**Group Performance –** The risk is that the Group fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care	Group Chief Delivery Officer	Performance, Estates and Finance Committees in Common	20 4 x 5	↔	16 4 x 4
8	**Group Strategy -** There is a risk that the Group Strategy is not effective and does not allow the Group to deliver high quality	Group Chief of Strategy and Partnerships	Boards in Common	12 3 x 4	↔	8 2 x 4

	and sustainable care and that the list of priorities do not align to investments, causing conflict					
9	**Group Strategic Capital -** The risk that the Group fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades	Group Chief of Strategy and Partnerships/Group Chief Financial Officer		15 3 x 5	↔	15 3 x 5
10	**Group Strategic Partnerships and Collaboration -** There is a risk that the Group does not prioritise actions at PLACE and ICB to fulfill its Anchor role which increases health inequalities, competition and competition in workforce. The Group also fails to work collaboratively to innovate and change pathways	Group Chief of Strategy and Partnerships		12 3 x 4	↔	8 2 x 4
			HUTH/NLAG			
	HUTH – Quality – There is a risk that the quality improvement measures set out in the Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating	Group Chief Nurse	Quality and Safety Committees in Common	16 4 x 4	↔	12 3 x 4
	HUTH – Patient Harm – There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED and Patients with No Criteria to Reside require partnership working to determine improvement plans.	Group Chief Medical Officer/Group Chief Nurse/Group Chief Delivery Officer	Quality and Safety Committees in Common	20 4 x 5	↔	16 4 x 4
	HUTH – Research and Innovation – There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment	Group Chief Medical Officer	Quality and Safety Committees in Common	**12** **3 x 4**	↔	8 2 x 4
	NLAG – Quality of Care - The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience	Group Chief Medical Officer/Group Chief Nurse	Quality and Safety Committees in Common	**15** **3 x 5**	↔	15 3 x 5

4. High Level Risk Register

This section provides a summary of the high-level risks across HUTH and NLAG. Aligning the risk registers to the new Care Groups is challenging by virtue of the two different risk management systems used across the Group, (HUTH use Datix and NLAG use Ulysses).With the advent of a group-wide system we anticipate the assignment of risks to categories, to CiC and strategic risks to improve. We also aim to provide more information on the changes to risks over time now that an aggregated dataset is available. The chart below shows the total number of risks on the Group Risk Register, split by risk rating.

The number of moderate risks are dominant across the Group

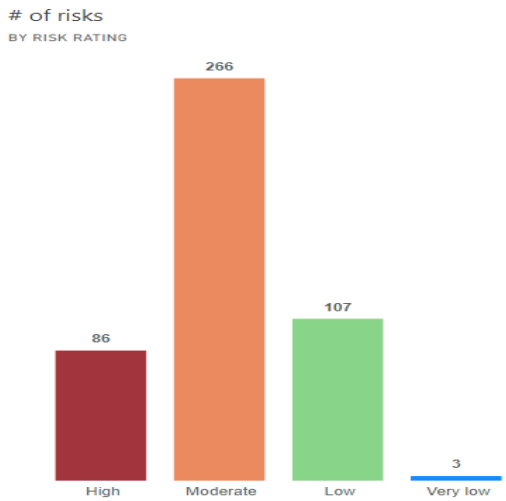

Table 2 below shows the profile of risks that are past their planned review date.

Table 2 – Time profile for risks overdue against the requirement to review

Risk Rating	2021	2023	2024	**Total**
High			71	**71**
Moderate		3	149	**152**
Low	1	1	27	**29**
Total	**1**	**4**	**247**	**252**

In total there are 71 High Risks that are overdue against the requirement to review High Risks every month.

Table 3 below shows the high level risks past their planned review date by Committees in Common.

Table 3 – High-level risks overdue against the requirement to review by CiC

Quality and Safety	42
Workforce, Education and Culture	18
Capital and Major Projects	8
Performance, Estates and Finance	3
Total	**71**

The high-level Risks that are overdue are now highlighted in each CIC BAF report and a breakdown of those risks are appended (appendix 2).

5. Next Steps

The Committee is asked to note that the BAF risks will be updated following the July 2024 Group Strategy launch.

The management of all risks will continue to be assessed through the Care Groups and the escalation processes in place via site and Group arrangements.

The Group expect to appoint a Group Risk Manager who will develop a Group Risk Management Strategy, system harmonisation and a Group wide risk management training programme.

6. Recommendation

The Boards in Common are asked to:

- note that there have been no changes to the risk ratings since July 2024
- note the High Level risks aligned to the BAF risks

Rebecca Thompson
Deputy Director of Assurance
July 2024

Appendix 1

Group BAF Risks – July 2024/25

Group BAF - Workforce				16
The Group does not effectively manage its risks around staffing levels, both quantitative and qualitative and does not provide quality of care to its patients.				
Executive Lead	Group Chief People Officer	Assurance Committee	Workforce Education and Culture Committees in Common	
Executive Group	Group Cabinet Risk and Assurance Committee	Latest review date	09/07/24	

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture		Partnership and integrated services		Link to BAF and CRR	S3162 - Acute And Emergency Medicine - Quality of Care and Patient Safety based on Nurse Staffing Position (20) S3232 - Community, Frailty And Therapy Services - Speech and Language Therapy Stroke staffing resource (20) N3983 - Specialist Cancer And Support Services - There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment (20) N4032 - Specialist Cancer And Support Services - Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting (20) N2949 - Specialist Cancer And Support Services - Oncology Service (20) N3646 - Specialist Cancer And Support Services - There is a risk to patient safety due to the lack of Haematology Medical Staffing (20) S3918 - Acute And Emergency Medicine - Lack of Adequate Substantive Consultant Workforce in Acute Medicine (16) S2898 - Acute And Emergency Medicine - Medical Staff - Mandatory Training Compliance (16) N4037 - Cardiovascular - Lack of Suitably Trained Staff to Perform Cardiac Stress Testing (16) N4324 - Cardiovascular - There is a risk of failing our perfusion accreditation due to non-compliance of utilising data management record keeping (16) N3045 - Digestive Diseases - Medical Workforce Vacancies in Gastroenterology (16) N3988 - Specialist Cancer And Support Services - Lack of Therapeutic Radiographer Staffing (16) S4130 - Specialist Medicine - Funding provision for 7 day IP DSN Service within Diabetes (16) S4148 - Specialist Medicine - Capacity Shortfalls in DEXA scanning (16) S3475 - Family Services - Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology (15)
	Well-led, skilled and sufficient workforce	✓	Research and innovation			
	High Quality Care		Financial Services			
	Great Clinical Services					

						S3346 - Family Services - Clinical capacity within hysteroscopy at DPOW (15) S4173 - Specialist Medicine - Nintedanib Change in guidance impacting on clinical capacity to deliver increasing numbers of patients (15)

Risk Scoring (Current)							
Quarter	Q1 (2024/25)				Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4				↔	4	12
Consequence	4					5	
Risk Score	16					20	

Controls and Assurance	
Key controls	Assurances
• HUTH Current People Strategy • NLAG Current People Strategy • Group Workforce Plan 2024/25 • Annual National Staff Survey	Internal • Development of the new Group People Strategy • Group Workforce Transformation Committee in development • Group Executive Management Committee will receive escalation reports from the Group Workforce Transformation Committee • Workforce, Education and Culture Committees in Common • Remuneration Committees in Common • Integrated Performance Report (Sickness, vacancy, appraisal rate, retention) • International recruitment drives • Certificate of Eligibility for Specialist Registration (CESR Programme) – specialist qualification before becoming a consultant External • HNY and Care Partnership ICB Workforce Board • Internal Audits • HR Director Chairs meeting (NHS Employers) • HR Network
	Gaps in Assurance **NLAG** • Vacancy position reducing overall • Nursing vacancies reducing • Consultant vacancy position remains high. • Agency spend remains high • Turnover reducing, but above target
Gaps in controls and assurances	
• Hard to recruit roles in medical specialties • Attract, recruit and retain staff to work in the geographical area • Culture and staff engagement	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Group People Strategy to be developed and launched 2025	SN	January 2025	
Launch new recruitment drives using the Group name to attract high caliber candidates	SN		

Group BAF – Culture and Leadership				16
The Group does not make progress towards further improving a positive working culture this year and must have leadership capacity to develop an outstanding working environment				
Executive Lead	Group Chief People Officer	Assurance Committee	Workforce Education and Culture Committees in Common	
Executive Group	Group Cabinet Risk and Assurance Committee	Latest review date	09/07/24	

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture	✓	Partnership and integrated services		Link to BAF and CRR	S3048 - Acute And Emergency Medicine - Challenges to recruitment of acute care physician vacancies in Acute (16)
	Well-led, skilled and sufficient workforce		Research and innovation			
	High Quality Care		Financial Services			
	Great Clinical Services					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)				Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4				↔	4	12
Consequence	4					5	
Risk Score	16					20	

Controls and Assurance	
Key controls	Assurances
• HUTH Current People Strategy • NLAG Current People Strategy • Group Workforce Plan 2024/25 • Annual National Staff Survey • NLAG Leadership Strategy • CQC Well Led Framework	Internal • Development of the new Group People Strategy • Group Workforce Transformation Committee in development • Group Executive Management Committee will receive escalation reports from the Group Workforce Transformation Committee • Workforce, Education and Culture Committees in Common • Disability Network • BAME Network • Group Leadership quarterly events • Group Values workshops • Circle Group • Care Group Recruitment • Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System External • HNY and Care Partnership ICB Workforce Board • Internal Audits

	• HR Director Chairs meeting (NHS Employers) • HR Network
	Gaps in Assurance • Risk around the New Care Group coming together and going live. There is an Organisational Development plan being developed to support the development of the 14 Care Groups
Gaps in controls and assurances	
• Group Staff Survey Results 2023	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Group People Strategy to be developed and launched 2025	SN		Monitored through WEC CIC
Organisational Development Plan being developed to support the new Care Groups	SN		Monitored through WEC CIC

Group BAF - Finance

There is a risk that the Group does not achieve delivery of the in-year financial plan or manage the underlying position appropriately	25

Executive Lead	Group Chief Financial Officer	Assurance Committee	Performance Estates and Finance Committees in Common
Executive Group	Performance Estates and Finance Committees in Common	Latest review date	09/07/24

Strategy and Risk Register

Link to Strategy					Link to BAF and CRR
	Honest, caring and accountable culture		Partnership and integrated services		S4275 - Specialist Medicine - Risk to deliver the financial plan for medicine (20) S3202 - Acute And Emergency Medicine - Delivery of Balanced Financial position to include CIP savings (16)
	Well-led, skilled and sufficient workforce		Research and innovation		
	High Quality Care		Financial Services	✓	
	Great Clinical Services				

Risk Scoring (Current)

Quarter	Q1 (2024/25)				Change from previous quarter	Inherent Risk	Target Risk
Likelihood	5				↔	5	5
Consequence	5					5	
Risk Score	25					25	

Controls and Assurance

Key controls	Assurances
• Operational and Financial Plan 2024/25 • Group Executive to Triumvirate Performance Review meetings • NHS E/ICS engagement • Group Counter Fraud and Internal Audit Plans • Group Budgetary Control System	**Internal** • Minutes of Audit Risk and Governance Committees in Common (Quarterly) • Minutes of Performance, Estates and Finance (Monthly) • Highlight reports to the Trust Board (Monthly) **External** • Internal Audit Reports • Financial planning updates to ICS • Meetings with NHSE Regional Team • Benchmarking

	Gaps in Assurance • £84m Cost Improvement Programme • Underlying deficit 2024/25 • Bed Pressures • ERF Delivery • Profile of EPR vs funding allocation • CQC Quality issues – financial implications • Junior Doctors strike implications
Gaps in controls and assurances	
• Ongoing development of accountability of Care Groups • Industrial Action • Cost Improvement Programme not fully formed. • Delivery plan to support activity targets not fully formed. • Clinical strategy required to inform Finance Strategy • As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process • Month on month adverse variants against operational budgets • Inability to recruit and retain staff to meet financial planning assumptions	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Cost Improvement Plan to be developed 2024/25	LB		Monitored through PEF CIC

Group BAF Estates	
The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.	20

Executive Lead	Chief Financial Officer	Assurance Committee	Performance, Estates Finance Committees in Common
Executive Group	Performance, Estates Finance Committees in Common	Latest review date	09/07/24

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	
	To be a good employer					
	To live within our means	✓				
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)				Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4				↔	3	15
Consequence	5					5	
Risk Score	20					20	

Controls and Assurance	
Key controls	Assurances
• Captial Programme in place and risk assessed • Comprehensive maintenance programme in place • Group Capital and Major Projects Committees in Common • Service level business continuity plans in place	• External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts • Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark) • Premises Assurance Model Internal: • Minutes of Performance, Estates and Finance Committees in Common, Audit Risk & Governance Committees in Common, Capital and Major Projects Committees in Common • Non-Executive Director Committee Chair Highlight Report to Trust Board • Specialist Technical Groups External: • ERIC (Estates Return Information Collection)

Gaps in controls and assurances	
Gaps in Controls: • Lack of ICS Funding aligned for key infrastructure needs/requirements • Insufficient Capital funding	**Gaps in Assurance:** • Integrated Performance Report - Estates and Facilities (development in progress)

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Capital Programme 2024/25	LB		Monitored through PEF CIC

BAF Digital – IT Failure				15
There is a risk that the Group will suffer a major failure of its digital systems, leading to loss of life, finance and reputation through inability to maintain business continuity.				
Executive Lead	Chief Medical Officer	Assurance Committee	Capital and Major Projects Committees in Common	
Executive Group	Capital and Major Projects Committees in Common	Latest review date	09/07/24	

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	S3439 - Acute And Emergency Medicine - Crowding in the Emergency Department (25) N2755 - Specialist Cancer And Support Services - SGH MRI scanner past end of 7 year life (20) S4278 - Specialist Medicine - Lack of reporting software for Bronchoscopy (20) N4344 - Cardiovascular - Risk to patient diagnostic/treatment delays due to Information management systems do not meet the requirements of the service (16) S3300 - Family Services - Colposcopy chair (16) N2996 - Specialist Cancer And Support Services - Provision of EMIS eMM standalones in both Pharmacy dispensaries (16) N3108 - Specialist Cancer And Support Services - Non compliance with MHRA guidance for managing medical devices Jan 21, NatPSA/2023/010/MHRA and Medical Device Management & Procurement Policy DCP047 (15) N4048 - Specialist Cancer And Support Services - There is a risk to the continuity of the service due to the ageing Radiotherapy Linac (Bunker 6) (15)
	To be a good employer					
	To live within our means					
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔		**10**
Consequence	5						
Risk Score	15						

Controls and Assurance	
Key controls	Assurances

● Up to date Organisational and Digital / IT policies, procedures and guidelines. ● Infrastructure investment and improvement plan in progress, but with scope to expand. ● Up to date software and hardware, with procedures for patching and replacement once at end of life ● Robust EPRR links with up to date, exercised BC/DR plans across all care groups. ● Digital Strategy Board ● Digital Solutions Delivery Group ● Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.	• NLAG N08/2024 IT Disaster Recovery Plan – Limited Assurance. Tracked at Internal Audit, Risk and Governance Committee. • NLAG N12/2024 Change Control Management – Limited Assurance. Tracked at Internal Audit, Risk and Governance CIC. • Internal Audit, Data Security and Protection Toolkit 2023/24 **Planned** Internal: ● Board awareness session around responsibilities under NIS 2018 (Maintenance of critical infrastructure) to be scheduled. • Digital strategy to be produced for the group, laying down our investment case for Group Digital Foundations. External: ● TBC

Gaps in controls and assurances	
Gaps in Controls: ● Legacy systems that cannot be retired and modernised due to reliance on out of date software and equipment (i.e, WebV and NLAG door access system). • Lack of policies and governance on HUTH estate.	**Gaps in Assurance:** ● No oversight of major digital systems that sit outside of the digital directorate. • Not currently compliant with industry standards such as ITIL V4, COBIT and ISO27001

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Complete our DSPT Audit to identify gaps in controls across the Group and develop a robust remediation plan.	CMO	Q1 24/25	On track to deliver
Plan to align digital governance across the Group	GCDO / GCTO	Q3 24/25	This is being monitored at the C&MP CIC

BAF Cyber Security			15
There is a risk that the Group will suffer Cyber-Attack, leading to loss of life, finance and reputation through inability to maintain business continuity.			
Executive Lead	Chief Medical Officer	Assurance Committee	Capital and Major Projects Committees in Common
Executive Group	Capital and Major Projects Committees in Common	Latest review date	09/07/24

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	S3439 - Acute And Emergency Medicine - Crowding in the Emergency Department (25) N2755 - Specialist Cancer And Support Services - SGH MRI scanner past end of 7 year life (20) S4278 - Specialist Medicine - Lack of reporting software for Bronchoscopy (20) N4344 - Cardiovascular - Risk to patient diagnostic/treatment delays due to Information management systems do not meet the requirements of the service (16) S3300 - Family Services - Colposcopy chair (16) N2996 - Specialist Cancer And Support Services - Provision of EMIS eMM standalones in both Pharmacy dispensaries (16) N3108 - Specialist Cancer And Support Services - Non compliance with MHRA guidance for managing medical devices Jan 21, NatPSA/2023/010/MHRA and Medical Device Management & Procurement Policy DCP047 (15) N4048 - Specialist Cancer And Support Services - There is a risk to the continuity of the service due to the ageing Radiotherapy Linac (Bunker 6) (15)
	To be a good employer					
	To live within our means					
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔		**10**
Consequence	5						
Risk Score	15						

Controls and Assurance	
Key controls	Assurances

● Up to date Organisational and Digital / IT policies, procedures and guidelines ● Up to date software and hardware, with procedures for patching and replacement once at end of life ● Cyber security partner to provide support in the event of an attack. ● Digital Strategy Board ● Digital Solutions Delivery Group in NLAG ● Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation. ● Annual Penetration Tests ● Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication	**Positive** ● Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023 **Planned** <u>Internal</u>: ● Board awareness session on Cyber-Security and Board statutory responsibility. ● Digital strategy to be produced for the group, laying down our posture and approach to cyber security. <u>External</u>: ● Data Security and Protection Toolkit (DSPT) audit Apr-Jun this year to assess our cyber and information governance performance and plans for the future.

Gaps in controls and assurances	
Gaps in Controls: ● Legacy systems that cannot be retired and modernised due to reliance on out of date software and equipment (i.e, WebV and NLAG door access system). ● Variation in cyber-resilience across the two organisations within the Group. ● Incomplete rollout of Multi-Factor Authentication (MFA) to secure our accounts from being compromised. ● Lack of dedicated cyber personnel across the group. ● Low levels of cyber awareness and digital maturity in some staff groups.	**Gaps in Assurance:** ● No oversight of major digital systems that sit outside of the digital directorate. ● Lack of Data Security Mandatory Training (critical that operational managers across all divisions ensure that staff completed the training) ● No organizational wide preparation or exercising of BCDR plans in relation to a cyber-attack.

Actions planned

Action	Lead	Due date	Progress update
Complete our DSPT Audit to identify gaps in controls across the Group and develop a robust remediation plan.	CMO	Q1 24/25	On track to deliver
Roll out MFA across the Group.	CMO	June 24	On track to deliver
Conduct Board Cyber Awareness training, highlighting Board and wider organizational accountability.	CMO	Q1 24/25	To be added to the Board Development Programme
Conduct organizational EPRR cyber-attack exercise	TBC	Q2 24/25	Monitored through the EPRR Board

BAF Performance

The risk is that the Group fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care	20

Executive Lead	Group Chief Delivery Officer	Assurance Committee	Performance Estates and Finance Committees in Common
Executive Group	Performance Estates and Finance Committees in Common	Latest review date	09/07/24

Strategy and Risk Register

Link to Strategy					Link to BAF and CRR
	Honest, caring and accountable culture		Partnership and integrated services	✓	S4319 - Specialist Medicine - ERG - 25% Reduction in Follow ups for Medical specialties (16)
	Well-led, skilled and sufficient workforce		Research and innovation		
	High Quality Care	✓	Financial Services		
	Great Clinical Services	✓			

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2	Q3	Q4	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4				↔	5	16
Consequence	5					5	
Risk Score	20					25	

Controls and Assurance

Key controls	Assurances (Positive, Negative and Planned)
• External scrutiny from NHSE/ICB/CQC • Constitutional performance targets • Operational Plan 2024/25 • Access Policy • Capacity and Demand planning • Unplanned Care Board • Cancer Improvement Plans • Primary and Secondary Care Collaborative Outpatient Transformation Programme • Planned Care Board • Emergency Department and Medicine Specialties Quality & Safety Groups • Planning and Performance • **Cancer Delivery Group** • **Diagnostic Delivery Group** • **RTT Delivery Group**	• Urgent Treatment Centre • Same Day Emergency Care review ongoing • Revised Cancer trajectories submitted to ICB and further funding received • CQC visit to ED in April 2025 • Benchmarking reports • Internal Audit Reports • Completed job plans for relevant clinicians for 2024/25 • Waiting List Assurance Meetings • Winter Planning Group • Policies, procedures, guidelines, pathways supporting documentation & IT systems • MDT Business Meetings • Risk stratification • Emergency Care Quality & Safety Group • System-wide Ambulance Handover Improvement Group • Executive to Triumvirate meetings

	• Executive Management Committee to be developed • Care Group Structure development • Performance, Estates and Finance Committees in Common challenge • Performance report to the PEF CIC • Integrated performance Report • **Cancer Delivery Group** • **Diagnostic Delivery Group** • **RTT Delivery Group** • **Planned Care Board** • **Unplanned Care Board** <u>External</u>: • Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited • NHSE Intensive Support Team • Independent Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022 • ECIST & GIRFT Support Team Visits Scheduled for Nov 2023
aps in controls and assurances	
• Mismatch between demand and capacity • Flow through the ED department • Patients with NCTR • Ambulance handover position • Cancer performance • Increase in GP referrals - referral triage and Advice and guidance • Impact of Industrial Action • IPC risks • Patient Choice and willingness to accept alternative providers • Quality of reports to board assurance committees • Quality and timeliness of data • Recruitment and development of Consultants, specialist nurses	• Evidence of compliance with 7 Day Standards • Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards • Diagnostic capacity and capital funding to be confirmed. • Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations • High levels of staff sickness • High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas

Actions planned			
Group Actions	**Lead**	**Due date**	**Progress update**
Consultant job plans to be signed off for 2024/25	CDO	Q3 24/25	This is being monitored through the WEC CIC

BAF 8 - Group Strategy				12
There is a risk that the Group Strategy is not effective and does not allow the Group to deliver high quality and sustainable care and that the list of priorities do not align to investments, causing conflict.				
Executive Lead	Group Chief of Strategy & Partnerships	Assurance Committee	Trust Boards in Common	
Executive Group	Trust Boards in Common	Latest review date	09/07/24	

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	None at present
	To be a good employer					
	To live within our means					
	To work more collaboratively	✓				

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔	3	**8**
Consequence	4					4	
Risk Score	12					12	

Controls and Assurance	
Key controls and mitigations	Assurances
• Integrated Care Board meetings • PLACE meetings • Group Structure/Governance • Collaboration of Acute Provider Boards • Humber Cancer Board • Acute and Community Care Collaborative • Health Overview and Scrutiny Committees	**Positive** ● NHSE Assurance and Gateway Reviews. ● OSC Engagement. ● Clinical Senate formal review ● The Consultation Institute (assurance on the engagement process) **Planned** <u>Internal</u>: ● Minutes from Capital and Major Projects Committees in Common ● Humber and North Yorkshire Integrated Care System ● ICS Leadership Group ● OSC Feedback ● Outcome of public, patient and staff engagement exercises. ● Executive Director Report to Trust Board ● Non-Executive Director Committee Chair Highlight Reports to Trust Boards in Common <u>External</u>: ● Clinical Senate Reviews. ● Independent Peer Reviews re; service change (ie Royal Colleges) ● Citizens Panel (Humber).

	● The Consultation Institute
Gaps in controls and assurances	
Gaps in Controls: ● A shared vision for the HAS programme is not understood across all staff/patients and partners	**Gaps in Assurance:** ● Feedback from public, patients and staff to be widespread and specific in cases, that is benchmarked against other programmes ● Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time ● Alignment of strategic capital

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Leadership at System level and PLACE	Group Chief of Strategy and Partnerships		

BAF 9 - Group Strategic Capital			15
The risk that the Group fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.			
Executive Lead	Group Chief Financial Officer and Group Chief of Strategy & Partnerships	Assurance Committee	Capital and Major Projects Committees in Common
Executive Group	Capital and Major Projects Committees in Common	Latest review date	09/07/24

Strategy and Risk Register						
Link to Strategy	To give great care		To provide good leadership		Link to BAF and CRR	None at present
	To be a good employer					
	To live within our means	✓				
	To work more collaboratively					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔	3	15
Consequence	5					5	
Risk Score	15					15	

Controls and Assurance	
Key controls and mitigations	**Assurances**
• Capital Investment Board (Internal Capital) • Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly • Trust Boards in Common • Trust Committees in Common • ICS Strategic Capital Advisory Group	• No strategic plan for all sites • Deteriorating infrastructure 10% per year • No money to fund major changes to sites HUTH £100m required, Scunthorpe £50m required.
	Planned Internal: ● Minutes of Internal Trust Meetings External: ● NHSE attendance at AAU / ED Programme Board ● CiC Minutes ● PLACE Boards
Gaps in controls and assurances	
Gaps in Controls: ● Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend ● Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability ● Control environment may not be able to	**Gaps in Assurance:** ● ICS CDEL not sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

eliminate or reduce risk of estates condition in the short term	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies	Group Chief Financial Officer/Group Chief of Strategy and Partnerships		In progress but off track (with mitigation)

BAF 10 - Group Strategic Partnerships and Collaboration

There is a risk that the Group does not prioritise actions at PLACE and ICB to fulfill its Anchor role which increases health inequalities, competition and competition in workforce. The Group also fails to work collaboratively to innovate and change pathways.	12

Executive Lead	Group Chief of Strategy & Partnerships	Assurance Committee	Trust Boards in Common
Executive Group	Trust Boards in Common	Latest review date	09/07/24

Strategy and Risk Register

Link to Strategy					Link to BAF and CRR	
	To give great care		To provide good leadership			None at present
	To be a good employer					
	To live within our means					
	To work more collaboratively	✓				

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔	3	8
Consequence	4					4	
Risk Score	12					12	

Controls and Assurance

Key controls and mitigations	Assurances (Positive, Negative and Planned)
● Audit Risk & Governance Committee (ARGC) ● Finance and Performance Committee (F&PC) ● Capital Investment Board (CIB) ● HAS Executive Oversight Group ● HNY ICS ● ICS Leadership Group ● Wave 4 ICS Capital Committee ● Executive Director of HAS and HAS Programme Director appointed ● Committees in Common ● Acute and Community Collaborative Boards ● Clinical Leaders & Professional Group ● Council of Governors ● Joint Overview & Scrutiny Committees ● MP cabinet and LA senior team briefings ● Primary/Secondary Interface Group (Northbank&Southbank) ● Place Boards	**Positive** ● HAS Governance Framework. ●Clinical Senate review approach and process ● Consultation Institute Review ● Place Boards and Place Working Groups established **Planned** <u>Internal</u>: ● Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, CIB, CoG ● Non-Executive Director Committees in Common Chair Highlight Report to Trust Board ● Executive Director Reports to the Trust Boards in Common

	External: ● Clinical Senate Reviews. ● Independent Peer Reviews re; service change (ie Royal Colleges). ● NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews. ● Councillors / MPs / Local Authority CEOs and senior teams ● Place Boards and Place Working Groups established ● Collaborative of Acute Providers Board
Gaps in controls and assurances	
Gaps in Controls: ● Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities. ● Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition) ● ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed	**Gaps in Assurance:** ● Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement. ● Lack of integrated plan and governance structure.

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Collaboration and Leadership within the Group to form strong partnership arrangements	Group Chief of Strategy and Planning		

BAF 3.1	
There is a risk that the quality improvement measures set out in the HUTH Quality Strategy are not met, which would result in the Trust not achieving its aim of a 'good' CQC rating.	16

Executive Lead	Group Chief Nurse	Assurance Committee	Quality and Safety Committees in Common
Executive Group	Quality and Safety Committees in Common	Latest review date	09/07/24

Strategy and Risk Register

Link to Strategy

Honest, caring and accountable culture		Partnership and integrated services	
Well-led, skilled and sufficient workforce		Research and innovation	
High Quality Care	✓	Financial Services	
Great Clinical Services			

Link to BAF and CRR

N3376 - Cardiovascular - A risk to patient outcome due to lack of Vascular Hybrid suite (16)
N4322 - Digestive Diseases - Risk to patients due to the lack of a High observation area (16)
N4294 - Head And Neck - Risk neonates & Paediatrics with hearing conditions will not receive timely care due to Paediatric Audiologist shortfall (16)
N4058 - Head And Neck - Risk to neonates, infants and children with hearing conditions not receiving timely care due to lack of specialist accommodation (16)
N4293 - Head And Neck - Risk neonates & Paediatrics with hearing conditions will not receive timely care due to poor performance in Paediatric Audiology (16)
N4286 - Cardiovascular - Risk to the acute patients due to lack of junior doctor cover. (15)
N1851 - Head And Neck - Shortfall in Capacity within the Ophthalmology Service (15)
N3962 - Specialist Cancer And Support Services - Cardiac CT demand outstripping capacity (15)
N3196 - Specialist Cancer And Support Services - Breast Imaging Service loss of capacity (15)
N3266 - Specialist Cancer And Support Services - Availability of Chaperones for intimate examinations in Radiology (15)

Risk Scoring (Current)

Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	4				↔	4	12
Consequence	4					4	
Risk Score	16					16	

Controls and Assurance

Key controls	Assurances (Positive, Negative and Planned)

• Quality committee structure & work-plans; • Health Group Governance Performance Management meetings;; • Patient Safety Specialist role; • Infection Prevention and Control (IPC) arrangements • Safeguarding processes • Fundamental Standards Nursing programme • Quality Strategy/Quality Improvement Plan • Serious Incident Management/ early adopter of PSIRF • Annual Clinical Audit programme • CQC improvement plans, overseen by Executive Check and Challenge process and Maternity Transformation Assurance Committee (MTAC). • External agency register and process • Horizon scanning Integrated Performance Report – BI Reporting • CQC Action Plans in place • Patient Safety Alert process	**Positive Assurances** ***Emergency Department*** • ICB quality team visit report (15 December 2023); • CQC ED engagement visit (non inspection/rating) positive feedback and observations including mental health (9 April 2024). • ED national Patient Safety award for a Quality improvement initiative (November 2023); • Friends and Family (FFT) monthly data demonstrating improvement since November 2023. ***Maternity*** • CQC Maternity action plan progress reported monthly; • Healthwatch HRI 'Big Push' Maternity review concluding "many improvements to patient experience since inspection" (April 2024); • FFT Birth score of 100% (maintained); ***Other prominent external assurances*** • Internal Audit CQC Action Plan Audit (Jan 24) – 35/35 (100%) of actions closed through Executive oversight corroborated to evidence supporting closure. • CQC IR(MER) inspection – report received (October 2023) with no residual actions. *Internal Measures* • Nursing staff (Registered Nurses) recruited to a level 2.5% over budget (April 2024), with turnover reduced to 7.1%, facilitating greater ward staffing. • Falls resulting in both number and rate of moderate or major harm remaining below the mean in 23/24 and Qt1 24/25 (QSC deep dive February 2024). • Pressure Ulcers within control limits and harm reducing (QSC deep dive March 2024). • Backlog of longstanding complaints addressed, quality sustained since August 2023 with limited reopened. • PSII after action reviews established.
	Negative • The Trust is an outlier in HSMR (116 Jan 24) and its SHMI mortality data is higher than expected (having increased to1.15 to Feb 24) • CQC Maternity Year 5 CNST declaration was not full compliance. • Emergency Department failed to deliver the 76% target by end of March 2024 (61%). • Ambulance turnaround times impacting on patients • VTE compliance rate has been below the Trust's 95% target, but starting to demonstrate some improvement Additional QI support is being provided to identify

	improvement actions • Infections due to rise in respiratory, norovirus, measles and diphtheria.
	Planned • CQC ED action plan full delivery; • CQC Maternity action plan full delivery; • Weekly patient safety summit continuation. • Development of the virtual ward and staff to support the falls team; • Delivery of Group wider Quality Priorities for 2024/25 to support consistent delivery across End of Life, Deteriorating patient; Sepsis; Medication safety; and Mental capacity.

Gaps in controls and assurances	
Maternity Leadership Interim reliance. VTE Compliance CQC Maternity Section 31 two conditions	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Delivery of 23/24 CQUIN programme	ADQG	Q4 23/24	Achieved with exception of CQUIN12: Assessment and documentation of pressure ulcer risk and CQUIN1: Flu vaccination.
Implementation of HUTH Patient Safety Incident Response Plan by April 2024	CNO	Q1 23/24	Completed
Deliver Improvements of Fundamental Standards Programme	CNO	Q4 23/24	Improvements noted quarterly.
VTE Quality Improvement Programme	CMO	Q3 24/25	QI team supporting targeted wards.
Mortality Strategy – The implementation of a refreshed Mortality Strategy to direct the work of the Mortality Improvement Group in responding to the Trust's higher than average SHMI.	CMO	Q2 24/25	In progress, targeted work at Castle Hill and against the three condition groups highlighted as an outlier.
Maternity Governance Structure – implement enhanced governance structure to expedite completion of Section 31 (two conditions) and CQC inspection actions	CNO	Q1 24/25	On track to establish enhanced governance oversight (May 2024)
Quality improvement project initiation in Emergency Department targeting the number of patients outside patient spaces, ambulance handover times and the length of time people are	CDO	Q1 24/25	Commenced 20 May 2024.

waiting to be seen.			
Development of Group (HUTH and NLAG) consistent Quality priorities for 2024/25 to focus on • End of Life; • Deteriorating patient; • Sepsis; • Medication safety; and • Mental capacity	CNO	Q1 24/25 (approval) – delivery throughout.	24/25 Group Quality Priorities and measures approved – now in delivery.

BAF 3.2			
There is a risk that patients suffer unintended or avoidable harm due to actions within the Trust's control. Crowding in ED and Patients with No Criteria to Reside require partnership working to determine improvement plans.			20
Executive Lead	Group Chief Medical Officer/Group Chief Nurse	Assurance Committee	Quality and Safety Committees in Common
Executive Group	Quality and Safety Committees in Common	Latest review date	09/07/24

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture		Partnership and integrated services	✓	Link to BAF and CRR	N4170 - Major Trauma Network - Risk of increased morbidity and mortality for elderly MTC patients due to inadequate DME support for Major Trauma Centre TARN (20) N2244 - Cancer Network - Risk to Overall Performance: Cancer Waiting / Performance Target 62 day (16) N3332 - Head And Neck - Lorenzo Upgrade (16) N3252 - Head And Neck - Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight (15) N3959 - Head And Neck - Risk of patient harm to new and follow-up patients due to delays within glaucoma service (15) N4011 - Head And Neck - Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity (15) N4012 - Head And Neck - Clinical risk to patients referred as new patients into the new wet macular degeneration pathway (15) N4013 - Head And Neck - Clinical risk to patients referred as new patients into new Medical Retina patient assessment clinic due to lack of capacity iss (15)
	Well-led, skilled and sufficient workforce		Research and innovation			
	High Quality Care	✓	Financial Services			
	Great Clinical Services					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk

Likelihood	4				↓	5	16
Consequence	5					5	
Risk Score	20					25	

Controls and Assurance	
Key controls	**Assurances (Positive, Negative and Planned)**
• Clinical harm review process • Prioritisation of P1 patients • Fundamental Standards programme • System and Community meetings • Patient Access Team • Weekly Patient Safety Summit • Quality Strategy • Rossmore rehabilitation facility • Emergency Care Standards • Ambulance Handovers waiting over 60 minutes	**Positive** • ICB quality team assurance visit report (15 December 2023); • CQC ED engagement visit (non inspection/rating) positive feedback and observations including mental health (9 April 2024). • ED national Patient Safety award for a Quality improvement initiative (November 2023); • Friends and Family (FFT) monthly data demonstrating improvement since November 2023. • Urgent Treatment Centre opening (Feb 24) and subsequent opening hour extension (April 24) provided additional capacity. • Elective – HUTH removed from NHSE Tiering (April 2024) • Friends and Family (FFT) data for Rapid Diagnostics, Radiology and Day Case all >95% positive responses for 2023/24. Same Day Emergency Care review ongoing • AMU HOB
	Negative • HUTH (and HNY system) remains in NHSE Tier 1 for cancer. • Over crowding in ED • Patients with no criteria to reside is the single largest factor affecting performance with up to 211 patients per day remaining within the hospital who have no medical need for acute services • GP capacity and increased referrals • Ambulance turnaround times – the Trust achieved the revised trajectory for type 1 and 3 performance at 59% (trajectory 50%)
	Planned • Aim to grow the Patient Safety Champion network and number of Learning Response Leads • Discharge to assess model pilot to • Trajectory of achieving zero 78 week waits by March 2024. • Cultural work between ED and Acute medicine ongoing • UEC GIRFT Deep Dive December 2023 • Direct admissions to wards – work with 111 Frailty SDEC staffing to provide 70 hours per week over 7 days
Gaps in controls and assurances	

• ED 4 hour performance below 76% March 2024 requirement. • Ambulance handover • Trust failing to achieve all cancer standards with the exception of combined Faster Diagnosis Standard • Patients with No Criteria to Reside • 12 Hour Trolley breaches	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Hull and East Riding MADE event	CDO	Q4 23/24	Held 25 March to 5 April 2024 – actions being taken forward.
Quality improvement project initiation in Emergency Department targeting the number of patients outside patient spaces, ambulance handover times and the length of time people are waiting to be seen.	CDO	Q1 24/25	Commences 20 May 2024.
Embed Group leadership arrangements across the Humber Health Partnership, including: • Site Executives; • Urgent and Emergency Services Care Group leadership model;	CDO	Q2 23/24	New leadership in place effective 1 April 2024 (Site Exec and Care Group level).

BAF 6			
There is a risk that Research and Innovation support service is not delivered operationally to its full potential due to lack of investment			12
Executive Lead	Group Chief Medical Officer	Assurance Committee	Quality and Safety Committees in Common
Executive Group	Quality and Safety Committees in Common	Latest review date	09/07/24

Strategy and Risk Register						
Link to Strategy	Honest, caring and accountable culture		Partnership and integrated services		Link to BAF and CRR	• None at present
	Well-led, skilled and sufficient workforce		Research and innovation	✓		
	High Quality Care		Financial Services			
	Great Clinical Services					

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔	4	8
Consequence	4					4	
Risk Score	12					16	

Controls and Assurance	
Key controls	Assurances

• trengthened partnership with the University of Hull • Infection Research Group • ICS Research Strategy • Health Research Authority	**Positive** • Continued working with HYMS and ICS • Joint working with NLAG • Academic Renal Research team – Lead role for renal studies and currently in the top third of recruiters nationally • GONDOMAR study – unique cohort platform providing data on diagnosis, treatment and outcomes of over 4,000 patients with Crohn's perianal fistula. • HUTH first site to be activated and first to enroll a patient for the AZUR-2 study, which relates to colon cancer. • HUTH is the top recruiting centre for SNAP study. The trial aims to identify which treatment options for Staphylococcus aureus bacteraemia results in the fewest patients dying within the first 90 days after an infection. • HUTH is the top recruiting site for the PACeS study which aims to determine whether the addition of blood thinners to anti-platelet drugs improves treatment outcomes in patients who develop AF after CABG surgery **Negative** • Funding availability • Research capacity hindered by the recovery plan • Demand for IT and Digital innovations are increasing
	Planned • Joint strategy discussions have commenced with the Group Chief Medical Officer and the Group Chief of Strategy and Partnerships
Gaps in controls and assurances	
Reduction in support services due to activity delivery Loss of commercial research income Capital developments will need to ensure research and innovation schemes can be accommodated and staff appropriately housed Demand for IT and Digital innovation is increasing	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Group R&I strategy development	KW	Q3 2024	In development

BAF 1.1	
The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience	15

Executive Lead	Group Chief Medical Officer and Group Chief Nurse	Assurance Committee	Quality & Safety Committees in Common (CiC)
Executive Group	Quality & Safety Committees in Common (CiC)	Latest review date	09/07/24

Strategy and Risk Register						
Link to Strategy	To give great care	✓	To provide good leadership		Link to BAF and CRR	S3997 - Acute And Emergency Medicine - Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E (25) S4285 - Acute And Emergency Medicine - Lack of senior clinical staffing at night is affecting patient safety (20) S3301 - Family Services - Antenatal clinic review capacity (20) S3308 - Family Services - NICU Incubators (20) S3243 - Family Services - Inadequate Consultant Obstetrician cover (20) S2982 - Family Services - Lack of Anaesthetic cover for Under 2's out of hours (20) S3114 - Family Services - Delays in Children being reviewed in DPOW Paediatric Endocrine Service (20) S3325 - Family Services - Delays in Children being reviewed in Cardiac Clinic (20) S4222 - Family Services - Significant clinical risk to patients not being seen in safe and timely manner due to capacity limitations in EPAU/EGU (20) S4284 - Family Services - Risk to patient flow and delayed assessment of paediatric patients due to removal of 2nd consultant for paediatric medicine (20) S4288 - Specialist Medicine - Risk to patients and staff within the Home Ventilation Service (20) SU3217 - Specialist Surgery - Breast Imaging workforce depletion (20) S4201 - Acute And Emergency Medicine - Missed Targets in the First Hour of the Management of Sepsis (16) S4025 - Family Services - Risk of patient harm due to insufficient Medical workforce numbers (Consultant level) (16) S4240 - Specialist Medicine - Staffing resource to support the delivery of the HUTH Specialist Asthma Service (16) S4277 - Specialist Medicine - NCTR / Stranded patients within the MHG acute bed base. (16) S2592 - Specialist Surgery - Risk to Overall Performance: Cancer Waiting / Performance Target 62 day (16) S2245 - Specialist Surgery - Risk to Overall Performance : Non compliance with RTT incomplete target (16) S3161 - Acute And Emergency Medicine - There is a risk of patient deterioration not being recognised and escalated appropriately. (15)
	To be a good employer					
	To live within our means					
	To work more collaboratively					

						S3204 - Family Services - Up to 1 year wait for new referrals to be seen by Consultant Paediatrician (single handed service) into the ADHD post diagnosis support service. (15) S4200 - Family Services - Increased risk of harm to patients and families due to inadequate co-located psychology support to children and young people. (15) S3129 - Family Services - Overdue follow-up and new patients waiting lists for Paediatric patients (Trustwide) (15) S4289 - Specialist Medicine - Risk to patients and staff within the Cystic fibrosis/bronchiectasis service (15) S2347 - Specialist Surgery - Risk to Overall Performance : Overdue Follow-ups (15)

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2024/25)	Change from previous quarter	Inherent Risk	Target Risk
Likelihood	3				↔	3	**15**
Consequence	5					5	
Risk Score	15					15	

Controls and Assurance	
Key controls	Assurances
● Operational Plan 2024/25 ● Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems ● Quality Board, NHSE ● Place Quality Meetings - N Lincs, N E Lincs, East Riding ● SI Collaborative Meeting with ICB, with Place Representatives ● Health Scrutiny Committees (Local Authority) ● Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group ● Nursing Metric Panel Meeting ● Nursing and Midwifery & AHP Board ● NICE Guidance implementation monitoring and reporting processes ● Learning from deaths process	**Positive** <u>External:</u> ● Internal Audit - Serious Incident Management, N2019/16, Significant Assurance ● Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance ● NHSE External Review of Safe Staffing Establishment and Recommendations ● Maternity Birth Rate Plus Review ● Internal Audit - CQC action plan compliance – Significant assurance ● Improved ratings in CQC inspection with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement ● Maternity CNST standards compliance submission ● Health Scrutiny Committees (Local Authority) • Quality and Safety Committees in Common • Risk Management Group • Patient feedback to Council of Governors • SafeCare Live • OPEL Nurse staffing levels and short term staffing SOP • Mortality Improvement Group ● Vulnerabilities Group ● Incident control group chaired by NHSE to support Paediatric Audiology service.
	Planned <u>Internal:</u> ● Minutes of Committees and Groups ● Integrated Performance Report ● Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board, Learning from deaths annual and

Controls and Assurance	
Key controls	Assurances
	quarterly reports. ● Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board ● NICE Guidance Assurance Report to Q&SC ● IPC - Board Assurance Framework and IPCC ● Inpatient surveys ● Nursing assurance safe staffing framework NHSI ● Audit Outlier Report to Quality Governance Group ● 15 Steps Accreditation Tool ● CQC action planning, monitoring and assurance of action completion processes
Gaps in controls and assurances	
Gaps in Controls: ● Estate and compliance with IPC requirements B12 – see Estates BAF ● Ward equipment and replacement programme see Estates BAF ● Attracting sufficiently qualified staff - see Workforce BAF ● Funded full time Transition post across the Trust ● Paediatric audiology service	**Gaps in Assurances:** ● Delays with results acknowledgement (system live, process not yet embedded) ● Progress with the End of Life Strategy ● Safety and delays on cancer pathways ● Patient safety risks increased due to longer waiting times (refer to BAF 1.2)

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Continue to develop metrics as data quality allows	CMO	Ongoing	On track to deliver
Delivery of deteriorating patient improvement plan	CN	Q4 23/24	Sustained improvements reported in the 2023/24 Quality Account, but this will remain a priority for 2024/25.
Implementation of End of Life Strategy (system-wide strategy)	CMO	Q4 24/25	In progress but off track requiring system input. Improvements reported in the 2023/24 Quality Account, but this will remain a priority for 2024/25.
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	CMO	Q3 23/24	Complete
Review and implement changes to Audiology Service	CMO	Q3 23/24	Update reported at Quality and Safety Committee in June 2024.
15 steps Star Accreditation Programme commenced	CN	Ongoing	Continued application going forward.
Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas.	CMO	Q4 23/24	Improvements reported in the 2023/24 Quality Account, but priorities have been rolled followed to further embed and sustain outcomes on a Group wide basis for 2024/25
Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients	CMO	Q4 23/24	Improvement in all schemes. 8/11 fully delivered, 1 (flu vaccination did not), 2 above minimum

			threshold as reported in June 2024.

Appendix 2 - Risks extracted from registers – Capital and Major Projects CIC

Care Group	Specialty	Title Risk	Risk Rate Score	Location	Risk Handler	Next Review Date	What Is Risk
Acute And Emergency Medicine	Acute Medicine	Acute Medicine Reporting	15	Trustwide - All Sites (DPoW, SGH and Goole)	Rhiannon Wilson	18/07/24	Since Lorenzo has been implemented in the Trust, all reporting in relation to Acute Medicine has been severely impacted with no accurate information available since 24th February 2024. This is impacting the ability to monitor activity performance.
	Acute Medicine	Type 5 ECDS SDEC Activity Reporting	15	Trustwide - All Sites (DPoW, SGH and Goole)	Rhiannon Wilson	18/07/24	Type 5 ECDS reporting is mandatory from July 2024. In order to be able to report this, SDEC activity requires recording through an appropriate digital system. This was identified as Symphony, however, this required an upgrade to allow for additional modules to be added. Business Case was written in support, still awaiting approval.
	A and E	Crowding in the Emergency Department	25	Hull Royal Infirmary	Rayner, Dr Ben	05/05/24	There is an issue that patient care is compromised due to the emergency department being crowded. The causes of this issue are: 1. Mismatch between demand and capacity 2. Flow through the department 3. Exit block The consequences of this issue are: 1.Increased Mortality 2. Increased length of stay 3. Reduced quality of care 4. Poor Patient experience 5. Staff Burnout 6. Difficulty in recruiting and retaining staff
	Acute Medicine	SGH SDEC/ IAAU Clean Utility Temperature	20	Scunthorpe General Hospitaltal	Rhiannon Wilson	18/07/24	The temperature within the IAAU department is exceptionally warm, more specifically within the clean utility room. This is providing potentially unsafe medications to patients. Medications management code states "Most medications requiring 'ambient' temperature storage need to be stored between 15°C and 25°C as per there manufacturing specification. The NHS Health Building Notice (HBN) 14-02 also states that ambient temperature storage should not be above 25°C. Currently, the area is consistently over 26 degrees. There is also a financial risk element as currently over £20K of medication has been unusable.
Cardiovascular	Cardiology	Risk to patient diagnostic/treatment delays due to Information management systems do not meet the requirements of the service	16	Castle Hill Hospitaltal	Buxton, Tracie	24/05/24	CAUSE The Cardiology department at HUTH use a number of software packages to allow the review, reporting and storage of images. Earlier this year the department was informed that the main software used to view and store images, Change Healthcare (CHC) is end of life. To continue maintenance support from the supplier the organisation must upgrade. Although the upgrade will ensure ongoing system support from the provider the upgrade brings about its own issues and does not address the ongoing issues from Risk 3910 in addition to raising new elements of risk. Change Healthcare 1. Server hardware provided by the supplier is end of life resulting in reliability issues and breakage, resulting in down time of the system. 2. Server hardware/storage requirements not comprehensive at initial discussions resulting a shortfall of space needed. 3. The software requires various anti-virus policy exclusions which HUTH IT do not deem appropriate. A compromise on security exclusions was

agreed but this has led to further error messages and crashes. Work is actively ongoing around these anti-virus exclusions.
4. System servers are aging and no longer supported by Dell for maintenance.
5. Cardiology service are unable to cover the cost to supply and maintain server required to undertake the required upgrade.
6. Archive storage full – silent brick storage currently at 99.9% full. No more files can be sent to archive since 26/03/2024 with 1524 folders waiting to be archived as of 11/04/2024.

Solus
7. Currently housed on EOL CHC server, not included in original server requirement scoping.
8. When Solus server size allocation is met system becomes unusable, no ability to notify when this getting low.
9. Requirement of CHC input to preform updates/patches.
10. Increased system issues following latest update affecting performance and usability of software for users. Slow response from supplier to resolve issues.

Medis
11. Currently housed on a PC in the admin block with remote licenses. There is currently no resilience should something happen to this PC. The PC is open to allow users access to the Medis main system remotely, this poses a security risk.

3Mensio
12. Delay in software installation
13. Inability to report on scans in-house, the service is reliant on reports being externally reports which are often delayed.

Modalities
14. Clinicians currently required to attend to theatre to review images due to security group differences

CONSEQUENCE
1. Missed/delayed diagnosis of patients due to system outage resulting in increased incidents, complaints and claims against the organisation.
2. Delayed diagnosis of patients suitability for TAVI and accurate case planning leading to delayed pathways, leading to inability to treat patients negativity impacting on mortality rates within the service (3Mensio)
3. Loss of system would lead to an inability to undertake Echocardiograms and cath lab procedures
4. Downtime of system/s has a direct impact on patients both in and outpatients, clinics delayed, diagnostics delay or cancellations resulting in additional patients appointments.
5. Inability to undertake upgrade, resulting in outdated software, system outage or complete loss of system including ability to view and review patient studies.
6. Loss of system would lead to an inability to undertake Echocardiograms and cath lab procedures
7. Loss of images from patient echos and cath lab procedures. Inability to archive files resulting in no back up for studies. Loss of the firstline storage would result in hundreds/thousands of patient studies being lost.
8. Costs incurred to patients and the organisation due to patients having to return for scans. In the case of cath lab procedures these would be never events due to the invasive nature of the procedure.
9. Acute Cath lab procedures could be lost resulting in inability to effectivity treat patients leading to higher mortality rates within the services.

							10. Negative impact on clinic waiting times. 11. Negative impact on MDT to implantation times. 12. Additional stress and pressure on clinic staff due instability of the system. 13. Inability to easily transfer images from none cardiology assigned ports resulting in delays of urgent treatment. 14. Impact on ability to provide services funded by CDC programme scheduled for go live in 2025 resulting in financial penalties and/or loss of income. 15. None compliance with National NICOR and BCIS audit requirements 16. None compliance with CQC recommendations following inspection from the Royal College of Physicians (3Mensio) 17. Lack of suitable software to review TAVI images could lead to the organisation losing the ability to undertake TAVI procedures. Impacting patient care and outcomes across the region. (3Mensio) 18. Financial impact on TAVI consumables, currently overstocked to allow flexibility due to delayed return of externally reported scans (3Mensio)
Family Services	Gynaecology	Colposcopy chair	16	Scunthorpe General Hospitaltal	Paris Willey	24/06/24	Ageing equipment which is becoming increasingly unreliable and has failed an infection control audit as it is now beyond being repaired.
Pathology Network	Microbiology	Boston Autoclave - end of life	15	Trustwide - All Sites (DPoW, SGH and Goole)	Benjamin Francis	12/07/24	The current Microbiology Class A waste autoclave at Boston is at end of life and in constant repair. There is a risk that the Boston Microbiology site would not be able to support respiratory sample processing i.e. sputums, bronchial lavages, pleural fluids, any high risk samples, unexpected Cat 3 pathogens eg. typhoid, Brucella, meningococci, E.coli O157, CSF (cerebrospinal fluid)samples querying CJD and other prion-related infections, as Microbiology would have no method of making waste from these tests safe prior to disposal (A legal requirement). This would require samples to be sent to reference laboratories or Scunthorpe laboratory for testing incurring substantial cost and delay to TaT impacting patient flow.
Specialist Cancer And Support Services	Pharmacy	Provision of EMIS eMM standalones in both Pharmacy dispensaries	16	Trustwide - All Sites (DPoW, SGH and Goole)	Paulash Haider	27/06/24	It has been identified that neither dispensary has adequate business continuity in the event the EMIS system goes off-line. This means in that scenario, there is no way to dispense and label medicines which is a significant risk to the safe provision of medicines for patient use
	Medical Engineering	Non compliance with MHRA guidance for managing medical devices Jan 21, NatPSA/2023/010/MHRA and Medical Device Management & Procurement Policy DCP047	15	Trustwide - All Sites (DPoW, SGH and Goole)	Karen Fisk	04/07/24	The MHRA guidance states that all medical devices maintained to manufacturer guidelines, this currently is not being achieved on DPOW, SGH and Goole sites due to lack of resource within the Medical Engineering department. The risk being that patients/staff may suffer harm due to the devices not being maintained, resulting patient safety incident and subsequent claim.
	Radiotherapy	There is a risk to the continuity of the service due to the ageing Radiotherapy Linac (Bunker 6)	15	Castle Hill Hospitaltal	Colley, Mr Peter	08/06/24	The condition of the risk is that there is increased unnecessary downtime of the Linac in bunker 6. The cause of the risk is the Linac in bunker 6 is approaching the end of its recommended life (10 years) in September 2022. The linac is of an “older design” meaning that the manufacturer appears to be stocking fewer spares and often sends spares for the “newer” design by mistake, resulting in increased downtime. The consequence of the risk is resulting patient treatment reschedule or delay, poor patient experience, additional staffing costs, lack of flexibility and robustness in the treatment service delivery.

	Radiology - MRI	SGH MRI scanner past end of 7 year life	20	Scunthorpe General Hospitaltal	Ruth Kent	17/06/24	Cause - due to lack of capital availability, the existing Scunthorpe MRI Scanner (scanner 1) has passed the 7 year life expectancy. Risk - there is potential for increased breakdowns due to its age which will impact on service delivery. This is the only scanner in the Trust able to deliver a full range of examinations. Update 2/6/21 this is no longer the only scanner able to deliver these examinations. Impact - is that should the scanner fail, then NLAG will have reduced capacity to deliver MRI scans for some cancer pathways.
Specialist Medicine	Chest Medicine	Lack of reporting software for Bronchoscopy	20	Castle Hill Hospitaltal	Hutton, Mr James	06/06/24	The standalone EBUS reporting software (from Unisoft) has stopped functioning. It appears Unisoft folded a few years ago and there is no support / technical fixes available for the reporting software which leaves us with lack of fit for purpose software No EBUS drop down option so procedure counting/coding/income issue with approx. 200 EBUS going through as Bronchoscopys There is an issue with a lack of drop down option for recording “no biopsy taken” (Is that correct??) The report for the EBUS shows a pic of the colon but all other clinical data available in the report.

Risks extracted from registers Performance, Estates and Finance CIC

Care Group	Specialty	Title Risk	Risk Rate Score	Location	Risk Handler	Next Review Date	What Is Risk
Acute And Emergency Medicine	Finance	Delivery of Balanced Financial position to include CIP savings	16	Trustwide - All Sites (DPoW, SGH and Goole)	Darren Marshall	19/04/24	Non-delivery of Divisional Finance
Specialist Medicine		Risk to deliver the financial plan for medicine	20	Hull Royal Infirmary	Faruqi, DR Shoaib	07/04/24	Condition: Risk to deliver the financial plan for medicine Cause: The unfunded no criteria to reside and additional capacity wards within medicine. The doctors strikes cost pressures. COVID and IPC impact across the trust. Identified CRES targets. Consequence: A compounded impact on our financial position for the next financial year and implications on the trusts overall position within the ICB
		ERG - 25% Reduction in Follow ups for Medical specialties	16	Trust Wide	Dyble, Mrs Debra	28/05/24	A number of medical specialties manage large patient cohorts for patients with chronic diseases requiring prescribing / monitoring on a monthly, quarterly or annual basis in accordance with NICE guidance, national shared care protocols and in accordance with red and amber medication guidance. Services will not be able to achieve the required 25% reduction in FU management based on existing management guidelines.

Risks extracted from registers – Quality and Safety CIC

Care Group	Specialty	Title Risk	Risk Rate Score	Location	Risk Handler	Next Review Date	What Is Risk
Acute And Emergency Medicine	Emergency Care	Failure to meet constitutional targets in ECC	20	Trustwide - All Sites (DPoW, SGH and Goole)	Nicola Glen	13/07/24	Due to a high level of demand at the front door and challenges with patient flow through the hospital, ED waits are a challenge which has an adverse effect on patient safety. Risk that the Trust's 4 hour A&E performance target may not be achieved and that 12 hour trolley breaches may occur. Due to a high level of demand at the front door and challenges in patient flow through the hospital, ED waits are an ongoing challenge, which has an adverse effect on patient safety.
	Emergency Care	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	16	Trustwide - All Sites (DPoW, SGH and Goole)	Simon Buckley	10/07/24	There is a risk to patient safety, quality of care and patient experience due to delayed admission to ward beds due to challenges with patient flow throughout the Trust.
	Nursing (All Specialties)	There is a risk of patient deterioration not being recognised and escalated appropriately.	15	Trustwide - All Sites (DPoW, SGH and Goole)	Joanne Foster	28/06/24	There is a risk that patients deterioration is not recognised and the recording and monitoring of NEWS is not consistently completed to guide further actions appropriate to the trust Deteriorating Patient Policy, including the use of risk assessments (Sepsis screening tool) to identify required clinical responses in a timely way.
	A and E	Persistent failure of A&E target - Percentage of patients who spent 4 hours or less in A&E	25	Hull Royal Infirmary	Smyth, Mr Stephen	05/05/24	Condition: There is a risk that patients may come to unintended harm Cause: Prolonged waiting times within the ED in excess of the 4-hour target Consequence: Deterioration of conditions, poorer clinical outcomes, delays in access to specialist treatment and possible regulatory action
	A and E	Lack of senior clinical staffing at night is affecting patient safety	20	Hull Royal Infirmary	Rayner, Dr Ben	05/05/24	There is a lack of senior staffing overnight in the ED department. It is agreed within the health group that at least two senior (ST4+) clinicians should be on shift to ensure patient safety, as well as providing support and preventing burnout of doctors/colleagues. Having only one registrar on a night shift can cause issues with wait times, juniors struggling to get advice and lack of breaks for that doctor. The consequence of this is patient safety is compromised, when senior level support is not available
	A and E	Missed Targets in the First Hour of the Management of Sepsis	16	Hull Royal Infirmary	Smithies, Dr Augustine	05/05/24	Cause Patients who triggered for sepsis only received antibiotics within an hour of arrival 8% of the time, and 38% after NEWS trigger. The cause is multifactorial – with long wait times to be seen or to be handed over from the ambulance and for antibiotics to be given once prescribed. Consequence Impact of patient safety and department mortality rates, of which our SMI is currently higher than expected
Cancer Network	Cancer Services	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	16	Trustwide - All Sites (DPoW, SGH and Goole)	Neil Rogers	28/02/24	Failure to treat patients within tWT (62 days) will result in poor patient experience and may have the potential for clinical harm in some specialties. The Trust consistently achieves the 14 day and 31 day standards. The likelihood of continuing to not achieve the 62 day standards is high due to some elements of the diagnostic or staging

							pathway being outside of the control of NLAG and sitting with the tertiary provider. Risk register also relates to Risk ID 2008.
Cardiovascular	Cardiology	Risk to the acute patients due to lack of junior doctor cover.	15	Castle Hill Hospital	Ramlall, Manish	09/05/24	Due to extreme pressures there is risk to acute patients on the day ward not receiving a medical review and a delay in completion of IDS for discharge, which can impact on patients having an increased length of stay. Cause: No junior doctors are rota'd for the day ward to cover acute patients. Consequence: Patient's do not get seen / reviewed, issues with medications, delays in discharge process.
	Vascular Surgery	A risk to patient outcome due to lack of Vascular Hybrid suite	16	Hull Royal Infirmary	Carradice, Daniel	31/05/24	Condition: There is currently no suitable Vascular hybrid suite for use by the vascular service. A key recommendation of the local GIRFT report is that this should be installed by July 2018. Cause: The current demands on the existing hybrid suite on the second floor by interventional radiology means that this cannot be utilised as a vascular hybrid suite. Also it's location on the second floor make it a remote site for anaesthetics and theatres. Equipment needs to be moved between the second and third floor for every case. Consequence: On the whole, vascular surgical procedures are performed in the theatre department on the 3rd floor with inadequate imaging available for this type of surgery. This leads to increased risk to the patients, reduce quality of outcomes, increased complication rates, increases return to theatre rates, critical care usage and length of stay. This prevents the delivery of a modern vascular service including recruitment of new vascular consultants placing service sustainability at risk.
Digestive Diseases	Endoscopy	Lorenzo Upgrade	16	Trustwide - All Sites (DPoW, SGH and Goole)	Joanne Avison	13/07/24	Risk: The loss of patient data could potentially cause harm to patients. Affecting staff moral and the workforce and patient pathways. Cause: Implementation of the Lorenzo system
	6th Floor Surgery	Risk to patients due to the lack of a High observation area	16	Hull Royal Infirmary	Rhodes, Mrs Katie	08/06/24	Lack of high observation areas available across both wards 6 & 60 to recognise the high acuity of patients on the ward, currently we have a high amount of patients requiring higher level of nursing intervention. The risk to not having the HOB facility is the longer length of hospital stay, prolonged ICU stay, use of PACU to extend the patient recovery, increase in patient incidents due to the deteriorating conditions and inadequate nursing ratio to support the high acuity of the patients.
Family Services	Obstetrics / Maternity	Inadequate Consultant Obstetrician cover	20	Trustwide - All Sites (DPoW, SGH and Goole)	Paris Willey	23/05/24	There is a risk that Consultant Obstetricians are not getting compensatory rest and as a result of this there is a significant risk of not delivering Ockenden immediate and essential actions, along with the risk of health and well being of a Consultant workforce.
	Obstetrics / Maternity	Antenatal clinic review capacity	20	Trustwide - All Sites (DPoW, SGH and Goole)	Vicki Booth	19/06/24	Not enough clinic capacity to accommodate the amount of obstetric patients seen on a weekly basis cross-site
	Neonatology (Newborn Intensive	NICU Incubators	20	Trustwide - All Sites (DPoW, SGH and Goole)	Paris Willey	12/04/24	There is a risk of suboptimal care delivery to sick newborns due to an inability to visualise the baby and to provide adequate humidity resulting in the need to unnecessarily expose and handle the baby to perform clinical interventions and this could lead to further temperature instability and potential clinical deterioration
	Neonatology (Newborn Intensive	CPAP Drivers	16	Trustwide - All Sites (DPoW, SGH and	Lisa Pearce	19/07/24	There is a risk of the CPAP drivers not being able to be repaired or serviced due to the age of the equipment and parts availability resulting in not giving the correct respiratory support for our babies. National

			Goole)			agreed guidelines are to provide noninvasive respiratory support where clinically indicated rather than invasive respiratory support (intubation). If unable to provide this service this could mean reduction in level of care provide in our units and babies needing to be transferred out. We have 8 CPAP drivers in total throughout the units and the age is maximum 16 years.
Obstetrics / Maternity	Risk of inability to safely staff maternity unit with Midwives	16	Trustwide - All Sites (DPoW, SGH and Goole)	Natalie Jenkin	17/07/24	The risk is the potential inability to safely staff the maternity unit in order to provide care and treatment to a defined establishment due to sickness and vacancies. If the staffing levels are reduced, this will impact on the ability to provide safe care to women and their babies, resulting in increased incidents and potential poor outcomes.
Gynaecology	Clinical Capacity within Colposcopy	15	Trustwide - All Sites (DPoW, SGH and Goole)	Lisa Pearce	19/07/24	There is a risk we are not meeting the national targets as a result of increase referrals which may led to potential harm.
Paediatrics	Delays in Children being reviewed in DPOW Paediatric Endocrine Service	20	Diana, Princess Of Wales Hospital	Lisa Pearce	23/05/24	There is a risk that children do not receive the correct treatment or monitoring of their potential or actual endocrine condition, as a result of the large backlog of overdue appointments and repeated risk stratification. The cause of this risk is due to the Consultant for Endocrine, DPOW left service in September 2020 and the new Consultant didn't start in post until August 2021 which created a gap in provision and left the Endocrine Specialist Nurse to manage with the support from the SGH Endocrine Consultant. When the Consultant was in post prior to leaving she did 5 clinics per month each with 6 slots, and the SGH Consultant did a further 2. 6 x per year there was a joint clinic with Sheffield Consultant for complex cases and those who required a review with an Endocrinologist. In addition to the above, the new Consultant requires time to develop their knowledge, skills and experience in caring for children with Endocrine conditions and is not in a position to run clinics independently in this speciality at present. The impact of this risk could lead to failure to treat and manage the child's condition lead to significant physical, mental, emotional and social issues and complications; that could be life limiting.
Paediatrics	Delays in Children being reviewed in Cardiac Clinic	20	Scunthorpe General Hospitaltal	Umaima Aboushofa	30/06/24	There is a long waiting list for patients to be seen in the local cardiac clinic for both new and follow up patients. There is a risk that children waiting will come to harm due to delayed assessment and will not receive the correct treatment or monitoring of their potential or actual cardiac condition as a result of decreased capacity and increased demand for cardiac patients to be seen, which may lead to failure to treat and manage the child's cardiac condition leading to significant physical, mental, emotional and social issues and complications; that could be life limiting.
Paediatrics	Up to 1 year wait for new referrals to be seen by Consultant Paediatrician (single handed service) into the ADHD post diagnosis support service.	15	Scunthorpe General Hospitaltal	Umaima Aboushofa	30/06/24	There is a risk that patients who are not seen in a timely manner in the post diagnosis support service will be unable to cope with their daily living activities (eg education - concentrating at school; socialising with friends; following routines and boundaries), especially if they require medication. This then impacts on family life.
Paediatrics	Overdue follow-up and new patients waiting lists for Paediatric patients (Trustwide)	15	Scunthorpe General Hospitaltal	Paris Willey	23/05/24	There is a risk of possible delays in diagnosis and treatment for Paediatric patients who have been waiting for a long time, as a result of a backlog from the Covid 19 pandemic (clinics being cancelled and staff shortage/ sickness), Doctors' strikes and lack of availability with Registrars and Consultants due to vacancies. This may lead to

						complications and side effects which can be avoidable if patients are seen on time.
Community Paediatrics	Increased risk of harm to patients and families due to inadequate co-located psychology support to children and young people.	15	Off site	Pearce, Lisa	13/03/24	Condition: There is an increased risk of patient harm due to inadequate co-located psychology support to children and young people. This service is provided by CAMHS and relates to children and young people supported by HUTH paediatrics. Cause Increase in demand for services Change in complexity of cases and national guidance Fragmented commissioning of services Multiple 'front doors' for families Consequence: Negative impact on ability to achieve best outcome for physical and mental health, leading to mental health crisis for child and parent/carer. Resulting in long waiting times Increased emotional and financial devastation for families
Paediatric Surgery	Lack of Anaesthetic cover for Under 2's out of hours	20	Hull Royal Infirmary	Kazmierski, Mr Marcin	12/04/24	The risk is a delay in treating a child for their surgery. The cause is the lack of paediatric anaesthetist emergency cover for children under the age of 2. The consequence is children and neonates may have to be transferred to another hospital for treatment.
Gynaecology	Significant clinical risk to patients not being seen in safe and timely manner due to capacity limitations in EPAU/EGU	20	Hull Royal Infirmary	Jopling, Melanie	24/05/24	Condition: Significant clinical risk to patients not being seen in safe and timely manner due to capacity limitations - medical and nursing, in EPAU/EGU. Failing to meet the physical and psychological needs of the patients and the inability to see patients in a timely manner. Cause: Lack of appointment slots Lack of physical space. Lack of appropriate capacity nursing workforce, Lack of dedicated appropriately experienced medical cover. Consequence: 1. Poor patient experience, 2. impacting on other services eg Cedar Ward and ED. 3. Medically unwell patients held on EPAU as not able to move to ward. 4. Delays in treatment and medical reviews and active treatment plans. 5. increase in demand on ward services on Cedar - both medical and nursing
Acute Paediatric Medicine	Risk to patient flow and delayed assessment of paediatric patients due to removal of 2nd consultant for paediatric medicine	20	Hull Royal Infirmary	Mehta, Dr Vishal	12/04/24	Condition: Risk to patient flow and delayed assessment of paediatric patients due to removal of 2nd consultant from paediatric assessment. This post forms part of the FACING THE FUTURE standards and is essential in it's delivery. The post has been funded since 2019 Cause Funding for the 2nd post has been removed as had been accessed via the 'Winter'pressures funding. Consequence

							1. Children are waiting longer in the department for senior review 2. Delays in transfer for patients in Paediatric ED 3. Unable to sustain delivery of advice and guidance 4. Failure to comply with FACING THE FUTURE standards
	Gynaecology	Risk of patient harm due to insufficient Medical workforce numbers (Consultant level)	16	Hull Royal Infirmary	Allen, Mrs Jane	24/05/24	The risk of patient harm due to insufficient Medical workforce numbers (Consultant level). The cause of the risk is that there is insufficient medical staff to deliver the Gynaecology elective and emergency services. The consequence of the risk are 1. Increased waiting times for first outpatient appointment and delayed diagnosis and treatment. 2. Potential delayed cancer diagnosis 3. Potential psychological harm. 4. Potential impact on fertility 5. Potential impact on daily living including financial and family breakdown (unable to work). 6. Increased waiting times for EPAU and EGU with potential delayed diagnosis and treatment. 5. Inability to provide adequate training and supervision the junior doctors.
Head And Neck	Audiology	Paediatric Audiology Service	16	Trustwide - All Sites (DPoW, SGH and Goole)	Aaron Sykes	21/07/24	Cause: Due to the volume of harm incidents (46 as at 27.10.23) these have been put under SI 2023/485 as a cluster; early investigations have raised a number of concerns around the delivery of this service, and the links with the Newborn Hearing Screening Programme (NHSP), leading to an external review. Impact: Loss of confidence in some aspects of the paediatric audiology service. Risk: Risk of harm to babies where hearing loss diagnosis is delayed or incorrect, with the potential to lead to developmental delays.
	ENT (Ear, Nose & Throat)	Lorenzo Upgrade	16	Trustwide - All Sites (DPoW, SGH and Goole)	Vicki Quinn	13/06/24	Risk: Loss of patient data could potentially cause harm to patients Impact: Staff moral and workforce and patient pathways Cause: Implementation of the Lorenzo System
	Ophthalmology	Shortfall in Capacity within the Ophthalmology Service	15	Trustwide - All Sites (DPoW, SGH and Goole)	Tom Foulds	06/06/24	The current risk, is the capacity does not meet the demand and the service is unable to meet this. Therefore, this impacts on ability to see patients within the clinical time scales.
	Audiology	Risk to neonates, infants and children with hearing conditions not receiving timely care due to lack of specialist accommodation	16	Trust Wide	Vokes, Mr Philip	05/07/24	The risk is the provision of a reduced and inadequate service for neonates, infants and children with hearing conditions The cause of the risk is inadequate access to appropriate specialist clinical accommodation due to the loss of accommodation to floods The consequence of the risk is cumulative irrecoverable waiting list, delayed diagnosis and interventional care for neonates, infants and children with hearing loss. Failure for children to develop their speech and language potential, failed KPIs, complaints, litigation and longer term state support for failed children.
	Audiology	Risk neonates & Paediatrics with hearing conditions will not receive timely care due to poor performance in Paediatric Audiology	16	Hull Royal Infirmary	Vokes, Mr Philip	05/07/24	Condition: The risk is the provision of a delayed and inadequate service for neonates, infants and children with hearing conditions The cause of the risk is: i) Inadequate access to appropriate specialist clinical accommodation

							ii) Significant ongoing shortfall in Paediatric Audiologists iii) Neighbouring request for mutual support iv) Regional and national demand to implement internal and external quality assurance measures The consequence of the risk is cumulative irrecoverable waiting list, delayed diagnosis and interventional care for neonates, infants and children with hearing loss. Failure for children to develop their speech and language potential, failed KPIs, complaints, litigation and longer term state support for failed children. The severity of the risk is noncompliance with our KPIs (DMO1 - 6 week diagnostic tests), NHSP KPIs {diagnostic follow-up within 4 weeks, hearing aid intervention within 4 weeks and timely reviews}). This translates to babies, infants and young children being deprived of optimal access to speech and language at a neuro-plastic critical time essential for long-term social and cognitive development (including speech and language acquisition). Independent review and complaints will follow, such as those observed within neighbouring services and Lothian if no recovery actions occur. We strongly felt the severity must merit 4, anything lower fails to acknowledge the long-term consequences of failing children at a most seminal time for their future success. Background • The demise of specialist accommodation at the Children's Centre, Walker Street in 2013 to flood damage causing the loss of 10 dedicated sessions of specialist accommodation per week. • Clinically inadequate accommodation used to transfer clinics from the Children's Centre to the HRI Tower Block was judged to be a no go for children by the Hospital Trust in 2020. Three weekly clinical sessions were permanently cancelled together with ad-hoc clinics needed to manage waiting list pressures. • During the pandemic community paediatric referral rates fell by approximately 50%. The referral rate has subsequently returned to near pre-pandemic rates exposing the consequences of the accommodation shortfall reported in 2013. It is no longer possible to mitigate the shortfall using what is unsuitable accommodation at the HRI Tower Block. • During the pandemic paediatric hearing assessments (7 months and above) were suspended for 3 months creating a backlog that has been unable to be recovered because of the accommodation shortfall. Additional time needed for decontamination between appointments has reduced clinic capacity. • Current performance is deteriorating further because of a significant and ongoing severe shortfall in specialist Paediatric Audiologists, including a failure to recruit to a Clinical Lead post, vacant from April 2022. • The risk has been escalated by recent requests from NLAG for mutual aid. • The Lothian Report has highlighted a national crisis in Paediatric Audiology provision and a lack of quality standards and mandatory quality assurance measures. In the meantime NHSE has called for services to carry out gap-analysis against a proposed quality standard audit tool. Services are being asked to devise and establish region-wide robust quality assurance measures, that local Paediatric services will be expected to sign up to and comply with. This work is considerable and has no funding attached to support paediatric services who are already under significant strain and falling short of existing service targets.
	Audiology	Risk neonates & Paediatrics with hearing conditions will not receive timely care due to Paediatric Audiologist shortfall	16	Hull Royal Infirmary	Vokes, Mr Philip	05/07/24	Condition: The risk is the provision of a delayed and inadequate service for neonates, infants and children with hearing conditions

							The cause of the risk is: i) Staffing shortfall ii) Insufficient timescale to train staff and overcome predicted skill gaps iii) Linked to accommodation shortfall (risk 4058) and poor performance (risk pending approval) The consequence of the risk is: 1. cumulative irrecoverable waiting list, 2. delayed diagnosis and interventional care for neonates, infants and children with hearing loss. 3. Failure for children to develop their speech and language potential, 4. failed KPIs, 5. complaints, 6. litigation and longer term state support for failed children. 7. There is also a risk of deterioration in the health and wellbeing of staff who are under increasing pressure with insufficient resources. Background • Deterioration in staffing levels due to retirement of Clinical Lead Audiologist (1wte) in April 2022 and recent resignation of Paediatric Audiologist (0.6wte). • The Paediatric Audiology team is relatively small (4.6wte in post) and developing service. Specialisms within Paediatric Audiology itself mean most existing staff are not skilled to cover all areas within the service. This, along with the service provision split across two community sites, means flexibility to cover the service and skill mix is more limited. • Failure to recruit to Clinical Lead post, since April 2022. • Inability to recruit replacement staff due to a national shortage of trained and highly skilled Paediatric Audiologists, acknowledged by the British Academy of Audiology (BAA) and Healthcare Science Workforce Lead, North East and Yorkshire. • Given the difficulty recruiting to posts the Paediatric Audiologist vacancy funding will be redeployed to uplift junior staff following completion of training. This will reduce staff headcount in the short term, further weakening flexibility in the team to respond to the requirements of the specialist areas within the Paediatric service. • Planned retirement of a further 2 highly skilled and key Paediatric staff expected in the next two years (1.2 wte). • Time taken to train Paediatric Audiologists is considerable (approximately 2 years) and requires funding. Even if the service can recruit trainees to fill forthcoming retirements now, there will still be a significant skill gap incurred before completion of training. • Work related staff sickness absence linked to current strains on the paediatric service adding further pressures to the Paediatric team. • The risk has been escalated by recent requests from NLAG for mutual aid. • The Lothian Report has highlighted a national crisis in Paediatric Audiology provision and a lack of quality standards and mandatory quality assurance measures. There is increasing requirement to engage in service improvement measures to safeguard local Paediatric Audiology provision. This work is considerable and has no funding attached to support paediatric services who are already under significant strain and falling short of existing service targets (see linked performance risk (pending approval) and accommodation risk 4058).
	Ophthalmology	Patients with Diabetic Eye Disease are experiencing delays in assessment and treatment resulting in potential loss of sight	15	Hull Royal Infirmary	Cook, Miss Helen	13/06/24	Condition: Ophthalmology is experiencing ongoing delays in the assessment and treatment of new and follow up patients with Diabetic Retinopathy. This is leading to harm events in some patients.

							Cause: This is inadequate Medical Retina Ophthalmology capacity (medical staff, nursing staff, technician staff, administration staff, equipment and physical space) to see all patients with active referable diabetic eye disease at the correct clinical time-frame for review and treatment of their diabetic eye disease. (Updated 30/01/24): -The number of medical retina consultants has increased by 1 in the last 18 years which is insufficient to meet demand. -The diabetic population is continually increasing. The prevalence of diabetic eye disease is continually increasing. -Medical retina clinical capacity is insufficient to meet demand. - Lack of failsafe officer is also contributing to the risk. This post was appointed to, however, the role has been removed. The lack of capacity to meet demand includes: -Clinical -Nursing staff -Admin -Technicians -Equipment -Clinic space Consequence: The result is risk of potential significant sight loss.
	Ophthalmology	Risk of patient harm to new and follow-up patients due to delays within glaucoma service	15	Hull Royal Infirmary	Downey, Ms Louise	09/02/24	The risk is: patients are coming to harm due to the delay in seeing the patients and also delayed follow-up within the glaucoma service. The cause of the risk is: loss of consultant PAs pre-pandemic, reduction in clinical capacity as a consequence of surge phase SOP and current waiting area restrictions. Delays in visual field testing. The consequence of the risk is: patients are coming to harm due to delay in their follow-up appointments. The glaucoma service was originally led by 2WTE consultants with support from junior medical staff and optometrists. The departure of 1 consultant and reduction in PAs of the remaining colleague left the service with reduced senior clinical input, with increasing delays in patient follow-up. Appointment of a permanent locum consultant in early 2020 plus risk stratification of the entire glaucoma access plan have prioritised the high risk patients, but there remain delays for the medium and low risk patients. The appointment of an agency locum consultant is a short-term, unsustainable solution, to help deal with the current backlog. Glaucoma: 2 vacant consultant posts
	Ophthalmology	Clinical risk to patients requiring sub-specialist Medical Retina outpatient follow-up due to lack of capacity	15	Hull Royal Infirmary	Cook, Miss Helen	13/06/24	Previously incorporated into Risk 2665 but agreement at Ophthalmology Speciality Governance in October 2021 to close Risk 2665 and split out the individual elements of this risk as the mitigations are different for the different elements of Risk 2665. Moderate harm and serious incidents linked to capacity issues in this pathway. The risk is a clinical risk to patient who need on-going follow-up assessment within a specialist Medical Retina patient clinic due to capacity issues in this pathway. The cause of the risk is lack of capacity to address the demand. The consequence of the risk is patients are coming to harm (moderate harm and serious incidents).
	Ophthalmology	Clinical risk to patients referred as new patients into the new wet macular degeneration pathway	15	Hull Royal Infirmary	Downey, Ms Louise	29/02/24	The risk is a clinical risk to patient who need urgent assessment and treatment with intravitreal injections to treat macular involving diseases (wet macular degeneration, central and branch retinal vein occlusion related macular oedema and diabetic macular oedema) due to capacity issues in this pathway.

							The cause of the risk is lack of capacity to address the demand which includes: -Clinical -Nursing staff -Admin -Technicians -Equipment -Clinic space The consequence of the risk is patients are coming to harm (moderate harm and serious incidents) and the department is failing to meet NICE quality standards for patients with wet age-related macular degeneration who must be treated within 2 weeks of referral. The service are also experiencing operational difficulties with stress on the Management, Clinical and Administration teams as planned non-urgent clinics are having to be cancelled at short-notice to try and create capacity to treat the higher clinical priority patients.
	Ophthalmology	Clinical risk to patients referred as new patients into new Medical Retina patient assessment clinic due to lack of capacity iss	15	Hull Royal Infirmary	Downey, Ms Louise	14/06/24	The risk is a clinical risk to patient who need urgent assessment within a specialist new Medical Retina patient clinic due to capacity issues in this pathway. The cause of the risk is lack of capacity to address the demand. This includes: Clinical nursing staff admin technicians equipment clinic space The consequence of the risk is patients are coming to harm (moderate harm and serious incidents).
Major Trauma Network	Major Trauma	Risk of increased morbidity and mortality for elderly MTC patients due to inadequate DME support for Major Trauma Centre TARN	20	Hull Royal Infirmary	Rayner, Dr Ben	31/05/24	Condition: Increased morbidity and mortality for elderly MTC patients due to inadequate DME Support for Major Trauma Centre. Cause: 1. Failure of Business Case for expansion of DME input 2. Increasing and aging Silver Trauma admissions 3. Frailer elderly population with increased polypharmacy 4. Silver Trauma input required as a peer review measure 5. MTC bed base insufficient for demand for elderly Consequence: 1. Increased death in the elderly (TARN proven) 2. Increased morbidity in the elderly 3. Increased Length of Stay 4. Risk of NHSE / CQC Special Measures for Trust Major Trauma Unit
Specialist Cancer And Support Services	Radiology - Ultrasound	Availability of Chaperones for intimate examinations in Radiology	15	Trustwide - All Sites (DPoW, SGH and Goole)	Ruth Kent	17/06/24	New guidance has been published regarding the need for chaperones for intimate exams in imaging departments. All ultrasound scans meet the definition of intimate examination due to closeness and touching of body parts as part of the exam. Due to the small numbers of support staff in Ultrasound teams there are insuffiicient staff to be able to provide chaperones for intimate examinations in Ultrasound, which is in breach of the guidelines. Risk is twofold: 1 - patients who have a right to a chaperone are potentially unable to be scanned, resulting in delays or cancellations

							2 - staff are put in a position where they are open to accusations of inappropriate behaviour, with no witness to defend them
	Breast Diagnostics And Screeni	Breast Imaging Service loss of capacity	15	Diana, Princess Of Wales Hospital	Ruth Kent	17/06/24	Due to the retirement of current Consultant Radiographic Practitioner at end of August 2023, there will be a loss in capacity for new and review symptomatic breast imaging, and a reduction in interventional capacity. This will impact on delivery of 2ww service, and delay patient pathways
	Radiology	Cardiac CT demand outstripping capacity	15	Trust Wide	Nutman, Ms Martine	31/05/24	Condition - Backlog & waiting list continues to increase (to greater than current capacity / faster than capacity growth) within CT. Cause - Insufficient capacity to meet demand. Consequence - Patients waiting longer for this diagnostic test & there are breaches of relevant targets being experienced.
Specialist Medicine	Chest Medicine	Risk to patients and staff within the Home Ventilation Service	20	Castle Hill Hospitaltal	Hutton, Mr James	06/06/24	As a result of increasing referrals in the last 7 years the Home Ventilation service is seeing nearly a 50 % increase in patients to a current cohort of 485 patients; 377 patients on NIV, 14 invasively ventilated and 98 using cough assist (some of which are also ventilated), with no budget uplift in clinical staff. Numbers of appropriate referrals for mechanical ventilation and cough augmentation are rising- this is likely to be because of updated guidance (MND NICE Guidance 2017) and a recent randomised controlled trial in patients with COPD. In 2017 the HOT-HMV trial showed that there was a 51% reduction in risk of readmission or death in persistently hypercapnic COPD patients treated with home non-invasive ventilation and oxygen therapy. Increased awareness by clinicians has already led to an increase in referrals of patients with COPD for consideration of long-term treatment. Due to increased workload due to enhanced infection control measures, additional new services (Cough Assist), increasing highly complex patients and increasing patient numbers, the home ventilation team are now unable to effectively manage the service and as a result, patients are not being seen in a timely manner and as recommended by national guidelines which increases the risk of hospital admission and premature death. The patient caseload for Home Ventilation has more than doubled since the last increase in staffing numbers 8 years ago and the number of highly complex patients has increased significantly. Potential complaints/DATIX due to time constraints and increase in patient numbers. The team have had patients expressing their dissatisfaction about the service resulting in poor patient experience. Delays/reductions in interventions to prevent admissions, which will affect ward staff and have ongoing cost implications. Additional risk to staff likely having to take on additional duties, working over contracted hours, resulting in work overload, increased sickness, potential burn out and increasing costs to the service. There is a financial risk with 0.53WTE employed over budget currently. In summary lacking additional staffing resource there is a risk resulting in increased waiting times, reduced quality of care e.g. timely reviews, delayed treatment, risk of hospital admission and worst case patient death. Increased staff stress levels/burnout, poor patient experience, risk to patient safety. New care group structure across NLAG and HUTH means potential for increasing numbers of patients (100 across grimsby) coming to be managed by HUTH team

	Chest Medicine	Risk to patients and staff within the Cystic fibrosis/bronchiectasis service	15	Castle Hill Hospitaltal	Hutton, Mr James	06/06/24	As a result of increasing referrals over the latter 5 years without extra nursing resource. The bronchiectasis service has received over 25 referrals in the last year alone increasing the number of patients up to almost 300 and rising, not taking into account potential increase of patients from NLAG. The CF service has increased by 10 patients to 57, with further patients to transition in 2024 plus 2 potential late diagnosis. Patient numbers of 10 appear low however, the CF service is labour intensive, and the patient cohort requires dedicated, knowledgeable, experienced clinicians to deal with their complex multi system conditions. There is a risk that a reduction in the frequency of routine planned reviews for bronchiectasis patients, which is crucial (especially for those on long-term antibiotic therapy prescribed by the service). Delays in initiating new time-consuming treatments, such as nebulised antibiotics, potentially leading to increased exacerbations/deterioration/hospital admission/death. Potential complaints/DATIX due to time constraints and increase in patient numbers. The team have had patients expressing their dissatisfaction about how both services have changed and it's not as easy to access/speak to team members etc. resulting in poor patient experience. Delays/reductions in interventions to prevent admissions, which will affect ward staff and have ongoing cost implications. Additional risk to staff likely having to take on additional duties, working over contracted hours, resulting in work overload, increased sickness, potential burn out and increasing costs to the service. There is a financial risk with 0.53WTE employed over budget currently. In summary lacking additional staffing resource there is a risk resulting in increased waiting times, reduced quality of care e.g. timely reviews, delayed treatment, risk of hospital admission/death. Increased staff stress levels/burnout, poor patient experience, risk to patient safety.
		NCTR / Stranded patients within the MHG acute bed base.	16	Hull Royal Infirmary	Faruqi, DR Shoaib	28/06/24	Condition: NCTR / Stranded patients within the MHG acute bed base. Within medicine there can be up to 160 plus stranded patients who belong in a community setting. One year ago there were less than 30 patients. Cause: The community has throughout the covid pandemic had a catastrophic failure and the community issue has inappropriately diverted onto the acute hospital. Consequence: Impact on patient flow, length of stay and acute capacity in the medical bed base. Its causing inefficiencies within workforce and contributing to two extra days stay per patient and also can cause an increased risk of hospital harm and deconditioning to patient. As a result we are being forced to lodge patients in the ED and board an additional three patients on a ward each day in order to force flow.
	Chest Medicine	Staffing resource to support the delivery of the HUTH Specialist Asthma Service	16	Hull Royal Infirmary	Hutton, Mr James	28/06/24	The specialist asthma service is struggling to meet the demand for specialist asthma care. The service currently has a single handed practitioner 1 WTE B7 Specialist Nurse + 2PA of consultant time. Access to biologics and new drugs pending will lead to increased demand on the service. Service currently has circa 260 patients on its caseload but with new guidance and increased access to biologics this is expected to increase marked

							Wait times and delays will increase to allow patients to start on biologic therapy. The capacity to follow up patients in a timely manner as per guidance will also be impacted
Specialist Surgery	Breast Surgery	Breast Imaging workforce depletion	20	Trustwide - All Sites (DPoW, SGH and Goole)	Mandy Hay	23/05/24	There is a risk of not offering essential breast imaging steps in patient pathways, due to retirement of the Breast Imaging Practitioner, resulting in the need to refer patients outside the Trust and delays to deliver care occurring to cancer standards.
	General Surgery	Risk to Overall Performance : Non compliance with RTT incomplete target	16	Trustwide - All Sites (DPoW, SGH and Goole)	Jennifer Orton	28/06/24	Given our current operating models, there is a risk that there is insufficient capacity to meet demand in a number of specialities which risks the RTT position and potential for adverse patient impact. Potential for 52 week breaches and potential to not meet current 40 week maximum RTT target This could result in clinical harm
	Cancer Services	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	16	Trustwide - All Sites (DPoW, SGH and Goole)	Jennifer Orton	28/06/24	Failure to treat patients within the cancer waiting times may result in poor patient experience and potential clinical harm. Risk register also relates to Risk ID 2244.
	General Surgery	Risk to Overall Performance : Overdue Follow-ups	15	Trustwide - All Sites (DPoW, SGH and Goole)	Jennifer Orton	28/06/24	There is a risk that there is insufficient capacity to meet demand in a number of specialities which risks overdue follow up position deteriorating Failure to review patients in clinically specified timescales.
	Plastics	Lack of Plastics Theatre Capacity to undertake DIEP procedures for Breast Surgery patients	20	Castle Hill Hospitaltal	Hanlon, Mr Jamie	31/07/24	The risk is that there is insufficient theatre capacity to undertake the present number of patients requiring DIEP reconstructive surgery. The cause is due to a backlog and increased demand for this type of surgery. The consequence is there will potentially be a delay in patients cancer treatment. The patients may have to opt for alternative surgery.
	Breast Surgery	Shortage of Breast Pathologist	16	Castle Hill Hospitaltal	Wooler, Mr Brendan	31/07/24	The Trust has 2 Consultant Pathologists who do Breast pathology. The crisis has been precipitated by one Consultant going off with a long term illness. The service is dependent on one Consultant, if she were to go off for any reason, not only will the symptomatic breast service collapse the breast screening service would also. There is likely to be a delay in turnaround time for biopsies and resection specimens that can potentially lead to cancer breaches and delay in treatment.

Risks extracted from registers – Workforce, Education and Culture CIC

Care Group	Specialty	Title Risk	Risk Rate Score	Location	Risk Handler	Next Review Date	What Is Risk
Acute And Emergency Medicine	Nursing (All Specialties)	Quality of Care and Patient Safety based on Nurse Staffing Position	20	Trustwide - All Sites (DPoW, SGH and Goole)	Joanne Foster	28/06/24	The Registered Nursing vacancy position in Medicine, against current, agreed establishment creates significant issues with producing a robust nursing roster. Reliance upon a pipeline of Newly Registered Nurses and Internationally Educated Nurses creates skill mix issues when set against numbers of leavers. The Nurse vacancy position within Medicine has a direct impact on quality of care and patient safety. There is a finance risk associated with the use of Bank & Agency Nurses in order to fill the gaps in the rosters. Service developments and new build areas (IAAU/SDEC/ED's) and investment in the establishments required have increased demand for Bank/Agency and vacancy in substantively funded posts. Medicine are also staffing escalation beds which adds further risk. Patient harm, increased sickness, staff retention are possible outcomes as a result.
	Acute Medicine	Challenges to recruitment of acute care physician vacancies in Acute	16	Trustwide - All Sites (DPoW, SGH and Goole)	Lynsey Chessman	13/06/24	This risk is to highlight the difficulties in workforce recruitment and the increased pressures on staff, which has been exacerbated by the Covid-19 We have vacancies for acute care physicians (ACP) Trust-wide and it is proving very challenging to fill these posts. The cause has been due to a national shortage of ACPs and lack of applicants for the posts when we have advertised them. The impact would result in failure to recruit the required ACPs and this will delay the planned expansion of acute medicine service with extended hours with senior clinician presence on the shop floor and could result in failure to launch phase 3 of the IAAU development plan for 2023. There is a risk that due to the pressures created by having less workforce and increased demands placed on services as a result of not having a balanced workforce, this may result in the current ACPs becoming exhausted, leading to gaps in rotas and therefore not sufficient senior medical staff to ensure quality and safety of patients. In addition, this may also result in doctors withdrawing from our hospitals, exacerbating staffing issues.
	Emergency Care	Medical Staff - Mandatory Training Compliance	16	Trustwide - All Sites (DPoW, SGH and Goole)	Victoria Marshall	21/06/24	Mandatory Training compliance for medical staff. There is a risk to patient safety if medical staff do not complete their mandatory training before each element has expired. Due to the volume of doctors demonstrating low compliance across all grades, this has impacted upon the divisional CQC improvement plan.
	Acute Medicine	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	16	Hull Royal Infirmary	Weerasekera, Dr Chaminda	10/06/24	The risk is that Speciality of Acute Medicine is unable to recruit into vacant Consultant posts within the department and that is not adequately established to provide the cover the Organisation expects for is patients. This will impact on patient care. Despite Acute Medicine being cited as “the fastest growing medical speciality in the UK” It is equally noted, “many posts are unfilled” (RCP

							2018). This is not just a local problem; however it is exacerbated by the fact that the city of Hull is economically deprived and isolated in location and therefore is not attractive to candidates from outside East Yorkshire. The Acute Consultant Team is currently supporting 3 areas, SEDC, AMU and InReach ED. The consequence of having a reduced workforce is the difficultly in providing consistent provision of appropriate shop floor cover; this impacts upon delivery of clinical quality indicators. It impacts on timely patient flow. It impacts on finances, through increased locum Consultant spending. The use of locum consultants or Registrars to fill gaps on the rota does not always lead to consistent and/or timely clinical management plans for patients; this lead to increased lengths of stay at the detriment of patient's wellbeing. To attract the limited pool of potential AIM consultants is a challenge for hospitals in the UK. Many hospitals offer attractive packages, including financial lump sums when joining. The Trust (with executive support) has recently supported the service with a bespoke advertising campaign, with the offer of an attractive financial relocation package. This most recent recruitment drive however, was not successful. There is a risk that that the pressures on the substantive consultant workforce, which has been exacerbated by the Covid-19 pandemic, could impact on the health and well-being of the existing team (as been seen in other specialties previously). This will further impact the safe, effective and timely delivery of high quality care for our patients.
Cardiovascular	Cardiology	Lack of Suitably Trained Staff to Perform Cardiac Stress Testing	16	Castle Hill Hospitaltal	Mill, Jill	09/05/24	The risk is the lack of suitably trained staff to perform cardiac stressing The cause of the risk is lack of investment, under funded service, maternity leave meaning insufficient skill mix to meet demand The consequence of the risk is closure of the cardiac stressing service in Nuclear Medicine
	Cardiology	Risk to Continuity of TAVI service due to staffing shortfalls	16	Castle Hill Hospitaltal	Magee, Mrs Wendy	13/07/24	At present there is only one specialist nurse attached to the TAVI service (in line with present business case). This nurse attends MDT and coordinates the ‘work up’ of patients awaiting TAVI as well as direct patient care and follow ups etc. There would be a significant impact to the service and the TAVI patients if this nurse goes off sick or takes extended leave. A one person service does not allow the service to succession plan or develop the nursing team to ensure that staff are appropriately trained and knowledge shared without detriment to the delivery service. Additional risk to service is lack of GA provision from the SHG to enable TAVI procedure to be undertaken, resulting in cancellation of patients. The cause of the risk is due to initial business case planning for initial service development Additional risk is lack of vascular scrub nurse support in the event of a vascular emergency occurring during the procedure.
	Cardiac Surgery	There is a risk of failing our perfusion accreditation due to non-compliance of utilising data management record keeping	16	Castle Hill Hospitaltal	Bell, Jill	10/06/24	There is a risk of failing our perfusion accreditation due to non-compliance of utilising data management record keeping. The outcome would be a non-accredited cardiac centre. There would be no clinical reaccreditation of the perfusionists whilst working for HUTH which would result in the perfusion staff being able to register as practising perfusionists and would close the perfusion service and therefore the cardiac service. Capital asset purchase is required. Risk Description: • Condition: No equipment available to monitor and store perfusion data electronically. • Cause: Never been a priority to buy electronic data

							management/records as not been raised to a requirement in the Standards for Monitoring before. • Consequence: Working outside of the Standards for Monitoring which are set and agreed by The Society of Perfusion Scientists of GB and Ireland, Association for Cardiothoracic Anaesthesia and Critical Care and the Society for Cardiothoracic Surgery in Great Britain and Ireland. Data missed due to no real time capture of perfusion management. No paperless record in continuity with ward/anaesthetic/ICU journey. Blank spot of critical data missing.
Community, Frailty And Therapy Services	Speech & Language - Adults	Speech and Language Therapy Stroke staffing resource	20	Trustwide - All Sites (DPoW, SGH and Goole)	Sarah Scrace	29/06/24	There is a risk that stroke patients in DPOW, SGH, Ward 3 Goole and community will receive suboptimal care related to the management of their swallowing and communication needs as a result of inadequate staffing resource for Speech & Language Therapy which does not meet new RCP National Clinical standard, ESD or community guidelines or allow for the required 7 day inpatient service, this is compounded by vacancies in established posts being hard to recruit to. This may lead to inpatients not receiving SLT swallowing assessments within 24 hours as per Stroke Standards; or the required frequency of intervention and rehabilitation in hospital or in community; poorer outcomes and patient experience; undiagnosed or mismanaged dysphagia potentially resulting in patient harm; long term dependence on enteral feeding; inability to reach maximum recovery potential, increased length of stay; reduced flow, unsafe discharges.
Digestive Diseases	Gastroenterology	Medical Workforce Vacancies in Gastroenterology	16	Trustwide - All Sites (DPoW, SGH and Goole)	Simone Woods	22/03/24	Following departure of 2 consultants in Gastroenterology there is insufficient workforce to deliver the range of services. Resulting in: - Failure to meet constitutional targets (RTT &Cancer) - Delays in patients being seen both as inpatient & outpatients - Increased waiting times - Increase LOS - Failure to fulfil emergency GI Bleed Rota - Lack of training and supervision - Unable to provide a Barrett's oesophagus service and registry in the Trust for appropriate follow up of these patients. The patients with Barrett's are being managed by gastroenterology, surgery and even some patient's are with primary care.
Family Services	Gynaecology	Concerns surrounding RCOG Trainee Curriculum - Obstetrics and Gynaecology	15	Trust Wide	Allen, Mrs Jane	24/05/24	Condition: Core Curriculum for Obstetrics & Gynaecology has been revised and was implemented in November 2019. Trainees ST3-5 who are not deemed entrustable and cannot be left without supervision immediately available are leaving themselves and patients at risk. Risk of non-compliance with Core Curriculum Royal College of Obstetrics & GMC. Trainees do not have to be deemed entrustable until end of ST5. The Trust cannot easily plan for these changes and there is a need to consider that all trainees ST3-5 need somebody more senior (ST6 plus) resident 24hours a day 7 days a week. Cause 36 consultants are required to ensure sufficient supervision and cover are available - only 24 in post. Consequence The service is potentially putting patients at risk from having staff looking after them who require direct supervision.

	Gynaecology	Clinical capacity within hysteroscopy at DPOW	15	Diana, Princess Of Wales Hospital	Lisa Pearce	28/06/24	There is a risk we are not meeting the national targets as a result of increase of referrals which may led to potential harm.
Specialist Cancer And Support Services	Clinical Oncology	Oncology Service	20	Trustwide - All Sites (DPoW, SGH and Goole)	Rhiannon Wilson	08/06/24	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 2)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a shortage of chemotherapy nurses at DPoW and difficulties in training new chemotherapy nurses.
	Pharmacy	Pharmacy staffing	15	Trustwide - All Sites (DPoW, SGH and Goole)	James Hargraves	17/07/24	Due to the number of vacancies and maternity leave at this time, the clinical pharmacy service is unable to maintain its current level of service delivery. The impact on service delivery is likely to be in effect for a number of months. The service has been recruiting to posts and continues to do so. Within the pharmacy workforce the applicants have been primarily from pharmacists due to qualify in August therefore resulting in a short term gap as staff have left now and will be replaced in August. With the pharmacy technician workforce multiple attempts have been made to recuruit to fixed term and permanent posts with little success.
	Clinical Haematology (Ward)	There is a risk to patient safety due to the lack of Haematology Medical Staffing	20	Castle Hill Hospitaltal	Pennington, Lisa	29/02/24	There is a risk that there will be a local and regional collapse of effective haematological clinical care. The cause of the risk is due to the inability to recruit to vacant haematology consultant posts. The consequence of the risk is there is increased waiting times for patients requiring follow ups within haematological cancer care. There is also a lack of effective haematology support to wider hospital. This will also have the potential to cause burnout / stress amongst existing medical staff.
	Radiotherapy	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	20	Castle Hill Hospitaltal	Colley, Mr Peter	26/05/24	The condition of this risk is that the Radiotherapy Physics service does not have enough staff to keep patients safe and is unable to perform the necessary routine and mandated activities required for high-quality service delivery. The team comprises several sub-specialist teams, with some teams being very difficult to recruit owing to the specialist nature of their knowledge and skills. The cause of the risk is that the Radiotherapy service has developed incrementally over several years in terms of the implementation of the Radiotherapy Operational Delivery Network (ODN) and complexity of treatment and equipment, however staffing investment has not kept pace with these changes. The COVID pandemic has exacerbated this in terms of more complex patient presentations, and influx of work backlog, requiring more input from the physics team. Radiotherapy Physics staffing falls well below recommendations for staffing for a service of the size and equipment profile delivered in HUTH using the IPEM staff requirement report. The radiotherapy patient backlog presents a significant challenge to the staff group which is unlikely to be able to deliver the required activity identified in the draft recovery plan with the current staff establishment and profile.

							The consequences of the risk are as follows: 1. Failure to adhere to legislative frameworks mandatory timescales (see also Risk ID 4032), and additionally adverse CQC and CQC IR(ME)R inspection outcomes. 2. Failure to undertake QMS tasks and provide continual assurance to inspection bodies with regards to quality frameworks (BS70000, ISO9000) with the potential loss of accreditation or certification and potential failure to adhere to NHSE service specification requirements and professional body recommendations. Specifically, the requirements of BS70000:2017 are affected due to insufficient staff within the service. 3. Failure to support the Radiotherapy Recovery Plan / continued failure to meet National CWT targets by not achieving the service specification for RT Physics as part of the larger organizational objectives. 4. Staff morale and burnout could result in lower productivity and higher sickness absence. Contributing to existing issues with retention and recruitment 5. Direct financial impact: The trust benefits from significant discounts on equipment service and support contracts owing to providing a local first-line service team. There is a risk of loss of these discounts. The impact of not providing first line service effectively will be additional downtime resulting in reduced patient throughput. 6. Reduced availability of equipment for clinical use may result in CWT breaches and loss of reputation. 7. In ability to implement new equipment, technology, techniques and clinical practises as indicated and required by service contract, best practise and professional guidelines.
	Radiotherapy	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	20	Castle Hill Hospitaltal	Colley, Mr Peter	08/06/24	The risk is that there is currently insufficient Radiotherapy Physics staff, due to existing demand on the senior Medical Physics Expert staff and as a result less capacity to investigate reported incidents within the allowed legislative timescales. The cause of the risk is that the Radiotherapy service has developed incrementally over several years in terms of the implementation of the Radiotherapy Operational Delivery Network (ODN) and complexity of treatment and equipment, however staffing investment has not kept pace with these changes. The COVID pandemic has exacerbated this in terms of more complex patient presentation, and influx of work backlog, requiring more input from the physics team. The consequence of the risk is: a potential failure of HUTH to report an incident to the CQC within the legislative timescale, which could result in prosecution under the IR(ME)R legislation.
	Radiotherapy	Lack of Therapeutic Radiographer Staffing	16	Castle Hill Hospitaltal	Hutton, Mrs Clare	05/07/24	The risk is that there are current challenges with current recruitment to the service resulting in the inability to fully cover the operational hours for the radiotherapy service. The cause of the risk is due to candidate qualifications and HCPC registrations timescales. Further to this there are current movements within the existing establishment due to internal promotions and staff leaving. The consequence of the risk is the current staffing levels will not be able

							to support the activity/operational hours within their contracted hours between July and September 2021. Therefore, patients will potentially be delayed to ensure safe delivery of radiotherapy.
Specialist Medicine	Diabetes and Endocrinology	Funding provision for 7 day IP DSN Service within Diabetes	16	Hull Royal Infirmary	Hutton, Mr James	28/06/24	There is a risk that the 7 day IP DSN service has not got identified funding to continue from Apr 24. This is caused by a lack of organisational funding being made available by the trust to support HG business cases. Capacity and demand continues to increase. Matron and Band 6 contracts are due to come to an end in March 24 and one of the DSN's has been moved to an alternative post for 2 years. Failure to fund will result in staff being put at risk and the 7 day IP DSN service will be discontinued with detriment to clinical quality.
	Diabetes and Endocrinology	Capacity Shortfalls in DEXA scanning	16	Hull Royal Infirmary	Aye, Dr Mo	10/05/24	Condition: Capacity shortfalls in DEXA scans for both undertaking and reporting Cause: The inability to meet the demand to perform and report DEXA scans Current staffing insufficient Consequence: Current impact 8 months reporting time for scan. Backlog approx 2950 scans. Carrying out around 150 scans per week. Backlogs for not scanning and reporting of scans. Potential for delays in treatment starts. There is a substantial risk to business continuity. Staff morale, though recently improved, remains fragile. This could lead to staff departures, and given the specialised nature of DXA technicians, replacement and operationalisation of new staff would be time-consuming and challenging. Alternative solutions, such as outsourcing to private providers, have previously been considered but found unfeasible.
	Chest Medicine	Nintedanib Change in guidance impacting on clinical capacity to deliver increasing numbers of patients	15	Castle Hill Hospitaltal	Hutton, Mr James	28/06/24	There has been a change in guidance in relation to a drug called Nintedanib which will mean a large increase in the numbers of patients that will be eligible to be prescribed this drug. This will impact on the IPF service due to increase in prescribing, monitoring and FUP We anticipate that there will be an increase of circa.....The guidance changes come into effect April 2023 https://bnf.nice.org.uk/drugs/nintedanib/

WORKFORCE, EDUCATION & CULTURE COMMITTEE-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief People Officer / Group Director of Assurance

1.0 Purpose

1.1 The Workforce, Education & Culture Committee-in-Common is responsible for oversight of risks to the delivery of the Trust's People Strategy, associated plans and priorities which may impact on the health and wellbeing of the workforce and / or on the quality of care, for providing assurance to the trust board as to the effectiveness of the arrangements in place and / or for escalating risks to delivery.

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Workforce, Education & Culture Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Workforce, Education & Culture Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Workforce, Education & Culture Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Workforce, Education & Culture Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Workforce, Education & Culture Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Workforce, Education & Culture Committee-in-Common** is accountable to the HUTH Trust Board.

3.2 The **Workforce, Education & Culture Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

3.3 The **Workforce, Education & Culture Committee-in-Common** will receive a routine report from the sub-groups that report into it (as detailed within the work plan).

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's People Strategy and priorities and ensure that the People Strategy is aligned with the agreed strategic direction, culture, vision and values of the trust and wider group.

4.2 To provide input into and monitor delivery of the recruitment, retention, leadership, talent management & succession planning, training & organisational development and culture work programmes for the trust and wider group.

4.3 To monitor and provide assurance to the Trust Board that workforce risks which threaten the achievement of the strategic objectives of the trust and wider group and / or which may impact on the quality of care, are being identified and appropriately mitigated and / or to escalate concerns, as appropriate.

4.4 To monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements including but not limited to:

- Workforce Key Performance Indicators (KPIs)
    - Vacancies
    - Turnover
    - Sickness Absence
    - Mandatory Training
    - Appraisal
    - Temporary staffing / agency spend
    - Employee Relations / HR cases (e.g. disciplinaries, exclusions etc.)
- Staff Survey (local and national)
- Occupational Health & Wellbeing
- Staff Vaccination
- Registered Nurse & Midwifery Staffing
- Equality, Diversity & Inclusion
- Freedom to Speak Up
- Guardian of Safe Working

- Job Planning
- Medical Revalidation
- Gender Pay Gap
- WRES
- WDES
- Modern Slavery

4.5 To monitor education, training and learning activities ensuring that they comply with the required legal and mandated standards and support service development / transformation and evidence-based practice.

4.6 To ensure that statutory workforce reporting requirements are met including escalation to the Trust Board for approval, as appropriate.

4.7 To support the development of emerging innovative roles.

4.8 To understand the workforce implications of service transformation and provide oversight of delivery of the agreed implementation plans.

4.9 To provide oversight of progress against the Trust's Research & Innovation Strategy and priorities.

4.10 To provide oversight of the Trust's arrangements for and monitor the progress of plans to improve staff engagement, communication and recognition.

4.11 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.12 To agree an annual work plan for the committee and monitor its delivery.

4.13 In summary, to cover the following areas of scope:

- Apprenticeships
- Clinical Education
- Culture, Vision & Values
- Education, Training & Development
- Employee Relations (including MHPS / other capability & conduct issues and exclusions)
- Equality, Diversity & Inclusion
- Freedom to Speak Up
- Gender Pay Gap
- Guardian of Safe Working
- Job Planning
- Leadership, Talent Management & Succession Planning
- Medical Revalidation

- Modern Slavery
- Nursing & Midwifery Staffing Report
- Occupational Health
- Occupational Health / Health & Wellbeing
- Organisational Development
- People Strategy & Delivery Plans
- Recruitment & Retention
- Research, Innovation & Continuous Improvement
- Staff Engagement, Communication & Recognition
- Staff Survey
- Staff Vaccination
- Workforce Finance (including temporary staffing / agency spend)
- Workforce Metrics
- Workforce Planning
- WRES / WDES

4.14 To agree at a high level the risks, controls and assurances provided by the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.15 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.16 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.17 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within HUTH, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief People Officer

5.1.3 Group Chief Medical Officer

5.1.4 Group Chief Nurse

5.2 In Attendance (all meetings)

5.2.1 Group Director of Assurance or deputy

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 North & South Bank Managing Directors

5.3.2 Other senior officers of the People Directorate & Trust

5.3.3 Others Non-Executive Directors

5.3.4 Director of Post Graduate Medical Education

5.3.5 Director of Undergraduate Medical Education

5.3.6 Guardian of Safe Working

5.3.7 Freedom to Speak Up Guardian

5.3.8 Other Topic & Network Leads

5.3.9 The Chair & Chief Executive* and have a right of attendance and speaking rights

* In his absence, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Workforce, Education & Culture Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the NED chairs of the respective **Workforce, Education & Culture Committees-in-Common** will alternate at each monthly meeting. Both NED chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second NED member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Workforce, Education & Culture Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive / Associate Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise,

including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Hull University Teaching Hospitals NHS Trust

APPENDIX A

Decisions Delegated to the Workforce, Education & Culture Committee-in-Common

(HUTH)

Type of Decision	Delegated to the Workforce, Education & Culture Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the People Strategy, Delivery Plan & Priorities	Approval of People Strategy & Priorities
People / Workforce	Monitor and provide assurance that workforce risks which threaten the achievement of the trust' strategic objectives are being identified and appropriately mitigated	Approval of: Gender Pay Gap Report Modern Slavery Statement WDES Submission WRES Submission
	Monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements	

WORKFORCE, EDUCATION & CULTURE COMMITTEE-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief People Officer / Group Director of Assurance

1.0 Purpose

1.1 The Workforce, Education & Culture Committee-in-Common is responsible for oversight of risks to the delivery of the Trust's People Strategy, associated plans and priorities which may impact on the health and wellbeing of the workforce and / or on the quality of care, for providing assurance to the trust board as to the effectiveness of the arrangements in place and / or for escalating risks to delivery.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Workforce, Education & Culture Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Workforce, Education & Culture Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Workforce, Education & Culture Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Workforce, Education & Culture Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Workforce, Education & Culture Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the '*Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Workforce, Education & Culture Committee-in-Common** is accountable to the NLaG Trust Board.

3.2 The **Workforce, Education & Culture Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

3.3 The **Workforce, Education & Culture Committee-in-Common** will receive a routine report from the sub-groups that report into it (as detailed within the work plan).

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's People Strategy and priorities and ensure that the People Strategy is aligned with the agreed strategic direction, culture, vision and values of the trust and wider group.

4.2 To provide input into and monitor delivery of the recruitment, retention, leadership, talent management & succession planning, training & organisational development and culture work programmes for the trust and wider group.

4.3 To monitor and provide assurance to the Trust Board that workforce risks which threaten the achievement of the strategic objectives of the trust and wider group and / or which may impact on the quality of care, are being identified and appropriately mitigated and / or to escalate concerns, as appropriate.

4.4 To monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements including but not limited to:

- Workforce Key Performance Indicators (KPIs)
    - Vacancies
    - Turnover
    - Sickness Absence
    - Mandatory Training
    - Appraisal
    - Temporary staffing / agency spend
    - Employee Relations / HR cases (e.g. disciplinaries, exclusions etc.)
- Staff Survey (local and national)
- Occupational Health & Wellbeing
- Staff Vaccination
- Registered Nurse & Midwifery Staffing
- Equality, Diversity & Inclusion
- Freedom to Speak Up
- Guardian of Safe Working

- Job Planning
- Medical Revalidation
- Gender Pay Gap
- WRES
- WDES
- Modern Slavery

4.5 To monitor education, training and learning activities ensuring that they comply with the required legal and mandated standards and support service development / transformation and evidence based practice.

4.6 To ensure that statutory workforce reporting requirements are met including escalation to the Trust Board for approval, as appropriate.

4.7 To support the development of emerging innovative roles.

4.8 To understand the workforce implications of service transformation and provide oversight of delivery of the agreed implementation plans.

4.9 To provide oversight of progress against the Trust's Research & Innovation Strategy and priorities.

4.10 To provide oversight of the Trust's arrangements for and monitor the progress of plans to improve staff engagement, communication and recognition.

4.11 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.12 To agree an annual work plan for the committee and monitor its delivery.

4.13 In summary, to cover the following areas of scope:

- Apprenticeships
- Clinical Education
- Culture, Vision & Values
- Education, Training & Development
- Employee Relations (including MHPS / other capability & conduct issues and exclusions)
- Equality, Diversity & Inclusion
- Freedom to Speak Up
- Gender Pay Gap
- Guardian of Safe Working
- Job Planning
- Leadership, Talent Management & Succession Planning
- Medical Revalidation

- Modern Slavery
- Nursing & Midwifery Staffing Report
- Occupational Health
- Occupational Health / Health & Wellbeing
- Organisational Development
- People Strategy & Delivery Plans
- Recruitment & Retention
- Research, Innovation & Continuous Improvement
- Staff Engagement, Communication & Recognition
- Staff Survey
- Staff Vaccination
- Workforce Finance (including temporary staffing / agency spend)
- Workforce Metrics
- Workforce Planning
- WRES / WDES

4.14 To agree at a high level the risks, controls and assurances provided by the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.15 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.16 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.17 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within NLaG, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief People Officer (lead group executive)

5.1.3 Group Chief Medical Officer (voting member)

5.1.4 Group Chief Nurse (voting member)

5.2 In Attendance (all meetings)

5.2.1 Group Director of Assurance or deputy

5.2.2 Governor Observer

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 North & South Bank Managing Directors

5.3.2 Other senior officers of the trust

5.3.3 Others Non-Executive / Associate Non-Executive Directors

5.3.4 Director of Post Graduate Medical Education

5.3.5 Director od Undergraduate Medical Education

5.3.6 Guardian of Safe Working

5.3.7 Freedom to Speak Up Guardian

5.3.8 Other Topic & Network Leads

5.3.9 The Chair & Chief Executive* and have a right of attendance and speaking rights

* In his absence, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 The Non-Executive Director member of the committee will be the chair of the **Workforce, Education & Culture Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the NED chairs of the respective **Workforce, Education & Culture Committees-in-Common** will alternate at each monthly meeting. Both NED chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second NED member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Workforce, Education & Culture Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one (voting) Non-Executive Director and two (voting) group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, voting members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No later papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Northern Lincolnshire and Goole NHS Foundation Trust

APPENDIX A

Decisions Delegated to the Workforce, Education & Culture Committee-in-Common

(NLaG)

Type of Decision	**Delegated to the Workforce, Education & Culture Committee-in-Common (NLaG)**	**Reserved for NLaG Board of Directors**
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the People Strategy, Delivery Plan & Priorities	Approval of People Strategy & Priorities
People / Workforce	Monitor and provide assurance that workforce risks which threaten the achievement of the trust' strategic objectives are being identified and appropriately mitigated	Approval of: Gender Pay Gap Report Modern Slavery Statement WDES Submission WRES Submission
	Monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements	

QUALITY & SAFETY COMMITTEE-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Nurse / Group Director of Assurance

1.0 Purpose

1.1 The purpose of the Quality & Safety Committee-in-Common is to provide oversight of and assurance to the trust board on the effectiveness of the quality governance arrangements in place across the clinical activities of the organisation in support of the provision of safe, effective and high-quality care and patient experience and / or to escalate risks to the achievement of that objective.

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Quality & Safety Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Quality & Safety Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Quality & Safety Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Quality & Safety Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Quality & Safety Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Quality & Safety Committee-in-Common** is accountable to the HUTH Trust Board.

3.2 The **Quality & Safety Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

3.3 The **Quality & Safety Committee-in-Common** will receive a routine report from the sub-groups that report into it.

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's quality strategy, priorities and key performance indicators (KPIs).

4.2 To provide oversight of the development and monitor delivery of other relevant strategies as delegated by the Trust Board to the committee.

4.3 To provide oversight of the development of the Trust's Annual Quality Report / Account in readiness for approval by the Trust Board and ensure that shared learning from the previous years' activities is disseminated throughout the trust and wider group.

4.4 To monitor and provide assurance to the Trust Board that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. *[Whilst the committee's remit covers all the trust's services, the committee has a specific oversight role in respect of the quality & safety of the Trust's maternity & neonatal services.]*

4.5 To assure the Trust Board that, where there are risks and issues that might jeopardise the Trust's ability to deliver excellent quality care, these risks and issues are being managed in a controlled and timely way.

4.6 To receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality and safety.

4.7 To maintain an overview of safe staffing and its impact on quality & safety.

4.8 To monitor information from adverse incidents, claims and concerns / complaints and other feedback received from patients / service users to demonstrate that the Trust is learning and making improvements.

4.9 To assure the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety and is responding appropriately to and learning from national and national reviews and other sources e.g. CQC, NHSE, royal colleges, NHS resolution, internal and external audit, Coroner etc.

4.10 To review and monitor clinical outcomes including but not limited to review of:

- clinical audit outcomes (and to approve the annual clinical audit programme);
- compliance with NICE guidance (and to approve any deviations from NICE guidance);
- outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths.

4.11 To understand themes/trends presenting in respect of patient safety and quality risks and to seek assurance on the control of those risks.

4.12 To utilise intelligence to identify where there are gaps in controls i.e. CQC Key Lines of Enquiry or Business Intelligence Software.

4.13 To initiate corrective action where gaps in the control of patient safety and quality risks are identified and monitor delivery of the agreed improvements. This will include requests for 'deep dives' and / or referral to another board committee for consideration.

4.14 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.15 To ensure that the trust continues to fulfil any requirements as determined by the CQC and other regulators and to provide assurance to the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety.

4.16 To review and approve annual reports, policies, procedures, guidelines and other documents (and any subsequent changes to those documents) which are applicable to the Trust's quality, patient safety and patient safety agenda and / or recommend their approval to the Trust Board.

4.17 To receive reports and/or minutes from the relevant reporting groups and meetings for monitoring and assurance purposes; ensuring action or decisions are made as and when identified.

4.18 To agree an annual work plan and monitor its delivery.

4.19 In summary, to cover the following areas of scope:

- Children & Young People
- Clinical Audit
- Clinical Effectiveness
- Clinical Harm
- Clinical strategy
- CQC / Regulatory Compliance
- CQUINS
- Deep Dives (Various Topics)
- Diabetes
- End of Life
- External Visits
- Infection Prevention & Control
- Maternity & Neonatal Safety (including CNST MIS, Ockenden)
- MCA & DoLS
- Medicines Safety & Optimisation
- MHA

- Mortality & Learning from Deaths
- NICE
- Nursing Assurance (Ward Accreditation: Fundamental Standards, IPC, Safe Staffing)
- Patient Experience
- Patient Safety including learning from incidents / DoC
- Pressure Ulcers
- PSIRF / Serious Incidents
- QIA
- Quality Strategy, Quality Account & Quality priorities
- Research & Innovation
- Safe Staffing
- Safeguarding
- Workforce (quality impact)

4.20 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.21 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.22 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.23 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within HUTH, in accordance with the schedule at Appendix A.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Nurse

5.1.3 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Clinical Governance

5.2.2 Group Director of Assurance or deputy

5.2.3 Patient participation / service user voice representative

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Group Chief Clinical Design Officer

5.3.2 North & South Bank Managing Directors

5.3.3 Other senior officers of the trust

5.3.4 Other Non-Executive / Associate Non-Executive Directors

5.3.5 Care Group Triumvirates

5.3.6 Research & Development Managers

5.3.7 ICB Observer Representative(s) (open invitation)

5.3.8 CQC (open invitation)

5.3.9 The Chair & Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Quality & Safety Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the Non-Executive Director chairs of the respective Quality & Safety Committees-in-Common will alternate at each monthly meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Quality & Safety Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Hull University Hospital NHS Trust

APPENDIX A

Decisions Delegated to the Quality & Safety Committee-in-Common (HUTH)

Type of Decision	Delegated to the Quality & Safety Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Quality Strategy & Priorities	Approval of Quality Strategy & Priorities Approval of Annual Quality Account
	Monitor the development and delivery of other relevant strategies	Approval of: Clinical Strategy Mental Health Strategy Quality Improvement Strategy Research, Development & Innovation Strategy
Quality & Safety / Patient Experience / Clinical Outcomes	Monitor and provide assurance that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated	Approval of Changes to the CQC Statement of Purpose
	Review and endorse changes to the CQC Statement of Purpose	Assurance in respect of the safety of the Trust's Maternity & Neonatal Services Approval of CNST Maternity Improvement
	Monitor and provide assurance on the safety of the Trust's services including Maternity & Neonatal Services	

Type of Decision	Delegated to the Quality & Safety Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
		Scheme (MIS) Submission
	Approval of relevant quality & safety annual reports e.g. safeguarding, infection control, medicines management	
	Monitor and provide assurance in respect of safe staffing and the impact on quality & safety	Approval of the recommendations from the Safe Staffing Review

QUALITY & SAFETY COMMITTEE-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Nurse / Group Director of Assurance

1.0 Purpose

1.1 The purpose of the Quality & Safety Committee-in-Common is to provide oversight of and assurance to the trust board on the effectiveness of the quality governance arrangements in place across the clinical activities of the organisation in support of the provision of safe, effective and high-quality care and patient experience and / or to escalate risks to the achievement of that objective.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Quality & Safety Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Quality & Safety Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Quality & Safety Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Quality & Safety Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Quality & Safety Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the '*Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Quality & Safety Committee-in-Common** is accountable to the NLaG Trust Board.

3.2 The **Quality & Safety Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

3.3 The **Quality & Safety Committee-in-Common** will receive a routine report from the sub-groups that report into it.

4.0 Responsibilities

4.1 To provide oversight of the development and monitor delivery of the Trust's quality strategy, priorities and key performance indicators (KPIs).

4.2 To provide oversight of the development and monitor delivery of other relevant strategies as delegated by the Trust Board to the committee.

4.3 To provide oversight of the development of the Trust's Annual Quality Report / Account in readiness for approval by the Trust Board and ensure that shared learning from the previous years' activities is disseminated throughout the trust and wider group.

4.4 To monitor and provide assurance to the Trust Board that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. *[Whilst the committee's remit covers all the trust's services, the committee has a specific oversight role in respect of the quality & safety of the Trust's maternity & neonatal services.]*

4.5 To assure the Trust Board that, where there are risks and issues that might jeopardise the Trust's ability to deliver excellent quality care, these risks and issues are being managed in a controlled and timely way.

4.6 To receive assurance that the Trust's Cost Improvement Programme is not adversely impacting on quality and safety.

4.7 To maintain an overview of safe staffing and its impact on quality & safety.

4.8 To monitor information from adverse incidents, claims and concerns / complaints and other feedback received from patients / service users to demonstrate that the Trust is learning and making improvements.

4.9 To assure the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety and is responding appropriately to and learning from national and national reviews and other sources e.g. CQC, NHSE, royal colleges, NHS resolution, internal and external audit, Coroner etc.

4.10 To review and monitor clinical outcomes including but not limited to review of:

- clinical audit outcomes (and to approve the annual clinical audit programme);
- compliance with NICE guidance (and to approve any deviations from NICE guidance);
- outcomes, themes and trends from mortality reviews and to receive assurance on meeting national guidance on Learning from Deaths.

4.11 To understand themes/trends presenting in respect of patient safety and quality risks and to seek assurance on the control of those risks.

4.12 To utilise intelligence to identify where there are gaps in controls i.e. CQC Key Lines of Enquiry or Business Intelligence Software.

4.13 To initiate corrective action where gaps in the control of patient safety and quality risks are identified and monitor delivery of the agreed improvements. This will include requests for 'deep dives' and / or referral to another board committee for consideration.

4.14 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

4.15 To ensure that the trust continues to fulfil any requirements as determined by the CQC and other regulators and to provide assurance to the Trust Board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality & safety.

4.16 To review and approve annual reports, policies, procedures, guidelines and other documents (and any subsequent changes to those documents) which are applicable to the Trust's quality, patient safety and patient safety agenda and / or recommend their approval to the Trust Board.

4.17 To receive reports and/or minutes from the relevant reporting groups and meetings for monitoring and assurance purposes; ensuring action or decisions are made as and when identified.

4.18 To agree an annual work plan and monitor its delivery.

4.19 In summary, to cover the following areas of scope:

- Children & Young People
- Clinical Audit
- Clinical Effectiveness
- Clinical Harm
- Clinical strategy
- CQC / Regulatory Compliance
- CQUINS
- Deep Dives (Various Topics)
- Diabetes
- End of Life
- External Visits
- Infection Prevention & Control
- Maternity & Neonatal Safety (including CNST MIS, Ockenden)
- MCA & DoLS
- Medicines Safety & Optimisation
- MHA
- Mortality & Learning from Deaths
- NICE

- Nursing Assurance (Ward Accreditation: Fundamental Standards, IPC, Safe Staffing)
- Patient Experience
- Patient Safety including learning from incidents / DoC
- Pressure Ulcers
- PSIRF / Serious Incidents
- QIA
- Quality Strategy, Quality Account & Quality priorities
- Research & Innovation
- Safe Staffing
- Safeguarding
- Workforce (quality impact)

4.20 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.21 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.22 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.23 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within NLaG, in accordance with the schedule at Appendix A.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Nurse

5.1.3 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Clinical Governance

5.2.2 Group Director of Assurance or deputy

5.2.3 Governor Observer

5.2.4 Patient Participation / Service User Voice Representative(s)

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Group Chief Clinical Design Officer

5.3.2 North & South Bank Managing Directors

5.3.3 Other senior officers of the trust

5.3.4 Other Non-Executive Directors

5.3.5 Care Group Triumvirates

5.3.6 Research & Development Managers

5.3.7 ICB Observer Representative(s) (open invitation)

5.3.8 CQC (open invitation)

5.3.9 The Chair & Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 The Non-Executive Director members of the committee will be the chair of the **Quality & Safety Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the Non-Executive Director chairs of the respective Quality & Safety Committees-in-Common will alternate at each monthly meeting. Both NED chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Quality & Safety Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one Non-Executive Director and two group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Northern Lincolnshire and Goole NHS Foundation Trust

APPENDIX A

Decisions Delegated to the Quality & Safety Committee-in-Common (NLaG)

Type of Decision	Delegated to the Quality & Safety Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Quality Strategy & Priorities	Approval of Quality Strategy & Priorities Approval of Annual Quality Account
	Monitor the development and delivery of other relevant strategies	Approval of: Clinical Strategy Mental Health Strategy Quality Improvement Strategy Research, Development & Innovation Strategy
Quality & Safety / Patient Experience / Clinical Outcomes	Monitor and provide assurance that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated	Approval of Changes to the CQC Statement of Purpose
	Review and endorse changes to the CQC Statement of Purpose	Assurance in respect of the safety of the Trust's Maternity & Neonatal Services Approval of CNST Maternity Improvement
	Monitor and provide assurance on the safety of the Trust's services including Maternity & Neonatal Services	

Type of Decision	Delegated to the Quality & Safety Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
		Scheme (MIS) Submission
	Approval of relevant quality & safety annual reports e.g. safeguarding, infection control, medicines management	
	Monitor and provide assurance in respect of safe staffing and the impact on quality & safety	Approval of the recommendations from the Safe Staffing Review

PERFORMANCE, ESTATES & FINANCE COMMITTEE-IN-COMMON (HUTH)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Financial Officer / Group Director of Assurance

1 Purpose

1.1 The committee is responsible for oversight of risks to the delivery of financial and operational performance and estates & facilities targets and priorities and for providing assurance to the trust board as to the effectiveness and sustainability of the arrangements in place and / or for escalating risks to delivery.

2 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Performance, Estates & Finance Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Performance, Estates & Finance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Performance, Estates & Finance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Performance, Estates & Finance Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Performance, Estates & Finance Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation'* are set out in **Appendix A**.

3 Accountability & Reporting Arrangements

3.1 The Performance, Estates & Finance Committee-in-Common is accountable to the HUTH Trust Board.

3.2 The Performance, Estates & Finance Committee-in-Common will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

4 Responsibilities

Strategy

4.1 To provide oversight of the development and monitor delivery of the Trust's financial strategy.

Financial and Operational Performance (NHS Constitutional Standards)

4.2 To review and challenge construction of operational and financial plans for the planning period as defined by the regulator.

4.3 To seek assurance that the organisation has in place robust and effective operational planning arrangements (including capacity & demand planning) to delivery contract levels of activity.

4.4 To review, challenge and monitor in-year financial and operational performance including but not limited to the delivery of access targets.

4.5 To oversee the development and delivery of any corrective improvement plans where performance may deviate from agreed trajectories and advise the Trust Board accordingly on these plans and any risks to delivery.

4.6 To review the plans for winter and make recommendations to the Trust Board. To monitor delivery of the agreed plans.

4.7 To review and support the development of operational performance and finance key performance indicators (KPIs), and associated reporting and escalation to inform the organisation and assure the Trust Board.

4.8 To consider loan applications prior to referral to the Trust Board for approval.

4.9 To refer issues to other committees for consideration, as appropriate, including where matters for which the committee has oversight have the potential to adversely impact on other areas of trust business e.g. quality & safety, workforce etc.

Business Planning

4.10 To approve the annual business planning timetable.

Procurement

4.11 To provide oversight and assurance on procurement processes and performance.

Estates, Facilities and Sustainability

4.12 To review the delivery of the Trust's estates strategy & priorities.

4.13 To consider initiatives and review proposals for land and property development and transactions prior to submission to the Trust Board for approval.

4.14 To receive and consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan.

4.15 To receive an annual update on the Trust's sustainability measures to achieve the Governments Net Zero target.

Cost Improvement Plans

4.16 To oversee the development and delivery of the Trust's cost improvement plans and associated efficiency and productivity programmes.

CQC Improvement Actions

4.17 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

Risk & Assurance

4.18 To monitor and provide assurance to the Trust Board that financial & operational performance and estates risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. To recommend appropriate responses and mitigation for such risks.

4.19 To review and approve policies and other documents relevant to the work of the committee and / or endorse such documents for approval by the Trust Board.

4.20 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.21 To agree an annual work plan and monitor its delivery.

4.22 In summary, to cover the following areas of scope:

- Budgetary Management
- Contract management
- Cost Efficiency & Improvement
- Debt Management
- Estates, Facilities & Sustainability including Green, Carbon & Travel Plans
- Financial & Operational Performance
- Financial Planning
- Financial Strategy
- Fire Safety
- Health & Safety
- Operational Planning
- Procurement (Strategy & Improvement Plan)

- Revenue Business Cases
- Security Management
- Winter Planning

4.23 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.24 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.25 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within HUTH, in accordance with the schedule at Appendix A.

5 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Delivery Officer

5.1.4 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Digital Information Officer

5.2.3 Group Director of Assurance or deputy

5.2.4 Deputy Director of Finance

5.2.5 Operational Director of Finance

5.3 In Attendance (as required / the agenda dictates)

5.3.1 Group Director of Transformation

5.3.2 Group Chief Strategy & Partnerships Officer

5.3.3 Other senior officers of the trust

5.3.4 Other Non-Executive Directors / Associate Non-Executive Directors

5.3.5 Care Group Triumvirates

5.3.6 The Chair and Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Performance, Estates & Finance Committee-in-Common.** In line with agreed CiC principles agreed between HUTH and NLaG, the Non-Executive Director chairs of the respective **Performance, Estates & Finance Committees-in-Common** will alternate at each monthly meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Performance, Estates & Finance Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

APPENDIX A

Decisions Delegated to the Performance, Estates & Finance Committee-in-Common (HUTH)

Type of Decision	Delegated to the Performance, Estates & Finance Committee-in-Common (HUTH)	Reserved for HUTH Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Financial Strategy & Priorities	Approval of Financial Strategy & Priorities
	Monitor the development and delivery of the Estates Strategy, Priorities & Associated Plans	Approval of Estates Strategy & Priorities Approval of Green Carbon & Travel Plans
Estates & Facilities	Monitor and provide assurance that estates & facilities risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated – includes risks associated with the ageing estate	Approval of Premises Assurance Model Submission & Improvement Plan
	Consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan	
Financial & Operational Performance	Approve the annual business planning timetable Monitor and provide assurance to the Trust Board that financial & operational performance risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. Recommend appropriate responses and mitigation for such risks.	Approval of Annual Plan: Operational & Financial Plan Approval of Winter Plan

Procurement	Monitor and approve procurement contracts and contract extensions in accordance with the limits set out in the Scheme of Delegation (and / or endorse for Trust Board approval) and receive assurance in respect of procurement processes, improvement and performance / KPIs.	Approval of Contracts and Contract Extensions in accordance with the limits set out in the Scheme of Delegation

PERFORMANCE, ESTATES & FINANCE COMMITTEE-IN-COMMON (NLAG)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
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Result of last review:	<Document Control use only>
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Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Financial Officer / Group Director of Assurance

1.0 Purpose

1.1 The committee is responsible for oversight of risks to the delivery of financial and operational performance and estates & facilities targets and priorities and for providing assurance to the trust board as to the effectiveness and sustainability of the arrangements in place and / or for escalating risks to delivery.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Performance, Estates & Finance Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Performance, Estates & Finance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Performance, Estates & Finance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Performance, Estates & Finance Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Performance, Estates & Finance Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the '*Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The Performance, Estates & Finance Committee-in-Common is accountable to the NLaG Trust Board.

3.2 The Performance, Estates & Finance Committee-in-Common will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

4.0 Responsibilities

Strategy

4.1 To provide oversight of the development and monitor delivery of the Trust's financial strategy.

Financial and Operational Performance (NHS Constitutional Standards)

4.2 To review and challenge construction of operational and financial plans for the planning period as defined by the regulator.

4.3 To seek assurance that the organisation has in place robust and effective operational planning arrangements (including capacity & demand planning) to deliver contract levels of activity.

4.4 To review, challenge and monitor in-year financial and operational performance including but not limited to the delivery of access targets.

4.5 To oversee the development and delivery of any corrective improvement plans where performance may deviate from agreed trajectories and advise the Trust Board accordingly on these plans and any risks to delivery.

4.6 To review the plans for winter and make recommendations to the Trust Board. To monitor delivery of the agreed plans.

4.7 To review and support the development of operational performance and finance key performance indicators (KPIs), and associated reporting and escalation to inform the organisation and assure the Trust Board.

4.8 To consider loan applications prior to referral to the Trust Board for approval.

4.9 To refer issues to other committees for consideration, as appropriate, including where matters for which the committee has oversight have the potential to adversely impact on other areas of trust business e.g. quality & safety, workforce etc.

Business Planning

4.10 To approve the annual business planning timetable.

Procurement

4.11 To provide oversight and assurance on procurement processes and performance.

Estates, Facilities and Sustainability

4.12 To review the delivery of the Trust's estates strategy & priorities.

4.13 To consider initiatives and review proposals for land and property development and transactions prior to submission to the Trust Board for approval.

4.14 To receive and consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan.

4.15 To receive an annual update on the Trust's sustainability measures to achieve the Governments Net Zero target.

Cost Improvement Plans

4.16 To oversee the development and delivery of the Trust's cost improvement plans and associated efficiency and productivity programmes.

CQC Improvement Actions

4.17 To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions.

Risk & Assurance

4.18 To monitor and provide assurance to the Trust Board that financial & operational performance and estates risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. To recommend appropriate responses and mitigation for such risks.

4.19 To review and approve policies and other documents relevant to the work of the committee and / or endorse such documents for approval by the Trust Board.

4.20 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.21 To agree an annual work plan and monitor its delivery.

4.22 In summary, to cover the following areas of scope:

- Budgetary Management
- Contract management
- Cost Efficiency & Improvement
- Debt Management
- Estates, Facilities & Sustainability including Green, Carbon & Travel Plans
- Financial & Operational Performance
- Financial Planning
- Financial Strategy
- Fire Safety
- Health & Safety
- Operational Planning
- Procurement (Strategy & Improvement Plan)

- Revenue Business Cases
- Security Management
- Winter Planning

4.23 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.24 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.25 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board and other groups within NLaG, in accordance with the schedule at Appendix A.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Delivery Officer

5.1.4 Group Chief Medical Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Digital Information Officer

5.2.3 Group Director of Assurance or deputy

5.2.4 Deputy Director of Finance

5.2.5 Operational Director of Finance

5.2.6 Governor Observer

5.3 In Attendance (as required / the agenda dictates)

5.3.1 Group Director of Transformation

5.3.2 Group Chief Strategy & Partnerships Officer

5.3.3 Other senior officers of the trust

5.3.4 Other Non-Executive / Associate Non-Executive Directors

5.3.5 Care Group Triumvirates

5.3.6 The Chair and Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1.1 Frequency of Meetings

6.1.2 Meetings will be held monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Performance, Estates & Finance Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the Non-Executive Director chairs of the respective **Performance, Estates & Finance Committees-in-Common** will alternate at each monthly meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Performance, Estates & Finance Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the five core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted on the day of the meeting without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within 2 working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agreed actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

APPENDIX A

Decisions Delegated to the Performance, Estates & Finance Committee-in-Common (NLaG)

Type of Decision	Delegated to the Performance, Estates & Finance Committee-in-Common (NLaG)	Reserved for NLaG Board of Directors
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board	
	Investigating or having investigated and / or to seek further action or assurance in relation to any activity within the terms of reference	
Strategy	Monitor the development and delivery of the Financial Strategy & Priorities	Approval of Financial Strategy & Priorities
	Monitor the development and delivery of the Estates Strategy, Priorities & Associated Plans	Approval of Estates Strategy & Priorities Approval of Green Carbon & Travel Plans
Estates & Facilities	Monitor and provide assurance that estates & facilities risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated – includes risks associated with the ageing estate	Approval of Premises Assurance Model Submission & Improvement Plan
	Consider the outcome of the Trust's annual self-assessment of compliance against the Premises Assurances Model (PAM) and to monitor the pace and progress of delivery of the resultant improvement plan	
Financial & Operational Performance	Approve the annual business planning timetable Monitor and provide assurance to the Trust Board that financial & operational performance risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate. Recommend appropriate responses and mitigation for such risks	Approval of Annual Plan: Operational & Financial Plan Approval of Winter Plan

Procurement	Monitor and approve procurement contracts and contract extensions in accordance with the limits set out in the Scheme of Delegation (and / or endorse for Trust Board approval) and receive assurance in respect of procurement processes, improvements and performance / KPIs.	Approval of Contracts & Contract Extensions in accordance with the limits set out in the Scheme of Delegation

Hull University Teaching Hospitals NHS Trust

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	DCT302HU
Version:	1.0
This version issued:	~~18/03/24~~
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Approving body:	Group Trust Board
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Owner:	Sean Lyons, Group Chair
Document type:	Terms of Reference
Number of pages:	17 (including front sheet)
Author / Contact:	Lee Bond, Group Chief Financial Officer / David Sharif, Group Director of Assurance

1.0 Purpose

1.1 The role of the **Audit, Risk & Governance Committee-in-Common** is to review the establishment and maintenance of the Trust's systems of internal governance, risk management and internal control and for providing assurance to the Trust Board as to the effectiveness of those arrangements and / or for escalating risk issues.

1.2 These terms of reference have been produced in line with guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024).

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has established a committee to be known at the **Audit, Risk & Governance Committee-in-Common**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Audit, Risk & Governance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Audit, Risk & Governance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Audit, Risk & Governance Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The **Audit, Risk & Governance Committee-in-Common** is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee. The committee is also authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

~~**2.7** The full schedule of decisions delegated to the **Audit, Risk & Governance Committee-in-Common** and those which are reserved to the Trust Board of HUTH, in accordance with the 'Trust Scheme of Delegation' are set out in **Appendix A.**~~

3.0 Accountability & Reporting Arrangements

3.1 The **Audit, Risk & Governance Committee-in-Common** is accountable to the HUTH Trust Board and shall report to the board on how it discharges its responsibilities.

3.2 The minutes of each meeting shall be submitted to the next meeting for formal approval as a true record of that meeting. The approved minutes will be submitted to the next meeting of the board for information.

3.3 The **Audit, Risk & Governance Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting highlighting issues that require disclosure to the board or require executive action.

3.4 The committee shall report to the board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the effectiveness of governance arrangements, the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

3.5 The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

4.0 Responsibilities

4.1 The specific duties & responsibilities of the committee are categorised as follows:

4.2 Governance, Risk Management and Internal Control

4.2.1 The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

4.2.2 In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of

Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board.

- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance, NHS Provider Licence and Fit and Proper Person Test.

- The organisations policy (Standards of Business Conduct Policy), systems and processes for the management of conflicts (including gifts and hospitality and bribery) to satisfy itself they are effective, including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

4.2.3 In carrying out this work the committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.2.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2.5 As part of its integrated approach, the committee will have effective relationships with other Trust Board committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other committee's governance of risk. This will include the exchange of their chair's action trackers and highlight reports to the Trust Board.

4.3 Internal Audit

4.3.1 The committee shall assure itself that there is an effective internal audit function that meets Public Sector Internal Audit Standards (PSIAS) and provides independent assurance to the committee, Chief Executive and board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.

- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, ~~that~~ which is consistent

with the audit needs of the Trust as identified in the assurance framework.

- Considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.

- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the committee can request the relevant operational manager to attend a meeting and give explanation.

- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.

- Reviewing the Internal Auditor's annual report.

- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with PSIAS.

4.4 External Audit

4.4.1 The committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Recommending to the Trust Board the appointment of the External Auditor. The committee will act as the Auditor Panel, as per the Trust's Standing Financial Instructions. The Auditor Panel's function is to oversee the selection and appointment of the External Auditor by agreeing and overseeing a robust procurement process, making a recommendation to the Board and ensuring any conflicts of interest are dealt with effectively. It will also advise the Board on any decision involving the removal or resignation of the External Auditor.

- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.

- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.

- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Reviewing and monitoring the External Auditor's independence and objectivity and the effectiveness of the audit process.

- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

4.5 Financial Reporting

4.5.1 The committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

4.5.2 The committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

4.5.3 The committee shall review the annual report and financial statements before submission to the board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the committee.

- Changes in, and compliance with, accounting policies, practices and estimation techniques.

- Unadjusted misstatements in the financial statements.

- Significant judgements in preparation of the financial statements.

- Significant adjustments resulting from the audit.

- Letters of representation.

- Explanations for significant variances.

4.6 Risk Management

4.6.1 The committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies.

- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks.

- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources.

- Providing the Board with assurance over developing partnership arrangements (e.g., integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work together to meet joint financial objectives and duties, and as such the Audit Committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the Audit Committee will need and where these will come from.

4.7 The Board will however retain the responsibility for routinely reviewing specific risks.

4.8 Counter Fraud

4.8.1 The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

4.9 System for Raising Concerns

4.9.1 The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensures that any such concerns are investigated proportionately and independently and in line with relevant policies.

4.9.2 The trust's Freedom to Speak Up Guardian, or his or her nominated deputy shall attend the committee at least annually to provide assurance on the design and operation of the function.

4.10 Management

4.10.1 The committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

4.10.2 The committee may also request specific reports from individual functions within the organisation (e.g., compliance reviews or accreditation reports).

4.11 Other Assurance Functions

4.11.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation . These may include, but

will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

4.11.2 In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the committee's own areas of responsibility. In particular this will include any committees covering safety / quality, for which assurance from clinical audit can be assessed, and risk management . The committee shall receive the action trackers and highlight reports to the Trust Board of the following Board committees for information:

- Performance, Estates & Finance Committees-in-Common
- Quality and Safety Committees-in-Common
- Workforce, Education & Culture Committees-in-Common
- Health Tree Foundation Trustees' Committee
- Capital & Major Projects Committees-in-Common
- Remuneration Committees-in-Common – Annual Summary report only
- Ethics Committee (when in operation)

4.11.3 The committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters.

4.11.4 The committee will receive the Board Assurance Framework (BAF) and the High-Level Risk Register ~~annually~~ on a routine basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

4.11.5 The committee will ensure escalation of issues requiring action or decision by the Trust Board or other groups within HUTH, as appropriate~~, in accordance with the schedule at **Appendix A**~~.

4.12 Summary Scope

4.12.1 In summary, to cover the following areas of scope:

- Annual Report and Accounts / Annual Governance Statement
- Counter Fraud
- Data Quality
- Debt Management
- Document Control
- Engagement of External Audit for Non-Audit Work
- Emergency Preparedness Resilience & Response and Business Continuity
- Financial Reporting and Control

- Freedom to Speak Up (Annual Review of Arrangements)
- Going Concern Review
- Governance / Risk
- Information Governance (IG) / IG Toolkit / Cyber Security
- Internal Audit / External Audit
- Losses and Compensation
- Management and Internal Control Systems
- Oversight of Work of Other Board Committees
- Procurement Key Performance Indicators
- Salary Over / Under Payments
- Standards of Business Conduct
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Waiving Standing Orders

5.0 Membership

5.1 Core Membership

5.1.1 The committee shall be appointed by the board from amongst its independent, Non-Executive Directors and shall consist of not less than three members (including the committee chair). One of the members shall have recent relevant financial experience.

5.1.2 The chair of the Trust and the Group Chief Executive shall not be ~~a~~ members of the committee. However, they may be invited to attend a meeting by the committee chair – see 5.3.1.

5.2 In Attendance (all meetings)

5.2.1 The following shall normally attend meetings:

- Group Chief Financial Officer
- ~~Group Chief Executive~~
- Group Director of Assurance
- Internal Audit Representative(s)
- External Audit representative(s)

5.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 At the invitation of the committee chair, the Trust Chair and Group Chief Executive may attend meetings. The Trust Chair (or Vice Chair) may attend to ensure that the committee is operating as expected and that the non-executives

are carrying out their tasks appropriately. The Group Chief Executive would be expected to attend for items around the annual report and accounts, including the Annual Governance Statement, for which they are directly accountable. ~~The Group Chair should be invited to attend and should discuss at least annually with the Audit, Risk & Governance Committee-in-Common the process of assurance that supports the Annual Governance Statement.~~

5.3.2 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.3 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above, particularly when the committee is discussing areas of risk or operation that are the responsibility of that individual. Such attendance will normally be for their items(s) only.

5.3.4 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

5.3.5 At least once a year, usually at its Audited Accounts meeting, members of the committee shall meet privately with the External and Internal Auditors, either separately or together. Other meetings will take place at the request of members or auditors. The Head of Internal Audit and representatives from External Audit and the Local Counter Fraud Specialist have a right of direct access to the chair of the committee.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 The committee will normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual work plan. Where required and in agreement with the committee chair and executive lead for the committee, additional meetings may be convened to consider matters that require urgent attention. The committee will review the meeting schedule annually.

6.1.2 The committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout the year as the committee sees fit. Ad-hoc reports, in addition to those set out in its workplan, may also be requested by the committee as necessary.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of each committee will be the chair of the respective committee and jointly chair the **Audit, Risk & Governance Committee-in-Common.** [In line with agreed CiC principles agreed between HUTH and NLaG both Non-Executive Director chairs will attend the agenda setting meeting with the lead group executive for the committee and will both

sign off the content of the combined highlight / escalation reports to the boards. In the absence of one or both Non-Executive Director chairs, the vice chair Non-Executive Director member(s) of the committee of the respective trust(s) will jointly chair the meeting.]

6.3 Secretary

6.3.1 The **Audit, Risk & Governance Committee-in-Common** will be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include agreement of agenda's with both chairs of the committee; ensuring papers are collated and circulated in good time; that those invited to each meeting attend; maintaining the action tracker; preparing the draft highlight / escalation reports for review and agreement by both chairs; advising the committees on pertinent issues / areas of interest and enabling the development and training of committee members.

6.3.2 Secretarial support for the taking and production of minutes will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members and regular attendees (as listed at 5.2) is required at a minimum 75% of meetings.

6.4.2 In the absence of group executive regular attendees, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 A quorum shall be two of the three members.

6.5.2 A quorum must be maintained at all meetings.

6.5.3 If quoracy cannot be achieved from the committee members, and the reason for lack of quoracy is short term and the papers have already been read, other Non-Executive Directors can be invited to attend for a single meeting (excluding the Trust Chair) or the meeting can go ahead and any actions or decisions (dependent upon the nature) could be ratified at the next meeting, or by the next Trust Board.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will see to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No later papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 In addition to the circulation of minutes, the 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.3 Minutes of meetings, once approved as true and accurate by the committee, will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation / self-assessment of its performance and attendance levels.

6.8.2 A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference and is based on the good practice guide found in the HFMA Audit Committee Handbook **(Appendix A refers)**, will be used for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.3 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties. The committee will recommend any changes to the Trust Board for approval.

Appendix A

HFMA NHS Audit Committee Handbook Extract (2024)

This checklist can be completed by the secretary to the committee, along with the chair of the committee, and the results shared with the whole committee. The value of this checklist is that it should be a simple (yes /no) check against the standard requirement. Where the answer is 'no' then the committee should consider whether it should comply (or explain why not).

Area/ Question	Yes	No	Comments/Action
1.0 Composition, establishment and duties			
1.1 Does the audit committee have written terms of reference and have they been approved by the governing body?			
1.2 Are the terms of reference reviewed annually?			
1.3 Has the committee formally considered how it integrates with other committees that are reviewing risk?			
1.4 Are committee members independent of the management team?			
1.5 Does at least one committee member have a financial background?			
1.6 Are all executive officers that you would expect to attend present at meetings?			New question 2024
1.7 Are the outcomes of each meeting and any internal control issues reported to the next governing body meeting?			
1.8 Does the committee prepare an annual report on its work and performance for the governing body?			
1.9 Has the committee established a plan of matters to be dealt with across the year?			

1.10 Are committee papers distributed in sufficient time for members to give them due consideration?			
1.11 Has the committee been quorate for each meeting this year?			
1.12 Is there a succession plan in place for the chair of the audit committee?			New question 2024
1.13 Are there clear arrangements in place in terms of how the committee works within the integrated care system?			New question 2024
2.0 Internal control and risk management			
2.1 Has the committee reviewed the effectiveness of the organisation's risk management framework?			New question 2024
2.2 Has the committee reviewed the effectiveness of the organisation's assurance framework?			
2.3 Does the committee receive and review the evidence required to demonstrate compliance with regulatory requirements - for example, as set by the Care Quality Commission?			
2.4 Has the committee reviewed the accuracy of the draft annual governance statement?			
2.5 Has the committee reviewed key data against the data quality dimensions?			
3.0 Annual report and accounts and disclosure statements			
3.1 Does the committee receive and review a draft of the organisation's annual report and accounts?			
3.2 Does the committee specifically review: • changes in accounting policies			

• changes in accounting practice due to changes in accounting standards • changes in estimation techniques • significant judgements made in preparing the accounts • the going concern assessment • significant adjustments resulting from the audit • explanations for any significant variances?			
3.3 Is a committee meeting scheduled to discuss any proposed adjustments to the accounts and audit issues?			
3.4 Does the committee ensure that it receives explanations for any unadjusted errors in the accounts found by the external auditors?			
4.0 Internal audit			
4.1 Is there a formal 'charter' or terms of reference, defining internal audit's objectives and responsibilities?			
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4.3 Is the committee confident that the audit plan is derived from a clear risk assessment process?			
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5.3 Does the committee review the external auditor's ISA 260 report (the report to those charged with governance)?			
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5.9 Has the committee approved a policy to govern the value and nature of non-audit work carried out by the external auditors?			
6.0 Clinical audit [Note: this section is only relevant for providers]			
6.1 If the committee is not responsible for monitoring clinical audit, does it receive appropriate assurance from the relevant committee?			
7.0 Counter fraud			
7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?			
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
7.3 Does the audit committee receive periodic reports about counter fraud activity?			
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
7.6 Does the committee receive and review an annual report on counter fraud activity?			
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

Northern Lincolnshire and Goole NHS Foundation Trust

AUDIT, RISK & GOVERNANCE COMMITTEES-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	DCT302
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Number of pages:	18 (including front sheet)
Author / Contact:	Lee Bond, Group Chief Financial Officer / David Sharif, Group Director of Assurance

1.0 Purpose

1.1 The role of the **Audit, Risk & Governance Committee-in-Common** is to review the establishment and maintenance of the Trust's systems of internal governance, risk management and internal control and for providing assurance to the Trust Board as to the effectiveness of those arrangements and / or for escalating risk issues.

1.2 These terms of reference have been produced in line with guidance contained within the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook (2024).

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has established a committee to be known at the **Audit, Risk & Governance Committee-in-Common**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Audit, Risk & Governance Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Audit, Risk & Governance Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Audit, Risk & Governance Committee-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The **Audit, Risk & Governance Committee-in-Common** is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the committee. The committee is also authorised by the board to obtain outside legal advice or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

~~**2.7** The full schedule of decisions delegated to the **Audit, Risk & Governance Committee-in-Common** and those which are reserved to the Trust Board of NLaG, in accordance with the 'Trust Scheme of Delegation and Powers Reserved for the Trust Board' are set out in **Appendix A**.~~

3.0 Accountability & Reporting Arrangements

3.1 The **Audit, Risk & Governance Committee-in-Common** is accountable to the NLaG Trust Board and shall report to the board on how it discharges its responsibilities.

3.2 The minutes of each meeting shall be submitted to the next meeting for formal approval as a true record of that meeting. The approved minutes will be submitted to the next meeting of the board for information.

3.3 The **Audit, Risk & Governance Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting highlighting issues that require disclosure to the board or require executive action.

3.4 The committee shall report to the board annually on its work in support of the Annual Governance Statement specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the effectiveness of governance arrangements, the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

3.5 The annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. The report will also outline its workplan for the coming year.

3.6 The committee's annual report and workplan will also be submitted to the Council of Governors for information.

4.0 Responsibilities

4.1 The specific duties & responsibilities of the committee are categorised as follows:

4.2 Governance, Risk Management and Internal Control

4.2.1 The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

4.2.2 In particular, the committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board.
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications, including the NHS Code of Governance, NHS Provider Licence and Fit and Proper Persons Test.
- The organisations policy (Standards of Business Conduct Policy), systems and processes for the management of conflicts (including gifts and hospitality and bribery) to satisfy itself they are effective, including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.
- The policies and procedures for all work related to counter fraud and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

4.2.3 In carrying out this work the committee use the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers, as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

4.2.4 This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

4.2.5 As part of its integrated approach, the committee will have effective relationships with other Trust Board committees (which may include reciprocal membership) to provide an understanding of processes and linkages and particularly to enable review and oversight of the other committee's governance of risk. This will include the exchange of their chair's action trackers and highlight reports to the Trust Board.

4.3 Internal Audit

4.3.1 The committee shall assure itself that there is an effective internal audit function that meets Public Sector Internal Audit Standards (PSIAS) and provides independent assurance to the committee, Chief Executive and board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Reviewing and approving the internal audit strategy, the annual internal audit plan and more detailed programme of work, ~~that~~ which is consistent with the audit needs of the Trust as identified in the assurance framework.
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Monitoring the implementation of agreed internal audit recommendations in line with agreed timescales, and where concerns exist in relation to the lack of implementation in a particular area the committee can request the relevant operational manager to attend a meeting and give explanation.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Reviewing the Internal Auditor's annual report before its submission to the Board.
- Monitoring the effectiveness of internal audit and carrying out an annual review and obtaining independent assurance that Internal Audit complies with PSIAS.

4.4 External Audit

4.4.1 The committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

- Assisting and advising the Council of Governors in their appointment of the External Auditors (and make recommendations to the Board when appropriate).
- Discussing and agreeing with the External Auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the External Auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Reviewing and monitoring the External Auditor's independence and objectivity and the effectiveness of the audit process.

- Establishing a clear policy for the engagement of external auditors to supply non-audit services, and for scrutinising and where appropriate approving uses of, or exceptions to, this policy.

4.5 Financial Reporting

4.5.1 The committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

4.5.2 The committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided.

4.5.3 The committee shall review the annual report and financial statements before submission to the board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the committee.

- Changes in, and compliance with, accounting policies, practices and estimation techniques.

- Unadjusted misstatements in the financial statements.

- Significant judgements in preparation of the financial statements.

- Significant adjustments resulting from the audit.

- Letters of representation.

- Explanations for significant variances.

4.6 Risk Management

4.6.1 The committee shall request and review reports and assurance from directors and managers as to the effectiveness of arrangements to identify and monitor risk, for any risks the committee considers it is appropriate to do so. This will include:

- Reviewing the Trust's information governance and cyber security arrangements, in order to provide assurance to the Board that the organisation is properly managing its information and cyber risks and has appropriate risk mitigation strategies.

- Reviewing arrangements for new mergers and acquisitions, in order to seek assurance on processes in place to identify significant risks, risk owners and subsequent management of such risks.

- Overseeing actions plans relating to regulatory requirements in terms of the NHS Oversight Framework and Use of Resources.

- Providing the Board with assurance over developing partnership arrangements (e.g., integrated care systems) and mitigation of risks which may arise at the borders between such organisations. The Health and Care Act 2022 introduced new requirements for NHS bodies to work together to meet joint financial objectives and duties, and as such the Audit Committee will need to take a wider view when considering audit and assurance. Organisations need to agree together how best to recognise and manage risk across a system, including what assurances the Audit Committee will need and where these will come from.

4.7 The Board will however retain the responsibility for routinely reviewing specific risks.

4.8 Counter Fraud

4.8.1 The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud that meet the NHS CFA's standards and shall review the outcomes of work in these areas. The committee shall receive the annual report and annual work plan from the Local Counter Fraud Specialist and shall also receive regular progress reports on counter fraud activities.

4.9 System for Raising Concerns

4.9.1 The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensures that any such concerns are investigated proportionately and independently and in line with relevant policies.

4.9.2 The Trust's Freedom to Speak Up Guardian, or his or her nominated deputy shall attend the committee at least annually to provide assurance on the design and operation of the function.

4.10 Management

4.10.1 The committee shall request and review reports, evidence and assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

4.10.2 The committee may also request specific reports from individual functions within the organisation (e.g., compliance reviews or accreditation reports).

4.11 Other Assurance Functions

4.11.1 The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. These may include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g., the Care Quality Commission, NHSE, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (e.g., Royal Colleges, accreditation bodies, etc.).

4.11.2 In addition, the committee will review the work of other committees within the Trust, whose work can provide relevant assurance to the committee's own areas of responsibility. In particular this will include any committees covering safety / quality, for which assurance from clinical audit can be assessed, and risk management. The committee shall receive the action trackers and highlight reports to the Trust Board of the following Board committees for information:

- Performance, Estates & Finance Committees-in-Common
- Quality and Safety Committees-in-Common
- Workforce, Education & Culture Committees-in-Common
- Health Tree Foundation Trustees' Committee
- Capital & Major Projects Committees-in-Common
- Remuneration Committee – Annual Summary report only
- Ethics Committee (when in operation)

4.11.3 The committee will review Standing Financial Instructions, Scheme of Delegation and those elements of the Trust Constitution (Standing Orders) that provide assurances on the internal management of procurement and financial matters.

4.11.4 The committee will receive the Board Assurance Framework (BAF) and the High-Level Risk Register ~~annually~~on a routine basis, to gain assurance that it is operating as part of the Trust's overarching governance / control systems.

4.11.5 The committee will ensure escalation of issues requiring action or decision by the Trust board or other groups within NLAG, as appropriate., ~~in accordance with the schedule at **Appendix A**~~.

4.12 Summary Scope

4.12.1 In summary, to cover the following areas of scope:

- Annual Report and Accounts / Annual Governance Statement
- Counter Fraud
- Data Quality

- Debt Management
- Document Control
- Engagement of External Audit for Non-Audit Work
- Emergency Preparedness Resilience & Response and Business Continuity
- Financial Reporting and Control
- Freedom to Speak Up (Annual Review of Arrangements)
- Going Concern Review
- Governance / Risk
- Information Governance (IG) / IG Toolkit / Cyber Security
- Internal Audit / External Audit
- Losses and Compensation
- Management and Internal Control Systems
- Oversight of Work of Other Board Committees
- Procurement Key Performance Indicators
- Salary Over / Under Payments
- Standards of Business Conduct
- Standing Orders, Standing Financial Instructions and Scheme of Delegation
- Waiving Standing Orders

5.0 Membership

5.1 Core Membership

5.1.1 The committee shall be appointed by the board from amongst its independent, Non-Executive Directors and shall consist of not less than three members (including the committee chair). One of the members shall have recent relevant financial experience.

5.1.2 The chair of the Trust and the Group Chief Executive shall not be ~~a~~ members of the committee. However, they may be invited to attend a meeting by the committee Chair – see 5.3.1.

5.2 In Attendance (all meetings)

5.2.1 The following shall normally attend meetings:

- Group Chief Financial Officer
- ~~Group Chief Executive~~
- Group Director of Assurance
- Internal Audit Representative(s)
- External Audit representative(s)

5.2.2 The Local Counter Fraud Specialist will attend to report upon and discuss counter fraud matters.

5.2.3 An invitation to join the committee as an attendee in an observer capacity with will be extended to a governor.

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 At the invitation of the committee chair, the Trust Chair and Group Chief Executive may attend meetings. The Trust Chair (or Vice Chair) may attend to ensure that the committee is operating as expected and that the non-executives are carrying out their tasks appropriately. The Group Chief Executive would be expected to attend for items around the annual report and accounts, including the Annual Governance Statement, for which they are directly accountable. ~~The Group Chair should be invited to attend and should discuss at least annually with the Audit, Risk & Governance Committee-in-Common the process of assurance that supports the Annual Governance Statement.~~

5.3.2 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.3 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above, particularly when the committee is discussing areas of risk or operation that are the responsibility of that individual. Such attendance will normally be for their item(s) only.

5.3.4 Representatives from other organisations (e.g. NHS Counter Fraud Authority (NHS CFA) and other individuals (e.g. Local Security Management Specialist) may be invited to attend on occasion.

5.3.5 At least once a year, usually at its Audited Accounts meeting, members of the committee shall meet privately with the External and Internal Auditors, either separately or together. Other meetings will take place at the request of members or auditors. The Head of Internal Audit and representatives from External Audit and the Local Counter Fraud Specialist have a right of direct access to the chair of the committee.

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 The committee will normally meet at least five times per year at appropriate times in the audit cycle to allow it to discharge all of its responsibilities in line with its annual work plan. Where required and in agreement with the committee chair and executive lead for the committee, additional meetings may be convened to consider matters that require urgent attention. The committee will review the meeting schedule annually.

6.1.2 The committee will maintain a twelve-month rolling workplan capturing its main items of business at each scheduled meeting. This will be updated throughout

the year as the committee sees fit. Ad-hoc reports, in addition to those set out in its workplan, may also be requested by the committee as necessary.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of each committee will be the chair of the respective committee and jointly chair the **Audit, Risk & Governance Committee-in-Common.** [In line with agreed CiC principles agreed between NLaG and HUTH, both Non-Executive Director chairs will attend the agenda setting meeting with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of one or both Non-Executive Director chairs, the vice chair Non-Executive Director member(s) of the committee of the respective trust(s) will jointly chair the meeting.]

6.3 Secretary

6.3.1 The **Audit, Risk & Governance Committee-in-Common** will be supported administratively by the Assistant Director of Finance – Compliance and Counter Fraud. Their duties in this respect will include agreement of agenda's with both chairs of the committee; ensuring papers are collated and circulated in good time; that those invited to each meeting attend; maintaining the action tracker; preparing the draft highlight / escalation reports for review and agreement by both chairs; advising the committees on pertinent issues / areas of interest and enabling the development and training of committee members.

6.3.2 Secretarial support for the taking and production of minutes will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members and regular attendees (as listed at 5.2) is required at a minimum 75% of meetings.

6.4.2 In the absence of group executive regular attendees, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 A quorum shall be two of the three members. Associate Non-Executive Directors will not form part of the quorum.

6.5.2 A quorum must be maintained at all meetings.

6.5.3 If quoracy cannot be achieved from the committee members, and the reason for lack of quoracy is short term and the papers have already been read, other Non-Executive Directors can be invited to attend for a single meeting (excluding the Trust Chair) or the meeting can go ahead and any actions or decisions

(dependent upon the nature) could be ratified at the next meeting, or by the next Trust Board.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than 5 clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 In addition to the circulation of minutes, the 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.3 Minutes of meetings, once approved as true and accurate by the committee, will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers)

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation / self-assessment of its performance and attendance levels.

6.8.2 A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference and is based on the good practice guide found in the HFMA Audit Committee Handbook **(Appendix A refers)**, will be used for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agree actions or improvements, will be reported to the Trust Board.

6.8.3 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge

of the committee's duties. The committee will recommend any changes to the Trust Board for approval.

The electronic copy of this document is held by Document Control within the Office of the Group Director of Assurance, Northern Lincolnshire and Goole NHS Foundation Trust

Appendix A

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7.1 Does the committee review and approve the counter fraud work plans and any changes to the plans?			
7.2 Is the committee satisfied that the work plan is derived from an appropriate risk assessment and that coverage is adequate?			
7.3 Does the audit committee receive periodic reports about counter fraud activity?			
7.4 Does the committee effectively monitor the implementation of management actions arising from counter fraud reports?			
7.5 Do those working on counter fraud activity have a right of direct access to the committee and its chair?			
7.6 Does the committee receive and review an annual report on counter fraud activity?			
7.7 Does the committee receive and discuss reports arising from quality inspections by NHSCFA?			

CAPITAL & MAJOR PROJECTS COMMITTEE-IN-COMMON

(HUTH)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Financial Officer / Group Director of Assurance

1.0 Purpose

1.1 The Capital & Major Projects Committee-in-Common is responsible for providing assurance to the Trust Board that large scale programmes and projects are being effectively managed, are delivered on time and deliver the intended benefits. This includes capital projects as well as significant operational transformation programmes and major service changes. The committee will also have oversight of and make recommendations for how capital resource is prioritised and allocated. The committees will work closely with the Performance, Estates & Finance Committees-in-Common.

2.0 Authority

2.1 In accordance with the NHS Trusts Membership and Procedures Regulations 1990 an NHS Trust may make arrangements for the exercise, on behalf of the trust, of any of its functions by a committee or sub-committee, subject to any restrictions and conditions as the trust thinks fit. An NHS trust may also appoint committees of the trust consisting wholly or partly of directors of the trust or wholly or partly of persons who are not directors of the trust.

2.2 The HUTH Trust Board has agreed to establish and constitute a committee to be known as the **Capital & Major Projects Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Capital & Major Projects Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Capital & Major Projects Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.

2.5 The **Capital & Major Projects Committee-in-Common** is authorised by the HUTH Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Capital & Major Projects Committee-in-Common (HUTH)** and those which are reserved to the Trust Board of HUTH, in accordance with the *'Trust Scheme of Delegation'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Capital & Major Projects Committee-in-Common** is accountable to the HUTH Trust Board.

3.2 The **Capital & Major Projects Committee-in-Common** will provide a highlight / escalation report to the HUTH Trust Board after each meeting.

3.3 The **Capital & Major Projects Committee-in-Common** will receive a routine report from the Capital Resource Allocation Committee.

4.0 Responsibilities

4.1 To review and inform the Trust's Capital Plan, ensuring that major capital investment schemes are in line with and support the agreed strategy and objectives of the trust and wider group. To monitor delivery of the annual capital programme (i.e. expenditure against plan).

4.2 To scrutinise and evaluate all business cases (including the review of outline and full business cases) for proposed capital investment that require either Capital & Major Projects Committee-in-Common or Trust Board approval, ensuring that outcomes and benefits are clearly defined and are measurable.

4.3 To approve investment (and dis-investment) proposals and business cases within delegated limits and / or to make recommendations to the Trust Board for approval of business cases above the committee's delegated limits.

4.4 To monitor the pace, progress and effectiveness of delivery of major capital projects ensuring that emerging risks are being appropriately managed & mitigated.

4.5 To undertake post-project implementation evaluation to determine whether the intended outcomes and benefits have been realised and / or to determine any lessons to be learned for future major capital projects.

4.6 To have oversight of and receive assurance on the pace and progress of delivery of agreed areas of major service change / transformation including:

- delivery of the consultation and decisions for the Humber Acute Services Programme (UEC, Maternity, Paediatrics and Neonatal);
- design and implementation of the Community Diagnostic Centre Programme within the agreed terms set out in the NHSE Approved Business Case(s);
- development and implementation of a joint strategic capital development plan.

4.7 To have oversight of delivery of the Digital Strategy and plan including major IT investment programmes and enablers.

4.8 To agree an annual work plan and monitor its delivery.

4.9 In summary, to cover the following areas of scope:

- Capital Investment and Business Cases
- Capital Planning & Delivery
- Digital

- HASR
- Joint Strategic Capital Development Plan
- Major Service Change / Transformation

4.10 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.11 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.12 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.13 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board or other groups within HUTH, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive / Associate Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Delivery Officer

5.1.4 Group Chief Digital Information Officer

5.1.5 Group Chief Strategy & Partnerships Officer

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Director of Transformation

5.2.3 Group Director of Assurance or deputy

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.2 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the trust not mentioned above including from the Care Group Triumvirates.

5.3.3 The Chair and Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held bi-monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Capital & Major Projects Committee-in-Common.** In line with agreed CiC principles agreed between HUTH and NLaG, the Non-Executive Director chairs of the respective Capital & Major Projects Committees-in-Common will alternate at each bi-monthly meeting. Both Non-Executive Director chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the combined highlight / escalation reports to the boards. In the absence of both Non-Executive Director chairs, the second Non-Executive Director member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Capital & Major Projects Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the six core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum. Associate NEDs do not count towards quoracy.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the Trust Board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

6.7.2 Draft minutes of the meeting will be shared with the committee chair for approval within two working days of the meeting.

6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers).

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agreed actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

APPENDIX A

Decisions Delegated to the Capital & Major Projects Committee-in-Common (HUTH)

Type of Decision	Delegated to the Capital & Major Projects Committee-in-Common (HUTH)	Reserved for HUTH Trust Board
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.	
	Investigating or having investigated and / or seeking further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.	
Significant operational transformation programmes and major service changes	Consideration of the design and oversight of proposed major service change	Decisions on major service change
	Consideration of the design and oversight of the delivery of key workstreams within the HASR programme	
	Consideration of the design and oversight of the delivery of large-scale strategic projects or enablers	Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation
Capital	Consideration and approval of investment (and disinvestment) decisions and the development and delivery of capital investment plans	Approval of Capital Plan Decisions on significant capital investment in accordance with the limits sets out in the Scheme of Delegation
Digital	Oversight of the development and delivery of the Digital Strategy and Plan	Approval of Digital Strategy

CAPITAL & MAJOR PROJECTS COMMITTEE-IN-COMMON

(NLAG)

Membership and Terms of Reference

Reference:	Reference?
Version:	Version?
This version issued:	Date?
Result of last review:	<Document Control use only>
Date approved by owner (if applicable):	*enter* date of approval
Date approved:	*enter* date of approval
Approving body:	Trust Board
Date for review:	*enter* date of review
Owner:	Trust Chair
Document type:	Terms of Reference
Number of pages:	10 (including front sheet)
Author / Contact:	Group Chief Financial Officer / Group Director of Assurance

1.0 Purpose

1.1 The **Capital & Major Projects Committee-in-Common** is responsible for providing assurance to the Trust Board that major programmes and projects are being effectively managed, are delivered on time and deliver the intended benefits. This includes capital projects as well as significant operational transformation programmes and major service changes. The committee will also have oversight of and make recommendations for how capital resource is prioritised and allocated. The committees will work closely with the Performance, Estates & Finance Committees-in-Common.

2.0 Authority

2.1 In accordance with the NHS Act 2006 and the Trust's Constitution, the board may make arrangements for the exercise, on behalf of the trust, of any if its functions by a committee of directors.

2.2 The NLaG Trust Board has agreed to establish and constitute a committee to be known as the **Capital & Major Projects Committee-in-Common**.

2.3 Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance & decision-making through a committees-in-common (CiC) approach, the **Capital & Major Projects Committee** of each board shall meet simultaneously with the corresponding committee from the other trust but remain separately constituted committees.

2.4 The **Capital & Major Projects Committee-in-Common** has the authority to make decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the NLaG Trust Board.

2.5 The **Capital & Major Projects Committees-in-Common** is authorised by the NLaG Trust Board to investigate or to have investigated and / or to seek further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.

2.6 The schedule of decisions delegated to the **Capital & Major Projects Committee-in-Common (NLaG)** and those which are reserved to the Trust Board of NLaG, in accordance with the '*Trust Scheme of Delegation and Powers Reserved for the Trust Board'* are set out in **Appendix A**.

3.0 Accountability & Reporting Arrangements

3.1 The **Capital & Major Projects Committee-in-Common** is accountable to the NLaG Trust Board.

3.2 The **Capital & Major Projects Committee-in-Common** will provide a highlight / escalation report to the NLaG Trust Board after each meeting.

3.3 The **Capital & Major Projects Committee-in-Common** will receive a quarterly report from the Capital Investment Board.

4.0 Responsibilities

4.1 To review and inform the Trust's Capital Plan, ensuring that major capital investment schemes are in line with and support the agreed strategy and objectives of the trust and wider group.

4.2 To monitor delivery of the annual capital programme (i.e. expenditure against plan).

4.3 To scrutinise and evaluate all business cases (including the review of outline and full business cases) for proposed capital investment that require either Capital & Major Projects Committee-in-Common or Trust Board approval, ensuring that outcomes and benefits are clearly defined and are measurable.

4.4 To approve investment (and dis-investment) proposals and business cases within delegated limits and / or to make recommendations to the Trust Board for approval of business cases above the committee's delegated limits.

4.5 To monitor the pace, progress and effectiveness of delivery of major capital projects ensuring that emerging risks are being appropriately managed & mitigated.

4.6 To undertake post-project implementation evaluation to determine whether the intended outcomes and benefits have been realised and / or to determine any lessons to be learned for future major capital projects.

4.7 To have oversight of and receive assurance on the pace and progress of delivery of agreed areas of major service change / transformation including:

- delivery of the consultation and decisions for the Humber Acute Services Programme (UEC, Maternity, Paediatrics and Neonatal);
- design and implementation of the Community Diagnostic Centre Programme within the agreed terms set out in the NHSE Approved Business Case(s);
- development and implementation of a joint strategic capital development plan.

4.8 To have oversight of delivery of the Digital Strategy and plan including major IT investment programmes and enablers.

4.9 To agree an annual work plan and monitor its delivery.

4.10 In summary, to cover the following areas of scope:

- Capital Investment and Business Cases
- Capital Planning & Delivery
- Digital
- HASR

- Joint Strategic Capital Development Plan
- Major Service Change / Transformation

4.11 To agree at a high level the risks, controls and assurances reported in the Board Assurance Framework and to scrutinise specific assurances it highlights.

4.12 To monitor on an ongoing basis the Trust's risk appetite and overall level of risk reported in the Board Assurance Framework.

4.13 To monitor and consider the quality of data provided and used to support Trust objectives. To oversee and gain assurance over actions aiming to rectify any data quality issues.

4.14 To ensure escalation of issues covered by these terms of reference and requiring action or decision by the Trust Board or other groups within NLaG, in accordance with the schedule at **Appendix A**.

5.0 Membership

5.1 Core Membership

5.1.1 Two Non-Executive Directors (including the committee chair)

5.1.2 Group Chief Financial Officer

5.1.3 Group Chief Delivery Officer

5.1.4 Group Chief Digital Information Officer

5.1.5 Group Director of Strategy & Partnerships

5.2 In Attendance (all meetings)

5.2.1 Group Director of Estates

5.2.2 Group Director of Transformation

5.2.3 Group Director of Assurance or deputy

5.2.4 Governor observer

5.3 Other Persons Attending Meetings (as the agenda dictates / by invitation)

5.3.1 Other Non-Executive / Associate Non-Executive Directors may be requested to attend specific meetings of the committee, as the agenda dictates.

5.3.2 The committee may, from time to time and as the agenda dictates, require attendance from other senior officers of the Trust not mentioned above including from the Care Group Triumvirates.

5.3.3 The Chair and Chief Executive* have a right of attendance and speaking rights

*In the absence of the Chief Executive, the Chief of Staff may be asked to represent

6.0 Procedural Issues

6.1 Frequency of Meetings

6.1.1 Meetings will be held bi-monthly. Where required and in agreement with the committee chair and group executive director lead for the committee, additional meetings may be convened to consider matters that require urgent attention.

6.2 Chairperson

6.2.1 One of the Non-Executive Director members of the committee will be the chair of the **Capital & Major Projects Committee-in-Common.** In line with agreed CiC principles agreed between NLaG and HUTH, the NED chairs of the respective Capital & Major Projects Committees-in-Common will alternate at each bi-monthly meeting. Both NED chairs will attend the agenda setting meetings with the lead group executive for the committee and will both sign off the content of the combined highlight / escalation reports to the boards. In the absence of both NED chairs, the second NED member of the committee of the respective trust will chair the meeting.

6.3 Secretary

6.3.1 Secretarial support to the **Capital & Major Projects Committee-in-Common** will be provided from the office of the Group Director of Assurance.

6.4 Attendance

6.4.1 Attendance by core members is required at a minimum 75% of meetings.

6.4.2 In the absence of an agreed group executive director core member, formally appointed deputies can be nominated to attend in their absence. The nominated deputy must be able to contribute to discussions and be able to make decisions in the absence of the relevant member.

6.5 Quorum

6.5.1 Meetings will be deemed to be quorate when three of the six core members are present including one of the two Non-Executive Directors and two of the group Executive Directors or their formally appointed deputies.

6.5.2 When considering if the meeting is quorate, only those individuals who are members (or their nominated deputies) can be counted; other attendees cannot be considered as counting to the quorum. Associate NEDs do not count towards quoracy.

6.6 Decision Making

6.6.1 Wherever possible, members of the committee will seek to make decisions and recommendations based on consensus. Where consensus on a particular matter cannot be reached and a vote may be required – particularly where the matter may be sensitive or contentious – the matter will be referred to the trust board.

6.7 Administration and Minutes of Meetings

6.7.1 Formal agendas and minutes will be prepared and distributed with supporting papers in advance of each meeting and no less than five clear working days prior to each meeting. No late papers will be accepted after the deadline without the express agreement of the committee chair.

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6.7.3 The 'action tracker' of actions agreed at each meeting will be circulated following each meeting. This will act as a reminder for the relevant action 'lead' and will assist in ensuring that actions are completed within the agreed timescale.

6.7.4 Minutes of meetings will be presented to the Trust Board along with the committee highlight / escalation report (section 3.2 above refers).

6.8 Monitoring & Compliance

6.8.1 In accordance with the requirements of good governance and, in order to ensure its ongoing effectiveness, the committee will undertake an annual evaluation of its performance and attendance levels. A performance evaluation tool, which reflects the requirements outlined within these Terms of Reference, has been developed for this purpose. Where gaps in compliance are identified arising from the evaluation, an action plan will be developed, and implementation will be monitored by the committee. The outcome of the annual evaluation exercise, including any agreed actions or improvements, will be reported to the Trust Board.

6.8.2 The effectiveness of all board committees will also continue to be tested as part of other relevant internal and external assurance processes e.g. development reviews using the Well Led Framework, governance reviews and audits.

6.9 Review

6.9.1 These Terms of Reference will be reviewed annually or sooner should the need arise to ensure that they remain fit for purpose and best facilitate the discharge of the committee's duties.

APPENDIX A

Decisions Delegated to the Capital & Major Projects Committee-in-Common (NLaG)

Type of Decision	Delegated to the Capital & Major Projects Committee-in-Common (NLaG)	Reserved for NLaG Trust Board
General	Making decisions on any matters of business within its remit and / or to ensure relevant decisions are referred to the HUTH Trust Board.	
	Investigating or having investigated and / or seeking further action or assurance in relation to any activity within their terms of reference. This includes referral of matters for consideration to another board committee.	
Significant operational transformation programmes and major service changes	Consideration of the design and oversight of the delivery of proposed major service change	Decisions on major service change
	Consideration of the design and oversight of the delivery of key workstreams within the HASR programme	
	Consideration of the design and oversight of the delivery of large-scale strategic projects or enablers	Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation
Capital	Consideration and approval of investment (and disinvestment) decisions and the development and delivery of capital investment plans	Approval of Capital Plan Decisions on significant capital investment in accordance with the limits set out in the Scheme of Delegation
Digital	Oversight of the development and delivery of the Digital Strategy and plan	Approval of Digital Strategy

6.10

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)147

Name of the Meeting	**Trust Boards In Common**
Date of the Meeting	8th August 2024
Director Lead	Simon Nearney, Group Chief People Officer
Contact Officer/Author	Lucy Vere, Group Director of Learning and Organisational Development Mano Jamieson, EDI Manager (HUTH) Karl Portz, EDI Manager (NLaG)
Title of the Report	Modern Slavery Statement – HUTH & NLaG
Executive Summary	The purpose of this paper is to share the Trust's Modern Slavery Statement for Trust Boards in Common final approval. Once approved, each statement will be published on the respective Trust's website as soon as possible, and by the very latest, the 30 September 2024 to meet statutory requirements.
Background Information and/or Supporting Document(s) (if applicable)	Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains.
Prior Approval Process	Workforce Education and Culture Committee in Common - Approved
Financial implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	To support meeting the Trust Public Sector Equality Duty and to meet the requirements of the Modern Slavery Act 2015. Once approved by the Trust Boards in Common, the statements must be published on each Trust's internet in line with statutory requirements (by 30 September 2024).
Recommended action(s) required	X Approval ☐ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement
Trust Submission 2023/24
Trust Boards in Common, Thursday 8th August 2024

1 Purpose

The purpose of this paper is to share the Trust's 2023/24 Modern Slavery Statement with the Trust Boards in Common for approval. Once approved, the statement will be published on the Trust's website as soon as possible, and by the very latest, the 30 September 2024 to meet statutory requirements.

2 Background

Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains.

The Act requires organisations to publish a Modern Slavery Statement which has been approved and signed by the Board on their website and include a link in a prominent place on it's homepage within six months of the end of the financial year.

3 The Trust's Proposed Statement for 2023/24

The Statement contained within Appendix 1 has been produced in partnership with colleagues from the Trusts Safeguarding, Procurement, People and Finance Teams.

4 Changes to Modern Slavery Statement

It is now good practice to publish statements on the Modern slavery statement registry - GOV.UK (modern-slavery-statement-registry.service.gov.uk)

5 Recommendation

The Workforce Education and Culture Committee in Common are asked to:

- Note, approve and sign off the content of the Trust's 2023/24 Modern Slavery Statement ready for its final sign off at Trust Boards in Common

Simon Nearney, Group Chief People Officer

Appendix 1

Hull University Teaching Hospitals NHS Trust

Modern Slavery Statement
1 April 2023 to 31 March 2024

1. Introduction

The Modern Slavery Act 2015 requires organisations to publish an annual Modern Slavery Statement on their website within six months of the end of the financial year (i.e. for the Trust this would require the statement to be published by 30 September).

With reports[1] of modern slavery victims increasing year on year and an estimate of more than 130,000 people being trapped in modern slavery, costing the UK £33 billion per year, it is imperative that the Trust continues to be committed to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking.

This statement sets out the steps that the Trust has taken over the financial year 1 April 2023 to 31 March 2024 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains and covers the following:

- Organisational structure and business
- Policies in relation to slavery and human trafficking
- Due diligence and managing risks in the Trust's business and supply chains
- Training and performance indicators

2. Organisational Structure and Business

Hull University Teaching Hospitals NHS Trust (HUTH) provides services across the East Riding of Yorkshire and Hull. The Trust's total turnover for 2023 / 2024 was £886m. The Trust employs over 11300 permanent and fixed term contracted staff (ESR April 2024).

Further details regarding the Trust's business and structure can be found in the Annual Report and Accounts 2022/23, available on the Trust website https://www.hey.nhs.uk/wp/wp-content/uploads/2023/09/Annual-Report-and-Accounts-2022-2023.pdf

- Note the HUTH Annual Report 2023/2024 is not at this time available.

3. Policies in Relation to Slavery and Human Trafficking

The Trust has a number of policies to support staff in relation to modern slavery, including:

- Raising Concerns at Work (Whistleblowing) Policy.
- Equality, Diversity and Inclusion in Employment Policy.
- Policy for Staff Conflict Resolution and Professionalism in the Workplace.

[1] https://www.antislavery.org/slavery-today/slavery-uk/

The Trust publishes a broad range of safeguarding policies and factsheets, for both service users and staff, which include:

- Modern slavery resources including Ukrainian Refugees and the risk from Human Trafficking.
- Home Office-Modern Slavery: Statutory Guidance for England and Wales Jan 2023.
- Eyes Open Campaign to stop child criminal exploitation.

Any new campaigns/policies in relation to modern slavery are published on the Trust intranet.

All Trust policies go through a robust consultation and ratification process and are available on the Trust's internal website.

3. Due Diligence Processes in the Trust's Business and Supply Chains

3.1 Due Diligence in Business

The Trust is committed to preventing slavery and human trafficking in corporate activities and ensuring that workers are not exploited, that they are safe and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to.

To support staff, the following steps are taken:

- All staff are employed on employment contracts which comply with UK law.
- Pre-employment checks are undertaken on all workers directly and non-directly employed by the Trust (e.g. employees, agency staff, contractors, volunteers, students and trainees on work experience etc.).
- All staff undertake mandatory safeguarding training, which covers modern slavery.
- As an equal opportunities employer, the Trust is committed to creating an inclusive working environment for all staff, which enables staff to feel confident that they can raise concerns without any risk to themselves via a number of avenues, including a Freedom to Speak up Guardian.
- A comprehensive range of modern slavery and safeguarding information for service users and staff is available for staff on the Trust intranet.
- All active agencies who supply staff to the Trust are asked to provide assurance that they are compliant with the Modern Slavery Act 2015 on an annual basis.
- Modern slavery is a term used that includes any form of human trafficking, slavery, servitude or forced labour, as set out in the Modern Slavery Act 2015.
- Modern slavery is widespread and can go unnoticed in our daily lives. Victims may face physical violence or coercion and may be forced into overwhelming debt. Additionally, they may have their passports taken away and be threatened with deportation. To safeguard against this, the Trust is constantly seeking ways to support and protect staff and service users from modern slavery and human trafficking. Some of the steps taken to achieve this include:

- Participation in the Humber Modern Slavery Partnership (HMSP) Strategic Board, a network of over 60 organizations in the Humber region dedicated to preventing and combating modern slavery.
- Incorporating modern slavery into mandatory safeguarding adults training.
- Sharing knowledge and information, including providing access to training across the Trust through the intranet.
- Monitoring the number of concerns raised to the Trust safeguarding adults team regarding exploitation and/or modern slavery. While these numbers are low, they show that staff have an understanding of this aspect of safeguarding.
- Collaborating with individuals to ensure that the principles of Making Safeguarding Personal are followed. Support and referrals should be consent-based and involve the person's input.
- Professionals should also consider child trafficking and the possibility of the child or young person being used in different forms of exploitation such as child sexual exploitation, fraud, forced marriage, criminal activity such as pick pocketing, cannabis cultivation or domestic servitude. The consequences of such involvement can have both short and long term consequences for the child, including guilt and confusion.
- The safeguarding children team raise awareness of the issue of modern slavery, child criminal exploitation (CCE) and child sexual exploitation (CSE) in their safeguarding children training.
- The safeguarding children team are active members at Multi Agency Child Exploitation (MACE) meetings and at National Referral Mechanism (NRM) meetings following completion of safeguarding referrals to Police and Children Social Care.

3.2 Due Diligence in Supply Chains

The Trust typically contracts with suppliers through relevant procurement frameworks where the award of a place on the framework will have required the supplier to confirm compliance with the Act as part of the process (amongst a range of other criteria). Where the Trust uses an ‘Open’ tender process in line with the Public Contracts Regulations 2015 then questions in relation to compliance with the Modern Slavery Act appear as mandatory questions in the pre-selection process. Contracts that sit outside of these examples will typically fall way below the annual turnover threshold although the Trust would still expect business to be carried out with regard to the provisions of the Act.

The Trust will continue to update records on the remaining suppliers as and when contracts are renewed.

- The Trust does not enter into business with any organisation, in the UK or abroad, which knowingly supports or is found to be involved in slavery, servitude and forced or compulsory labour. Steps taken to reduce the risk of modern slavery occurring within the supply chain include:
- Use NHS Terms and Conditions for Goods and Services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions.

- Continue to ensure there are robust processes in place to mitigate risks associated with procuring goods and services outside of the tendering process, including:
  - All goods purchased outside the tendering process must adhere to the Trust's Standing Financial Instructions and are subject to the Purchase Order Version of the Terms and Conditions for both goods and services (January 2018) which references modern slavery.
  - All purchases where the expenditure is over £10,000 and less than £50,000 must have three official quotations.
  - When requesting information for values lower than the £10,000 referenced in the Standing Financial Instructions, suppliers are requested to complete the Trust's formal quotation form, which includes reference to modern slavery.

4. Training and Performance Indicators

Compliance with the Trust's modern slavery agenda is measured by reviewing the number of staff who have completed the following mandatory courses/eLearning packages (which include modern slavery):

- Safeguarding Adults
- Safeguarding Children

As of June 2024 92% of Trust staff are compliant with the required safeguarding training.

The Safeguarding training and advice:
In addition to the mandatory training, the Safeguarding Teams provide ad-hoc training and day to day support around modern slavery when requested. Modern slavery is also embedded within other relevant training programmes which staff can choose to enrol on, including but not limited to:

- Modern Slavery and Human Trafficking
- Introduction to Migration
- Children Vulnerable to Abuse and Exploitation

5. Summary

The Trust continues to be committed to preventing modern slavery and human trafficking in any part of its business or supply chains. The Trust is committed to:

- Continuing to educate staff on the importance of preventing modern slavery and to meet the obligations under the national modern slavery agenda.
- Monitoring and reviewing ongoing modern slavery legislation and best practice.
- Obtaining assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015 and record and monitor these as required.
- Reviewing Trust policies and including references to modern slavery where appropriate.

Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed	Signed
Chairman	**Chief Executive**
Dated:	Dated:

Northern Lincolnshire and Goole NHS Trust

Modern Slavery Statement
Trust Submission 2023/24
Trust Boards in Common, Thursday 8th August 2024

1 Purpose

The purpose of this paper is to share the Trust's 2023/24 Modern Slavery Statement with the Trust Boards in Common for approval. Once approved, the statement will be published on the Trust's website as soon as possible, and by the very latest, the 30 September 2024 to meet statutory requirements.

2 Background

Following the introduction of the Modern Slavery Act in 2015, businesses are required to produce a statement setting out the steps they have taken to ensure there is no modern slavery in their own business and supply chains.

The Act requires organisations to publish a Modern Slavery Statement which has been approved and signed by the Board on their website and include a link in a prominent place on its homepage within six months of the end of the financial year.

3 The Trust's Proposed Statement for 2023/24

The Statement contained within Appendix 1 has been produced in partnership with colleagues from the Trusts Safeguarding, Procurement, People and Finance Teams.

4 Changes to Modern Slavery Statement

It is now good practice to publish statements on the Modern slavery statement registry - GOV.UK (modern-slavery-statement-registry.service.gov.uk)

5 Recommendation

The Workforce Education and Culture Committee in Common are asked to:

- Note, approve and sign off the content of the Trust's 2023/24 Modern Slavery Statement ready for its final sign off at Trust Boards in Common

Simon Nearney, Group Chief People Officer

Appendix 1

Northern Lincolnshire and Goole NHS Trust

Modern Slavery Statement
1 April 2023 to 31 March 2024

1. Introduction

The Modern Slavery Act 2015 requires organisations to publish an annual Modern Slavery Statement on their website within six months of the end of the financial year (i.e., for the Trust this would require the statement to be published by 30 September).

With reports[1] of modern slavery victims increasing year on year and an estimate of more than 130,000 people being trapped in modern slavery, costing the UK £33 billion per year, it is imperative that the Trust continues to be committed to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking.

This statement sets out the steps that the Trust has taken over the financial year 1 April 2023 to 31 March 2024 to ensure that slavery and human trafficking is not taking place in any part of its business or supply chains and covers the following:

- Organisational structure and business
- Policies in relation to slavery and human trafficking
- Due diligence and managing risks in the Trust's business and supply chains
- Training and performance indicators

2. Organisational Structure and Business

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provides services across North Lincolnshire, North East Lincolnshire, East Riding of Yorkshire and West and East Lindsey. The Trust's total turnover for 2023 / 2024 was £574,190,000. The Trust employs over 7600 permanent and fixed term contracted staff (ESR April 2024).

Further details regarding the Trust's business and structure can be found in the Annual Report and Accounts 2022/23, available on the Trust website Annual reports and accounts - Northern Lincolnshire and Goole NHS Foundation Trust (nlg.nhs.uk)

- Note the NLaG Annual Report 2023/2024 is not currently available.

3. Policies in Relation to Slavery and Human Trafficking

The Trust has several policies to support staff in relation to modern slavery, including:

- Freedom to Speak Up Policy for the NHS (DCP 126).
- Bullying and Harassment Policy and Procedure ((DCP004).
- Staff Exposed to Domestic Abuse Guidance (DCM 275).

[1] https://www.antislavery.org/slavery-today/slavery-uk/

- Managing Relationships at Work Policy (DCP 413).

The Trust publishes a broad range of safeguarding policies and factsheets, for both service users and staff, which include:

- Safeguarding Adults Policy and Guidance (DCP 017)
- Safeguarding Children Policy (DCP 064)

Any new campaigns/policies in relation to modern slavery are published on the Trust intranet.

All Trust policies go through a robust consultation and ratification process and are available on the Trust's internal website.

3. Due Diligence Processes in the Trust's Business and Supply Chains

3.1 Due Diligence in Business

The Trust is committed to preventing slavery and human trafficking in corporate activities and ensuring that workers are not exploited, that they are safe and that relevant employment (working hours etc.), health and safety, human rights laws and international standards are adhered to.

To support staff, the following steps are taken:

- All staff are employed on employment contracts which comply with UK law.
- Pre-employment checks are undertaken on all workers directly and non-directly employed by the Trust (e.g., employees, agency staff, contractors, volunteers, students, and trainees on work experience etc.).
- All staff undertake mandatory safeguarding training, which covers modern slavery.
- As an equal opportunities' employer the Trust is committed to creating an inclusive working environment for all staff, which enables staff to feel confident that they can raise concerns without any risk to themselves via several avenues, including a Freedom to Speak up Guardian.
- A comprehensive range of modern slavery and safeguarding information for service users and staff is available for staff on the Trust intranet.
- All active agencies who supply staff to the Trust are asked to provide assurance that they are compliant with the Modern Slavery Act 2015 on an annual basis.
- Modern slavery is a term used that includes any form of human trafficking, slavery, servitude or forced labour, as set out in the Modern Slavery Act 2015.
- Modern slavery is widespread and can go unnoticed in our daily lives. Victims may face physical violence or coercion and may be forced into overwhelming debt. Additionally, they may have their passports taken away and be threatened with deportation. To safeguard against this, the Trust is constantly seeking ways to support and protect staff and service users from modern slavery and human trafficking. Some of the steps taken to achieve this include:
  - Participation in the Humber Modern Slavery Partnership (HMSP) Strategic Board, a network of over 60 organizations in the Humber region dedicated to preventing and combating modern slavery.

- Participation in the North East Lincolnshire Modern Slavery Partnership, a local network aimed at raising awareness of modern slavery.
- Incorporating modern slavery into mandatory safeguarding adults training.
- Sharing knowledge and information, including providing access to training across the Trust through the intranet.
- Monitoring the number of concerns raised to the Trust safeguarding adults' team regarding exploitation and/or modern slavery. While these numbers are low, they show that staff understand of this aspect of safeguarding.
- Collaborating with individuals to ensure that the principles of Making Safeguarding Personal are followed. Support and referrals should be consent-based and involve the person's input.
- Professionals should also consider child trafficking and the possibility of the child or young person being used in different forms of exploitation such as child sexual exploitation, fraud, forced marriage, criminal activity such as pick pocketing, cannabis cultivation or domestic servitude. The consequences of such involvement can have both short- and long-term consequences for the child, including guilt and confusion.
- The safeguarding children team raise awareness of the issue of modern slavery, child criminal exploitation (CCE) and child sexual exploitation (CSE) in their safeguarding children training.
- The safeguarding children team are active members at Multi Agency Child Exploitation (MACE) meetings and at National Referral Mechanism (NRM) meetings following completion of safeguarding referrals to Police and Children Social Care.

3.2 Due Diligence in Supply Chains

The Trust typically contracts with suppliers through relevant procurement frameworks where the award of a place on the framework will have required the supplier to confirm compliance with the Act as part of the process (amongst a range of other criteria). Where the Trust uses an 'Open' tender process in line with the Public Contracts Regulations 2015 then questions in relation to compliance with the Modern Slavery Act appear as mandatory questions in the pre-selection process. Contracts that sit outside of these examples will typically fall way below the annual turnover threshold, although the Trust would still expect business to be carried out in line with the provisions of the Act.

The Trust will continue to update records on the remaining suppliers as and when contracts are renewed.

- The Trust does not conduct business with any organisation, in the UK or abroad, which knowingly supports or is found to be involved in slavery, servitude and forced or compulsory labour. Steps taken to reduce the risk of modern slavery occurring within the supply chain include:
- Use NHS Terms and Conditions for Goods and Services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions.
- Continue to ensure there are robust processes in place to mitigate risks associated with procuring goods and services outside of the tendering process, including:

- All goods purchased outside the tendering process must adhere to the Trust's Standing Financial Instructions and are subject to the Purchase Order Version of the Terms and Conditions for both goods and services (January 2018) which references modern slavery.
- All purchases where the expenditure is over £10,000 and less than £50,000 must have three official quotations.
- When requesting information for values lower than the £10,000 referenced in the Standing Financial Instructions, suppliers are requested to complete the Trust's formal quotation form, which includes reference to modern slavery.

4. Training and Performance Indicators

Compliance with the Trust's modern slavery agenda is measured by reviewing the number of staff who have completed the following mandatory courses/eLearning packages (which include modern slavery):

- Safeguarding Adults
- Safeguarding Children

As of June 2024, 90% of Trust staff are compliant with the required safeguarding training.

The Safeguarding training and advice:

- Modern Slavery is included with the safeguarding adults and children training.
- The safeguarding adults and children's teams are available Monday / Friday 9.00 – 5.00pm to offer advice, support, and information to staff if they have concerns about identification of modern slavery and how to make appropriate referrals to safeguard adults and children.
- Gaining Respect and Finding Trust team) in children social care deliver bespoke training to wards and departments within the Trust which covers modern slavery, child criminal exploitation and child sexual exploitation.

5. Summary

The Trust continues to be committed to preventing modern slavery and human trafficking in any part of its business or supply chains. The Trust is committed to:

- Continuing to educate staff on the importance of preventing modern slavery and to meet the obligations under the national modern slavery agenda.
- Monitoring and reviewing ongoing modern slavery legislation and best practice.
- Obtaining assurances from main suppliers/agencies etc. that they comply with the Modern Slavery Act 2015 and record and monitor these as required.
- Reviewing Trust policies and including references to modern slavery where appropriate.

Trust Board has considered and approved this statement and will continue to support the requirements of the legislation.

Signed	Signed
Chairman	**Chief Executive**
Dated:	Dated:

NHS
Hull University Teaching Hospitals
NHS Trust

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Boards-in-Common Front Sheet

Agenda Item No: BIC(24)148

Name of Meeting	Trust Boards-in-Common
Date of the Meeting	Thursday 8th August 2024
Director Lead	**Lee Bond – Group Chief Financial Officer**
Contact Officer / Author	**Simon Tighe – Group Deputy Director – Estates, Compliance & Information Services**
Title of Report	**Premises Assurance Model reports for Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS FT**
Executive Summary	The NHS Premises Assurance Model (PAM) is a mandatory management tool driven by NHS E and is designed to provide a nationally consistent approach to evaluating the premises performance against a set of standardised indicators. The data submission is required by 13th September 2024.
Background Information and/or Supporting Document(s) (if applicable)	National PAM central reporting requires that Trust Boards are presented with the end of year reports giving details of assurance against the PAM domains for both Trusts.
Prior Approval Process	HUTH Estates Governance June 26/6/24, NLaG Estates Governance 13/6/24 & Performance, Estates & Finance Committees-in-Common 24/07/24
Financial Implication(s) (if applicable)	Within current Estates, Facilities & Development Resources.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable
Recommended action(s) required	✓ Approval ☐ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Directorate of Estates, Facilities and Development

NHS Premises Assurance Model Report for

Hull University Teaching Hospitals and

Northern Lincolnshire and Goole NHS FT

1.0 Executive summary

1.1 **Background** - The NHS Premises Assurance Model (PAM) is a mandatory management tool driven by NHS E and is designed to provide a nationally consistent approach to evaluating the premises performance against a set of standardised indicators listed below:

- Policy and Procedures
- Roles and Responsibilities
- Risk assessments (both safety and strategic)
- Maintenance of assets & equipment.
- Training and development of key roles
- Emergency Preparedness and business continuity
- Process review
- Costed action plans in place.

1.1.1 For each criterion, a self-assessment judgement is selected based on risk:

- Outstanding
- Good
- Requires minimal improvement.
- Requires moderate improvement.
- Inadequate

1.1.2 The submission is required by 13th September 2024.

1.2 **Update** - For HUTH an improvement on the previous year detailed in the report. However, an inadequate is recorded across all elements of the Safety In Other Premises (SH18) due to health groups occupying other premises to deliver clinical services where lease agreements etc cannot be confirmed so responsibilities for areas such as legionella control results in limited assurance in relation to staff safety and welfare.

1.2.1 For NLaG progress continues to be made towards a “Good” rating however, the impact of the national hygiene standards has seen a reduction in soft FM. An “inadequate” was noted related to non-compliance with the deadline for the Safety Alert for maintenance of beds including community beds. An action plan is in place and progress monitored. It is also necessary to note that the final question set was issued after the end of the reporting period

so NLaG was not able to assess against SH21 relating to ligature issues within the built environment. This will be addressed in the 24/25 assessment process. In addition SH20 (Healthcare Safety Investigation Branch) has now been withdrawn but was included NLaG's report as it was part of the covid Oxygen HSIB investigation.

1.3 **Recommendation** – this committee is requested to approve the two organisational PAM reports for 2023-24 prior to submission to Trust Board in August 2024.

Estates and Facilities

Premises Assurance Model

2023-2024

End of Year Report

Hull University Teaching Hospital NHS Trust

Contents

Purpose

The purpose of this report is to provide an end-of-year summary of the main findings of completing the mandatory NHSE 2023-24 Premises Assurance Model (PAM), which is required to have Trust Board oversight/sign off.

Background Information

Regulated by NHSE, the PAM is a national, mandatory standardised approach to self-assessing assurance levels within Estates & Facilities[1]. Through the coordinated engagement with both internal and external stakeholders, there are six domains comprising of 47 self-assessment questions that provide the assessment structure:

1. Safety Hard (Estates) – x20 assessment categories
2. Safety Soft (Facilities) - x10 assessment categories
3. Organisational Governance - x3 assessment categories
4. Patient Experience - x6 assessment categories
5. Effectiveness - x4 assessment categories
6. Efficiency - x5 assessment categories
7. Helipad – x1 assessment category

Additionally, there are a small number of new sections for 2023-24 of the assurance model which specifically look at:

- FM Maturity (FMS 001: Management Services)
- FM Maturity (FMS 002: Asset Data) (optional last reporting year)

Contained within each domain are:

- Self-assessment questions (SAQs) which are answered through a series of sub-questions based on NHSE set criterion.
- National Metrics: a standardised method of determining levels of adherence to healthcare and government legislation requirements with regards to Estate and Facilities. The judgement metrics are:
    - Outstanding
    - Good
    - Requires Minimal Improvement
    - Requires Moderate Improvement
    - Inadequate
    - Not Applicable.

[1] Although categorised as *Estates and Facilities* departments/services are assessed which do not sit within Estates and Facilities in the structure of HUTH

HUTH has undertaken the PAM since 2018/19, HUTH's Estates, Facilities & Development Directorate has actively engaged in the PAM self-assessment process with the EF&D Information & Governance team facilitating the process. Additionally, the Trust is represented at a national level consulting every quarter at the NHSE Premises Assurance User Group.

The PAM programme has only recently become a mandatory requirement - appearing for the first time in the 2021 NHS Standard Contract.

Hull University Teaching Hospitals NHS Trust's PAM Model

HUTH's annual self-assessment usually commences each November and concludes at the end of March in the following calendar year. The period between April and August enables internal and external reporting to be completed. For 2023/24 the process was delayed due to the formation of the Group structure and its impact on HUTH EF&D. It commenced mid-February 2024 and concluded early May 2024. The PAM sessions where conducted with the SAQ Leads.

The existing model has been presented previously, and is deemed suitable for the organisation, resulting in transparent and credible assurances.

The electronic solution was not used for 2023/24 process, as it was for the 2022/23 PAM, due mainly to timescales, but working collaboratively with other similar PAM software users, consideration will be given to re-introducing the software solution for the 2024/25 PAM.

Inherently, the self-assessment process is a subjective process and no physical evidence is collected. It is understood by the SAQ Leads that any external enquiries or audits would require production of any evidence to support their self-assessment ratings.

Additionally, national guidance such Health Technical Memorandums (HTM) and Trust policy requirements also inform the level of assurance for the operational teams.

The outcome of the PAM self-assessment process is presented at the HUTH EF&D Governance & Assurance Group for approval, prior to seeking Trust Board approval to submit the return to NHSE. It is intended that from the 2023/24 PAM all relevant actions will be discussed and progress towards completion will be monitored at the Technical/Operation Subgroups.

As the PAM is near the end of the 6th year of the current model and upon review, the delivery model is assessed as fit for purpose and delivers a meaningful self-assessment within the confines of the national mandated process. It should be further noted that individual self-assessment questions are subject to scrutiny annually and may change. Additionally, there has been inclusions of subject matters which were not included in the original model, such as Helipad, PSTN 'switch-off' and Reducing Harm by Ligature in Practice.

2023-24 Estates and Facilities PAM Summary of Findings

The charts below capture the end of year comparisons that visually represents the judgements for the EF&D primary service provision (Hard and Soft FM) domains of Estates, Facilities & Development against each standardised question set. Appendix 1 provides the full data capture for each domain.

Graphical illustration of the displacement of judgements for both Estates (SH1 to SH21 (SH20 removed)) and Facilities (SS1 to SS10).

Figure 1 - Safety Hard - Comparison for 21/22 – 23/24 period

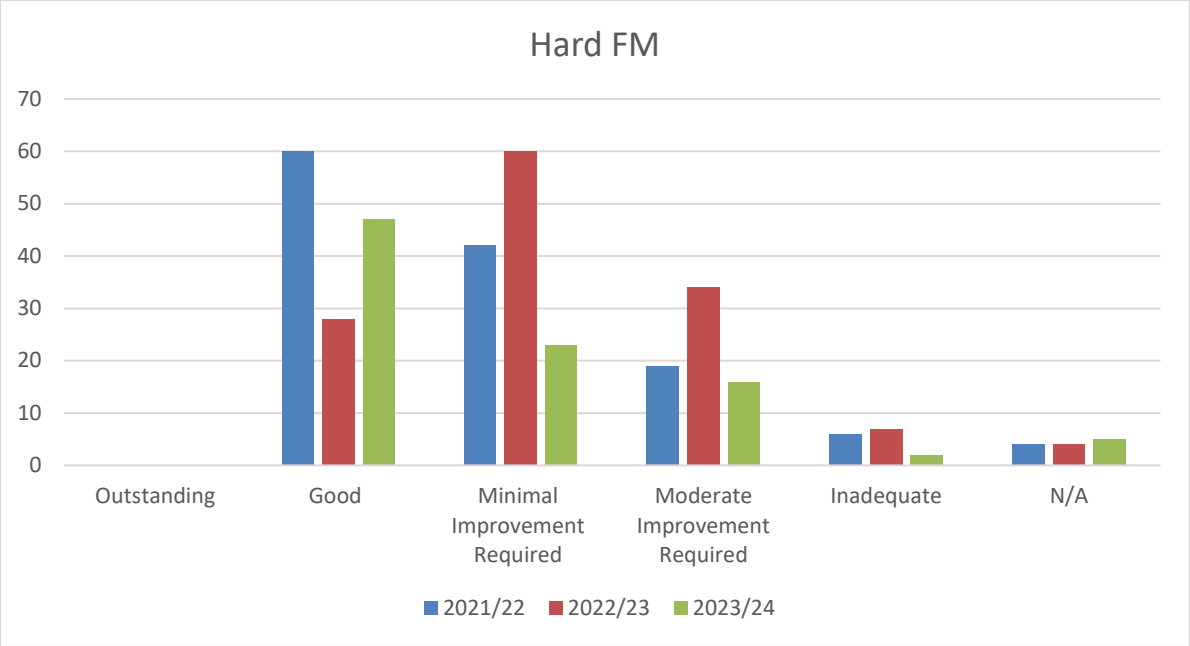


Figure 2 - Safety Soft - Comparison for 21/22 – 23/24 period

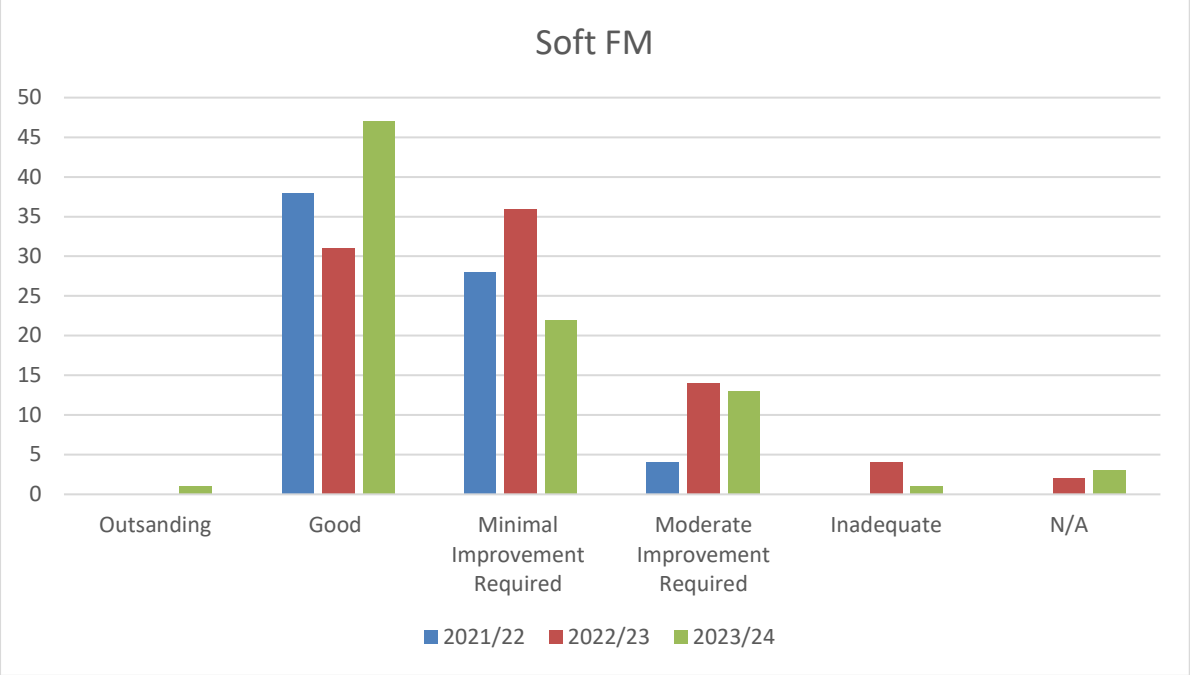


Figure 1 shows an increase in the self-assessment rating of Good with an equal reduction in Minimal Improvement Required, Moderate Improvement Required and Inadequate. This is as a result of the development and approval of technically specific policies and key personal appointments being made and reported at the HUTH EF&D Governanace & Assurance Group.

There is one SAQ in the Safety Hard domain that is self-assesed as being Inadequate throughout. This is SH18 Safety in Other Premises. This is when HUTH operates out of premises not owned by the Trust and is typical of 'outreach clinical services'. The weakness in assurance is considered an organisational issue and not solely isolated to EF&D. It has been self-assessed as part of the PAM as the Property Manager resides within the EF&D directorate. The root cause is due mainly to Health Groups occupying facilities in other 'landlord's premises', in order to deliver services close to the patient. However, this is invariably undertaken without any Heads of Terms, lease or rental agreement being put in place. This has the potential to put HUTH staff at risk, as they may be unaware of local procedures and arrangements, e.g. fire alarms and evacuation, health and safety arrangements, lone working, key handling, etc.

For the safety soft (see figure 2) there has also been an improvement in the level of assurance provided as service specific policies and by the introduction of national standards (Cleaning and Food & Nutrition). These issues have provided a stregthened framework on which to measure compliance and therefore the provision of assurance.

Figures 3 and 4 illustrate the self-assessment ratings for the core components for the technical and operationally specific SAQs in the Safety Hard and Safety Soft domains:

- Policy & Procedures
- Roles & Responsibilities
- Risk Assessment
- Maintenance
- Training & Development
- Emergency & Business Continuity Planning
- Review Process

It should be noted that Not Applicable (0) is used when the question is not included for that particular SAQ. This shows which element in each domain needs to be improved. Those with a score of 4 or above should be seen as priority to address.

Figure 3 - 23/24 SAQ Outcome Safety Hard

	P&P	R&R	RA	Mtce	T&D	EPRR	Review
SH1	3	3	2	3	3	2	3
SH2	4	2	2	3	3	2	2
SH3	4	3	3	3	0	3	4
SH4	3	3	4	0	4	0	4
SH5	2	2	3	0	3	2	2
SH6	3	2	3	3	2	3	3
SH7	3	2	2	3	3	3	2
SH8	4	3	3	3	3	3	2
SH9	4	3	2	3	2	3	2
SH10	4	2	3	3	3	3	2
SH11	2	3	3	4	2	3	2
SH12	3	3	2	3	2	3	2
SH13	2	3	2	2	3	2	2
SH14	4	3	4	3	3	3	4
SH15	2	4	4	2	2	2	3
SH16	2	3	2	4	3	0	2
SH17	2	2	2	0	2	2	0
SH18	5	5	5	5	5	5	5
SH19	3	2	2	3	3	3	3
SH21	3	4	4	5	0	0	4
Average	3	3	3	3	3	2	3

Figure 4 - 23/24 SAQ Outcome Safety Soft

SS1	4	4	4	3	4	3	2
SS2	2	4	3	3	3	2	2
SS3	4	4	3	2	4	3	3
SS4	3	3	3	2	2	2	2
SS5	3	3	2	2	2	2	2
SS6	2	2	2	2	2	2	2
SS7	5	3	2	2	2	2	3
SS8	2	2	2	3	3	2	2
SS9	3	3	2	2	1	2	2
SS10	0	3	3	2	0	0	2
Average	3	3	3	2	2	2	2

Key Considerations

- This year was a domain lead review year, the coming year will see the full-stakeholder review recommence with the potential of the re-introduction of the software solution.
- Some SAQs have been updated, or introduced, which has seen a limited change in terms of year-on-year comparison.

Areas of Good Practice

- Generally, there has been a noticeable shift to the positive in Safety Hard.
- Asbestos (SH5) has seen improvement in most areas, following some focus in recent years with regards to the Asbestos Archive, formal training and the appointment of qualified key personnel, approved Asbestos Policy and Asbestos Management Plan, appointment of Asbestos Consultant and more formalised data quality checks of the Asbestos management survey data for inclusion on the formal Asbestos Register.
- Electrical Systems (SH9) has also improved in a number of areas, in line with a number of other engineering disciplines.
- In the Safety Soft domain SS1 (Catering) appears to remain static but this is due mainly to the new national standards and the increased framework requirements.
- Security management (SS6) has demonstrated significant improvement from the previous year with approved policies and more robust training being undertaken.
- The rating of Outstanding was recommended for the Portering Services training and development process and the linking of Safe Systems of Work staff 'sign off'as read and understood. This maintains records for the Portering Service management team with embedded alerts when staff are about to expire.
- The Governance framework (G1) has improved significantly which is evident from the established monthly Governance & Assurance Group, improved risk register identifying controls and gaps and actions to mitigate the risk. Services are required to provide assurance reports based on HTMs, Legislative and Regulatory requirements, National guidance etc.

Key Areas for Improvements

- Safety in Other Premises (SH18) has been rated as Inadequate throughout, for the second consecutive year. This is seen as a Trust wide risk and has been included on the Trust Operational Risk Register (Risk ID 4312)
- SH14 Fire Safety has also seen a slight deterioration, which is attributed to the appointment of an AE (Fire) conducting their initial audit. This has introduced a challenge into the current processes within the Fire Safety Team. Work is required to strengthen the team and the processes.
- Work required to strengthen the level of assurance provided in the Transport Services SAQ (SS7).
- Waste Management (SS3) continues to plateau when improved assurance is needed in order to strengthen the waste management process.
- Policies and procedural documents are required for all relevant SAQ areas in the Safety Hard and the Safety Soft domains.
- The review process in the Safety Hard and the Safety Soft domains are on the whole 'Good', consideration should be given to independent reviews. Currently some services reviews are conducted by the staff within the services, which does not demonstrate impartiality.

Conclusion

Completed in isolation of any verification process, the very nature of self-assessment is a subjective process at best. However, the EF&D Information and Governance team acts semi-independently of the main Estates, Facilities & Development departments and offer an element of impartiality that challenges the validity of the assessment judgements as part of the validation process. The team cannot be seen to be semi-independent of all services as it currently reports to the Head of Operational Estates.

The Facilities department and its 'soft' services have experienced the absence of key personnel which could be the reason as to why levels of assurance have not improved significantly. However, there is a clear overall judgement of 'Good' assurance levels across the Facilties portfolio for the core components of the SAQ's .

Below are the reports recommendations for improvement :

Recommendations

- Complete the current implementation of a Trustwide Estates asset data-capture to improve asset management and maintenance with progress monitored through the Estates meeting structure.
- Strengthen the number of Policy and Procedural documents for all technical/operational services.
- Create comprehensive suite of Standard Operating Procedures (SOPs) for all disciplines.
- Consider how independent reviews/audits might be strengthened in areas where there is no external audits/monitoring.

Mark Green
Head of Information & Governance

June 2024

Appendix

1 – National Premises Assurance Model SAQ Reference Worksheets

HUTH Appendix 1.xlsx

Instructions: NHS Premises Assurance Model 2023: Please also read the separate NHS PAM Guidance Document

appendix 1 HUTH

Purpose and structure of this file	This file contains Self-Assessment Questions that help evaluate the way your organisation/site manages its estate and facilities in 5 Domains. Although the Safety Domain is notionally split between hard and soft Facility Management (FM) services some questions within the 'Combined and Hard FM' supply to both sections. These questions should be assessed across both hard and soft FM e.g. the SAQ relating to Health and Safety is within the 'Safety: Combined and Hard FM' but clearly applies to soft FM also. A number of other relevant sheets are also provided
How to complete it	The way to use this file is to fill in the 5 worksheets with yellow tabs, which include the domain self-assessment questions (SAQs). Year 1 | Year 2 | The assessment can be for one or two years if comparisons are required. 2022-23 | 2023-24 | ◄Use the drop down in the yellow boxes to alter the years where relevant Each SAQ contains several prompt questions. By answering the prompt questions, a result is automatically calculated for the SAQs and the domains. Please note it is not possible to give a rating to the SAQ directly, it has to be rated indirectly using the prompt questions or, alternatively, classified as not applicable. There are six possible responses for a prompt question: - Not applicable: this prompt question does not apply to your organisation/site. - Outstanding: compliant with no action plus evidence of high quality services and innovation. - Good: compliant no action required. - Requires minimal improvement: the impact on people who use services, visitors or staff is low. - Requires moderate improvement: the impact on people who use services, visitors or staff is medium. - Inadequate: action is required quickly - the impact on people who use services, visitors or staff is high.
Results	The "Summary' sheets show graphically the results of the NHS PAM self-assessment. - The 'summary' one shows the ratings at the domain level. It includes the average rating and the distribution of SAQ ratings for the 5 domains (i.e. the % of SAQs that obtain a rating of "Outstanding", the % of SAQs that obtain a rating of "Good", etc.) - The other 5 red 'Results' sheet detail the average rating and the distribution of the prompt questions ratings for each SAQ within the domain. This allows the user to see which SAQs are driving the results of the domains.

Annual Changes	**Annual changes may be required in line with updates to guidance and legislation, you can find an overview of the latest changes listed below.** **Changes for 2024:** **There has been several updates to the HBN and HTM guidance, the links within the spreadsheet remain up to date, but please familiarise yourself with the latest publications:** **https://www.england.nhs.uk/estates/complete-list-of-publications-related-to-nhs-estates/** **Please also note there has been some technical bulletins published this year these can be found: https://www.england.nhs.uk/estates/netb/** **Safety Hard** **Legislation & guidance updated.** **SH16, SH17, SH18 and G2 evidence: 'The organisation demonstrates that it undertakes process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working'** **SH4 H&S - MH wording added - (cell E47)** **Mental Health (MH) service Providers (and Trusts who may treat MH patients such as A&E) should consider:** **• Ligature Reduction** **• Barricade Reduction ironmongery** **• Absconding Reduction** **• Windows/Falls from Height** **• Ceiling Height** **• Air Locks** **• Fence heights** **• Bolt down Fixed Furniture and Equipment** **• Non Pick Mastic** **• Reduced breakable glass/plastic/fabric** **• MH court yards and Garden/furniture** **SH4 H&S - MH wording added (cell E45)** **4. The ability to report on the regulatory requirements regarding safer wards (ligature).** **5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.** **SH10 - wording updated** **•SH14 - Fire safety guidance added (cell F147)** **18. Approved Document B** **19. Equality Act 2010** **20. Regulation 38 – operating within the building on Fire Safety.** **SH19 - Safety Hard added - SH19.3 'contract expiry' and updated wording SH19.2** **Previous SH20 - regarding medical gasses (Framework TBC) - removed - will be added next year if the guidance is available on this)** **SH20 - removed** **SH21– Added separate question regarding ligature** **Safety Soft** **Legislation and guidance updated** **Cleanliness and infection control** **Legislation and guidance updated** **SS1.sub questions 15-21 wording updated slightly** **SS4 - Cleanliness and infection control - Sub questions 9,10,11 added** **SS4.8&9 wording added: (Although the mandatory requirement is to display in patient facing areas however a trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff) also guidance note 'Consider ambulance cleaning supplement'** **SS9 - Portering services - wording added within the guidance (cell f114):** **To note we are working on guidance for portering which will be available for reference next year, covering:** **- Service strategy (workforce)** **- Technology and equipment** **- Policy** **- Working with clinical teams** **SS10 - PSTN - added sub question SS10.7 - updated** **Efficiency** **Evidence updated:** **F3 Improved efficiencies in capital procurement, refurbishments and land management guidance and evidence updated (Cell E30 and F25)** **F3 Efficiency - added F3.2. 'Capital project Management' (also updated wording for F3.1)** **F4 Efficiency - added F4.3. 'Board reporting and contracting'** **'health system' updated, Procure 23 added - 10. NHS Net Zero Building Standard, 11. Estates Net Zero Carbon Delivery Plan (NZCDP), evidence wording updated to 'site level' 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects** **Effectiveness** **Evidence updated (Cell E33-39)** **Guidance legislation updated.** **-New Transport question proposed in E4.5** **- Updated E4.7 regarding procurement** **-Recently published Net Zero Travel & Transport strategy added to 'relevant guidance & legislation'** **Helipad - This question has been restructured to provide more evidence examples** **(cell B7-9) wording added to sub questions** **1.-The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.** **2. -The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to general helipad factors and considerations within the Trust.** **3. - In addition - The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.** **4- Added evidence and updated questions** **Maturity Tab '001' added**

NHS Premises Assurance Model (NHS PAM)

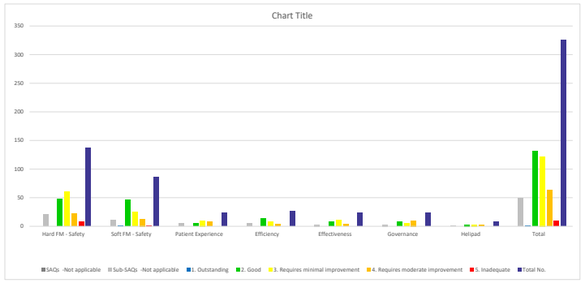
appendix 1 (HUTH)

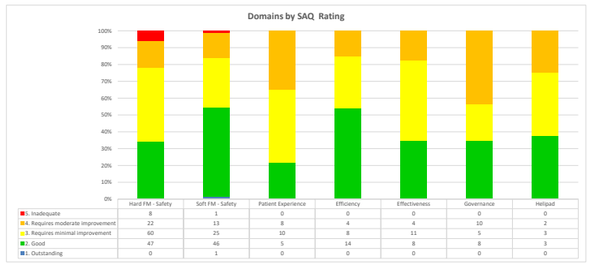
Trust:	HULL UNIVERSITY HOSPITALS NHS TRUST
Site Name:	
Year:	2023/24

SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH1	Estates and Facilities Operational Management	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable													0	0	
SH2	Design, Layout and Use of Premises	Hard FM - Safety	Applicable	4. Requires moderate in	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable													0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Document Management System in Place	2. Approval of documents	3. Review of documents	4: Availability of documents	5. Legibility of Documents	6: Document Control	7. Obsolescence	8. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH3	Estates and Facilities Document Management	Hard FM - Safety	Applicable	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate improvement													0	3000	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH4	Health & Safety at Work	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate improvement		4. Requires moderate in	Not applicable	Not applicable	Not applicable													0	0	
SH5	Asbestos	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal improvement		3. Requires minimal imp	2. Good	2. Good	Not applicable													0	0	
	Self Assessment Question (SAQ) Subject	Hard FM - Safety	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	9. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
SH6	Medical Gas Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate improvement													0	20000	
	Self Assessment Question (SAQ) Subject	Hard FM - Safety	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	
SH7	Natural Gas and specialist piped systems	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable													0	0	
SH8	Water Safety Systems	Hard FM - Safety	Applicable	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable													0	0	
SH9	Electrical Systems	Hard FM - Safety	Applicable	4. Requires moderate in	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	Not applicable													0	0	
SH10	Mechanical Systems and Equipment	Hard FM - Safety	Applicable	4. Requires moderate in	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable													0	0	
SH11	Ventilation, Air Conditioning and Refrigeration Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate in	2. Good	3. Requires minimal imp	2. Good	Not applicable													0	0	
SH12	Lifts, Hoists and Conveyance Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	Not applicable													0	0	
SH13	Pressure Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	Not applicable													0	0	
	Self Assessment Question (SAQ) Subject		Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Governance	4. Enforcement	5. Risk Assessment	6. Maintenance	7. Training and Development	8. Resilience, Emergency & Business Continuity Planning	9. Review Process	10. Costed Action Plans														
SH14	Fire Safety	Hard FM - Safety	Applicable	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	Not applicable											0	0	
SH15	Medical Devices and Equipment	Hard FM - Safety	Applicable	2. Good	4. Requires moderate in	4. Requires moderate in	2. Good	2. Good	2. Good	3. Requires minimal imp	Not applicable													0	0	
SH16	Resilience, Emergency and Business Continuity Planning	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	4. Requires moderate in	3. Requires minimal improvement		2. Good	Not applicable													0	0	
SH17	Safety Alerts	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	Not applicable		2. Good	2. Good	Not applicable													0	0	
SH18	Externally supplied estate	Hard FM - Safety	Applicable	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	5. Inadequate	4. Requires moderate improvement													0	80000	
SAQ No.19	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3.Contract Expiry	4. Risk Assessment	5. Maintenance	6. Contractor Compliance	7. Resilience, Emergency & Business Continuity Planning	8.. Review Process	9.. Costed Action Plans												Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH19	Contractor Management for Soft and Hard FM services	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable												0	0	
SAQ No.20	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy	2: Roles and Responsibilitie	3: Risk Assessment	4: Maintenance	5: Contractor Compliance	6: Review Process	7: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH21	Prompt Ops - Safety hard FM's	Hard FM - Safety	Applicable	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	5. Inadequate	4. Requires moderate in	4. Requires moderate in	Not applicable														Applicable	3. Requires minimal improvement	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8.Food Standards: Board Director	9.Food Standards: Strategy	10.Food Standards:Diatition	11.Food Standards: Safety Specialist	12.Food Standards: Workforce	13.Food Standards:Matrix	14.Food Standards: Waste	15.Food Standards: 24/7 Restaurant	16.Food Standards: 24/7 Café	17.Food Standards: 24/7 Vending machines	18.Food Standards: 24/7 Retail	19.Food Standards: Cold Vending	20. Food Standards: Smart Fridges	21.Food Standards: From home	22. Costed Action Plans	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS1	Catering services	Soft FM - Safety	Applicable	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	3. Requires minimal imp	4. Requires moderate in	3. Requires minimal imp	2. Good	4. Requires moderate in	4. Requires moderate in	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	3. Requires minim	2. Good	2. Good	2. Good	4. Requires moderat	0	1000	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS2	Decontamination process	Soft FM - Safety	Applicable	2. Good	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable													0	0	
SS3	Waste and Recycling Management	Soft FM - Safety	Applicable	4. Requires moderate in	4. Requires moderate in	3. Requires minimal imp	2. Good	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	Not applicable													0	0	
SAQ No.SS4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Cleaning Standards 2021: Star Ratings	9. Cleaning Standards 2021: Charter	10. Cleaning Standards 2021: Matrix	11.Cleaning Standards 2021: 95%	12: Costed Action Plans										Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS4	Cleanliness and Infection Control	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	4. Requires moderate in	2. Good	Not applicable										0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS5	Laundry and Linen Services	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable													0	0	
SS6	Security Management	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable													0	0	
SS7	Transport Services	Soft FM - Safety	Applicable	5. Inadequate	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	Not applicable													0	0	
SS8	Pest control	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	4. Requires moderate improvement													0	2000	
SS9	Portering services	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	1. Outstanding	2. Good	2. Good	Not applicable													0	0	
SS10	Estates IT and Building Information Management (BIM) systems	Soft FM - Safety	Applicable	Not applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable	Not applicable	#REF!	Not applicable													0	0	
SAQ No. P1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Views and Experiences	2. Engagement	3. Staff Engagement	4. Prioritisation	5. Value	6: Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P1	Engagement and involvement	Patient Experience	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	Not applicable															0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. PLACE Assessment	2. Other Assessments	3. Cleaning Schedules	4. Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P2	Condition, appearance, maintenance and privacy and dignity perception	Patient Experience	Applicable	3. Requires minimal imp	3. Requires minimal improvement		Not applicable																	0	0	
P3	Cleanliness	Patient Experience	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	Not applicable																	0	0	
P4	Access and Car Parking	Patient Experience	Applicable	3. Good	4. Requires moderate improvement		Not applicable																	100000	50000	
P5	Grounds and Gardens	Patient Experience	Applicable	3. Requires minimal imp	2. Good		Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Regulation	3. Choice	4. Equality issues	5. Information	6. PLACE Assessment	7. Other Assessments	8. Legal Standards	9: Costed Action Plans												Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P6	Catering services	Patient Experience	Applicable	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate improvement												0	50000	
SAQ No.F1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Analysing Performance	2: Benchmarking	3: Costed Action Plans																		Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F1	Performance management	Efficiency	Applicable	3. Requires minimal imp	3. Requires minimal imp	Not applicable																		0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Business Planning	2: Estate Optimisation	3: Commercial Opportunities	4: Partnership working	5: New Technology	6: PFI and LIFT contracts	7: Other contracts	8. Property	9. Cost Improvement plans	10: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F2	Improving efficiency - running	Efficiency	Applicable	4. Requires moderate in	4. Requires moderate in	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable												0	0	
SAQ No. F3	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Capital Procurement.	2. Capital Project Management	3. Capital Procurement Efficiencies	4. Flexibility	5. Identification and disposal of surplus land	6: Net zero carbons	7: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F3	Improving efficiency - capital	Efficiency	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable														0	0	
SAQ No.F4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy & Procedures	2: Review Process	3: Board Reporting & Contracting	4: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F4	Financial controls	Efficiency	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Quality and Sustainability	2. Financial Pressure	3. Continuous Improvement	4. Quality Improvements	5. Recognition	6. Use of Information	7: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F5	Continuous improvement	Efficiency	Applicable	4. Requires moderate in	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate in	Not applicable														0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Vision and Values	2. Strategy	3. Development	4. Vision and Values Understood	5. Strategy Understood	6. Progress	7: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E1	Vision and strategy	Effectiveness	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable														0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Local Planning	2. Neighbourhood Planning	3. Planning Control	4. Special Interests	5. Enforcement	6: Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E2	Town planning	Effectiveness	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	4. Requires moderate in	Not applicable															0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Disposal of land and property	2: Granting of Leases	3: Acquisition of land and property	4: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E3	Land and Property management	Effectiveness	Applicable	2. Good	2. Good	2. Good	Not applicable																	0	0	
SAQ No.E4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Green Plan / Sustainability Strategy	2: Energy	3: Waste	4: Air Pollution	5.Travel & Transport	6.Water	7. Climate Change Adaptation	8. Procurement	9: Costed Action Plans												Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E4	Sustainability	Effectiveness	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	4. Requires moderate in	3. Requires minimal imp	4. Requires moderate in	3. Requires minimal imp	4. Requires moderate improvement												0	1000	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Framework	2. Roles	3. Partners	4. Framework	5: Assurance	6. Monitoring	7. Audit	8. Mitigation	9. Alignment	10: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G1	Governance process	Governance	Applicable	3. Requires minimal imp	4. Requires moderate in	2. Good	2. Good	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	2. Good	3. Requires minimal imp	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Effectiveness	2. Challenges	3. Visibility	4. Relationships	5. Respect	6. Behaviours.	7. Culture	8. Honesty.	9. Safety & Wellbeing	10. Healthier workplace	11. Collaboration	12: Costed Action Plans									Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G2	Leadership and culture	Governance	Applicable	2. Good	4. Requires moderate in	3. Requires minimal imp	4. Requires moderate in	4. Requires moderate in	2. Good	4. Requires moderate in	4. Requires moderate in	4. Requires moderate in	2. Good	4. Requires moderate in	Not applicable									0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Professional advice	2. In-house advisors	3. External advisors	4: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G3	Professional advice	Governance	Applicable	2. Good	2. Good	3. Requires minimal imp	Not applicable																	0	0	

SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Compliance Assessment and Policy Review: Adherence to CAP1264 and Downwash Helipad Considerations in the Trust:	2: Roles and Responsibilities	3: Risk Assessment and Mitigation Strategies for Helipad and Estate	4: Resilience, Emergency & Business Continuity Planning	5: Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads	6: Resilience, Emergency & Business Continuity Planning	7: Review Process	8. Collaboration	10. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
H1	Helipad	Helipad	Applicable	4. Requires moderate im	4. Requires moderate im	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Q1 How integrated is facilities management - Soft Services?	Q2. How integrated is facilities management - Hard Services?	Q3. How integrated is Property Leadership?	Q4. How integrated are your FM Management IT Systems?	Q5 - How closely does FM management work with the FM delivery organisation(s)?	Q6 - How strategic and effective are supplier relationships?	Q7 - How transparent is FM delivery between the management organisation and delivery organisation?	Q8 - Does the FM team collaborate outside of the management organisation?	Q9 - How effective is your hard compliance management approach?	Q10 - How effective is your soft compliance management approach?	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	Q13 - How well defined are FM roles and responsibilities within Hard Services?	Q14 - How well defined are FM roles and responsibilities within Soft Services?	Q15 - How flexible is FM to changing business needs?	Q16 -How strategic is FM?	Q17 -Do you have effective FM governance in place?	Q18 -Do you have a clear definition and recognised Intelligent client function?	Q19 - Is an effective client department in place?	Q20 -How well do you understand the levers to improve performance?	Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	Q22 - How proactive is FM service delivery in your organisation?		Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
H1	FM01	FM Maturity Framework																									#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject		Q1 - What level of location hierarchy is asset data captured against?	Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	Q3 - How consistently is the data specification applied across the estate?	Q4 - What is the level of coverage of assets in the asset register data?	Q5 - How complete is the data captured against assets in the asset register?	Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	Q9 - What processes are in place for data quality checks (5.4)?	Q10 - What processes are in place for data update assurance (5.5)?	Q11 - What governance is in place to support data assurance and quality (5.6)?	Q12 - What level of documentation exists for the these data quality processes and governance (5.7)?	Q13 - Is the data contractually owned by the organisation (6.1)?	Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	Q15 - What level of access management exists for controlling user privileges (6.3)?	Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	Q18 - Does the asset management systems sync to a common data platform (7.3)?	Q19 - Do the systems meet data security requirements (7.4)?	Q20 - Do the systems meet data backup management requirements (7.5)?	Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	Q22 - How does asset data inform decisions relating to contract management (8.2)?	Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	Q26 - What is the capacity of the teams working with asset data (9.1)?
H1	FM02	FM Maturity Framework																									#REF!	#REF!	

Domain	SAQs -Not applicable	Sub-SAQs -Not applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total No.
Hard FM - Safety	0	21	0	47	60	22	8	137
Soft FM - Safety	0	11	1	46	25	13	1	86
Patient Experience	0	5	0	5	10	8	0	23
Efficiency	0	5	0	14	8	4	0	26
Effectiveness	0	3	0	8	11	4	0	23
Governance	0	3	0	8	5	10	0	23
Helipad	0	1	0	3	3	2	0	8
Total	0	49	1	131	122	63	9	326





	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance	Helipad
5. Inadequate	8	1	0	0	0	0	0
4. Requires moderate improvement	22	13	8	4	4	10	2
3. Requires minimal improvement	60	25	10	8	11	5	3
2. Good	47	46	5	14	8	8	3
1. Outstanding	0	1	0	0	0	0	0

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)

◄◄ Back to instructions

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "inadequate" the whole of the Safety Domain will be rated as "inadequate".

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH1	**SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 2. CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. •Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Health Building Note 00-08: The efficient management of healthcare estates and facilities 5. Health Building Note 00-09: Land and Property Appraisal - Available on the NHS Estates Collaboration Hub 6 A Risk-Based Methodology for establishing and Managing Backlog (NHS Estates 2004) 7. Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services 8. BS ISO 55000, 55001 & 55002: 2014 Asset Management 9 Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent.	
SH1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/health-technical-memorandum/ https://www.england.nhs.uk/estates/health-building-notes/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148143/Backlog_costing.pdf https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/guidance-and-support/ https://www.iso.org/standard/55088.html Health Technical Memorandum https://www.iso.org/iso-9001-quality-management.Health Technical Memorandum Government Property Standard Launch 7th September 2022 Government Property Strategy 2022-2030 - GOV.UK (www.gov.uk) Government Asset Data Standard Launched Jan 2022 Government Function: Property - FMS 002: Asset Data (publishing.service.gov.uk) Government Facilities Management Standard Launched April 2022 Facilities Management Standard 001: Management and Services - GOV.UK (www.gov.uk)	
SH1	**2: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH1	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place;		
SH1	**5: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. If technical expertise outsourced - appointment of qualified consultant or investment in training for staff in functional suitability issues (critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs) 4. If technical expertise in-house - PDP's, TNA, training plans, certificates of attendance/accreditation Purpose is to be able to identify levels of compliance to inform strategy/priority/investment		
SH1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH1	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS FAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH2	**SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability??**	Applicable	Applicable	SH2: With regard to the Design, Layout and Use of Premises in relation to functional suitability can the organisation evidence the following? Critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs	1. Health and Social Care Act 2008 Regulations 14 and CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 2. CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 3. Land and property appraisal (2007 DH) 4. Estates April 2010 5. SH10 to 2015 government policy: compassionate care in the NHS 6. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 7. Healthb Building Note 00-01 General design guidance for healthcare buildings 8. Health Building Note 00-08 Strategic framework for the efficient management of healthcare estates and facilities 9. Health Building Note 00-02 Designing sanitary spaces 10. Building Regulations Parts M and K 11. Dementia design checklist 12. Health Building Note 08-02 Dementia friendly health and social care environments 13. NHSE Dementia assessment and improvement framework 14. Privacy and dignity report by the CNO into mixed sex accommodation in hospitals 15. Health Building Note 00-09 Infection control in the built environment 16. Secure by design 17. NetZero Travel & Transport Strategy https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.hee.gov.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/other-guidance/ https://www.legislation.gov.uk/ukpga/2010/15/contents https://www.gov.uk/government/publications/2010-to-2015-government-policy-compassionate-care-in-the-nhs/2010-to-2015-government-policy-compassionate-care-in-the-nhs https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03 https://www.england.nhs.uk/estates/health-building-noteshttps://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces https://www.gov.uk/government/publications/consolidation-and-simplification-of-parts-m-k-and-n-of-the-building-regulations https://www.dementiaaction.org.uk/assets/0000/4336/dementia_friendly_environments_checklist.pdf https://www.england.nhs.uk/estates/health-building-notes/ https://improvement.nhs.uk/resources/dementia-assessment-and-improvement-framework/ NEW-Delivering_same_sex_accommodation_wp2019.pdf (england.nhs.uk) https://cdb.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment https://www.securedbydesign.com/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ For consideration: Protect legislation will be updated and released this year – Trusts should be prepared to self assess against threats of risk of your estate (i.e. minimising threats against the estate - reference 'Martins law' which is due to be released).	
SH2	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Estate strategy setting out current baseline, plans to address deficiencies including organisations risk management process/system; 4. Space and strategy/policy 5. Privacy and dignity strategy/policy 6. Equality Act accessibility assessment 7. Local Authority approved travel plan 8. Security policy 9. Standard specification		
SH2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Good	3. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. If technical expertise in-house - job descriptions, PDP's, TNA, training plans 5. If technical expertise outsourced - specification, qualifications and references. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandum's and other standards.		
SH2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Sit/Sept survey		
SH2	**4: Maintenance** Are relevant assets, equipment and plant adequately maintained? (Note 1)	3. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place;		
SH2	**5: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. If technical expertise outsourced - appointment of qualified consultant or investment in training for staff in functional suitability issues (critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs) 4. If technical expertise in-house - PDP's, TNA, training plans, certificates of attendance/accreditation Purpose is to be able to identify levels of compliance to inform strategy/priority/investment		
SH2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans in place if sept/sit is closed due to unacceptable levels of compliance - breach of 15 (1) (c, d and f) 6. Business continuity plans 7. Escalation to relevant committees 8. Peer review output		
SH2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Sit/Sept survey; 4. Access audits; 5. Technical reports to cover critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs 6. Audit plan 7. Audit reports 8. Peer review output		
SH2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS FAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH3	**SH3: With regard to Estates and Facilities Document Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the coordination and control of the flow (storage, retrieval, processing, printing, copying, routing, distribution and disposal) of electronic and paper documents for Estates & Facilities documents in a secure and efficient manner.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. BS EN 15221 Facilities Management 5. BS ISO 55000, 55001 & 55002: 2014 Asset Management 6. Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent.	
SH3	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures	https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/2992764/HTM_00.pdf https://shop.bsigroup.com/ProductDetail?pid=000000000030206404 https://www.iso.org/standard/55088.html https://www.iso.org/iso-9001-quality-management.html https://wfpm.org/wfpm-model/	
SH3	**2: Approval of documents** Are documents approved for adequacy prior to issue?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH3	**3: Review of documents** Are documents reviewed and updated as necessary with changes identified?	3. Requires minimal improvement	3. Requires minimal improvement	1. Regular of policies and procedures to ensure implementation;		
SH3	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of document availability both in terms of policies/procedures as well as spot checks on availability;		
SH3	**5: Legibility of Documents** Are all relevant documents legible and readily identifiable?	Not applicable	Not applicable	1. Review of document availability both in terms of policies/procedures as well as spot checks on legibility;		
SH3	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of policies and procedures to ensure implementation;		
SH3	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	4. Requires moderate improvement	4. Requires moderate improvement	1. If formal procedures in place to identify and replace obsolete documents; 2. Records of document replacement; 3. Review of documents replacement records to ensure completeness and accuracy;		
SH3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	4. Requires moderate improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS FAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£30,000	£3,000			
SH4	**SH4: With regard to Health & Safety at Work can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to overall H&S management. Most of the Safety SAQs will contain aspects of compliance with H&S legislation also e.g. risk assessments and COSHH assessments.	1. The Health and Safety at Work etc. Act 1974. The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. Management of Health and Safety at Work Regulations 1999 3. Leading health and safety at work: leadership actions for directors and board members INDG417(rev1)– hse.gov.uk 4. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended) Approved Code of Practice L146 - hse.gov.uk 5. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. 7. CQC Provider Handbooks W3.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
SH4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Evidence that H&S regulations are: - Understood by all teams involved - Applied by all teams involved - Systematically checked for compliance - Reported for exceptions 4. H&S Committee involvement - committee structure chart and terms of reference 5. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities		
SH4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 1. Adequate welfare facilities 4. CQC/HH assessments 5. Health and Safety audits / inspections (completed internal and examples of any external agency reports and associated action plans) 6. Plant and equipment are safe including maintenance, service and test reports 7. Safe arrangements for the use, handling, storage and transport of articles, materials and substances, 8. Safe access and egress.		
SH4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Examples of completed risk assessments – including COSHH, DSE, stress etc.		
SH4	**4: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements? (Note 1)	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports		
SH4	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	Not applicable	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. H&S information for staff 6. Copies of permits to work issued and documented procedures and training records for staff responsible for issue of permit to work 7. Copies of insurance and written schemes of inspection certificates 8. Evidence of compliance with all relevant published HBNs, CDFPs and Health technical Memorandum TMs 9. Meeting minutes 6. Documentation and procedures for Safe systems of work		
SH4	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Requires moderate improvement	4. Requires moderate improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports and subsequence investigations including root cause analysis investigations 4. The ability to report on the regulatory requirements regarding refer words (figatures) 5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible risks/surface temperatures) particularly when in relation to Mental health facilities and A&E wards.		
SH4	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS FAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH4	Capital cost to achieve compliance	£0	£0			
SH4	Revenue consequences of achieving compliance	£0	£0			
SH5	**SH5: With regard to Asbestos can the organisation evidence the following?**	Applicable	Applicable		1. Control of Asbestos Regulations 2012 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 3. CQC Guidance for providers on meeting the regulations 4. REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2008). 5. HSE equipment and method series (sim1 etc.) 6. HSE asbestos essentials task sheets (A1 etc.) https://www.legislation.gov.uk/ukdsi/2012/9780111117613/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.hse.gov.uk/reach/ https://www.hse.gov.uk/pubns/guidance/emseries.htm https://www.hse.gov.uk/pubns/guidance/emseries.htm	
SH5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	3. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Permits to work 4. Procedures to undertake work 5. Asbestos management plan 6. Asbestos register		
SH5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Procedures to ensure staff and contractors have appropriate competencies, licenses, professional indemnities and liability insurance. Evidence that these have been checked. 5. Permits to work 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Evidence of assessment of the location and condition of the asbestos containing materials - or materials which are presumed to contain asbestos. 5. Evidence of risk assessments relating to the potential exposure to fibres from the materials identified. 6. A plan that sets out in detail how the risks from these materials will be managed and how this has been actioned.		
SH5	**4: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	4. Requires moderate improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records;		
SH5	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Good	3. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence that reasonable steps have been taken to find out if there are materials containing asbestos in non-domestic premises, and if so, its amount, where it is and its condition. 6. Evidence that there is a period review of the plan and the arrangements in place to ensure that the plan remains relevant and up-to-date.		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)

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The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "inadequate" the whole of the Safety Domain will be rated as "inadequate".

	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH6	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Requires moderate improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence that information on the location and condition of the materials is provided to anyone who is liable to work on or disturb them 4. Active asbestos register 5. Significant findings from Authorising Engineer reports and action plans.		
SH6	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or "requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	4. Requires moderate improvement	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve corrollance	£0	£0			
	Revenue consequences of achieving compliance	£6,000	£0			
SH6	**SH6: With regard to Medical Gas Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 02-01: Medical gas pipeline systems 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. Central Alert System – Organizations to familiarise themselves with this alert: https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103223 https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_acc_residential_services_provider_handbook_march_15_update_01.pdf	
SH6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	3. Requires minimal improvement	1. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B. 2. The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid oxygen system. 3. The organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)		
SH6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Good	2. Good	1. Trust management structure/organogram for this area; 2. The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions 3. Key relevant Objectives for the period:1. Permit to work 4. Approved persons 5. Authorised Persons 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Organisation has a risk assessment as per section 6.6 of the HTM 02-01 3. Organisation has undertaken an annual review of the risk assessment as per section6.134 of the Health Technical Memorandum 02-01 (please indicated in the organisational evidence column the date of your last review)		
SH6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Up to date asset register incorporated into CAFM system; 4. Quality control/inspection records 5. Copies of test certificates/EC Declarations of Conformity 6. Records of inspections/thorough examinations 7. Written schemes of examination 8. Copies of insurance certificates/formal documentation from notified bodies A Are you sampling the air of the environment as minimum period at least annually. In relation to the frequency & sampling of the environment of nitrous oxide in the air are other considerations made, e.g., Seasonal impact, for example if the windows have been opened. 5. The organisation demonstrates compliance to COSHH, having a high level policy which outlines roles and responsibility and strategic documentation 6. The organisation has proven testing methodology related to environmental sampling, seeking assurance of contracted laboratories upon their processes and any third party assurance of those laboratories, e.g., accreditation or certification		
SH6	**5: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Good	3. Good	1. The organisation has reviewed the skills and competencies of identified roles within the Health Technical Memorandum and has assurance of resilience for these functions; including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	4. Requires moderate improvement	3. Requires minimal improvement	1. The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases; 2. The organisation has a clear escalation plan and processes for management of surge in oxygen demand either bulk or cylinder 3. Regular testing of Emergency response, business continuity plans and escalation plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports and action plans. 4. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities; 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working		
SH6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or "requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	4. Requires moderate improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve corrollance	£0	£0			
	Revenue consequences of achieving compliance	£20,000	£20,000			
SH7	**SH7: With regard to Natural Gas and specialist piped systems can the organisation evidence the following?**	Applicable	Applicable	See SAQ SH6 for Medical gas systems. This SAQ covers other gas installations and piped systems with specialist requirements such as high purity, compressed air negative pressure systems.	1. Gas Appliances (Safety) Regulations 1995 2. Gas Safety (Installations & Use) Regulations 1998 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpf/1995/1629/contents/made https://www.legislation.gov.uk/ukxi/1998/2451/contents/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Approved persons, including employing a suitably qualified person where appropriate, i.e. "Gas Safe Registered" 5. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards. 6. Permit to work		
SH7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/inspection records		
SH7	**5: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Quality Control Evidence 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working.		
SH7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or "requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve corrollance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH8	**SH8: With regard to Water Safety Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 00: Policies and principles of healthcare engineering 2. Water Supply (Water Fittings) Regulations 1999 3. Defra's guidance to the Water Supply (Water Fittings) Regulations 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: the control of legionella, hygiene, safe hot water, cold water and drinking water systems (Scheduled to be replaced in April 2016 by Health Technical Memorandum 04-01: Safe water in healthcare premises) 5. Notification of Cooling towers and Evaporative Condensers Regulations 1992 6. HSE's Approved Code of Practice L77 (2013) Control of substances hazardous to health 7. Health Technical Memorandum 07-01: Water Management and Water Efficiency 8. Health Technical Memorandum 07-04: Water management and water efficiency – best practice advice for the healthcare sector 9. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.legislation.gov.uk/uksi/1999/1148/contents/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.hse.gov.uk/pubns/books/l8.htm https://www.gov.uk/government/publications/hot-and-cold-water-supply-storage-and-distribution-systems-for-healthcare-premises https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities; 4. Water Safety Plans in place, including legionella written scheme 5. Action Plans, including their implementation 6. Control Measures and testing micro- organisms including Legionella and Pseudomonas 7. Organisational with boreholes must comply with the Private Water Supplies Regulations 2009		
SH8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Water Safety Group with relevant advice and attendees		
SH8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH8	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/inspection records 4. HSE's Approved Code of Practice (ACoP) L8 (2013), HSG274 Parts 1, 2 and 3, Health Technical Memorandum 04-01: Safe Water in Health Care Premises		
SH8	**5: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Reports to Infection Control Committee or other groups within the Governance Structure 4. Significant findings from Authorising Engineer reports and action plans. 5.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working.		
SH8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or "requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	3. Requires minimal improvement	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve corrollance	£0	£0			
	Revenue consequences of achieving compliance	£50,000	£0			
SH9	**SH9: With regard to Electrical Systems can the organisation evidence the following?:**	Applicable	Applicable	This SAQ covers all aspects of electrical safety such as high and low voltage, switchgear, BMS, fire detection, communication, security, Lightening protection, PAT testing etc.	1. Electricity at Work Regulations 1989 (EAWR) 2. Electrical Equipment (safety) Regulations 1994 3. Electromagnetic Compatibility regulations 1992 4. Supply of Machinery (Safety) (Amendment) Order 1992 5. Health Technical Memorandum 06-01: Electrical Services/Safety 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health Technical Memorandum 06-01: Electrical Services/Safety 8. Health Technical Memorandum 06-02: Electrical Safety Guidance for Low Voltage Systems in healthcare premises 9. Health Technical Memorandum 06-03:Electrical safety guidance for high voltage systems in healthcare premises 10. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 11. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1989/635/contents/made https://www.legislation.gov.uk/uksi/1994/3260/contents/made https://www.legislation.gov.uk/uksi/1992/2372/contents/made https://www.legislation.gov.uk/uksi/1992/1031/made https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.gov.uk/government/publications/electrical-safety-guidance-for-high-voltage-systems-in-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of the policies and procedure through the ESG, or add separate bullet point for the ESG;		
SH9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2.Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards and Authorised Persons appointed as recommended by Authorising Engineer.		
SH9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Good	2. Good	1. Risks reviewed and included in local risk register; 2. The Risk register should be developed and monitored by the ESG as per Health Technical Memorandum 06-01; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Up to date asset register incorporated into CAFM system; 4. Quality control/inspection records 5. Copies of test certificates/EC Declarations of Conformity 6. Records of inspections/thorough examinations 7. Written schemes of examination 8. Copies of insurance certificates/formal documentation from notified bodies		
SH9	**5: Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	4. Requires moderate improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or "requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve corrollance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH10	**SH 10: With regard to Mechanical Systems and Equipment can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers work systems not included elsewhere e.g. Space heating (Equipment with a medical use is assessed under SH15). This also covers devices and equipment covered under LOLER and PUWER. Please use the guidance for further information (PUWER and LOLER) but some examples (not all) are: powered tugs and pallet trucks, temporary platforms, hop ups, fork lifts, cherry pickers, autoclaves, washer disinfectors, pneumatic tube systems, auto valets, lathes, presses, steam cleaners, riggers, tractors commercial lawn mowers.	1. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 2. Provision and Use of Work Equipment Regulations 1998 (PUWER) 3. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 5. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/work-equipment-machinery/loler.htm https://www.hse.gov.uk/pubns/books/puwer.htm https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		

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The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH01	**2: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	4. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH01	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records 4. Copies of test certificates/EC Declarations of Conformity 5. Records of inspections/thorough examinations 6. Copies of insurance certificates/formal documentation from notified bodies 7. Written schemes of examination		
SH01	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH01	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH01	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH01	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH11	**SH11: With regard to Ventilation, Air Conditioning and Refrigeration Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH01	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH01	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH01	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH01	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Health Technical Memorandum 03-01 part B recommends: a. All ventilation plant should meet a minimum requirement in terms of the control of Legionella and safe access for inspection and maintenance. b. All ventilation plant should be inspected annually. c. The performance of all critical ventilation systems (such as those servicing operating suites) should be verified annually		
SH01	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH01	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH01	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports;		
SH01	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH12	**SH12: With regard to Lifts, Hoists and Conveyance Systems can the organisation evidence the following?**	Applicable	Applicable	Medical hoists and lifts are covered under SH15 Medical Devices and Equipment.	1. Lifts Regulations 1997 2. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 3. Health Technical Memorandum 08-02: Design and maintenance of lifts in the health sector - Lifts 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1997/831/contents/made https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.gov.uk/government/publications/guidance-concerning-the-planning-installation-and-operation-of-lifts-in-healthcare-buildings https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH01	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of protocols and procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site aligned to guidance; 2. Regular assessment of policies and procedures; 3. Local operating procedures in place including such items as contractors working on fire compartments		
SH01	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH01	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH01	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records		
SH01	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH01	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH01	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH01	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH13	**SH13: With regard to Pressure Systems can the organisation evidence the following?**	Applicable	Applicable	Users can assess the specific requirements around Pressure Systems in this SAQ or within relevant SAQ with pressure systems e.g. medical gases. The approach used should be explained in the notes column.	1. Simple Pressure Vessels (Safety) Regulations 1991 2. Pressure Systems Safety Regulations 2000 (PSSR) 3. Pressure Equipment Regulations 1999 4. HSE Guidance Note PM5: 1999 Automatically Controlled steam and hot water boilers now Safe Management of Industrial Steam and Hot Water Boilers HSE ACG434 2011 5. ACoP L122 Safety of Pressure Systems 6. Health Technical Memorandum 00: Policy and Principles of Healthcare Engineering 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/uksi/1991/2749/contents/made https://www.legislation.gov.uk/uksi/2000/128/contents/made https://www.legislation.gov.uk/ukpga/1999/20/contents/made https://www.hse.gov.uk/research/rhal_pdf/2005/rr335-11.pdf https://www.hse.gov.uk/pubns/books/l122.htm#:~:text=The%20Pressure%20Systems%20Safety%20Regulations,one%20of%20the%20components%20parts. https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_00.pdf https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH01	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH01	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH01	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH01	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records		
SH01	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH01	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH01	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH01	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH14	**SH14: With regard to Fire Safety can the organisation evidence the following?**	Applicable	Applicable	This SAQ assesses Fire Safety in its entirety including detection and alarm systems, sprinklers/water mist systems, fire pumps/ generator test. There may be some overlap with other SAQs, e.g. SH9 and SH11 that can be cross referred to avoid duplication	1. Regulatory Reform (Fire Safety) Order 2005 2. Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 3. The Fire and Rescue Services Act 2004 4. Health and Safety (Training for Employment) Regulations 1990 5. Health and Safety at Work Act 1974 6. Management of Health and Safety at Work Regulations 1999 7. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 8. Safety Representatives and Safety Committees Regulations 1977 9. Building Regulations 2000 10. The Housing Act 2004 11. Health Technical Memorandum 05-01: Managing Healthcare Fire Safety 12. Health Technical Memorandum 05-02 Guidance in Support of Functional Provisions for Healthcare Premises 13. Health Technical Memorandum 05-03 Fire safety - Operational Provisions 14. HM Government – fire safety risk assessment 'Means of Escape for Disabled People' 15. HM Government – fire safety risk assessment 'Healthcare premises' 16. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 17. CQC Guidance for providers on meeting the regulations 18. Approved document B in the building regulations volume B2 19. Equality Act 2010 20. Regulation 38 – operating within the building on Fire Safety 21.Estates Technical Bulletin - Risks of electrical batteries for the NHS estate 22. Building safety Act 2022 - https://www.legislation.gov.uk/ukpga/2022/30/contents/enacted https://www.legislation.gov.uk/uksi/2005/1541/contents/made https://www.legislation.gov.uk/uksi/2003/3457/contents/made https://www.legislation.gov.uk/ukpga/2004/21/pdfs/ukpga_20040021_en.pdf https://www.legislation.gov.uk/uksi/1990/1380/contents/made https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1995/3163/contents/made https://www.legislation.gov.uk/uksi/1977/500/contents/made https://www.legislation.gov.uk/uksi/2000/2531/contents/made https://www.legislation.gov.uk/ukpga/2004/34/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.gov.uk/government/publications/fire-safety-risk-assessment-means-of-escape-for-disabled-people https://www.gov.uk/government/publications/fire-safety-risk-assessment-healthcare-premises https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1124736/Approved_Document_B__fire_safety_-_volume_2_-_Buildings_other_than_dwellings__2019_edition_incorporating_2020_and_2022_amendments.pdf https://gb01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.legislation.gov.uk%2Fukpga%2F2010%2F27%2F21%2Fregulation%2F38%2Fmade&data=05%7C01%7Cayley.morris1@nhs.net%7Cb384c2985c7e4f5597df68d9a53e5ee3%7C37c354b292bf4f7f8a2291d1749edb7e%7C0%7C0%7C638038715851352527%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=2vuEuMuvHfcqMWuMFwR4233BOiQ7hqQFjEeDMrY7k%3D&reserved=0 https://www.england.nhs.uk/long-read/the-estates-technical-bulletin-neb-risks-of-electrical-batteries-for-the-nhs-estate/ For consideration to relevant Trusts Building Safety Act 22	
SH01	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH01	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH01	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH01	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records		
SH01	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH01	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5.Plans for fire alarm mitigation in cases of system failure 6. Reduction of unwanted fire signals (both false alarms and spurious calls on the fire and rescue authority)		
SH01	**9: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures? (Note 1) Is the annual audit of fire safety and fire safety management undertaken, and the outcomes communicated to the Trust Board as outlined in HTM 05-01 section 7.14?	4. Requires moderate improvement	4. Requires moderate improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Significant findings from Authorising Engineer reports; 4. Fire service audits; 5. Evacuation tests; 6. Fire risk assessment review frequency aligned to legislative requirements and risk.		
SH01	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non-compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH15	**SH15: With regard to Medical Devices and Equipment can the organisation evidence the following?**	Applicable	Applicable	Decontamination is covered under SAQ SS1	1. Provision and Use of Work Equipment Regulations 1998 2. ACoP 22 Safe Use of work Equipment 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Medicines and Healthcare Products Regulatory Agency (MHRA) Guidance 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations https://www.hse.gov.uk/pubns/books/puwer.htm https://www.hse.gov.uk/pubns/books/l22.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/290276/HTM_00.pdf https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH01	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH01	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period.		
SH01	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	4. Requires moderate improvement	4. Requires moderate improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)

◄◄ Back to Instructions

The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***

Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".

	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH01	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records		
SH02	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH03	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	3. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH04	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH05	**8: Costed Action Plans** If any ratings in this SAQ are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH06	**SH16: With regard to Resilience, Emergency and Business Continuity Planning can the organisation evidence the following?**	Applicable	Applicable	This SAQ looks at the overall approach to resilience, emergency and business continuity planning. This is in relation to estates and facilities	1. Civil Contingencies Act 2004 2. NHS Standard Contract; 3. Health Building note 00-07 Resilience planning for NHS facilities 30 April 2014: Guidance 4. NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and Associated Guidance 5. BCI 22301:2014 'Business Continuity Management Systems' 6. BCI 22313:2012 'Business Continuity management Systems Guidance'. 7. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/2004/36/contents https://www.england.nhs.uk/nhs-standard-contract/ https://www.gov.uk/government/publications/resilience-planning-for-nhs-facilities https://www.england.nhs.uk/wp-content/uploads/2017/12/epr-guidance-chart-v3.pdf https://shop.bsigroup.com/ProductDetail/?pid=000000000030292502 https://www.iso.org/standard/75107.html https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH07	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301; 2. The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcomes of any audits, reviews and status of any corrective action are annually reported to the board;		
SH08	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation's Estates and Facilities team is appropriately represented at the organisation's committee(s) which oversee Business Continuity and/or Emergency Preparedness; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH09	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Good	3. Good	1. The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH10	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Requires moderate improvement	4. Requires moderate improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records		
SH11	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH12	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Good	1. The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s); 2. Outputs of reviews and their inclusion in Action Plans;		
SH13	**7: Costed Action Plans** If any ratings in this SAQ are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH14	**SH17: With regard to the reporting of safety related issues and actioning of safety related alerts for estates and facilities issues can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to: 1. Reporting safety related incidents and accidents, 2. Ensuring corrective action is taken where notified in E&F safety alert system and similar.	1. National Framework for Reporting and Learning from Serious Incidents Requiring Investigation 2. Regulation 16 and 18 of the Care Quality Commission (Registration) Regulations 2009 3. Department of Health Never Events Policy Framework 4. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 6. CQC Guidance for providers on meeting the regulations 7. Health and Care Act 2022 https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incdnt-framwrk-upd.pdf https://www.cqc.org.uk/files/care-quality-commission-registration-regulations-2009 https://www.england.nhs.uk/patient-safety/revised-never-events-policy-and-framework/ https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SH15	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH16	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Embedding bulletins into practice		
SH17	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH18	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	Not applicable	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH19	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH20	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports 4. Investigations		
SH21	**7: Costed Action Plans** If any ratings in this SAQ are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH22	**SH18: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services can the organisation evidence the following?**	Applicable	Applicable	This SAQ mainly refers to ensuring rented (or similar) premises and related services are safe and suitable. Duties and services will generally be considered under the relevant SAQ as the Contractor management SH16. See the NHS PAM guidance for details on the PAM assessment for multiple small sites.	1. Health and Safety at Work Act 1974 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 3. CQC Guidance for providers on meeting the regulation 4. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH23	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Inadequate	4. Inadequate	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH24	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	4. Inadequate	4. Inadequate	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH25	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	4. Inadequate	4. Inadequate	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4.. A fire safety risk assessment has been undertaken and that a practice fire evacuation of the building has been undertaken		
SH26	**4: Maintenance** Are assets, equipment and plant adequately maintained?	4. Inadequate	4. Inadequate	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records		
SH27	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff that meets all safety, technical and quality requirements?	4. Inadequate	4. Inadequate	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and contol the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH28	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	4. Inadequate	4. Inadequate	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		
SH29	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Inadequate	4. Inadequate	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Safe systems in place for electrical safety to include Portable Appliance Testing (PAT) testing 4. Control of Substances Hazardous to Health(COSHH) assessment has been undertaken and documented 5. Fire safety measures of the premises, e.g., panic alarms in the cowelling rooms; 6. A safe and effective system for storage of all waste 7. All staff are aware of their roles and responsibilities in the event of an emergency		
SH30	**8: Costed Action Plans** If any ratings in this SAQ are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	4. Requires moderate improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£80,000	£80,000			
SH31	**SH19: With regard to Contractor Management for Soft and Hard FM services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers using E&F contractors for a full range of services from maintenance and servicing to major construction, **both Hard and Soft FM**. It is about ensuring: competent contractors are appointed, adequately informed, instructed and trained, managed and supervised, co-ordinated and co-operate.	1. Health and Safety at Work etc. Act 1974 2. Construction (Design and Management) Regulations 3. HSE INDG368 4. Management of Health and Safety at Work Regulations 5. Legislation relevant to the service provided, as detailed in relevant SAQs. 6. Building Regulations 7. Planning Legislation including listed building consents 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 9. CQC Guidance for providers on meeting the regulations 10. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.hse.gov.uk/construction/cdm/2015/index.htm https://www.hse.gov.uk/pubns/indg368.htm https://www.legislation.gov.uk/ukdsi/1998/9780110824322/contents/made Planning (Listed Buildings and Conservation Areas) Act 1990 (legislation.gov.uk) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SH32	**1: Policy** Does the organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.	4. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SH33	**2: Roles and Responsibilities** Does the Organisation have sufficient and appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood who are responsible for the management of contractors? Is there a named SRO and Trust representative for major contracts including PFI.	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH34	**3. Contract expiry** Does the Trust procedural requirements and notice periods in relation to the expiry of major contracts (major or complex and whole contract period of 42mnt or over) such as PFI and have plans in place to manage these and the transition of services.	Not applicable	2. Good	1. Documented end dates for contracts and contractual requirements		
SH35	**4: Risk Assessment** Are contractors risk assessments and if applicable, method statements (RAMS) requested from the contractor(s) prior to works commencing and reviewed for their appropriateness?	3. Requires minimal improvement	3. Requires minimal improvement	1. Agreed allocation of risk is monitored; 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers;		
SH36	**5: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality controls/inspection records 4. Documented evidence of audits and reviews to support compliance. 5. Auditing and inspecting the 'Contractors' work, ensuring that they comply with the contractual requirements on quality, Health and Safety, environmental and legislative requirements. 6. Managing communication between the Contracting Body and the Sub-Contractors.		
SH37	**6. Contractor Competence** With regards to the competence of the contractors - has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Adequate insurance. 2. Performance monitoring against agreed Key Performance Indicators. 3. Evidence of professional qualifications and experience;		
SH38	**7: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Supplier Business Continuity and Disaster Recovery Plan.		
SH39	**8: Review Process** Is there a robust regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Monitoring, reviewing and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors;		
SH40	**9: Costed Action Plans** If any ratings in this SAQ are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
N/A - REMOVED						
SH41	**SH21:The built environment: Reducing harm by figature in practice.** **With regards to self-harm risks associated with the built environment, can the organisation evidence that they have taken consideration for the following:**	**Not applicable**	**Applicable**	This question is in relation to Mental Health service users being treated on site. This question is to offer assurance to the Trust Board that self harm risks in relation to the built environment has been considered and action taken where it is seen to be required. It is for the Trust to have oversight where Contractors are used, and up to the Trust to decide where there are service user risks in relation to this. The CQC lists 4 key themes which should be considered when answering these questions.	1. The Health and Safety at Work etc. Act 1974: The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. Management of Health and Safety at Work Regulations 1999 3. Leading health and safety at work: leadership actions for directors and board members (NDG417(rev 1)) - hse.gov.uk 4. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended): Approved Code of Practice L286 - hse.gov.uk 5. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations (b)(i) All premises and equipment used by the service provider must be— (ii)(i)(ii) properly used,	
SH42	**1: Policy** The Trust has a policy in place which specifically relates to figature and can evidence it is being followed in line with the CQC guidance?	Not applicable	3. Requires minimal improvement	1. Policy and procedures for E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.	5(1)(e) properly maintained, and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 37(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 37(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Where risks are identified providers must introduce measures to reduce or remove the risks within a timescale that reflects the level	
SH43	**2: Roles and Responsibilities** The trust has reviewed and specified the key roles, responsibilities and competencies for those who are accountable for safety covering figature assessments?	Not applicable	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period.		

NHS Premises Assurance Model: Safety Domain (Combined and Hard FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**
◄◄ Back to Instructions		

	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
Ref.	SAQs in green shaded cells can be rated N/A in which case prompt / question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
Shall	**3: Risk Assessment** Has a full risk assessment been completed	Not applicable	4: Requires moderate improvement	1. Agreed allocation of risk is monitored; 2. Risks are assessed and included in the Unit risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers; 5. Mental Health (MH) service Providers (and Trusts who may treat MH patients such as A&E, the CQC generally expect ligature reduction considerations across different service types/facilities to be proportionate to the service type and the needs of people, for example community services vs inpatient wards) the following should be considered although this is not a comprehensive list: • Ligature Reduction • Barricade Reduction ironmongery • Anti-Grip Reduction • Windows Safe from Height • Ceiling Height • Air Locks • Fence heights • Bolt down Fixed Furniture and Equipment • Non-Pick Mastic • Reduced breakable glass/plastic/fabric • Mental Health court yards and Garden/furniture 6.Consideration, procedures for securing and using tools whilst on Mental Health Wards (for example- count tools on and off wards to ensure nothing has been left behind that could be a weapon or for a ligature and have to have lockable tool bags on the wards) 7.Never Events policy/Reducing harm - Consider the two sections, to load releasing fixings, and window restrictors, along with others that may be pertinent to estates and facilities	Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. 7. CQC Provider Handbooks W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 6.HBN 03-01 Adult mental health units: planning and design: https://www.england.nhs.uk/publication/adult-mental-health-units-planning-and-design-hbn-03-01/ 6.HBN 03-02 Facilities for child and adolescent mental health units: https://www.england.nhs.uk/publication/facilities-for-child-and-adolescent-mental-health-services-hbn-03-02/ https://www.england.nhs.uk/wp-content/uploads/2021/03/PAN00618-hbn-00-10-curtains-end-tracking-v14.pdf 9A. https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance - CQC ligature harm minimisation guidance	
Shall	**4: Maintenance** Does the organisation hold the necessary proof to demonstrate consistent contractor maintenance activities - for its contracted services.	Not applicable	1: Inadequate	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place 3. Quality controls/inspection records 4. Demonstrable evidence of audits and reviews to support compliance. 5. Auditing and inspecting the 'Contractors' work, ensuring that they comply with the contractual requirements on quality, Health and Safety, environmental and legislative requirements; 6. Managing communication between the Contracting Body and the Sub-Contractors. 7. Risk assessing the impact of any backlogs in maintenance work	
Shall	**5: Contractor Compliance** Where contractors are used for fixture and fittings they should be adequately qualified to ensure the specific ligature risks have been identified if applicable.	Not applicable	4: Requires moderate improvement	1. Adequate insurance. 2. Performance monitoring against agreed Key Performance Indicators. 3. Evidence of professional qualifications and experience; 4.There is a process for the local induction and orientation of contractors when working on-site, to inform them of any site-specific safety requirements and arrangements		
Shall	**6: Review Process** Is there a robust, regular review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	Not applicable	4: Requires moderate improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Reviewing, checking and authorising invoices for payment for additional services. 4. Monitoring Contractors' approach to rectifying defects. 5. Problem solving and dispute (prevention and) resolution where appropriate. 6.Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors; 7. The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working' 8. The ability to report on the regulatory requirements regarding safer wards (ligatures) 9. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non-collapsible risks/furniture temperatures) particularly when in relation to Mental Health facilities and A&E wards.		
Shall	**7: Costed Action Plans** If any ratings in this SAQ are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	Not applicable			
Shall	Capital cost to achieve compliance	£0	£0			
Shall	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS1	**SS1: With regard to Catering Services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the safety aspects of catering and food with SAQ PE4 looking at patient feedback on food. Note: This applies to all food sources on-site including commercial and charitable outlets.		
SS1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy, Food Safety Management System and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has the organisation documented all processes and procedures in an approved HACCP document?	4. Requires moderate improvement	4. Requires moderate improvement	1. Food Standards Agency ratings and Nonmental Health Officer reports. 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers; 5. Nutritional screening programme identifying patients at risk from malnutrition and dehydration. 6. Allergens screening		
SS1	**4: Maintenance** Are assets, equipment and plant adequately maintained, regularly and monitored to ensure equipment relating to temperature control is functioning correctly?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements including level 2 hygiene for all food handlers and HACCP at the appropriate level for supervisors and Managers?	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	1. Food Hygiene (England) Regulations 2006. 2. Control of Substances Hazardous to Health 2002 3.Food Safety Act 1990.(Amended Regulations 2004) 4. HSG (96) 20 -Management of Food Hygiene & Food Services in the National Health Service. 5. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 6. Regulation EC 852/2004 on the hygiene of foodstuffs. 7. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2007 8. Compliance with Healthcare Commission Core Standard 14 (Food) 9. Health Act 2006 Code of Practice for Prevention and Control of Health Care Associated Infections (Department of Health 2006) revised January 2008 10. Food Safety(England) Regulations 2005 11. Food Safety (Temperature Control) Regulations 1995 12..CQC Guidance for providers on meeting the regulations 13. Fire Hazards have been considered for any catering service 14. NHS 10 Key Characteristics of Good Nutrition and Hydration 15. British Dietetic Association's Nutrition and Hydration Digest 16. British Dietetic Association guidelines 17. The MUST Toolkit (Malnutrition Universal Screening Tool) 18. National standards for healthcare food and drink 19. Food Review .https://www.legislation.gov.uk/uksi/2006/14/contents/made https://www.hse.gov.uk/coshh/ https://www.legislation.gov.uk/uksi/2004/2990/contents/made https://www.legislation.gov.uk/eur/2004/852/contents https://www.cqc.org.uk/guidance-providers/regulationsenforcement/regulation-14-meeting-nutritional-hydration-needs https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance https://www.legislation.gov.uk/uksi/2005/2059/contents/made https://www.legislation.gov.uk/uksi/1995/2200/contents/made https://www.cqc.org.uk/guidance-providers/regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ https://www.bda.uk.com/specialist-groups-and-branches/food-services-specialist-group/nutrition-and-hydration-digest.html https://www.bda.uk.com/professional/practice/practice_guidance/hom	
SS1	**7: Review Process** Is there a robust regular review process to assure compliance and effectiveness of relevant standards, policies and procedures which includes sampling and testing where required?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS1	8. **Food Standards (No.1)** Organisations should have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.	5. Inadequate	4. Requires moderate improvement	1. Documented and readily available		
SS1	9. **Food Standards (No.2)** Organisations should have a food and drink strategy.	4. Requires moderate improvement	4. Requires moderate improvement	1. Documented and readily available		
SS1	10. **Food Standards (No.3)** Organisations should consider the level of input from a named food service dietitian to ensure choices are appropriate.	4. Requires moderate improvement	3. Requires minimal improvement	1. Documented and readily available 2. Minutes of nutritional steering group available 3. Name and details of dietitian from contacts page 4. Documented evidence of dietitian involvement in menu engineering		
SS1	11. **Food standards (No. 4)** Organisations should nominate a food safety specialist and this person should chair a food safety group	5. Inadequate	2. Good	1. Documented and readily available 2. Minutes of food safety group available 3. Evidence of food safety audit management and safety system		
SS1	12. **Food Standards (No.5)** Organisations invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services, including training report, matrices or other evidence of chef, catering and nurse training including L2 food safety.	4. Requires moderate improvement	3. Requires minimal improvement	1. Documented and readily available training matrices' and training programme 2. available on ESR		Guidance for Food Standard no 8. - If patient/staff/visitors are not present 24/7, approach this question as having a food provision for 100% of the time they are on site. If the type of food service is not present within your trust, put not applicable, however you cannot put not applicable for all 7 Food Standard No. 8 questions as you should be working to provide a 24/7 offering for your staff of one of these types of food service If your trust operates 24/7 services but the food provision operates only daytime hours, the maximum score should be requires minimal improvement

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SS1	13 **Food Standards (No.6)** Organisations are able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.	4. Requires moderate improvement	3. Requires minimal improvement	1. Documented and readily available training matrices' and training programme 2. available on ESR	e https://www.bapen.org.uk/screening-and-must/must/must-toolkit/the-must-itself https://www.bapen.org.uk/must-and-self-screening/must-toolkit/ https://www.england.nhs.uk/long-read/national-standards-for-healthcare-food-and-drink/ .https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food	
SS1	14.**Food Standards (No. 7)** Organisations are able to monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals, a full waste strategy including food waste	4. Requires moderate improvement	2. Good	1. Documented and readily available 2. Evidence provided of involvement of waste management measurements and systems 3. Evidence food is included within waste management strategy 4. Completed ERIC return inline with this		
SS1	15.**Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour restaurant.	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**16.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour café	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**17.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a hot vending services.	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**18.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have retail services	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**19.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have cold vending	2. Good	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**20.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have smart fridges	Not applicable	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**21.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have staff provision for storage and heating of food brought from home.	Not applicable	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**22: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	4. Requires moderate improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£6,000	£1,000			
SS2	**SS2: With regard to Decontamination Processes can the organisation evidence the following?**	Applicable	Applicable	Management, operation and maintenance of decontamination equipment and processes covering the decontamination of surgical equipment, linen, dental equipment and flexible endoscopes. As set out in the HTM 01 Suite 01-06		
SS2	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Quality manual and supporting processes.		

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SS2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Trust management structure for decontamination 5. Appointment letter for AE, job descriptions e.g. decontamination lead, SSD manager, Endoscopy Unit decontamination team 6. Appointment letter for AP(D) 7. Evidence of employing appropriately qualified experienced people in key roles as identified in the HTMs and other standards.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained 2. CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained, and 3. Health Technical Memorandum01-01A, B, C, D, E 4. Health Technical Memorandum01-04A 5. Health Technical Memorandum01-05 6. Health Technical Memorandum01-06A, B, C, D, E; 7. ISO 9001 8. ISO13485 9. Estate/MHRA alerts 10. Medical Devices Directive. 11. Revision to the Medical Devices Directive. 12. CQC Guidance about compliance. - Guidance about compliance Essential standards of quality and safety 13. GS1 coding. 14. NHS Operating Framework 15. Medical Devices Regulations (MDR) 2002. 16. BS EN ISO 13485. 17. Executive Letter EL(98)5. 18. Decontamination Services Agreement. 19. In-vitro Diagnostic Devices Directive. 20. Kirby, E., Dickinson, J., Vassey, M., Dennis, M., Cornwall, M., Mcleod N. et al. (2012). Bioassay stunnex L. 21. IHEEM AE(D) register. 22. Institute of Decontamination Sciences (IDSc). 23. Institute of Healthcare Engineering and Estate Management (IHEEM). 24. ESAC-Pr report. 25. MHRA's 'Managing medical devices: guidance for healthcare and social services organisations' 26. MHRA 'Medical devices: conformity assessment and the CE mark'. 27. BSG Guidance for flexible endoscopy 28. JAG Guidance for endoscopy 29. BS EN ISO 15883 (washers – surgical and endo) 30. BS EN ISO 285 (sterilizers) 31. BS EN ISO 14662 (drying cabinets endo) https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda ISO - ISO 9000 family — Quality management https://shop.bsigroup.com/ProductDetail?pid=000000000303531936&creative=435401337506&keyword=&matchtype=b&network=g&device=c&gclid=Cj0KCQjwhb36BRCfARIsAKcXh6GMNUjeSJRKxBsGuwxpkqp_2sQxy7VOg8DODJbCx0VtftiaOupLFzQaAoDMEALw_wcB https://www.cas.mhra.gov.uk/Home.aspx https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf https://www.gs1.org/standards/barcodes https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13 https://www.legislation.gov.uk/uksi/2002/618/contents/made https://shop.bsigroup.com/products/medical-devices-quality-management-systems-requirements-for-regulatory-purposes/tracked-changes https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376918/Guidance_on_the_In_Vitro_Diagnostic_Medical_Devices_Directive.pdf http://eprints.gla.ac.uk/75539/1/75539.pdf https://www.iheem.org.uk/IHEEM-Authorising-Engineer-Decontamination-Register https://www.idsc-uk.co.uk/ https://www.iheem.org.uk/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271414/Frequently_asked_questions.pdf https://www.gov.uk/government/publications/managing-medical-devices https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.bsg.org.uk/clinical-resource/guidance-on-decontamination-of-equipment-for-gastrointestinal-endoscopy-2017-edition/ https://www.theiet.org.uk/	
SS2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS2	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Validation reports for washer disinfectors and drying cabinets. 5. Permits to work for service engineers. Service contracts. PPM dockets and maintenance instructions 6. Permit to work system		
SS2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training needs analysis, staff training matrix for SSD/Endoscopy and Estates Teams. Specialist training with external providers. Scope cleaning training 4. Competency documents for endoscopy technicians 5. Competency documents for contractors required to work on decontamination equipment 6. Agency staff - if used include matrix of assessment of competency etc?		
SS2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business Continuity plans for SSD and Endoscopy Unit. 6. Test reports for efficacy of plans. 7. Training records for staff following testing		
SS2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Internal and external audit reports 4. Use of ISO 9001 and ISO13485 can be incorporated into evidence 5. AE audit of Trust policy and processes 6. IHEEM JAG audit report and certificate 7. Significant findings from Authorising Engineer reports and action plans.		

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SS2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;	https://www.thejag.org.uk/ https://shop.bsigroup.com/ProductDetail?pid=00000000003035319 6&creative=386044230705&keyword=iso13485&matchtype=b&net work=g&device=c&gclid=Cj0KCQjw-uH6BRDQARIsAI3I-UebTMtTTunz4BVFa_wZGh4Z4faiqjOB6iywmYHF2wdiVHKQL0EP DNkaAseTEALw_wcB https://shop.bsigroup.com/ProductDetail/?pid=0000000000302786 77#:~:text=It%20specifies%20requirements%20and%20the,of%20 at%20least%2060%20l. https://www.iso.org/standard/55290.html	
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS3	**SS3: With regard to Waste and Recycling Management can the organisation evidence the following?**	Applicable	Applicable	The scope of this SAQ may gross over into Effectiveness Question E4 (SDMP)		
SS3	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS3	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	4. Requires moderate improvement	4. Requires moderate improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS3	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS3	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Waste Electrical and Electronic Equipment Regulations 2006 2. Pollution Prevention and Control (England and Wales) Regulations 2000 3. Environment Act 1995 4. Environmental Protection Act 1990 5. Health Technical Memorandum 07-01; Safe Management of Healthcare Waste 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 7. CQC Guidance for providers on meeting the regulations 8. CQC Provider Handbooks https://www.legislation.gov.uk/uksi/2006/3289/contents/made https://www.legislation.gov.uk/uksi/2000/1973/contents/made https://www.legislation.gov.uk/ukpga/1995/25/contents https://www.legislation.gov.uk/ukpga/1990/43/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SS3	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	4. Requires moderate improvement	4. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS3	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS3	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Requires moderate improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

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SS4	**SS4: With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence the following ?**	Applicable	Applicable	This SAQ covers the safety aspects of cleaning and infection control. SAQ PE3 looks at patient feedback relating to cleanliness.		
SS4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. 4. Framework of responsibility at trust level, linking into departmental responsibilities.		
SS4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS4	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS4	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Use of NHS England Cleaning Manual	1. Health and Care Act 2022 2. (Health Building Note 00-09) Infection control in the built environment 3. Association of Healthcare Cleaning Professionals (AHCP) (2009) Colour Coding Hospital Cleaning Materials and Equipment: Safer Practice Notice 15 4.National infection prevention and control manual (NIPCM) for England 5. Health Building Note 04-01) Adult in-patient facilities: planning and design 6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8. National Standards of Healthcare Cleanliness 2021 9. NHS Cleaning Manual (on the E+F hub since 2021, to be published on web March 2024) 1. https://www.legislation.gov.uk/ukpga/2022/31/contents 2.. https://www.england.nhs.uk/publication/infection-control-in-the-built-environment-hbn-00-09/ 3.. https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-clea-ng-manual-2009-06-v1.pdf 4. https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/ 5.. https://www.england.nhs.uk/publication/adult-in-patient-facilities-planning-and-design-hbn-04-01/ 6&7. https://www.cqc.org.uk/guidance-providers/regulations 8.. https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/ 9. Hub not yet published	(For SS8 and 9 - Although the mandatory requirement is to display in patient facing areas, a Trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff - it is best prac tice to share this information wider)
SS4	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS4	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS4	**8. Cleaning Standards 2021** Can you evidence that Star ratings are Displayed in patient facing areas?	2. Good	2. Good	1. Audit evidence 2. Publicly displayed and available		
SS4	**9. Cleaning Standards 2021** **As a minimum has 95% of the estate achieved a star rating of 4* or above, following their technical audits, in FR categories 1 – 4?**	2. Good	2. Good	1. Documented and readily available 2. Publicly displayed and available 3. Reviewed annually		
SS4	**10. Cleaning Standards 2021** **Have you undertaken efficacy audits in a minimum of 95% in each FR categories 1 – 4?**	5. Inadequate	4. Requires moderate improvement	1. Audit evidence 2. Reported to Board quarterly		
SS4	**11. Cleaning Standards 2021** **Do you have evidence that audits scoring 3* stars or below are following an escalation and review process?**	2. Good	2. Good	1. Audit evidence 2. Reported to Board quarterly		

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Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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SS4	**12: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS5	**SS5: With regard to Laundry and Linen Services can the organisation evidence the following?**	Applicable	Applicable	There may be some cross over with this SAQ and SS4.		
SS5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	4. Requires moderate improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS5	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. (HTM 01-04) Decontamination of linen for health and social care 2. Department of Health Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers 2020 3. Immunisation against infectious disease: 'The Green Book' 4. HSE (1999) Management of Health and Safety at Work Regulations. London: Stationery Office 5.. HSE (2002) Control of Substances Hazardous to Health Regulations. London: Stationery Office- Health and Care Act 2022 6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8.. The Textile Services Association 1 .https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04/ 2. https://www.england.nhs.uk/publication/uniforms-and-workwear-guidance-for-nhs-employers/ 3. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book 4.. https://www.hse.gov.uk/pubns/hsc13.pdf 5. https://www.hse.gov.uk/coshh/ 6https://www.legislation.gov.uk/ukpga/2022/31/contents 7. https://www.cqc.org.uk/guidance-providers/regulations 8. https://tsa-uk.org/healthcare/	
SS5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training matrix available		
SS5	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		
SS5	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS5	**8. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS6	**SS6: With regard to Security Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates only to the Physical Security infrastructure and labour related to the security of NHS facilities and not fraud or cybersecurity.		

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SS6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Identified and allocated resources are stipulated in the policy 4. The organisation has in place a security management strategy as a standalone document or as part of a policy statement. 5. Evidence of a Security Policy, Violence and Aggression Policy, 6. Procedure for the dissemination of key and vital information e.g. security alerts. The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.	1. Counter-Terrorism and Border Security Act 2019 2. National Counter Terrorism Security Office guidance 3.Human Rights Act 1998 4. Criminal Procedure and Investigations Act 1996 5.. Guidance from the Surveillance Commissioners Office 6.. General Data Protection Regulations 2018 7.. Criminal Justice and Immigration Act 2008 8.. Criminal Law Act 1967 9.. Following the principle of NHS Protect - Standards for providers 2017-18 Fraud, bribery and corruption 10. Health and Safety at work act 19741. 11. Updated - NHSE National Contract 22/23 Service condition 24 – counter fraud (previously 'Protect')- NHS Requirements | Government Functional Standards | NHS Counter Fraud Authority (cfa.nhs.uk) .12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 13. CQC Provider Handbooks 14. Martyn's Law (currently under consultation - it is important to be aware of updates) https://www.legislation.gov.uk/ukpga/1996/25/contents https://www.legislation.gov.uk/ukpga/2019/3/contents/enacted https://www.gov.uk/government/latest?departments%5B%5D=national-counter-terrorism-security-office https://www.npcc.police.uk/ https://www.legislation.gov.uk/ukpga/1998/42/contents https://www.legislation.gov.uk/ukpga/1996/25/contents https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786444/Guide_to_the_Regulation_of_Surveillance.pdf https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted https://www.legislation.gov.uk/ukpga/2008/4/contents https://www.legislation.gov.uk/ukpga/1967/58/contents https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcfa.nhs.uk%2Fgovernment-functional-standard%2FNHS-requirements&data=05%7C02%7Chayley.morris10%40nhs.net%7C8a406c7e22d942e9aabc08dc1bec2ccc%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638415948376320929%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=0wnDVJjTpnmL0RVCYtj1eczCmOtHPHDkLtQm5T1jQQE%3D&reserved=0 https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.protectuk.police.uk/martyns-law/martyns-law-overview-and-what-you-need-know	
SS6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Board nominated executive with the responsibility for overseeing security management 5. Nominated Qualified and Accredited Security Management Specialist to oversee and undertake the delivery of the full range of security management work - external/internal. 6. Evidence of internal (including capital development) and external liaison and involvement in local and national groups and with agency partners also to be included in job descriptions.		
SS6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risks identified include those related to; -Violent and aggressive individuals - Premises suitability - Lone working arrangements. - Evidence of Security assessment programme		
SS6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Evidence of security involvement in new builds. 5. Evidence of a managed and maintained security access control system		
SS6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Evidence of the promotion of security awareness via multiple mediums 4. Evidence of tiered security training commensurate with duties based on a training needs analysis which is monitored, evaluated and reviewed as needed. 5. Demonstration of staff training in relation to incident reporting		
SS6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence of plans as required by the security standards; - Planning for Lockdowns; - Planning for child abductions;		

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SS6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Demonstration that risks identified through assessment are sufficiently funded to enable mitigation and response 4. Annual report to board in relation to security management 5. Evidence of work plan and ongoing review and update of plan 6. Evidence that incidents where harm or injury occur or had the potential to occur are sufficiently followed up and investigated including where appropriate support being provided to victims.		
SS6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS7	**SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?**	Applicable	Applicable	SAQ covers fleet management and transport of goods and services on and between sites. It excludes patient transport apart from the management of taxi services. Related patient experience is covered in SAQ P5. Access arrangements may also be covered under SH2. This includes car parking.		
SS7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	5. Inadequate	5. Inadequate	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health Technical Memorandum 07-03: Transport Management and Car Parking 2. Building Research Establishment BRE - BREEAM Travel Plan documentation. 3. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/estates/health-technical-memoranda/ https://kb.breeam.com/knowledgebase/transport-assessments-and-transport-statements/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-Procurement-Guide.pdf	
SS7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	4. Requires moderate improvement	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		

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SS7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS8	**SS8: With regard to Pest Control can the organisation evidence the following?**	Applicable	Applicable			
SS8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;. 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SS8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS8	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974 4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukpga/1972/66 https://www.legislation.gov.uk/uksi/1988/1657/contents/made https://www.legislation.gov.uk/uksi/1986/1510/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Records of pest infestation, COSHH data sheets for pesticides, records of bait placement etc. 4. Documented evidence of audits and reviews to support compliance.		
SS8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	3. Requires minimal improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£2,000	£2,000			

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS9	**SS9: with regard Portering Services can the organisation evidence the following?**	Applicable	Applicable	In line with local organisational portfolio for this area.	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1988 3. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1988/1222/contents/made https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf To note we are working on guidance for portering which will be available for reference next year, covering: - Service strategy (workforce) - Technology and equipment - Policy - Working with clinical teams	
SS9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Patient transfer policy. 4. Infection control procedures and training.		
SS9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risk assessments for injury from needles and exposure to harmful substances and bodily fluids		
SS9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	3. Requires minimal improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Training matrix available		
SS9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	1. Outstanding	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Manual handling training		
SS9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence of patient involvement and feedback. 4. Patient Feedback considered and actioned		
SS9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
S10+A	**SS10:Estates IT and Building Information Management (BIM) systems** **Please confirm you have a plan for your trusts to engage with their current providers of telecoms services who will be able to assist them in identifying their Public Switch Telephone Network services. Once this has been completed, trusts need decide how best these services should be replaced or removed.** **The systems that need to be considered include:** **• Plant alarms;** **• Staff Attack Systems;** **• Security Alarms;** **• Lockdown/Access Control intercoms;** **• Car Park Barriers;** **• Catering freezers & fridges;** **• Pathology & Blood freezers and fridges;** **• Fire alarm auto dial;** **• Lift emergency calls;** **• Building Management Systems (BMS) alarms (oxygen, gas shut out, fuel alarms (leak and level), ventilation, generator etc);** **• Fax machines;** **• Credit card terminals.** **The PSTN situation is discussed at your Local Resilience Forums (LRF) and therefore we suggest you link with your Trust EPRR lead who will be able to assist with the wider work being undertaken by LRF partners, to identify any potential interdependencies within your Trust.**	Applicable	Applicable			
SS10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	1 .Public Health Act 1961 2. Health and Safety at Work Act 1974 3. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	4. Requires moderate improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS10	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Process for monitoring operators handling of calls for quality purposes		
SS10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	Not applicable	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business continuity procedures in place in case of fire or other emergency to maintain service including standby operating facilities located on individual sites 6. Loss of service plans including bleeps and mobile phones. 7. Robust call out procedures tested over all sites monthly with table top exercises.		

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
	7. Technology replacement plan & Review process Is there a technology migration plan in place for removal of service/infrastructure reliance on PSTN and ISDN by December 2025? When answering this sub-question, "Not Applicable" should only apply where no PSTN connections have ever existed within your organisation. If you have completed migration, please use "Outstanding". Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Identified services reliant on PSTN within your organisation? 2. Have an appropriate replacement solution identified with your provider that ensures continuity of service? 3. Is there a plan in place with your provider to migrate services away from PSTN? 4. Has the identified plan been executed to migrate services to replacement solution? 5 Annual reviews of standards, policies and procedures documented; 6 Outputs of reviews and their inclusion in Action Plans; 7. KPIs on performance including call pick up times		
SS10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	Applicable	Applicable	P1 replicates the CQC Provider handbooks KLOE R4 and assesses your processes for patient involvement, compliments and complaints	1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. NHS England Transforming Participation in Health and Care – September 2013 7. The Kings Fund Research Paper; Patient Engagement and Involvement 8. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010 https://www.legislation.gov.uk/ukpga/1998/29/contents https://www.legislation.gov.uk/ukpga/2000/36/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/2013/09/trans-part/ https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement	
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	4. Requires moderate improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Review of the Patient Led Assessment of the Care Environment (PLACE) results and implementation of the outcomes;		
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	4. Requires moderate improvement	3. Requires minimal improvement	1. Engagement process and methodology 2. Friends and Family Test 3. Patient Advice and Liaison Service (PALS)		
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	4. Requires moderate improvement	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Engagement feedback influencing services developments and improvements		
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	4. Requires moderate improvement	4. Requires moderate improvement	1. Governance and process for dealing with feedback		
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	4. Requires moderate improvement	4. Requires moderate improvement	1. Adherence to confidentiality policy 2. Feedback to stakeholders and patients		
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on condition, appearance, maintenance and P&D. Safety aspects are dealt with in the safety domain.	1. NHS England: Delivering same sex accommodation guidance. Responsibility transferred to NHSE/I in 2017 .The DHSC guidance was revised and published in 2019. 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association guidance and advice 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks https://improvement.nhs.uk/resources/delivering-same-sex-accommodation/ https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://www.ombudsman.org.uk/publications/care-and-compassion https://www.cqc.org.uk/publications/surveys/surveys https://www.nhsconfed.org/resources/2012/06/delivering-dignity-securing-dignity-in-care-for-older-people-in-hospitals-and-care#:~:text=hospitals%20and%20care-,Delivering%20Dignity%3A%20Securing%20dignity%20in%20care%20for,people%20in%20hospitals%20and%20care&text=Delivering%20Dignity%20is%20the%20final,underlying%20causes%20of%20poor%20care. https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf https://www.patients-association.org.uk/Pages/FAQs/Category/policy https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	4. Requires moderate improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services 7evelopments and improvements 8. Adherence to confidentiality policy 9. Feedback to stakeholders and patients 10. Complaints Procedure 11. Diversity considerations		
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	4. Requires moderate improvement	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements		
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on cleanliness. Safety aspects of cleanliness are covered in the safety domain.		

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 9. Diversity considerations	1. Health and Social Care Information Centre: Patient Led Assessments of the Care Environment (PLACE) https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/	
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	3. Requires minimal improvement	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements		
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	3. Requires minimal improvement	3. Requires minimal improvement	1. Reviews of policy stating where schedules are available compared with actual checking of availability.		
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements		
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations	1.. NHS patient visitor and staff car parking principles 2022 2. Health Technical Memorandum 07-03 (2006): NHS car parking management 3. Car Parking Code of Practice 4. Healthcare Travel Cost Scheme https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles https://www.england.nhs.uk/estates/health-technical-memoranda/Private Parking Code of Practice - GOV.UK (www.gov.uk) https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	4. Requires moderate improvement	4. Requires moderate improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements		
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	4. Requires moderate improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£150,000	£100,000			
	Revenue consequences of achieving compliance	£5,000	£50,000			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P5	**P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	1. The Occupiers Liability Act 1957 (amended 1984) 2. The Health and Safety at Work Act 1974 3. The Management of health and safety at Work Regulations 1999 4. Provision and Use of Work Equipment Regulations 1998 5. Control of Substances Hazardous to Health (COSHH) Regulations 2002 6. Personnel Protective Equipment at Work Regulations 1992 7. Management of Health and Safety at Work Regulation 1999 approved code of practice 8. Workplace, Health, Safety and Welfare Regulations 1992 approved code of practice and guidance 9. Work Equipment Provision and use of Work Equipment Regulations 1998 10. First Aid at Work, Health and Safety Regulations 1981 11. Hand-Arm Vibration 12. Corporate Manslaughter and Corporate Homicide Act 2007 13. RIDDOR 2013 RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 14. Working at Height Regulations 2005 15. BS ISO 15799:2003 Soil quality - guidance on eco-toxicological characterization ofsoils and soil materials 16. BS 3882:1994 Specification for topsoil 17. BS 6031:1981 Code of practice for earthworks 18. BS 7562-4:1992 Planning, design and installation of irrigation schemes guide to water resources 19. BS 4428:1989 guide of practice for general landscape operations (excluding hard surfaces) AMD 6784 20. BS 3882:1994 specification for topsoil and AMD 9938 21. BS 3936-1:1992 Nursery stock specification for trees and shrubs 22. BS 3936-5:1985 nursery stock specification for poplars and willows 23. BS 3936-10:1990 nursery stock specification for ground cover plants 24.BS 7370-3:1991 grounds maintenance recommendations for maintenance • 25. BS 3998:1989 recommendations for tree work and AMD 6549 Horticulture 26. BS EN 12579:2000 Soil improvers and growing media - sampling 27. BS EN 13037:2000 Soil improvers and growing media - determination of pH Turf 28. BS 3969:1998 Recommendations for turf for general purposes 39. BS 4428:1989 Code of practice for general landscape operations14 (excluding hard surfaces). 30. Horticultural Trades Association guidelines on plant handling and establishment 31. BS 1129 Specification for portable timber ladders, steps, trestles and lightweight stagings British Standards Institution •BS 2037 Specification for portable aluminium ladders, steps, trestles and lightweight stagings British Standards Institution 32. BS EN 131 Ladders (Specification for terms, types, functional sizes; Specification for requirements, testing, marking; User instructions; Single or multiple hinge-joint ladders) British Standards Institute https://www.legislation.gov.uk/ukpga/1984/3 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/2002/2677/regulation/7/made https://www.legislation.gov.uk/uksi/1992/2966/contents/made https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1992/3004/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/1981/917/regulation/3/made https://www.hse.gov.uk/vibration/hav/ https://www.legislation.gov.uk/ukpga/2007/19/contents https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/uksi/2005/735/contents/made https://www.iso.org/standard/29085.html https://shop.bsigroup.com/ProductDetail/?pid=000000000001382025#:~:text=BS%203882%3A1994%20specifies%20requirements,in%20situ%20topsoil%20or%20subsoil. https://shop.bsigroup.com/ProductDetail/?pid=000000000000078031 https://shop.bsigroup.com/ProductDetail?pid=000000000000285806 https://shop.bsigroup.com/ProductDetail?pid=000000000000198326 https://shop.bsigroup.com/ProductDetail/?pid=000000000001382025 https://shop.bsigroup.com/ProductDetail?pid=000000000000262241 https://shop.bsigroup.com/ProductDetail/?pid=000000000000151386 https://shop.bsigroup.com/ProductDetail?pid=000000000000209042 https://shop.bsigroup.com/ProductDetail?pid=000000000000238150 https://shop.bsigroup.com/ProductDetail/?pid=000000000000194564 https://shop.bsigroup.com/ProductDetail/?pid=000000000030006469 https://standardsdevelopment.bsigroup.com/projects/1992-06005#/section https://shop.bsigroup.com/ProductDetail?pid=000000000030260283 https://shop.bsigroup.com/ProductDetail?pid=000000000000198326 https://hta.org.uk/ https://shop.bsigroup.com/ProductDetail/?pid=000000000001635045 https://landingpage.bsigroup.com/LandingPage/Series?UPI=BS%20EN%20131	
P5	**1. PLACE Assessment** The organisation has completed the PLACE External areas assessment relating to Grounds and Gardens for all relevant sites and published a local improvement plan.	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations 11. The local improvement plan is included within the Green Plan.		
P5	**2. Other Assessments** Is there a system/process, additional to PLACE External areas assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	3. Requires minimal improvement	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements		
P5	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
P5	Capital cost to achieve compliance	£0	£0			
P5	Revenue consequences of achieving compliance	£0	£0			
P6	**P6: How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with Catering Services and also complying with Regulation 14. Safety aspects of food and catering are dealt with in the safety domain.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. National Specifications for healthcare cleanliness 2007 4. PAS:5748 5. NHS Estates (2000) Reducing food Waste in the NHS Department of Health. Better Hospital Food 6. Hospital Catering Association – Protected Mealtimes 7. Council of Europe Resolution food and nutritional Care in hospitals NHS England – 10 Key Characteristics of Good Nutritional Care in Hospitals 2006 8. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2009 9. Water for Health – Hydration Best Practice Toolkit for Hospitals and Healthcare 10. NHS Executive 'Hospital catering delivering a quality service.' 11. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related	
P6	**1. Policy & Procedures** Does the organisation have in place a policy for healthcare catering which is aligned to current National Standards for Healthcare Catering which has been reviewed via an MDT process within the last 3 years?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Internal structure to consider and action feedback 4. Adherence to confidentiality policy 5. Feedback to stakeholders and patients 6. Complaints Procedure 7. Benchmarking, KPIs and peer comparison process 8. Meetings and dialogue with CQC identifying improvements 9. Public/patient information e.g. handbooks, pre visit information		

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P6	**2. Regulation** Does the organisation have a food and drink strategy as defined in the NHS Standard Contract	4. Requires moderate improvement	4. Requires moderate improvement	1. Review of relevant Policies and Procedures. 2. Nutritional screening programme identifying patient at risk from malnutrition and dehydration	products. 12. Improving Nutritional Care – a joint action plan from the department of health and nutrition summit stakeholders 13. HCA Ward Service guide 14. British Dialectic Association Improving Outcomes through Food and Beverage Services Nutritional & Hydration digest "15. Sustainable procurement: the GBS for food and catering services Official Government Buying Standards (GBS) for food and catering services" 16. NHS Standards Contract 17.The NHS Hospital Food Review 2020 18. British Association for Parenteral and Enteral Nutrition - Malnutrition Screening Tool 19. Public Health England - Healthier and More Sustainable Catering Nutrition Principles 20. A Toolkit to Support the Development of a Hospital Food and Drink Strategy 21. CQC Provider Handbooks https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/news/hospital-cleaning-revised-specification-published https://www.bsigroup.com/en-GB/about-bsi/media-centre/press-releases/2014/december/Standard-for-providing-a-clean-and-safe-hospital-environment-is-revised/ Reducing waste in the NHS: an overview of the literature and challenges for the nursing profession - PubMed (nih.gov) http://www.hospitalcaterers.org/publications/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ http://www.hospitalcaterers.org/publications/ https://www.choiceforum.org/docs/dohplan.pdf http://www.hospitalcaterers.org/publications/ https://www.bda.uk.com/uploads/assets/c24296fe-8b4d-4626-aeebb6cf2d92fccb/NutritionHydrationDigest.pdf https://www.gov.uk/government/publications/sustainable-procurement-the-gbs-for-food-and-catering-services https://www.england.nhs.uk/nhs-standard-contract/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929234/independent-review-of-nhs-hospital-food-report.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523049/Hospital_Food_Panel_May_2016.pdf https://www.malnutritionselfscreening.org/self-screening.html https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499745/Toolkit_Feb_16.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
P6	**3. Choice** The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs	4. Requires moderate improvement	4. Requires moderate improvement	1. Review of relevant Policies and Procedures.		
P6	**4. Equality issues** Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background	3. Requires minimal improvement	2. Good	1. Diversity considerations as set out in Policies and Procedures.		
P6	**5. Information** Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.	3. Requires minimal improvement	3. Requires minimal improvement	1. Patient, visitor and staff charter		
P6	**6. Patient Led Assessment of the Care Environment (PLACE) Assessment** The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Completed PLACE assessments reviewed and actioned; 2. PLACE training records		
P6	**7. Other Assessments** Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?	3. Requires minimal improvement	3. Requires minimal improvement	1. Engagement process and methodology 2. Surveys and questionnaires 3. Focus Groups 4. Engagement feedback influencing services developments and improvements		
P6	**8. Legal Standards** Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract	3. Requires minimal improvement	4. Requires moderate improvement	1. Review of policies and procedures to ensures compliance.		
P6	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	3. Requires minimal improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£45,000	£50,000			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F1	**F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 2	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection 5. Patient Lead Assessments of the Care Environment (PLACE) 6. In patient Survey 7. NHS Premises Assurance Model Metrics Dashboard - RICS Real Estate 8. ISO 55000/01/02 Asset Management 2004 ISO 55000:2014 Asset management — Overview, principles and terminology" Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://nhssurveys.org/surveys/survey/02-adults-inpatients/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.iso.org/standard/55088.html	
F1	**1: Analysing Performance** A process in place to analyse estates and facilities services and costs and if these continue to meet clinical and organisational needs?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F1	**2: Benchmarking** A process in place to regularly benchmark estates and facilities costs?	3. Requires minimal improvement	3. Requires minimal improvement	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position 2. Benchmarking including the use of metrics and KPIs from suitable sources including: - Estates Return Information Collection (ERIC) - Contract/Service Level agreement KPIs - Estate Strategy KPIs - Energy and sustainability targets - Cost Improvement Plan targets - NHS Model Hospital		
F1	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F2	**F2: With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following and is this in line with the ICS infrastructure strategy?**	Applicable	Applicable	HBN 00-08 Part A Section 3	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 - The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Premises Assurance Model Metrics 6. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.england.nhs.uk/estates/health-building-notes/ https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/model-hospital/ https://www.iso.org/standard/55088.html	
F2	**1: Business Planning** An effective and efficient estate and facilities business planning process in place?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Business plans.		
F2	**2: Estate Optimisation** An effective and efficient process in place to ensure estate optimisation and space utilisation?	3. Requires minimal improvement	4. Requires moderate improvement	1. Space utilisation studies and monitoring of usage. 2. Response to NHS Long Term Plan of reduction to 30% non clinical space.		
F2	**3: Commercial Opportunities** An effective and efficient process in place to identify and maximise benefits from commercial opportunities from land and property that support the main business of the NHS ?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts. 2. Land and property sale receipts. 3. Commercial Strategy or agreements such as letting of space for retail use.		
F2	**4: Partnership working** An effective and efficient process in place to investigate and implement improvements through partnership working?	2. Good	2. Good	1. Partnership Working, i.e. One Public Estate		
F2	**5: New Technology** An effective and efficient process in place to maximise the benefits from new technologies?	2. Good	2. Good	1. New Technology and Innovation - examples of product design or system implementation 2. IT strategy.		
F2	**6: PFI and LIFT contracts** An effective and efficient process in place to achieve value for money from existing PFI and LIFT contracts?	2. Good	2. Good	1. Date and outcome of PFI/PPP reviews and next steps.		
F2	**7: Other contracts** An effective and efficient process in place to achieve value for money from existing other contracts?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts.		
F2	**8. Property** An effective and efficient process in place to record and managing property interest and leases held	2. Good	3. Requires minimal improvement	1. Asset/Estate Terrier		

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

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F2	**9. Cost Improvement plans** A robust methodology for identifying the delivery and implications of cost improvement plans	2. Good	2. Good	1. Regular and accurate submission of CIPs 2. Monitoring of progress of delivery		
F2	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F3	**F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 4.0		
F3	**1. Capital Procurement** Capital procurement and refurbishment projects progressed in line with local standing orders and financial instructions and relevant procurement guidance, HM Treasury and DHSC and NHSE guidance.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F3	**2. Capital project management** Processes and procedures that ensure there are robust processes for the management of projects during construction including change control and lessons learnt/benefits realisation once projects are completed.	Not applicable	2. Good	1. Project governance documentation in line with capital management 2. Track how many projects are delivered on time or late and track that these were delivered within budget 3. Lessons learnt/benefits realisation and evidence of applying learning to subsequent projects		
F3	**3.. Capital Procurement Efficiencies** Capital procurement and refurbishment projects that actively seek efficiency such as through cost benchmarking, Building Information Modelling and repeatable designs?	3. Requires minimal improvement	2. Good	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position	1. Health Building Note 00-08, The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 2. NHS Model Health System 3. Estates Return Information Collection (ERIC) 4. Building Cost information Service 5. Government Construction Strategy 6. ProCure22/ProCure23 guidance 7. Naylor Review: 8. Lord Carter Review: 9. NHS Long Term Plan: 10. NHS Net Zero Building Standard 11. Estates Net Zero Carbon Delivery Plan (NZCDP)	
F3	**4. Flexibility** Capital procurement and refurbishment projects that actively seek flexible designs to accommodate changes in services?	3. Requires minimal improvement	2. Good	1. Consideration of innovative design and building options e.g. "New for Old".		
F3	**5. Identification and disposal of surplus land** An effective and efficient process for the identification and disposal of surplus land?	2. Good	2. Good	1. Benchmarking including the use of metrics and KPIs from suitable sources 2. Surplus land identified in Annual Surplus Land Return, STP/ICS Estate Strategy, and EPIMS and shared through One Public Estate.	1. https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 2. https://model.nhs.uk/ 3. https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection 4. https://www.rics.org/uk/products/data-products/bcis-construction/ 5. https://www.gov.uk/government/publications/government-construction-strategy 6. https://procure22.nhs.uk/ and https://procure22.nhs.uk/p23/ 7. https://www.gov.uk/government/publications/naylor-review-government-response#:~:text=The%20Naylor%20review%20was%20a,response%20capitalises%20on%20those%20opportunities. 8. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals 9. https://www.longtermplan.nhs.uk/ 10. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/ 11. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117	
F3	**6.Net Zero Carbon** Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?	3. Requires minimal improvement	2. Good	1. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance) 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects.		
F3	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	3. Requires minimal improvement	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

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	Revenue consequences of achieving compliance	£50,000	£0			
F4	**F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?**	Applicable	Applicable			
F4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. NHS Standing Financial Instructions -These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by us. 3. Audit Commission Report 2004 - Achieving first-class financial management in the NHS 4. The Public Contracts Regulations 2015 5. The Bribery Act 2010 - Guidance (publishing.service.gov.uk) 6. Leading the fight against NHS Fraud, organisational strategy 2017-2020 -Standards for NHS Providers 2020-21 Fraud, bribery and corruption January 2020 7. HFMA Finance training modules https://www.england.nhs.uk/estates/health-building-notes/https://www.england.nhs.uk/publication/standing-financial-instructions/ http://www.wales.nhs.uk/documents/FinanceinNHS_Report.pdf https://www.legislation.gov.uk/uksi/2015/102/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832011/bribery-act-2010-guidance.pdf https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2020_v1.3.pdf https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance	
F4	**2: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Requires minimal improvement	3. Requires minimal improvement	1. Internal Audits 2. Financial controls and scheme of delegation 3. Business Case procedure and Capital regime		
F4	**3. Board reporting and contracting** Is there comprehensive and regular reporting relating to estates and facilities services to the trust board highlighting performance, risks and issues. Are contracts in place for all estates and facilities services, documenting requirements with appropriate ability to terminate or manage poor performance and defined change control arrangements.	Not applicable	3. Requires minimal improvement	1. Board reports 2. Do you have robust change control and review of costs 3. Contracts in place for all services with appropriate provisions for cost control and service incentivisation		
F4	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F5	**F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?**	Applicable	Applicable	SAQ taken from CQC KLOE W5. Prompt 6 can be cross referred to SAQ F1 and Patient Experience SAQs		
F5	**1. Quality and Sustainability** When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability and net zero carbon targets assessed, understood and monitored, before, during and after the development?	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Action from surveys and feedback. 4. Backlog Risk Assessment, impact assessment and mitigation and action plan.		
F5	**2. Financial Pressure** Are there examples of where financial pressures have negatively affected estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Estates Incidents impacting on clinical care- ERIC returns, & feedback to EFM Division to NHS England and NHS Improvement.	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Model Health System 6. Department of Health Built Environment Key Performance Indicators (KPIs) 7. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy	
F5	**3. Continuous Improvement** Do leaders and staff strive for continuous learning, improvement and innovation?	3. Requires minimal improvement	3. Requires minimal improvement	1. Risk Assessments and Registers 2. Derogations documented with clinical impact assessment and clinical sign-off. 3. Training and Development plans and records.		
F5	**4. Quality Improvements** Are staff focused on continually improving the quality of estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Regular assessments of quality outputs e.g. PLACE scores; 2. Inclusion of quality assessments in Costed Action Plans.		

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F5	**5. Recognition** Are improvements to quality and innovation recognised and rewarded?	2. Good	2. Good	1. Staff suggestion scheme. 2. Staff awards and recognition.	https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://model.nhs.uk/ https://improvement.nhs.uk/resources/model-hospital/ https://www.gov.uk/government/statistics/key-performance-indicators https://www.iso.org/standard/55088.html	
F5	**6. Use of Information** Is information used proactively to improve estates and facilities services?	4. Requires moderate improvement	4. Requires moderate improvement	1. Use of design evaluation tools.		
F5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this inline with the ICS infrastructure strategy?**	Applicable	Applicable	SAQ is taken from CQC KLOE W1 and covers the estates and other related strategies as described in HBN 00-08 Part B section 2. Prompt 3 can be linked to SAQ PE1. Operational management is covered in SAQ S01		
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	2. Good	2. Good	1. Estates Strategy and related documents;	1. Developing an Estate Strategy document 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Health building Note 00-08The efficient management of healthcare estates and facilities (part A): Land and Property Appraisal 4. Strategic Health Asset Planning & Evaluation (SHAPE) tool 5. RICS UK Commercial Real Estate Agency Standards. 6. RICS Guidance Notes- Real Estate disposal and acquisition. 7. Assets in Action 8. Healthcare providers: asset register and disposal of asset 9. Strategy development: a toolkit for NHS providers 10. Developing strategy What every trust board member should know 11. Energy guidance section (how to produce an SDMP) to the current guidance for green plans: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf https://www.gov.uk/government/publications/developing-an-estate-strategy https://www.england.nhs.uk/estates/health-building-notes/ https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards	
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Documentary evidence relevant to the prompt questions e.g. document articulating the vision such as mission statement		
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	3. Requires minimal improvement	3. Requires minimal improvement	1. Regular discussions/meetings/exchanges with interested parties; 2. Integration of these discussions into Strategies and Visions/Values;		
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	3. Requires minimal improvement	3. Requires minimal improvement	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;		
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	3. Requires minimal improvement	3. Requires minimal improvement	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;		
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	2. Staff, Patient and stakeholder engagement and feedback 2. Analysis of relevant complaints;		
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 3.0.		
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	2. Good	2. Good	1. Involvement in town planning issues		
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	2. Good	3. Requires minimal improvement	3. Involvement in town planning issues		
E2	**4. Special Interests** **A**n effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	2. Good	2. Good	1. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 2. Preventing third parties gaining inappropriate rights over land and property 3. Management of easement agreements 4. Management of tenancy and other contractual arrangements 5. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented	1. Health Building Note 00-08: The efficient management of healthcare estates and facilities 2. Health building Note 00-08:The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. Health Technical Memorandum 05 Fire code 4. Estates Net Zero Carbon Delivery Plan 5.Health Technical Memorandum 07-02 6. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/estates/health-building-notes https://www.england.nhs.uk/estates/health-building-notes/ https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/	
E2	**5. Enforcement** **A**n effective and efficient process to deal with any enforcement procedures served on the organisation?	2. Good	4. Requires moderate improvement	1. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green		
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 4.0 to 8.0		

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Demonstration of re-investment of income. 8. Maintenance of an up-to-date and accurate property asset register 9. All statutory obligations to be identified and met 10. Preventing third parties gaining inappropriate rights over land and property 11. Management of easement agreements 12. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green 13. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented 14. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. Health Building Note 00-08: The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. RICS UK Commercial Real Estate Agency Standards. 4. RICS Guidance Notes- Real Estate disposal and acquisition. 5. Assets in Action 6. Real estate management - 3rd edition, October 2016" 7. Healthcare providers: asset register and disposal of asset 8. Estates Net Zero Carbon Delivery Plan https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/real-estate-management-3rd-edition-rics.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets	
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	2. Good	2. Good	1. Management of leases, tenancy and other contractual arrangements		
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Maintenance of an up-to-date and accurate property asset register 8. All statutory obligations to be identified and met 9. Preventing third parties retaining inappropriate rights over land and property 10. Management of easement agreements 11. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 12. Consideration of mandatory energy efficiency ratings.	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	Applicable	Applicable			
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	3. Requires minimal improvement	2. Good	1. The Green Plan / Sustainability Strategies published on the Trust's website and has been updated within the last 3 years 2. The organisation tracks its progress using the Green Plan Support Tool 3. The Green Plan / Sustainability Strategy names an executive lead for sustainability 4. The Green Plan / Sustainability Strategy states progress against carbon emission reduction targets in line with the 'Delivering a net zero NHS report' 5. Alignment with STP/ICS estates strategy; 6. Green Plan is published on the Trust's website & has been updated within the last 3 years 7. Green plan states progress against carbon emission reduction targets in line with national NHS net zero targets.	1. How to produce a Green Plan 2. Green Plan Support Tool 3. Delivering a net zero NHS report 4. Estates Net Zero Carbon Delivery Plan 5. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 1. https://improvement.nhs.uk/resources/how-produce-sustainable-development-management-plan-sdmp/ 2. https://future.nhs.uk/sustainabilitynetwork/view?objectID=40820880 3. https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ 4. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117	

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	3. Requires minimal improvement	3. Requires minimal improvement	1. The organisation has evidence of TM44 Air Conditioning System Assessments 2. Organisations which qualify for the EU Emissions Trading Scheme (EUETS) have an EUETS assessor and can demonstrate relevant annual reporting systems 3. Organisations with Combined (Cooling) Heat and Power Plant (CHP/CCHP) have a CHP Quality Assurance (CHPQA) Certificate for Climate Change Levy (CCL) exemption for each unit installed 4. The organisation has a current energy efficiency policy 6. Evidence that utility bills are checked and validated before payment 7. The organisation has rolled out smart metering across the estate, or has a programme to roll out within the next 3 years 9. Monthly meter readings are taken and recorded, and automated readings validated physically 10. The organisation employs a dedicated (spends > 50% of their time working on energy management activities) energy manager / responsible person for energy 11. The Organisation is compliant to HTM 07-02; Making Energy work in Healthcare 12. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex. 13. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance)	1. CIBSE TM44 : Inspection of Air Conditioning Systems 2. EU Emissions Trading System 3. Combined Heat and Power Quality Assurance Programme 4. Making energy work in healthcare (Health Technical Memorandum 07-02) 5. ISO 50001 Energy Management 6. Estates Net Zero Carbon Delivery Plan (NZCDP) 7. NZCDP Technical annex 1. https://www.cibse.org/AirConditioning_1 2. https://ec.europa.eu/clima/policies/ets_en 3. https://www.gov.uk/guidance/chpqa-guidance-notes 4. https://www.england.nhs.uk/estates/health-technical-memoranda/ 5. https://www.iso.org/iso-50001-energy-management.html 6. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 7. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557#	
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	4. Requires moderate improvement	3. Requires minimal improvement	1.The organisation has a current waste management and minimisation policy 2.The organisation's Dangerous Goods Safety Advisor (DGSA) has reported within the last 12 months 3.The organisation can evidence completion of Pre-acceptance Audits? 4.The Trust can demonstrate processes to fulfil their Duty of Care for waste 5.The organisation holds regular contract review meetings 6.The organisation can evidence record receipt and review of monthly progress reports 7.The organisation holds regular operational meetings 8.The organisation conducts monthly independent audits of the service 9.The organisation maintains statutory waste records (disposal notes, destruction certificates) and compliance audits 10.The organisation can evidence staff waste 11.The organisation employs a dedicated (spends > 50% of their time working on waste management activities) waste manager / responsible person for waste 12.The organisation is compliant with HTM 07-01; Safe Management of Healthcare Waste 13. The organisation is compliant with the Clinical Waste Strategy 14. The organisation is compliant with the 20:20:60 split of Alternative Treatment, Incineration (clinical waste) and Offensive Waste volume	1. HTM 07-01; Safe Management of Healthcare Waste 2. NHS Clinical Waste Strategy 1. https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ 2. https://www.england.nhs.uk/publication/nhs-clinical-waste-strategy/	
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	3. Requires minimal improvement	2. Good	1.The organisation has completed the Clean Air Hospitals Framework Tool 2.The organisation has a Clean Air policy including anti-idling 3.The organisation has an action plan for tackling air pollution from its buildings 4. The organisation has an action plan for tackling air pollution from its own vehicles and those that visit the organisation's site(s) 5.The organisation keeps an FGAS register 6.The organisation has a plan for migrating to Zero Emission Vehicles 7. The organisation has an action plan to meet air pollution targets in the Long Term Plan	1. Clean Air Hospital Framework 2. Fluorinated gas (F gas): guidance for users, producers and traders 3. NHS Long Term Plan https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/air-pollution/ https://www.globalactionplan.org.uk/clean-air-hospital-framework/ https://www.gov.uk/government/collections/fluorinated-gas-f-gas-guidance-for-users-producers-and-traders	
E4	**5.: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	Not applicable	4. Requires moderate improvement	1. The organisation has a sustainable travel plan. 2. Zero emissions vehicles are integrated into procurement practices - in-line with Net Zero Travel & Transport strategy. 3. A staff travel survey is completed at least every 24 months. 4. The organisation has a parking policy covering staff, patient & visitor travel. 5. The organisation provides secure bike storage, changing facilities and good quality on and off-site walking and cycling routes. 6. The organisation considers sustainable transport, flexible working and route planning/optimisation in its business travel (or similar) policy. 7. The organisation reports to the Greener NHS Fleet Data Collection	1. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 2. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 3. Delivering a Net Zero NHS https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-Procurement-Guide.pdf	
E4	**6.: Water** Are water services efficiently and effectively delivered?	3. Requires minimal improvement	3. Requires minimal improvement	1.The organisation has a water efficiency policy 2.Monthly meter readings are taken and recorded, and automated readings validated physically 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. NZCDP Technical annex 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557	
E4	**7.: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	3. Requires minimal improvement	4. Requires moderate improvement	1.The organisation has a climate change adaptation risk assessment on the Trust risk register 2.The organisation reports on estate related events, such as extreme weather events including flooding, heatwave and cold winter events 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. HBN 00-07 Resilience planning for the healthcare estate 3. Flood Risk Toolkit 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://www.england.nhs.uk/publication/resilience-planning-for-nhs-facilities-hbn-00-07/ 3. https://tabanalytics.data.england.nhs.uk/#/views/FloodRiskToolkit/TitlePage?=null&:iid=3	

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E4	**8.: Procurement** Is all relevant procurement consistent with NHS England's net zero and sustainable procurement policies?	3. Requires minimal improvement	3. Requires minimal improvement	1.The organisation takes account of the NHS Net Zero Supplier Roadmap and reports against compliance with this through the quarterly Greener NHS data collection. 2.The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects.	1. NHS Net Zero Supplier Roadmap 2. Greener NHS quarterly data collection 3. Applying net zero and social value in the procurement of NHS goods and services (building on PPN06/20) 4. Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works (aligning to PPN06/21) 5. Evergreen Sustainable Supplier Assessment 6. NHS Net Zero Building Standard 1. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/ 2. https://future.nhs.uk/sustainabilitynetwork/view?objectID=40822960 3. https://www.england.nhs.uk/greenernhs/publication/applying-net-zero-and-social-value-in-the-procurement-of-nhs-goods-and-services/ 4. https://www.england.nhs.uk/long-read/carbon-reduction-plan-requirements-for-the-procurement-of-nhs-goods-services-and-works/ 5. https://www.england.nhs.uk/nhs-commercial/central-commercial-function-ccf/evergreen/ 6. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/	
E4	**9: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	4. Requires moderate improvement	4. Requires moderate improvement	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
E4	Capital cost to achieve compliance	£0	£0			
E4	Revenue consequences of achieving compliance	£5,000	£1,000			

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
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Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W2.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 2. NHS Constitution and Handbook to the NHS Constitution 3. NHS Long Term Plan 4. Quality Governance in the NHS 5. Gov.uk - Quality governance in the NHS - A guide for provider boards 6. Monitor Code of Governance for Foundation Trusts 7. NHS TDA Delivering High Quality Care 8. NHS Good Corporate Citizen 9. Monitor: Risk Assessment Framework for NHS Foundation Trusts 10. HSE five steps to risk assessment - INDG163 (rev 4) 06/11 11. Developing strategy What every trust board member should know 12. Modern Slavery Act 2015 13. Public Services (Social Value) Act 2012 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.longtermplan.nhs.uk/ https://www.gov.uk/government/publications/quality-governance-in-the-nhs-a-guide-for-provider-boards https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance Foreword: https://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdf https://healthbusinessuk.net/features/good-corporate-citizenship-nhs https://www.gov.uk/government/publications/risk-assessment-framework-raf https://www.hse.gov.uk/pubns/INDG163.pdf https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted https://www.legislation.gov.uk/ukpga/2012/3/enacted	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	5. Inadequate	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	4. Requires moderate improvement	4. Requires moderate improvement	1. Governance Structure 2. Annual Plan/Programme Board 3. Structure chart 4. Committee terms of reference and minutes		
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	2. Good	2. Good	1. Local sustainability and transformation partnership plans		
G1	**4. Framework** The governance framework and management systems are regularly reviewed and improved?	4. Requires moderate improvement	2. Good	1.Estate Strategy 2 Standing Orders		
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	4. Requires moderate improvement	3. Requires minimal improvement	1. Evidence of walkarounds 2. Signed-of processes and procedures documentation, including risk register. 3. Signed-off roles and responsibilities documentation.		
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	4. Requires moderate improvement	4. Requires moderate improvement	1. Audit reports, peer and external reviews.		
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	5. Inadequate	4. Requires moderate improvement	1. Surveillance Programme 2. Audit Programme		
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	3. Requires minimal improvement	2. Good	1. Job descriptions and training records for risk management. 2. Corporate, current risk register in place, with an identifiable owner. 3. Signed-off risk management strategy by the Board		
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	3. Requires minimal improvement	3. Requires minimal improvement	4. Evidence risks are passed into corporate risk register and actions taken, do not simply disappear without action		
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	4. Requires moderate improvement	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£5,000	£0			
G2	**G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W3.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 3. CQC Regulation 20: Duty of candour (FS) 4. NHS Long Term Plan 5. Conduct for NHS Managers	
G2	**1. Effectiveness** Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.	4. Requires moderate improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies		
G2	**2. Challenges** Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback		
G2	**3. Visibility** Leaders are visible and approachable.	3. Requires minimal improvement	3. Requires minimal improvement	1. Organograms and structure charts		
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback		
G2	**5. Respect** Staff feel respected and valued.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback		
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	3. Requires minimal improvement	2. Good	1. Performance reviews 2. Local and national staff surveys and feedback		

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence (examples listed below) Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	Relevant guidance and legislation The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	Comments
G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	3. Requires minimal improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback 2.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working	6. NHS Constitution and Handbook to the NHS Constitution 7. NHS complaints procedure in England SN / SP / 5401 24.01.14 "8. ISO 10002:2004 Quality management — Customer satisfaction — Guidelines for complaints handling in organizations" 9. NHS whistleblowing procedures in England SN06490 13.12.13 10. Public Interest Disclosure Act 1998 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour https://www.longtermplan.nhs.uk/ https://www.nhsemployers.org/~/media/Employers/Documents/Recruit/Code_of_conduct_for_NHS_managers_2002.pdf https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.england.nhs.uk/contact-us/complaint/ https://www.iso.org/standard/35539.html https://www.england.nhs.uk/ourwork/whistleblowing/ https://www.gov.uk/government/publications/the-public-interest-disclosure-act	
G2	**8. Honesty** The culture encourages candour, openness and honesty.	4. Requires moderate improvement	4. Requires moderate improvement	1. Local and national staff surveys and feedback		
G2	**9. Safety & Wellbeing** There is a strong emphasis on promoting the safety, health and wellbeing of staff.	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies		
G2	**10. Healthier workplace** Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G2	**11. Collaboration** Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.	4. Requires moderate improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G2	**12: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	Applicable	Applicable			
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors		
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	3. Requires minimal improvement	3. Requires minimal improvement	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors		
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

◄◄ Back to instructions	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
H1	**H1. Confirmation of Safe Helipad Operations and Evidencing Planning and Implementation Practices: Can the organisation confirm they have processes in place to safely maintain the operation of their helipad?** **The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad.** **This includes evidencing the planning and implementation of the helipad, with clearly defined responsibilities about quality, performance, and risk management.** **The organisation should also be able to evidence the planning and implementation of a helipad with clear responsibilities for quality, performance and risks, can the organisation evidence the following?**	Applicable	Applicable	**•Documented Safety Protocols and Procedures** These documents should detail safety protocols for helipad operations, including emergency procedures, maintenance schedules, and guidelines for safe landings and take-offs. **•Maintenance Records** Regular helipad maintenance is essential. Logs and records must show consistent inspections and upkeep to required standards. **•Training Records of Personnel** Ensure all helipad personnel, ground staff, and emergency teams, are trained and qualified. Training records must confirm staff adherence to current safety practices and procedures. **•Risk Assessment Documentation** Evidence must show regular risk assessments for helipad operations, identifying and mitigating potential hazards. **•Quality and Performance Monitoring Records** Documentation should demonstrate the monitoring and evaluation of helipad operations, including incident logs, response times, and corrective actions taken. **•Certifications and Compliance Reports** Any relevant certifications or compliance reports that show the helipad meets national and international safety standards. **•Operational Guidelines and Manuals** Comprehensive operational manuals outlining procedures and responsibilities for safe helipad operation. **•Emergency Response Plans** Documentation of emergency response plans, including coordination with local emergency services and contingency plans for various emergency scenarios. **•Feedback and Incident Reports** Records of user feedback and incident reports for the helipad, including follow-up actions taken. **• hsurance and Liability Documents** Proof of appropriate insurance coverage and liability protections related to helipad operations. **CAA training should be undertaken Hospital Helipad – Aviation Awareness | Training Course by the UK CAA (caainternational.com)**	
H1	1. Compliance Assessment and Policy Review: Adherence to CAP1264 and Downwash Helipad Considerations in the Trust: Policy, Procedures and Compliance: Is the organisation compliant and does the organisation have a current, approved policy and an underpinning set of procedures that comply with CAP1264? The Trust should have a responsible person able to demonstrate and a documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.	4. Requires moderate improvement	4. Requires moderate improvement	CAP1264 Compliance and Operations: The Trust must have documentation proving its helipad design and operations comply with CAP1264 standards. This includes assessing the helipad's layout, safety features, and protocols. Approved Helipad Policy: A regularly reviewed helipad policy, in line with CAP1264 guidelines, should be established. It should encompass emergency procedures, maintenance, and staff training. Documented Evidence/Policy for Downwash Considerations: Downwash Factors Records and analyses are needed to manage helicopter downwash, a key safety concern in helipad design and operations, in accordance with CAP1264. Responsibility and Documentation Appoint a responsible person or team knowledgeable in CAP1264 to oversee helipad operations. Their role includes managing documentation related to downwash, including risk assessments, mitigation strategies, and staff training. Regular Audits and Reviews Conduct frequent audits to ensure the Trust's helipad policies and procedures remain compliant with CAP1264. These should review downwash management and adapt to changes in helicopter technology or operational practices.	
H1	2. Roles and Responsibilities Ensuring Qualified Personnel and Clear Governance Does the Organisation have appropriately qualified, trained, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? When developing the policy and procedures have you consulted with internal and external stakeholders? The Trust should have a responsible person and a documented evidence/policy in relation to general helipad factors and considerations within the Trust.	4. Requires moderate improvement	4. Requires moderate improvement	Governance Structure Documentation This should outline the overarching framework within which helipad operations are conducted. It includes details on decision making processes, accountability and how different roles within the organisation contribute to helipad management. Organisational Structure Chart This chart should visually represent the hierarchy and reporting lines relevant to helipad operations. It clarifies who is responsible for what, ensuring that roles and responsibilities are clearly defined and understood. Post Profiles and Training Records Detailed job descriptions for each role involved in helipad operations, along with records of individual training, are crucial. These profiles should include specific qualifications, competencies, and experience required for each position. Training records prove that staff members have been adequately trained for their roles. Evidence of Training and Development Documentation should be provided to show that all staff involved in helipad operations have received proper training. This includes training that meets safety, technical, and quality requirements. Evidence may include certificates, course completion records, and ongoing professional development logs. Specific Training Certifications For instance, the CAA training for Hospital Helipad - Aviation Awareness. This specialised training, offered by the UK Civil Aviation Authority (CAA), ensures that staff is aware of aviation-specific considerations and safety practices related to helipad operations. To ensure comprehensive compliance, the Trust should have a designated responsible person who can present and manage these documents. This individual should be well-versed in the operational aspects of the helipad and the regulatory environment. They should also be capable of liaising with both internal and external stakeholders to ensure that all policies and procedures are up-to-date, effective, and widely understood. Regular consultations with stakeholders, including emergency services, aviation experts, and hospital staff, are vital for maintaining a safe and efficient helipad operation.	

H1	3. Risk Assessment and Mitigation Strategies for Helipad and Estates In relation to this, has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	3. Requires minimal improvement	Documented Risk Assessment Report This should include a comprehensive risk assessment of the helipad and surrounding estate. The report should detail identified risks, the likelihood of occurrence, potential impact, and the scoring methodology used to prioritise risks. Mitigation Strategies and Implementation Evidence Documentation should be provided showing the specific risk mitigation strategies that have been applied. This could include engineering controls, procedural changes, training programs, or any other relevant measures. Evidence of implementation might include records of changes made, training completed, or equipment installed. Regular Review and Update Records Compliance requires not just a one-time assessment but ongoing monitoring and reassessment of risks. Documentation should show how often the risk assessment is reviewed and updated and how new risks or changes in the environment are incorporated. Alignment with Civil Aviation Authority Standards Evidence should be presented that the organisation's risk assessment and mitigation strategies are in line with the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, as detailed in CAP 1264. This might include a comparative analysis or a compliance checklist. Audit and Inspection Reports Regular audits or inspections of the helipad and related facilities can provide evidence of compliance. These reports should detail the findings of the audits, any non-compliances identified, and how these were addressed. Incident and Accident Records Records of any incidents or accidents related to the helipad should be maintained. This includes how these incidents were investigated and what measures were taken to prevent recurrence. Stakeholder Consultation Records Documentation of consultations with stakeholders, including hospital staff, emergency services, and aviation experts, can provide evidence of a thorough and inclusive risk assessment process. Training Record Evidence of training provided to relevant staff in helipad operations and safety can demonstrate commitment to risk mitigation. Emergency Response Plan A documented emergency response plan specific to helipad operations should be available, detailing procedures for various potential emergencies.	
	4. Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads When conducting fire risk assessments and ensuring compliance with relevant guidelines for NHS helipads, please confirm the Trust understands the distinct regulatory considerations for ground-based and elevated helipads.	Not applicable	2. Good	Ground-Based Helipads Accessibility: Ground-based helipads typically offer easier access to emergency services and fire-fighting equipment. This accessibility needs to be factored into the risk assessment and mitigation strategies. Surrounding Environment The assessment must consider the immediate environment around the helipad, including the types of surfaces (grass, concrete, etc.) and nearby structures or natural features that might influence fire risk. Elevated Helipads (such as on rooftops) Structural Integrity Elevated helipads require careful assessment of the building's structural integrity to support the helipad's weight, especially during fire emergencies. Evacuation Routes Special attention must be given to evacuation routes and emergency access, as elevated helipads may present more challenges in these areas compared to ground-based helipads. Wind and Weather Conditions Elevated helipads are more exposed to wind and other weather elements, which can impact fire behaviour. This must be considered in the fire risk assessment. Fire Suppression System Due to their location, elevated helipads may require specialised fire suppression systems that are effective at higher elevations and in potentially limited spaces. In both cases, the NHS Trust should ensure compliance with the Civil Aviation Authority's standards (CAP 1264) and incorporate specific guidelines for each type of helipad into their overall fire risk management strategy. Regular training, emergency drills, and clear documentation are crucial components of this strategy, regardless of the helipad type.	Possible updates to follow 2023/24
H1	5. NHS Helipad Fire Risk Assessment and Compliance Guidelines Has there been a specific fire risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has this assessment taken into account the helipad and the potential healthcare buildings in its curtilage In addition the Trust should have a responsible person and a documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.	3. Requires minimal improvement	2. Good	Specific Fire Risk Assessment for the Helipad Area The NHS Trust should conduct a thorough fire risk assessment specifically for the helipad area. This assessment should consider all potential fire hazards associated with helicopter operations, including fuel, electrical systems, and potential ignition sources. The assessment should also consider the unique characteristics of the helipad, such as its location, size, and proximity to healthcare buildings and other infrastructure. Regular Review and Update of the Fire Risk Assessment The fire risk assessment should not be a one-time activity. It needs to be regularly reviewed and updated to reflect any changes in the operating environment, new helicopter models, or changes in surrounding infrastructure. Regular reviews ensure that any new risks are identified and mitigated promptly. Risk Mitigation Strategies Based on the findings of the fire risk assessment, the Trust should implement appropriate risk mitigation strategies. These might include fire suppression systems, emergency response plans, and safety protocols for fuel handling and storage. The effectiveness of these mitigation strategies should be regularly tested and evaluated. Documentation and Policy The Trust should maintain comprehensive documentation of the fire risk assessment process, including the findings, decisions made, and actions taken. This documentation serves as evidence of compliance with relevant guidelines and legislation. There should also be a clear policy outlining the responsibilities and procedures related to fire risk management at the helipad. Responsibility and Training The Trust should designate a responsible person or team to oversee fire safety at the helipad. This individual or team should have the necessary training and expertise in fire risk management and helicopter operations. Regular training and drills should be conducted for all staff involved in helipad operations to ensure they are aware of fire risks and know how to respond in an emergency. Compliance with Civil Aviation Authority Standards The Trust's risk assessment and mitigation strategies should take into account the relevant sections of the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, outlined in CAP 1264. This includes ensuring that the design, operation, and maintenance of the helipad meet the safety standards set by the Civil Aviation Authority.	

H1	6. Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff in relation to helipad and the estate.	3. Requires minimal improvement	3. Requires minimal improvement	Business Continuity Audit Reports for Helipads: These reports analyse an organization's capacity to maintain operations amidst major disruptions like natural disasters or cyber attacks, with a focus on helipad operations and continuity measures. Trust's Incident Response Plan for Helipads: A detailed plan outlining response procedures for incidents impacting the helipad, including emergency medical situations and natural disasters. Committee/Group Terms of Reference: Document detailing the responsibilities of the committee overseeing the helipad's emergency and business continuity plans, including test frequency, scope, and review processes. Corporate Risk Register for Helipad Operations: A comprehensive list of risks related to helipad operations, detailing the nature, likelihood, impact, and mitigation measures for each risk, regularly updated and maintained by an assigned owner. Board-Approved Risk Management Strategy: A strategy document outlining the approach to managing helipad risks, aligning with the organization's broader risk management policies, and subject to periodic review. Board-Signed Incident Response and Business Continuity Plans: Documents detailing emergency response and continuity strategies for the helipad, indicating organizational commitment to preparedness and safety. Stakeholder Collaboration in Risk Assessment and Meeting Records: Documentation evidencing collaboration with stakeholders, including helipad users, emergency services, and staff, in risk assessment processes, and minutes from meetings discussing safety, security, and operational procedures. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement.	
H1	7: Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	3. Requires minimal improvement	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors; 7. The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working' 8. The ability to report on the regulatory requirements regarding safer wards (ligature). 9. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.	
H1	8. Collaboration Has the organisation in undertaking the risk assessment processes collaborated with helipad users, fire and rescue services re pre-determined site attendance and police with regard to safety & security (in particular terrorism threat) and staff members whose role includes receiving patients from/transferring a patient to, a helicopter	2. Good	2. Good	1. Working with relevant organisations to ensure best practice is followed. 2. Consider external sites being used	
H1	9. Costed Action Plans If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	Not applicable	Detailed Action Plans: Outlining investments needed for compliance with the NHS Premises Assurance Model (PAM), including specific steps, timelines, and responsible parties. Financial Documentation and Risk Assessments: Detailed cost estimates and risk assessments for areas needing improvement. Board and Committee Escalation Evidence: Documentation showing board-level awareness and action plan discussions. Budget Inclusion Proof and Prior Investment Assessment: Evidence of budgetary allocation for actions and analysis of the impact of previous investments. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards.	
H1	Capital cost to achieve desired improvements/outcomes	£0	£0	Capital Cost Analysis and Legislative Alignment Detailed Cost-Benefit Analysis: Breakdown of costs and benefits of helipad improvements, including patient care and operational efficiency. Post-Implementation Review Plan: Outline for evaluating helipad performance and impact after implementation. Revenue Implications of NHS Helipad Improvements	
Ref.	Revenue consequences of achieving desired improvements/outcomes	£0	£0	Cost-Benefit Analysis and Comparative Case Studies: Financial analysis of improvements and case studies from similar healthcare facilities. Regulatory Compliance and Projected Revenue Impact Reports: Documentation on compliance with laws and projected revenue changes. Stakeholder Feedback and Performance Metrics: Input from various stakeholders and clear metrics for evaluating improvement outcomes. Risk Analysis and Sustainability Assessments: Financial risk identification and assessments of long term sustainability.	

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

Integrated	**Integrated Leadership**		**Scoring**	**1**	**2**	**3+**		
		Q1 How integrated is facilities management - Soft Services?	**3+**	Soft services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Soft services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q2. How integrated is facilities management - Hard Services?	**3+**	Hard services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Hard services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q3. How integrated is Property Leadership?	**2**	FM works in a silo, reactive to demand with little engagement with wider property leadership	FM links in some what with construction, design and asset management teams, but gaps remain.	leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.		
	CAFM		**Scoring**	1	2	3	4	5
		Q4. How integrated are your FM Management IT Systems?	**2**	No CAFM, basic spreadsheets or similar used to monitor and manage FM.	Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.	A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of the truth.	An integrated CAFM is in use holding all but financial data, which is held in corporate finance system.	Organisation has a single, integrated CAFM system holding a single version of the truth, with other key systems feeding into a master system.
			Scoring	1	2	3	4	5
Collaborative	**Partnership & Transparency**	Q5 - How closely does FM management work with the FM delivery organisation(s)?	**3**	Minimal, adversarial relationship	Weekly or monthly meetin	Regular, joint meetings held taking both a backwards look at performance and a forward look at opportunity for improvement and upcoming changes	Genuine partnership, both sides work in an open and honest way to improve service delivery, built on trust. Very little discussion on poor performance or penalties.	A fully open and trusting relationship, working both ways to improve performance and value
			Scoring	1	2	3+		
		Q6 - How strategic and effective are supplier relationships?	**1**	Supplier relationships are transactional only.	A supplier relationship model (SRM) is in place (See CCS)	Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective SRM model is in place.		
			Scoring	1	2	3+		
		Q7 - How transparent is FM delivery between the management organisation and delivery organisation?	**2**	No transparency regarding performance or cost.	Data held by supplier but re	Organisation has real time access to key data in a transparent and open way and is regularly audited.		
			2	1	2	3+		
		Q8 - Does the FM team collaborate outside of the management organisation?	**3+**	Little engagement with wider government departments, occasional attendance at events or key meetings.	Actively involved in cross g	In addition to formal cross gov groups, work closely with equals and leadership in other government departments to share best practice and go develop solutions, driving continuous improvement and innovation.		
			Scoring	1	2	3	4+	
	Compliance	Q9 - How effective is your hard compliance management approach?	**3**	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (Asbestos, Water, Fixed Wiring, Fire, Gas, Lifts). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3	4+	5

		Q10 - How effective is your soft compliance management approach?	**3**	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (security, risk assessments, data). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3+		
Delivery Excellence	**Standards and Best Practice**	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	**3+**	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, but less maturity on other aspects	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
		Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	**3+**	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, such as SFG20 but less maturity on other aspects.	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
	Defined Roles	Q13 - How well defined are FM roles and responsibilities within Hard Services?	**3+**	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3+		
		Q14 - How well defined are FM roles and responsibilities within Soft Services?	**3+**	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3	4+	
	Enabling	Q15 - How flexible is FM to changing business needs?	**4+**	FM works on fixed price or	Part fixed, part variable arr	Work in partnership with suppliers to continually improve support for changing business objectives.	Supplier is engaged in the organisations service and strategy planning and understands their role. They work in partnership to proactively deliver change.	
			Scoring	1	2	3	4+	

Strategic	**FM Strategy**	Q16 -How strategic is FM?	**2**	No FM strategy or service plan. FM is delivered in a reactive way.	Basic FM strategy and servi	FM Strategy in place, consi	Long-term vision of what good FM looks like and how to get there. Consideration for external impact (e.g. sustainability) fully embedded into delivery model with robust monitoring and reporting in place. Horizon scanning undertaken including strategic risk management. Strategy fully aligned with aims and values of department/	
			Scoring	1	2	3		
	Governance	Q17 -Do you have effective FM governance in place?	**2**	No management/minimal management. Risk poorly allocated.	Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.	Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.		
			Scoring	1		3	4+	
Intelligent	**Intelligent Client**	Q18 -Do you have a clear definition and recognised Intelligent client function?	**3**	The ICF is dispersed without a clear, recognised function.		A recognised intelligent client function is in place, with defined roles and responsibilities, recognised by the wider organisation and has the capabilities and capacity required to be effective.	A highly effective ICF is in place with it's value recognised at an organisational level.	
			Scoring	1	2	3+		
		Q19 - Is an effective client department in place?	**3+**	No recognisable client department, a number of individuals within the organisation may be responsible for various aspects	An identifiable client department is in place, acting as a conduit between the wider organisation and the delivery organisations to maximise value.	A strong and effective client department is in place, with centralised oversight of all aspects of FM.		
				1	2	3+		
	Control Levers	Q20 -How well do you understand the levers to improve performance?	**3+**	A basic understanding of levers available in the contract, primarily performance failure driven	A good understanding of commercial, financial and quality control levers and their impact of performance	Regular, demonstrable use of all types of control levers to drive continuous improvement		
	Management structure		**Scoring**	1	2	3+		
		Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	**3+**	Unclear roles and responsibilities, disjoined management with FM and property spread over multiple departments, devolved FM model - no "corporate landlord".	A defined, central FM team undertaking most FM duties, but with some aspects still devolved.	Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.		
	Forward Planning		**Scoring**	1	2	3+		
		Q22 - How proactive is FM service delivery in your organisation?	**2**	Reactive works only, failure driven.	Short term planning - next financial year only.	Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.		

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

Data Structure	**Hierarchy**		**Scoring**	1	2	3+		
		Q1 - What level of location hierarchy is asset data captured against?	**2**	Asset level data is captured against the site and building it is in.	Asset level data is captured against the site, building, floor and location it is in.	Asset level data is captured against the site, building, floor, location and system it is in.		
	Data Specification		**Scoring**	1	2	3	4	5
		Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	**1**	No defined data specification for FM asset data.	Defined data specification for FM asset data is not aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and inconsistently aligned to 'non-core' fields (4.2.2).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and 'non-core' fields (4.2.2).
			Scoring	1	2	3+		
		Q3 - How consistently is the data specification applied across the estate?	**1**	No defined data specification for FM asset data.	The data specification is inconsistently applied across the estate.	The data specification is consistently applied across the estate.		
Data Assurance & Quality	**Coverage and Completeness**		**Scoring**	1	2	3+		
		Q4 - What is the level of coverage of assets in the asset register data?	**1**	The asset data covers some assets in some estates.	The asset data covers all assets in some estates but only some assets in other estates.	The asset data covers all assets in all estates.		
			Scoring	1	2	3	4	5
		Q5 - How complete is the data captured against assets in the asset register?	**2**	Data is not captured against assets for the 'core fields' in the data standard (4.2.1).	Data is captured against some assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and some assets for the 'non-core fields' in the data standard (4.2.2).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and all assets for the 'non-core fields' in the data standard (4.2.2).
	Audit		**Scoring**	1	2	3+		
		Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	**1**	Data is out of date or incomplete and requires a full asset verification exercise.	Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.	Data is up to date and complete. An asset verification exercise is not currently required.		
			Scoring	1	2	3	4	5
		Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	**2**	No / limited sample surveys.	Inconsistent and ad-hoc sample surveys for some of the estates.	Consistent and regular sample surveys for all estates. There is a defined methodology to logically work through the all estates over time.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in some parts of the estate.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in all estates.
	Data Quality Control		**Scoring**	1	2	3	4	5
		Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	**1**	No / limited processes in place.	Inconsistent processes exist covering some parts of the estate.	Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.	Partially automated processes with frequent updates to change log.	Automated processes across all estates with close to real-time updates to change log.
			Scoring	1	2	3	4	5
		Q9 - What processes are in place for data quality checks (5.4)?	**1**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using basic checks covering some parts of the estate.	Consistent and regular processes exist using checks based on business rules covering all estates.	Partially automated processes using data quality check algorithms and data quality dashboards.	Automated processes using real-time data quality check algorithms, business rules, quality control dashboards and user feedback.
			Scoring	1	2	3	4	5

		Q10 - What processes are in place for data update assurance (5.5)?	**1**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using minimal data quality checks covering some parts of the estate.	Consistent and regular processes exist using verification tools and update logs covering all estates.	Partially automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering parts of the estate.	Automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering all estates.
	Governance		**Scoring**	1	2	3	4	5
		Q11 - What governance is in place to support data assurance and quality (5.)?	1	No / limited governance / informal group for asset data quality.	A dedicated asset data-quality governance group/board exists but meets on an irregular basis or without the required attendees.	A dedicated asset data-quality governance group/board exists, which meets regularly with all the relevant attendees.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with the suppliers.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with suppliers and cross-organisational governance board/group.
			Scoring	1	2	3+		
		Q12 - What level of documentation exists for the these data quality processes and governance (5.6)?	**1**	No / limited documented items for processes and governance.	Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.	Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis.		
Data Ownership and Access			**Scoring**	1	2	3+		
	Ownership	Q13 - Is the data contractually owned by the organisation (6.1)?	**3+**	The organisation does not contractually own the data.	The organisation contractually owns the data for some data stores/parts of estate.	The organisation contractually owns the data for all estates.		
			Scoring	1	2	3	4	5
	Accessibility	Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	**3**	No / limited access to the data (e.g. data extracts requested via email to FM provider).	Access to some data tables/extracts across some data stores/parts of the estate.	Access to all data tables/extracts across all data stores/all estates and manually extract the required data.	The ability to access data in via desktop tool or automated APIs for some data stores/parts of estate.	The ability to access data in data in via desktop tool or automated APIs for all data stores/all estates.
			Scoring	1	2	3+		
		Q15 - What level of access management exists for controlling user privileges (6.3)?	**3+**	No / limited access management privileges.	Some access management privileges exist across some data stores/parts of the estate. These are inconsistently applied.	Access management privileges exist across all data stores/all estates. These are consistently applied and tightly controlled.		
Data Systems			**Scoring**	1	2	3+		
	Flexibility	Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	**1**	Systems with limited flexibility to accommodate the data standards.	Systems with some flexibility to partially accommodate the data standards for some data stores/parts of the estate.	Systems with flexibility to fully accommodate the data standards for all data stores/all estates.		
			Scoring	1	2	3+		
	Interoperability	Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	**1**	Systems with limited interoperability between systems.	Systems with some interoperability between some systems and data is not transferable in COBie format.	Systems with interoperability between all systems and data is transferable in COBie format.		
			Scoring	1	2	3	4	5
		Q18 - Does the asset management systems sync to a common data platform (7.3)?	**1**	No common data platform exist.	Common data platform exists but data from some data stores/parts of the estate are stored. Data sources are updated on an ad-hoc basis.	Common data platform exists where data from all data stores/all estates are stored. Data sources are updated on a regular basis.	Common data platform exists where data from all data stores/all estates are aggregated using desktop tools and databases. Data sources are updated frequently.	Common data platform exists where data from all data stores/all estates are aggregated using automated APIs (applications). Data sources are updated in real-time.

	Management		**Scoring**	1	2	3+		
		Q19 - Do the systems meet data security requirements (7.4)?	**3+**	No systems meet minimum requirements across any estate.	Some of the systems meet data security requirements across some data stores/parts of the estate.	All systems meet data security requirements across all estates.		
			Scoring	1	2	3+		
		Q20 - Do the systems meet data backup management requirements (7.5)?	**3+**	No systems meet minimum requirements across any estate.	Some of the systems meet data backup management requirements across some data stores/parts of the estate. Backup processes are ad-hoc.	All systems meet data backup management requirements. Backup processes are on a regular basis.		
Data Usage	**Management Information**		**Scoring**	1	2	3	4	5
		Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	**2**	No / ad hoc reporting and dashboarding to support the use of FM asset data.	Inaccurate reports generated from data gathered point in time.	Standard reporting and interactive dashboards generated regularly with reliable processing and calculations.	Standard reporting and interactive dashboards generated from frequently updated data via robust data pipelines.	Ability to create bespoke customisable reports to answer the latest business questions.
	Insights		**Scoring**	1	2	3	4	5
		Q22 - How does asset data inform decisions relating to contract management (8.2)?	**1**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	**2**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	**3**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	**1**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
	Capacity		**Scoring**	1	2	3	4	5
		Q26 - What is the capacity of the teams working with asset data (9.1, 9.2)?	**2**	No dedicated teams/informal teams.	Dedicated team exists within the organisation covering some parts of the estate. Individuals do not have assigned responsibilities and accountabilities.	Dedicated team exists within the organisation covering some parts of the estate. Individuals have clear with responsibilities and accountabilities. Identified individuals with responsibilities and accountabilities to manage, monitor and generate required reports/insights from FM asset data.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers and cross-organisational data team.
			Scoring	1	2	3	4	5

Team Capacity and Capability	**Capability**	Q27 - What is the capability of the teams working with asset data (9.3)?	**3**	No dedicated personnel/informal teams.	Team with some FM and data/technical understanding.	Team with good FM and data/technical understanding. Ability to extract, transform, load and report data to generate required reports and insights.	Team with the ability to create robust and repeatable data processes along interactive dashboard to support in generating insights.	Team with the ability to use predictive and prescriptive analytical techniques used to create forward-looking insights.
	Training		**Scoring**	1	2	3	4	5
		Q28 - What training is provided for teams working with asset data (9.4)?	**1**	No / limited training provided.	Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.	Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.	Frequent pieces of training focusing on better understanding and upskilling in extended processes and tools used within the organisation.	Frequent pieces of training focusing on upskilling in advanced analytical and automation skills.
			Scoring	1	2	3+		
		Q29 - What training materials exists relating to asset data (9.5)?	**1**	No training and guidance material for asset data and processes.	Some training and guidance material exist related to asset data and processes covering some parts of the estate. These are reviewed and referred to on an ad-hoc basis.	Consistent training and guidance material exist covering onboarding, quality and audit processes, etc. for all estates. These are reviewed and referred to on regular basis.		
			Scoring	1	2	3	4	5
		Q30 - What knowledge sharing exists relating to asset data (9.6)?	**2**	No / limited knowledge sharing in place.	Some knowledge sharing exists within the organisation and some irregular knowledge sharing exists between organisations.	Consistent knowledge sharing exists between different organisations on a regular basis.	Consistent knowledge sharing exists between different organisations on a regular basis. Some knowledge sharing with suppliers on an irregular basis.	Consistent knowledge sharing exists between different organisations. Consistent knowledge sharing with suppliers on a regular basis.

Section	Area	Question	Add Details
All	Contact details	1. **Identify Lead for:** Insert name for board representative	Mr Lee Bond, Chief Financial Officer
		1.a Insert contact details	lee.bond@nhs.net
Food	Contact details	2. **Identify Lead for:** Insert name of catering dietitian	Unappointed.
		2a. Contact details of the dietitian	N/A
		2b Indicate if this is in house in-house, from an FM provider or an external contract (including NHS Supply Chain)	N/A
Food	Contact details	3. **Identify Lead for:** Organisations must nominate a food safety specialist. Provide details of person or company supplying service	Unappointed.
Medical Gas	Contact details	4. Medical gas committee: Board Executive responsible for medical gasses	Joanne Goode, Chief Pharmacist
Medical Gas	Contact details	5. Authorised Engineer	Peter Williams, Health Technical Limited
Medical Gas	Contact details	6. Authorised Person	Neil Kaye, Head of Engineering

NHS PAM Safety Prompt Question Guidance Sheets	◄◄ Back to instructions
Introduction	
This sheet supplements the 'generic' prompt questions contained within NHS PAM safety domain. It provides key references from the following documents that users should consider when undertaking their assessment of the relevant prompts: 1. Health and Safety Executive publication HSG 65 'Managing for health and safety' 2. The Care Quality Commission Provider Handbooks Appendix A 'Key Lines of Enquiry' 3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Associated CQC guidance	
Extracts from HSG 65 primarily relate to H&S regulations so may not be strictly relevant in all instance. However the advice may still be useful. HSG 65 'Managing for health and safety' is available from: http://www.hse.gov.uk/pubns/priced/hsg65.pdf. Similarly some references from the regulations and CQC guidance, particularly around training and development, may relate primarily to clinical and clinical support staff but again they still may be useful.	
1: Policy & Procedures **Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?**	
1.1 HSG 65 page 21:	
Policies should be designed to meet legal requirements, prevent health and safety problems, and enable you to respond quickly where difficulties arise or new risks are introduced.	
1.2 Regulations and CQC Guidance	
15(1)d • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	
15(1)d&e • All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	
1.3 Regulations and CQC Guidance	**CQC KLOE**
15(1)d • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
2: Roles and Responsibilities **Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?**	
2.1 HSG 65	
HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including: ■ ensuring there is adequate and appropriate supervision in place; ■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;	
HSG 65 page 17: The competence of individuals is vital, whether they are employers, managers, supervisors, employees or contractors, especially those with safety-critical roles (such as plant maintenance engineers). It ensures they recognise the risks in their activities and can apply the right measures to control and manage those risks.	
2.2 Regulations and CQC Guidance	
15(1)d&e • Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	
2.4 Regulations and CQC Guidance	**CQC KLOE**
18(1) Guidance: Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).	E3.1. Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis?
3: Risk Assessment **Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?**	
3.1 HSG	
HSG 65 Page 27) **What the law says on assessing risks** The law states that a risk assessment must be 'suitable and sufficient', i.e. it should show that: ■ a proper check was made; ■ you asked who might be affected; ■ you dealt with all the obvious significant risks, taking into account the number of people who could be involved; ■ the precautions are reasonable, and the remaining risk is low; ■ you involved your workers or their representatives in the process. The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work. Insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks. Your risk assessment should only include what you could reasonably be expected to know – you are not expected to anticipate unforeseeable risks.	
HSG 65 page 14) Leaders, at all levels, need to understand the range of health and safety risks in their part of the organisation and to give proportionate attention to each of them. This applies to the level of detail and effort put into assessing the risks, implementing controls, supervising and monitoring.	
HSG 65 page 13) The risk profile of an organisation informs all aspects of the approach to leading and managing its health and safety risks.	
HSG 65 page 13) Every organisation will have its own risk profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible and immediate safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent.	
3.2 Regulations and CQC Guidance	
15(1)c: • Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	

17(2)(b)
Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

17(2)(b)
Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.

3.3 Regulations and CQC Guidance	**CQC KLOE**
15(1)d&e • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?

4: Maintenance
Are assets, equipment and plant adequately maintained?

4.1 Regulations and CQC Guidance

15(1)d
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

5. Training and Development
Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?

5.1 HSG 65

HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

3.2 Regulations and CQC Guidance

18(2) Persons employed by the service provider in the provision of a regulated activity must
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.

Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised.

Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.
Other mandatory training, as defined by the provider for their role.
Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

Other mandatory training, as defined by the provider for their role.
Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.

Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.

All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.

18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.

4.3 Regulations and CQC Guidance	**CQC KLOE**
Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.	E3.2. How are the learning needs of staff identified? E3.3. Do staff have appropriate training to meet their learning needs? E3.4. Are staff encouraged and given opportunities to develop?
Staff should be supported to make sure they are can participate in: Statutory training.	S3.2. Do staff receive effective mandatory training in the safety systems, processes and practices?
Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.	E3.5. What are the arrangements for supporting and managing staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) E3.6. How is poor or variable staff performance identified and managed? How are staff supported to improve?

6: Resilience, Emergency & Business Continuity Planning
Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?

6.1 CQC KLOE

S5.2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed?

S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?

7: Review Process
Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?

7.1 Regulations and CQC Guidance

17(2)(f)
Providers must ensure that their audit and governance systems remain effective.

7.2 Regulations and CQC Guidance	**CQC KLOE**
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).

8: Costed Action Plans
If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?

References to risk assessment and management are details under prompt 3 above

8: Scoring
Scoring should be based on the following:

	Self-assessment rating	% to score in given area
	Not applicable: This prompt question does not apply to the trust e.g. Mental Health trusts do not use Medical Gases;	
	Outstanding: Compliant with no action required, plus evidence of high-quality services and innovation. This Score is likely to be rarely applied.	100%
	Good: compliant no action required.	85% or above
	Requires minimal improvement: The impact on people who use services, visitors or staff is low.	66% to 85%
	Requires moderate improvement: The impact on people who use services, visitors or staff is medium.	45% to 65%

	Inadequate	45% or less

NHS Premises Assurance Model 2016

◄◄ Back to instructions	
This sheet shows the relationship and link between the NHS PAM SAQs and: 1. Relevant parts of the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' 2. Associated CQC guidance to providers on meeting the Regulations 3. CQC provider Handbooks Annex A: Key Lines of Enquiry	
Regulations (bold text) **CQC Guidance** (non-bold text), **CQC KLOE** (bold italics)	**PAM Ref.**
Regulation 14: Meeting nutritional and hydration needs (FS)	
CQC KLOE: E1.4. How are people's nutrition and hydration needs assessed and met?	
14(1) The nutritional and hydration needs of service users must be met.	SS1
Providers must include people's nutrition and hydration needs when they make an initial assessment of their care, treatment and support needs and in the ongoing review of these. The assessment and review should include risks related to people's nutritional and hydration needs. Providers should have a food and drink strategy that addresses the nutritional needs of people using the service.	
14(2) Paragraph 1 applies where— **(a) care or treatment involves—** **the provision of accommodation by the service provider, or** **an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or** **(b) the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.**	SS1
Providers must meet people's nutrition or hydration needs wherever an overnight stay is provided as part of the regulated activity or where nutrition or hydration are provided as part of the arrangements made for the person using the service.	
14(3) But paragraph (1) does not apply to the extent that the meeting of such nutritional or hydration needs would— **(a) result in a breach of regulation 11, or** **(b) not be in the service user's best interests**	NA
14(4)(a) receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,	
Nutrition and hydration assessments must be carried out by people with the required skills and knowledge. The assessments should follow nationally recognised guidance and identify, as a minimum: requirements to sustain life, support the agreed care and treatment, and support ongoing good health dietary intolerances, allergies, medication contraindications how to support people's good health including the level of support needed, timing of meals, and the provision of appropriate and sufficient quantities of food and drink.	SS1 should demonstrate following the Nutrition & hydration assessment but assessment is not part of PAM
Nutrition and hydration needs should be regularly reviewed during the course of care and treatment and any changes in people's needs should be responded to in good time. A variety of nutritious, appetising food should be available to meet people's needs and be served at an appropriate temperature. When the person lacks capacity, they must have prompts, encouragement and help to eat as appropriate.	SS1
Where a person is assessed as needing a specific diet, this must be provided in line with that assessment. Nutritional and hydration intake should be monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Action must be taken without delay to address any concerns. Staff must follow the most up-to-date nutrition and hydration assessment for each person and take appropriate action if people are not eating and drinking in line with their assessed needs. Staff should know how to determine whether specialist nutritional advice is required and how to access and follow it.	NA
Water must be available and accessible to people at all times. Other drinks should be made available periodically throughout the day and night and people should be encouraged and supported to drink. Arrangements should be made for people to receive their meals at a different time if they are absent or asleep when their meals are served. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.	SS1
14(4)(b) receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,	NA
14(4)(c) the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and	

People should be able to make choices about their diet. People's religious and cultural needs must be identified in their nutrition and hydration assessment, and these needs must be met. If there are any clinical contraindications or risks posed because of any of these requirements, these should be discussed with the person, to allow them to make informed choices about their requirements. When a person has specific dietary requirements relating to moral or ethical beliefs, such as vegetarianism, these requirements must be fully considered and met. Every effort should be made to meet people's preferences, including preference about what time meals are served, where they are served and the quantity.	SS1
14(4)(d) if necessary, support for a service user to eat or drink	NA
Regulation 15: Premises and equipment (FS)	
15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean,	
CQC KLOE S3.5. How are standards of cleanliness and hygiene maintained?	
• Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance.	
• Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant.	
• Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. o Make sure that staff with responsibility for cleaning have appropriate training.	Safety SAQ SS4
• Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance.	
CQC KLOE S3.9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	Safety SAQ SS3
15(1) All premises and equipment used by the service provider must be— 15(1)(b) secure,	Safety SAQ SS6
• Security arrangements must make sure that people are safe while receiving care, including:	
CQC KLOES3.4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	Safety SAQ SS6
o Protecting personal safety, which includes restrictive protection required in relation to the Mental Capacity Act 2005 and Mental Health Act 1983. This includes the use of window restrictors or locks on doors, which are used in a way that protects people using the service when lawful and necessary, but which does not restrict the liberty of other people using the service.	Safety SAQ SS6
CQC KLOE E1.7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	
o Protecting personal property and/or money.	
o Providing appropriate access to and exit from protected or controlled areas.	
o Not inadvertently restricting people's movements.	
o Providing appropriate information about access and entry when people who use the service are unable to come and go freely and when people using a service move from the premises as part of their care and treatment.	
o Using the appropriate level of security needed in relation to the services being delivered. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Guidance for providers on meeting the regulations March 2015 57	Safety SAQ SS6
• If any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. Any surveillance should be operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website.	
15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used,	Safety SAQ SH2
Premises must be fit for purpose in line with statutory requirements and should take account of national best practice.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe?	
• Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time. There must be sufficient equipment to provide the service.	Safety SAQ SH2 & SH15
• Adequate support facilities and amenities must be provided where relevant to the service being provided. This includes sufficient toilets and bathrooms for the number of people using the service, adequate storage space, adequate seating and waiting space.	Safety SAQ SH2
• People's needs must be taken into account when premises are designed, built, maintained, renovated or adapted. Their views should also be taken into account when possible.	Patient Experience SAQ P1

• People should be able to easily enter and exit premises and find their way around easily and independently. If they can't, providers must make reasonable adjustments in accordance with the Equality Act 2010 and other current legislation and guidance.	Safety SAQ SH2 & Patient Experience SAQ P6
• Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences. This includes making sure that privacy, dignity and confidentiality are not compromised.	Safety SAQ SH2
• Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.	Safety SAQ SH15
15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and	Safety prompt questions 1,4 & 7 for each technical area e.g. electrical safety
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe? S3.8. Does the maintenance and use of equipment keep people safe?	
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	Safety SAQ SH2 & SH15
• Any change of use of premises and/or equipment should be informed by a risk assessment and providers must make appropriate alterations to premises and equipment where reasonably practical. Where this is not possible, providers should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. Alterations must be in line with current legislation and guidance.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required.	SH4 & safety SAQ prompt 3
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures.	Safety SAQ SH1 & Safety SAQ prompt 4
• Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	Safety SAQ SH1 & Safety SAQ prompt 4
S3.8. Does the maintenance and use of equipment keep people safe?	
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	Safety SAQ SH15 & Safety SAQ prompt 2&5
15(1) All premises and equipment used by the service provider must be— 15(1)(f) appropriately located for the purpose for which they are being used.	
• When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.	Patient Experience SAQ P1
• Facilities should be appropriately located to suit the accommodation that is being used. This includes short distances between linked facilities, sufficient car parking that is clearly marked and reasonably close, and good access to public transport.	Safety SAQ SH2
Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical equipment, and moving and handling equipment.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.	
• Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Safety SAQ SS4

S3.6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection?	
• Where applicable, premises must be cleaned or decontaminated in line with current legislation and guidance, and equipment must be cleaned, decontaminated and/or sterilised in line with current legislation and guidance and manufacturers' instructions. Equipment must be cleaned or decontaminated after each use and between use by different people who use the service.	Safety SAQ SS4
• Ancillary services belonging to the provider, such as kitchens and laundry rooms, which are used for or by people who use the service, must be used and maintained in line with current legislation and guidance. People using the service and staff using the equipment should be trained to use it or supervised/risk assessed as necessary.	Safety SAQ SS1, SS4 & SH10
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this.	Safety SAQ SS2 & SS4
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Regulation 16: Receiving and acting on complaints (FS)	Patient Exp SAQ P1
R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?	
16(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.	P1
People must be able to make a complaint to any member of staff, either verbally or in writing. All staff must know how to respond when they receive a complaint. Unless they are anonymous, all complaints should be acknowledged whether they are written or verbal. Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf. Appropriate action must be taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. Information must be available to a complainant about how to take action if they are not satisfied with how the provider manages and/or responds to their complaint. Information should include the internal procedures that the provider must follow and should explain when complaints should/will be escalated to other appropriate bodies. Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, the provider should cooperate with any independent review or process.	P1
16(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.	P1
Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service. Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested. When complainants do not wish to identify themselves, the provider must still follow its complaints process as far as possible. Providers must have effective systems to make sure that all complaints are investigated without delay. This includes: Undertaking a review to establish the level of investigation and immediate action required, including referral to appropriate authorities for investigation. This may include professional regulators or local authority safeguarding teams. Making sure appropriate investigations are carried out to identify what might have caused the complaint and the actions required to prevent similar complaints. When the complainant has identified themselves, investigating and responding to them and where relevant their family and carers without delay.	P1

Providers should monitor complaints over time, looking for trends and areas of risk that may be addressed. Staff and others who are involved in the assessment and investigation of complaints must have the right level of knowledge and skill. They should understand the provider's complaints process and be knowledgeable about current related guidance. Consent and confidentiality must not be compromised during the complaints process unless there are professional or statutory obligations that make this necessary, such as safeguarding. Complainants, and those about whom complaints are made, must be kept informed of the status of their complaint and its investigation, and be advised of any changes made as a result. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reasons for this should be recorded. Providers must act in accordance with Regulation 20: Duty of Candour in respect of complaints about care and treatment that have resulted in a notifiable safety incident.	P1
16(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of— **(a) complaints made under such complaints system,** **(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and** **(c) any other relevant information in relation to such complaints as the Commission may request.**	P1
CQC can ask providers for information about a complaint; if this is not provided within 28 days of our request, it may be seen as preventing CQC from taking appropriate action in relation to a complaint or putting people who use the service at risk of harm, or of receiving care and treatment that has, or is, causing harm. The 28-day period starts the day after the request is received.	P1
Regulation 17: Good governance (FS)	
W2.6. Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance ***S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?*** ***W2. Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?***	The NHS PAM is designed to be used as a system that meets this requirement
17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.	
Providers must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service.	
The system must include scrutiny and overall responsibility at board level or equivalent.	Governance domain
17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—	
17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); ***S3.3. Is implementation of safety systems, processes and practices monitored and improved when required?***	
1. Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. The audits should be baselined against Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and should, where possible, include the experiences people who use the service. The systems and processes should be continually reviewed to make sure they remain fit for purpose. Fit for purpose means that: systems and processes enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. providers have access to all necessary information.	The NHS PAM is designed to be used as a system that meets this requirement
17(2)(a) 2. Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken.	
W2.7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? ***W5.6. How is information used proactively to improve care?***	G1.7
17(2)(a) 3. Providers should have effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review.	NA

17(2)(a) 4. Providers should actively seek the views of a wide range of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, about their experience of, and the quality of care and treatment delivered by the service. Providers must be able to show how they have: analysed and responded to the information gathered, including taking action to address issues where they are raised, and used the information to make improvements and demonstrate that they have been made	Patient Experience SAQ P1
W4. How are people who use the service, the public and staff engaged and involved?	
Providers must seek professional/expert advice as needed and without delay to help them to identify and make improvements.	Governance SAQ G3
17(2)a Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected.	PE domain and action plan prompt under each SAQ
Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.	Safety SAQ SH17
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	Safety SAQ prompt Question 1
E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	
17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	
S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? ***S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?*** ***S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?***	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	Safety SAQ prompt question 3 & G1.9 & G1.10
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	
17(2)(b) Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;	NA
17(2)(d) maintain securely such other records as are necessary to be kept in relation to— **(i) persons employed in the carrying on of the regulated activity, and** **(ii) the management of the regulated activity;**	
Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance.	
Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This applies to all staff, not just newly appointed staff. Providers must observe data protection legislation about the retention of confidential personal information.	

Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents.	Safety SAQ SH3
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Records must be kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so.	
Information in all formats must be managed in line with current legislation and guidance.	
Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 1998.	
17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;	Patient Experience SAQ P1
17(2)(e) Providers should actively encourage feedback about the quality of care and overall involvement with them. The feedback may be informal or formal, written or verbal. It may be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.	
17(2)(e) All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider.	
17(2)(e) Improvements should be made without delay once they are identified, and the provider should have systems in place to communicate how feedback has led to improvements.	
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	
17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).	Safety SAQ prompt question 7, SAQ G1.8 & G1.4
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
17(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—-	NA
Regulation 18: Staffing (FS)	see also 'prompt guidance sheet'
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	Safety SAQ prompt question 2: See 'prompt guidance sheet'
S4.1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available?	
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,	Safety SAQ prompt question 5: See 'prompt guidance sheet'
S3.2. Do staff receive effective mandatory training in the safety systems, processes	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to	
Regulation 19: Fit and proper persons employed (FS)	NA
Regulation 20: Duty of candour (FS)	**G2.9**

Northern Lincolnshire and Goole NHS Foundation Trust

Estates and Facilities

Premises Assurance Model

2023-2024

End of Year Report

Northern Lincolnshire & Goole NHS Foundation Trust

Contents

Purpose

The purpose of this report is to provide an end-of-year summary of the main findings of completing the mandatory NHSE 2023-24 Premises Assurance Model (PAM), which is required to have Trust Board oversight/sign off.

Background Information

Regulated by NHSE, the PAM is a national, mandatory standardised approach to self-assessing assurance levels within Estates & Facilities[1]. Through the coordinated engagement with both internal and external stakeholders, there are six domains comprising of 47 self-assessment questions that provide the assessment structure:

1. Safety Hard (Estates) - x19 assessment categories
2. Safety Soft (Facilities) - x10 assessment categories
3. Organisational Governance - x3 assessment categories
4. Patient Experience - x6 assessment categories
5. Effectiveness - x4 assessment categories
6. Efficiency - x5 assessment categories

Additionally, there are a small number of new sections for 2023-24 of the assurance model which specifically look at:

- FM Maturity (FM1) (optional last reporting year)
- FM Maturity (FM2)

Contained within each domain are:

- Self-assessment questions (SAQ's) which are answered through a series of sub-questions based on NHSE set criterion.
- National Metrics: a standardised method of determining levels of adherence to healthcare and government legislation requirements with regards to Estate and Facilities. The judgement metrics are: *Outstanding, Good, Requires Minimal Improvement, Requires Moderate Improvement, Inadequate, Not Applicable.*

[1] Although categorised as *Estates and Facilities* departments/services are assessed which do not sit within Estates and Facilities in the structure of NLaG.

NLaG was one of the first voluntary adopters of PAM and for the past 9 years, NLaG's Estates and Facilities Directorate has actively engaged in the PAM self-assessment process with the E&F Safety and Statutory Compliance team facilitating the process. Additionally, the Trust is represented at a national level consulting every quarter at the NHSE Premises Assurance Model development steering group.

The PAM programme has only recently become a mandatory requirement - appearing for the first time in the 2021 NHS Standard Contract.

Northern Lincolnshire and Goole NHS Foundation Trust's PAM Model

NLaG's annual self-assessment commences each September and concludes at the end of March in the following calendar year. The period between April and August enables internal and external reporting to be completed.

The existing model has been presented previously, and is deemed suitable for the organisation, resulting in transparent and credible assurances.

This model was devised to best utilise the significant resources required to complete a 360° self-assessment. Therefore, a full stakeholder review is conducted every other year with a management desk-top review being carried out in the interim years.

Inherently, the self-assessment process is a subjective process therefore, underpinning this process is an annual programme of internal auditing activities conducted by the E&F Safety and Statutory Compliance team. Utilising the PAM Safety Hard (Estates) and Safety Soft (Facilities) self-assessment categories; a risk-based approach is employed to direct auditing activities to maximise targeted resource allocation. The primary objective is to determine assurance levels from suggested evidence provided by Estates and Facilities departments as to their justifications of:

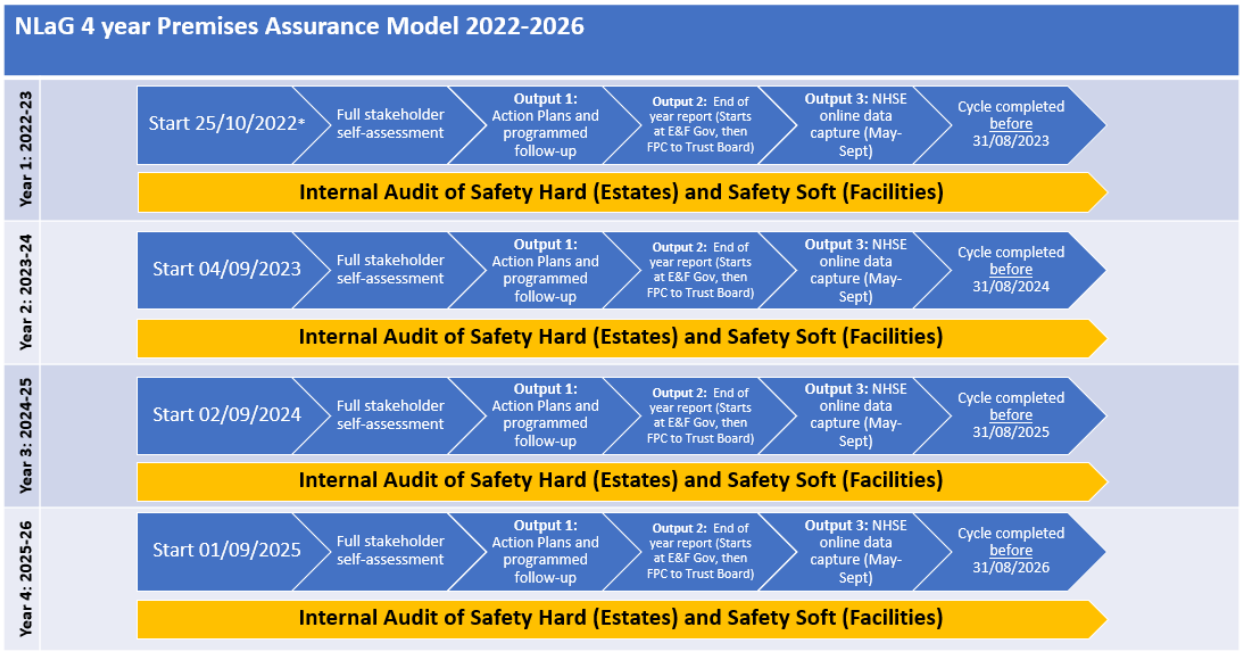
- Not Applicable [<45%]
- Inadequate *(red)* [45-65%]
- Requires Moderate Improvement *(amber)* [66-85%]
- Requires Minimal Improvement *(yellow)* [>85%]
- Good *(green)* [100%]
- Outstanding *(blue)*

Additionally, national guidance such Health Technical Memorandums (HTM) and Trust policy requirements also inform the audit scope for their operational accuracy. Findings of internal audit reports are summarised each month at the E&F Governance meeting group along with PAM completion progress as well as the progress made against improvement actions that are identified from each self-assessment session.

As the PAM is near the end of the 6th year of the current model and upon review, the delivery model is assessed as fit for purpose and delivers a meaningful self-assessment within the confines of the national mandated process.

The future plan for PAM is represented in Table 1, below, represents the next four year period of the PAM delivery model (years 2022 to 2026).

Table 1 *NLaG PAM 4 Year Cycle 2022 – 2026*



2023-24 Estates and Facilities PAM Summary of Findings

The charts below capture the end of year comparisons that visually represents the judgements for the E&F primary service provision (Hard and Soft FM) domains of Estates and Facilities against each standardised question set. Appendix 1 provides the full data capture for each domain.

Graphical illustration of the displacement of judgements for both Estates (SH1 to SH19) and Facilities (SS1 to SS10).

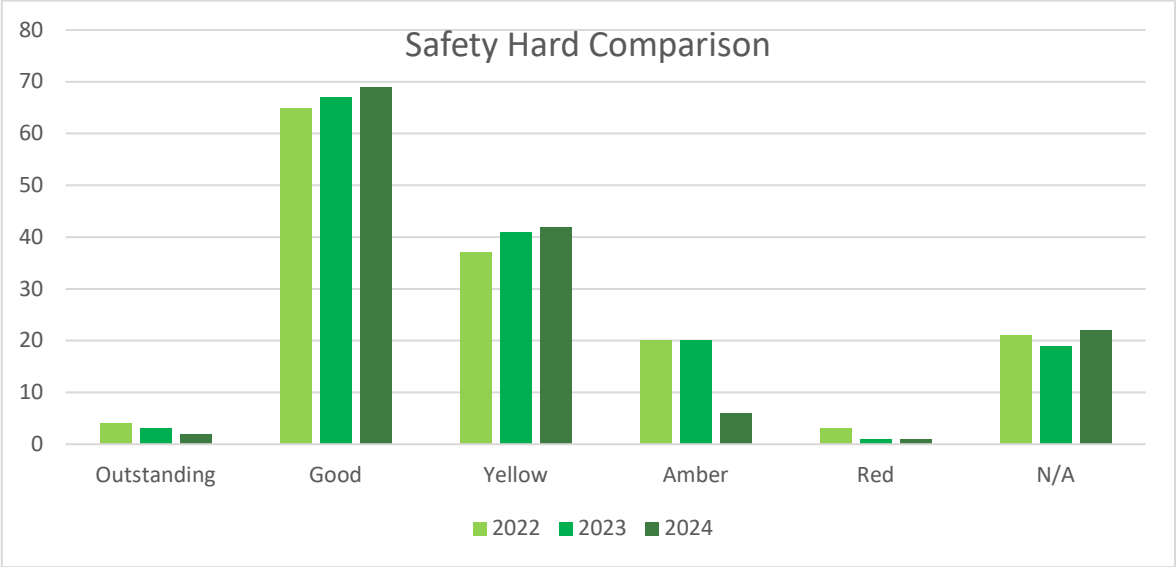


Figure 1 - Safety Hard - Comparison for 22 - 24 period

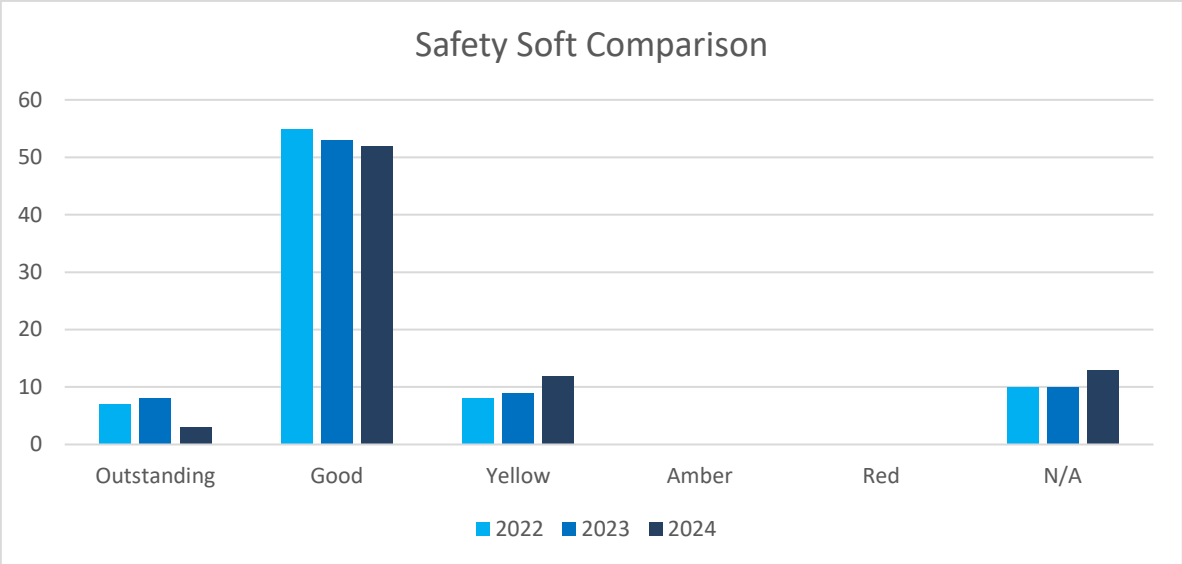


Figure 2 - Safety Soft - Comparison for 22-24 period

Figure 1 shows a reduction in “outstanding” as the criteria for this has been further clarified by the National User Group and this is reflected in the trend seen. The number of “good” has however seen a continuous increase as has the yellow category (i.e. requires minimal improvements). For those requiring moderate

improvement (i.e. amber) there is a significant reduction compared to previous years. The “inadequate” rating has been identified for one element which is detailed further below.

For the safety soft (see figure 2) there has been a downward trend as some ratings have moved from good to “requires minimal improvement” (yellow). This is due to a number of elements including the introduction of national standards requiring additional aspects which have not yet been fully implemented.

	Policy	R & R	RA	Maint	T&D	EPRR	Review	*Average*
SH1	2	2	2	2	2	2	2	***2***
SH2	2	2	2	3	2	3	2	***2***
SH4	2	2	2		3	2	2	***2***
SH5	2	3	3		3	3	2	***3***
SH6	3	3	2	2	2	3	2	***2***
SH7	2	2	3	3	2	3	2	***2***
SH8	3	2	2	3	2	3	2	***2***
SH9	3	3	2	2	3	3	2	***3***
SH10	2	2	3	3	3	2	2	***2***
SH11	2	2	3	2	3	2	2	***2***
SH12	2	3	2	2	2	2	2	***2***
SH13	4	3	4	3	3	3	2	***3***
SH14	2	3	3	4	4	4	2	***3***
SH15	2	2	2	5	3	2	2	***3***
SH16	2	2	3	2	3		2	***2***
SH17	3	3	2		2	4	2	***3***
SH18	1	1	2	3	3	2	2	***2***
SH19	3	3	2	2	2	2	3	***2***
Average	***2***	***2***	***2***	***3***	***3***	***3***	***2***	

Figure 3 - 23/24 SAQ Outcome Safety Hard

	Policy	R & R	RA	Maint	T&D	EPRR	Review	*Average*
SS1	1	2	3	3	3	2	1	***2***
SS2	2	3	2	2	2	2	2	***2***
SS3	2	3	2	2	2	2	2	***2***
SS4	2	2	2	2	3	2	2	***2***
SS5	2	2	2	2	1	2	2	***2***
SS6	2	2	2	2	2	2	2	***2***
SS7	2	3	3	2	2	2	2	***2***
SS8	2	2	2	2	2	2	2	***2***
SS9	2	2	2	2	2	2	2	***2***
SS10	3	3	3			3		***3***
Average	***2***	***2***	***2***	***2***	***2***	***2***	***2***	

Figure 4 - 23/24 SAQ Outcome Safety Soft

Figures 3 & 4 show the scoring for each SAQ within the different domains and the average scores for the entire domain. This shows which element in each domain

needs to be improved. Those with a score of 4 or above should be seen as priority to address.

Key Considerations

- This year was a domain lead review year, the coming year will see the full-stakeholder review recommence as per the embedded cycle.
- Some SAQs have been updated, or introduced, which has seen a limited change in terms of year-on-year comparison.
- Maintenance in Safety Hard (Estates) is improving as full asset reviews have been undertaken over the past few years and work is well underway to implement a new asset management and Planned Preventative Maintenance (PPM) regime which will be more modernised and link with labour management and give considerably more accurate reporting.

Areas of Good Practice

- Generally, there has been a noticable shift to the positive in Safety Hard.
- Medical Gas Pipeline Systems has seen improvement in most areas, following some focus in recent years – also in the context of Covid 19.
- Water management has also improved in a number of areas, in line with a number of other engineering disciplins.
- In the safety domain SS1 (Catering) SS3 (Waste) and SS4 (Cleanliness) have all seen improvement this year, which is attributed to a slight drop in previous year(s) due to the release of relevent guidance/standards in those areas in the recent years, and work being undertaken to impliment new practices, which are now well underway, or indeed fully embedded.
- Mature review process and monitoring processes across all sector specialisms supported by dedicate E&F internal auditing programme and risk and governance provision.

Key Areas for Improvements

- Asbestos Management has shifted from *Good* to *requires minimal improvement*.
- Pressure systems has deteriorated slightly, but this is believed to be partially because of, and partially mitigated by the appointment of a new Authorising Engineer (AE) in this area who has conducted a full management audit and GAP analysis.
- SH5 Fire Safety has also seen a slight deterioration, which is attributed to the appointment of an AE (Fire) conducting their initial audit, combined with the issues with the SGH fire alarm system (risk 2038) (replacement to be commissioned in Q1-Q2 of 2024-25) and a comprehensive review of all fire doors across the Trust.
- SH15 (Medical Devices) was the only area to score an *Inadequate* this year, this is reflective of risk register entry 3108 which is related to the NPSA Safety Alert requirement. A large number of Trusts have declared a risk of not being able to

comply with the deadline for actions to be completed. The element of concern is to have significant maintenance of the equipment listed in the alert in place. The issue identified is that a proportion of the equipment is technically obsolete with parts difficult to attain and to rectify this additional funding is required through the capital equipment budget which has been significantly reduced over the last few years.

Conclusion

Completed in isolation of any verification process, the very nature of self-assessment is a subjective process at best. However, the E&F Safety and Statutory Compliance team acts independently of the main Estates and Facilities departments and offer an impartiality that challenges the validity of the assessment judgements as part of the validation and auditing process. There is therefore a level of assurance that standardisation across all Self-Assessment Questions (SAQs) due to standardisation provided by the facilitators; some of whom are either actively, or recently involved with other Trusts' PAM process.

The Facilities department and its 'soft' services continue to benefit from longevity of key roles being in post for a sustained period, bringing with them the accompanying knowledge and experience. There is a clear overall judgement of 'Good' assurance levels across the Facilties provision.

Below are the reports recommendations for improvement with supporting estimated completion timescales:

Recommendations

- Complete the current implementation of a Trustwide Estates asset data-capture to improve asset management and maintenance with progressmonitored through the Estates meeting structure ***(action continued from previous reports)***
- Assign PPMs to all Estates Assets, to ensure compliance with statutory obligations. ***(action continued from previous reports)*.**
- Create comprehensive suite of Standard Operating Procedures (SOPs) for all engineering disciplines. Water SOPs have recently been reviewed, however some areas, such as MGPSs remain in need of attention[2].

Bill Parkinson
Associate Director of Safety and Statutory Compliance

Appendacies
1 – Premises Assurance Model SAQ

20240328-NLaG NHS_PAM_SAQ 24-5

[2] SOPs feature at safety groups/sub-groups for oversight.

Instructions: NHS Premises Assurance Model 2023: Please also read the separate NHS PAM Guidance Document

appendix 1 NLAG

Purpose and structure of this file	This file contains Self-Assessment Questions that help evaluate the way your organisation/site manages its estate and facilities in 5 Domains. Although the Safety Domain is notionally split between hard and soft Facility Management (FM) services some questions within the 'Combined and Hard FM' supply to both sections. These questions should be assessed across both hard and soft FM e.g. the SAQ relating to Health and Safety is within the 'Safety: Combined and Hard FM' but clearly applies to soft FM also. A number of other relevant sheets are also provided
How to complete it	The way to use this file is to fill in the 5 worksheets with yellow tabs, which include the domain self-assessment questions (SAQs). Year 1 | Year 2 | The assessment can be for one or two years if comparisons are required. 2022-23 | 2023-24 | ◄Use the drop down in the yellow boxes to alter the years where relevant Each SAQ contains several prompt questions. By answering the prompt questions, a result is automatically calculated for the SAQs and the domains. Please note it is not possible to give a rating to the SAQ directly, it has to be rated indirectly using the prompt questions or, alternatively, classified as not applicable. There are six possible responses for a prompt question: - Not applicable: this prompt question does not apply to your organisation/site. - Outstanding: compliant with no action plus evidence of high quality services and innovation. - Good: compliant no action required. - Requires minimal improvement: the impact on people who use services, visitors or staff is low. - Requires moderate improvement: the impact on people who use services, visitors or staff is medium. - Inadequate: action is required quickly - the impact on people who use services, visitors or staff is high.
Results	The "Summary' sheets show graphically the results of the NHS PAM self-assessment. - The 'summary' one shows the ratings at the domain level. It includes the average rating and the distribution of SAQ ratings for the 5 domains (i.e. the % of SAQs that obtain a rating of "Outstanding", the % of SAQs that obtain a rating of "Good", etc.) - The other 5 red 'Results' sheet detail the average rating and the distribution of the prompt questions ratings for each SAQ within the domain. This allows the user to see which SAQs are driving the results of the domains.

Annual Changes	**Annual changes may be required in line with updates to guidance and legislation, you can find an overview of the latest changes listed below.** **Changes for 2024:** **There has been several updates to the HBN and HTM guidance, the links within the spreadsheet remain up to date, but please familiarise yourself with the latest publications:** **https://www.england.nhs.uk/estates/complete-list-of-publications-related-to-nhs-estates/** **Please also note there has been some technical bulletins published this year these can be found: https://www.england.nhs.uk/estates/netb/** **Safety Hard** **Legislation & guidance updated.** **SH16, SH17, SH18 and G2 evidence: 'The organisation demonstrates that it undertakes process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working'** **SH4 H&S - MH wording added - (cell E47)** **Mental Health (MH) service Providers (and Trusts who may treat MH patients such as A&E) should consider:** **• Ligature Reduction** **• Barricade Reduction ironmongery** **• Absconding Reduction** **• Windows/Falls from Height** **• Ceiling Height** **• Air Locks** **• Fence heights** **• Bolt down Fixed Furniture and Equipment** **• Non Pick Mastic** **• Reduced breakable glass/plastic/fabric** **• MH court yards and Garden/furniture** **SH4 H&S - MH wording added (cell E45)** **4. The ability to report on the regulatory requirements regarding safer wards (ligature).** **5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.** **SH10 - wording updated** **•SH14 - Fire safety guidance added (cell F147)** **18. Approved Document B** **19. Equality Act 2010** **20. Regulation 38 – operating within the building on Fire Safety.** **SH19 - Safety Hard added - SH19.3 'contract expiry' and updated wording SH19.2** **Previous SH20 - regarding medical gasses (Framework TBC) - removed - will be added next year if the guidance is available on this)** **SH20 - removed** **SH21– Added separate question regarding ligature** **Safety Soft** **Legislation and guidance updated** **Cleanliness and infection control** **Legislation and guidance updated** **SS1.sub questions 15-21 wording updated slightly** **SS4 - Cleanliness and infection control - Sub questions 9,10,11 added** **SS4.8&9 wording added: (Although the mandatory requirement is to display in patient facing areas however a trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff) also guidance note 'Consider ambulance cleaning supplement'** **SS9 - Portering services - wording added within the guidance (cell f114):** **To note we are working on guidance for portering which will be available for reference next year, covering:** **- Service strategy (workforce)** **- Technology and equipment** **- Policy** **- Working with clinical teams** **SS10 - PSTN - added sub question SS10.7 - updated** **Efficiency** **Evidence updated:** **F3 Improved efficiencies in capital procurement, refurbishments and land management guidance and evidence updated (Cell E30 and F25)** **F3 Efficiency - added F3.2. 'Capital project Management' (also updated wording for F3.1)** **F4 Efficiency - added F4.3. 'Board reporting and contracting'** **'health system' updated, Procure 23 added - 10. NHS Net Zero Building Standard, 11. Estates Net Zero Carbon Delivery Plan (NZCDP), evidence wording updated to 'site level' 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects** **Effectiveness** **Evidence updated (Cell E33-39)** **Guidance legislation updated.** **-New Transport question proposed in E4.5** **- Updated E4.7 regarding procurement** **-Recently published Net Zero Travel & Transport strategy added to 'relevant guidance & legislation'** **Helipad - This question has been restructured to provide more evidence examples** **(cell B7-9) wording added to sub questions** **1.-The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.** **2. -The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to general helipad factors and considerations within the Trust.** **3. - In addition - The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.** **4- Added evidence and updated questions** **Maturity Tab '001' added**

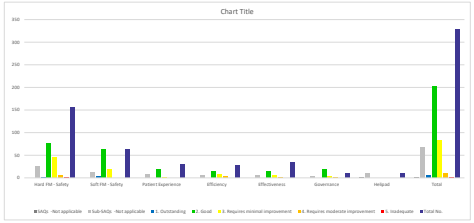
NHS Premises Assurance Model (NHS PAM)

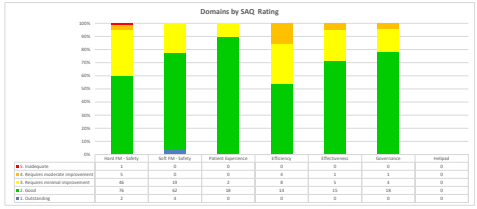
Trust:
Site Name:
Year:

SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH1	Estates and Facilities Operational Management	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SH2	Design, Layout and Use of Premises	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable															0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Document Management System in Place	2. Approval of documents	3. Review of documents	4: Availability of documents	5. Legibility of Documents	6: Document Control	7. Obsolescence	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH3	Estates and Facilities Document Management	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	Not applicable															0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH4	Health & Safety at Work	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable	Not applicable															0	0	
SH5	Asbestos	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	movement	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	9. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH6	Medical Gas Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Requires minimal imp	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable															0	0	
SAQ No.	Self-Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH7	Natural Gas and specialist piped systems	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Requires minimal imp	2. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SH8	Boiler Safety Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	2. Good	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH9	Electrical Systems	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH10	Mechanical Systems and Equipment	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH11	Ventilation, Air Conditioning and Refrigeration Systems	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH12	Lifts, Hoists and Conveyance Systems	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SH13	Pressure Systems	Hard FM - Safety	Applicable	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH14	Fire Safety	Hard FM - Safety	Applicable	2. Good	3. Requires minimal imp	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	4. Requires moderate im	2. Good	Not applicable															0	0	
SH15	Medical Devices and Equipment	Hard FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Outstanding	3. Requires minimal imp	3. Requires minimal imp	2. Good	Not applicable															0	0	
SH16	Resilience, Emergency and Business Continuity Planning	Hard FM - Safety	Applicable	2. Good	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal improvement		2. Good	Not applicable															0	0	
SH17	Safety Alarms	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SH18	Externally supplied estate	Hard FM - Safety	Applicable	1. Outstanding	1. Outstanding	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	Not applicable															0	0	
SAQ No.19	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3.Contract Expiry	4. Risk Assessment	5. Maintenance	6. Contractor Compliance	7. Resilience, Emergency & Business Continuity Planning	8.. Review Process	9.. Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH19	Contractor Management for Soft and Hard FM services	Hard FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	Not applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	Not applicable														0	0	
SAQ No.20	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy	2: Roles and Responsibilite	3: Risk Assessment	4: Maintenance	5: Contractor Compliance	6: Review Process	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SH20	Premet On - Safety hand FM1	Hard FM - Safety	Applicable	Not applicable	Not applicable	2. Good	2. Good	Not applicable	Not applicable	Not applicable																Applicable	Not applicable	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8.Food Standards: Board Director	9.Food Standards: Strategy	10.Food Standards: Diatition	11.Food Standards: Safety Specialist	12.Food Standards: Workforce	13.Food Standards: Matrix	14.Food Standards: Waste	15.Food Standards: 24/7 Restaurant	16.Food Standards: 24/7 Cafe	17.Food Standards: 24/7 Vending machines	18.Food Standards: 24/7 Retail	19.Food Standards: Cold Vending	20. Food Standards: Smart Fridges	21.Food Standards: From home	22. Costed Action Plans	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS1	Caterine services	Soft FM - Safety	Applicable	1. Outstanding	1. Good	2. Good	2. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	1. Outstanding	1. Requires minimal imp	2. Good	3. Good	3. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	3. Good	Not applicable	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS2	Decontamination process	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS3	Waste and Recycling Management	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SAQ No.SS4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilite	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Cleaning Standards 2021: Star Ratings	9. Cleaning Standards 2021: Charter	10. Cleaning Standards 2021: Matrix	11.Cleaning Standards 2021: 95%	12: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS4	Cleanliness and Infection Control	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	1. Outstanding	2. Good	2. Good	3. Good	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Roles and Responsibilities	3. Risk Assessment	4. Maintenance	5. Training and Development	6. Resilience, Emergency & Business Continuity Planning	7. Review Process	8. Costed Action Plans															Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
SS5	Laundry and Linen Services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Outstanding	2. Good	2. Good	Not applicable															0	0	
SS6	Security Management	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS7	Transport Services	Soft FM - Safety	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS8	Pest control	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS9	Portering services	Soft FM - Safety	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable															0	0	
SS10	Estates IT and Building Information Management (BIM) systems	Soft FM - Safety	Applicable	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	Not applicable	Not applicable	3. Requires minimal imp	##EF1	Not applicable															0	0	
SAQ No. P3	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Views and Experiences	2. Engagement	3. Staff Engagement	4. Prioritisation	5. Value	6: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P1	Engagement and involvement	Patient Experience	Applicable	2. Good	2. Good	3. Requires minimal imp	2. Good	2. Good	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. PLACE Assessment	2. Other Assessments	3. Cleaning Schedules	4. Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P2	Condition, appearance, maintenance and privacy and dignity perception	Patient Experience	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
P3	Cleanliness	Patient Experience	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
P4	Access and Car Parking	Patient Experience	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
P5	Grounds and Gardens	Patient Experience	Applicable	Not applicable	3. Requires minimal improvement		Not applicable																			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Policy & Procedures	2. Regulation	3. Choice	4. Equality issues	5. Information	6. PLACE Assessment	7. Other Assessments	8. Legal Standards	9: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
P6	Caterine services	Patient Experience	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable	Not applicable														0	0	
SAQ No.F1	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Analysing Performance	2: Benchmarking	3: Costed Action Plans																				Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F3	Performance management	Efficiency	Applicable	4. Requires moderate im	2. Good	Not applicable																				0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Business Planning	2: Estate Optimisation	3: Commercial Opportunities	4: Partnership working	5: New Technology	6: PFI and LIFT contracts	7: Other contracts	8. Property	9. Cost improvement plans	10: Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F2	Improving efficiency - running	Efficiency	Applicable	2. Good	4. Requires moderate im	2. Good	2. Good	4. Requires moderate im	Not applicable	3. Requires minimal imp	2. Good	2. Good	Not applicable													0	0	
SAQ No. F3	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Capital Procurement.	2. Capital Project Management	3. Capital Procurement Efficiencies	4. Flexibility	5. Identification and disposal of surplus land	6: Net zero carbons	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F3	Improving efficiency - capital	Efficiency	Applicable	2. Good	4. Requires moderate im	2. Requires minimal imp	3. Requires minimal imp	2. Good	2. Requires minimal imp	Not applicable																0	0	
SAQ No.F4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Policy & Procedures	2: Review Process	3: Board Reporting & Contracting	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F4	Financial controls	Efficiency	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Quality and Sustainability	2. Financial Pressure	3. Continuous Improvement	4. Quality Improvements	5. Recognition	6. Use of Information	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
F5	Continuous improvement	Efficiency	Applicable	2. Good	3. Requires minimal imp	3. Requires minimal imp	3. Requires minimal imp	2. Good	3. Requires minimal imp	Not applicable																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Vision and Values	2. Strategy	3. Development	4. Vision and Values Understood	5. Strategy Understood	6. Progress	7: Costed Action Plans																Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E1	Vision and strategy	Effectiveness	Applicable	2. Good	3. Requires minimal imp	2. Good	2. Good	3. Requires minimal imp	2. Good	Not applicable																0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Local Planning	2. Neighbourhood Planning	3. Planning Control	4. Special Interests	5. Enforcement	6: Costed Action Plans																	Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E2	Town planning	Effectiveness	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable																	0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Disposal of land and property	2: Granting of Leases	3: Acquisition of land and property	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E3	Land and Property management	Effectiveness	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
SAQ No.E4	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Green Plan / Sustainability Strategy	2: Energy	3: Waste	4: Air Pollution	5.Travel & Transport	6.Water	7. Climate Change Adaptation	8. Procurement	9: Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
E4	Sustainability	Effectiveness	Applicable	2. Good	2. Good	2. Good	3. Requires minimal imp	3. Requires minimal imp	Not applicable	4. Requires moderate im	2. Requires minimal imp	Not applicable														0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Framework	2. Roles	3. Partners	4. Framework	5: Assurance	6. Monitoring	7. Audit	8. Mitigation	9. Alignment	10: Costed Action Plans													Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G1	Governance process	Governance	Applicable	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	2. Good	Not applicable													0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Effectiveness	2. Challenges	3. Visibility	4. Relationships	5. Respect	6. Behaviours.	7. Culture	8. Honesty	9. Safety & Wellbeing	10. Healthier workplace	11. Collaboration	12: Costed Action Plans											Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G2	Leadership and culture	Governance	Applicable	3. Requires minimal imp	2. Good	3. Requires minimal imp	2. Good	3. Requires minimal imp	3. Requires minimal imp	2. Good	2. Good	2. Good	4. Requires moderate im	2. Good	Not applicable											0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1. Professional advice	2. In-house advisors	3. External advisors	4: Costed Action Plans																			Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
G3	Professional advice	Governance	Applicable	2. Good	2. Good	2. Good	Not applicable																			0	0	
SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Applicable?	1: Compliance Assessment and Policy Review: Adherence to CAP1264 and Downwash Helipad Considerations in the Trust:	2: Roles and Responsibilities	3: Risk Assessment and Mitigation Strategies for Helipad and Estate	4: Resilience, Emergency & Business Continuity Planning	5: Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads	6: Resilience, Emergency & Business Continuity Planning	7: Review Process	8. Collaboration	10. Costed Action Plans														Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
H1	Helipad	Helipad	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable														##EF1	##EF1	

SAQ No.	Self Assessment Question (SAQ) Subject	Domain	Q1 How integrated is facilities management - Soft Services?	Q2. How integrated is facilities management - Hard Services?	Q3. How integrated is Property Leadership?	Q4. How integrated are your FM Management IT Systems?	Q5 - How closely does FM management work with the FM delivery organisation(s)?	Q6 - How strategic and effective are supplier relationships?	Q7 - How transparent is FM delivery between the management organisation and delivery organisation?	Q8 - Does the FM team collaborate outside of the management organisation?	Q9 - How effective is your hard compliance management approach?	Q10 - How effective is your soft compliance management approach?	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	Q13 - How well defined are FM roles and responsibilities within Hard Services?	Q14 - How well defined are FM roles and responsibilities within Soft Services?	Q15 - How flexible is FM to changing business needs?	Q16 -How strategic is FM?	Q17 -Do you have effective FM governance in place?	Q18 -Do you have a clear definition and recognised intelligent client function?	Q19 - Is an effective client department in place?	Q20 -How well do you understand the levers to improve performance?	Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	Q22 - How proactive is FM service delivery in your organisation?		Capital cost to achieve compliance (£)	Revenue consequences of achieving compliance (£)	Notes
H1	FMD1	FM Maturity Framework																									#REF!	#REF!	
SAQ No.	Self Assessment Question (SAQ) Subject		Q1 - What level of location hierarchy is asset data captured against?	Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	Q3 - How consistently is the data specification applied across the estate ?	Q4 - What is the level of coverage of assets in the asset register data?	Q5 - How complete is the data captured against assets in the asset register?	Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	Q9 - What processes are in place for data quality checks (5.4)?	Q10 - What processes are in place for data update assurance (5.5)?	Q11 - What governance is in place to support data assurance and quality (5.6)?	Q12 - What level of documentation exists for the these data quality processes and governance (5.7)?	Q13 - Is the data contractually owned by the organisation (5.1)?	Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	Q15 - What level of access management exists for controlling user privileges (6.3)?	Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	Q18 - Does the asset management systems sync to a common data platform (7.3)?	Q19 - Do the systems meet data security requirements (7.4)?	Q20 - Do the systems meet data backup management requirements (7.5)?	Q21 - What types of management information reports and dashboards are used for FM asset data at n/a	Q22 - How does asset data inform decisions relating to contract management (8.2)?	Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	Q26 - What is the capacity of the teams working with asset data (9.1)?
H1	FMD2	FM Maturity Framework																									#REF!	#REF!	

Domain	SAQs -Not applicable	Sub-SAQs -Not applicable	1. Outstanding	2. Good	3. Requires minimal improvement	4. Requires moderate improvement	5. Inadequate	Total No.
Hard FM - Safety	0	26	2	76	46	9	1	155
Soft FM - Safety	0	12	4	62	19	0	0	63
Patient Experience	0	8	0	18	2	0	0	28
Efficiency	0	5	0	14	8	4	0	28
Effectiveness	0	5	0	15	5	1	0	26
Governance	0	3	0	18	4	1	0	9
Helpad	1	9	0	0	0	0	0	10
Total	1	68	6	203	84	11	1	329





NHS Premises Assurance Model: Safety Domain (Combined and Hard FM) ◄◄ Back to instructions	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***	**Note 1: This prompt is considered critical to the delivery of safe Estates & Facilities on an NHS site and therefore, if it is rated as "Inadequate" the whole of the Safety Domain will be rated as "Inadequate".**

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SH1	**SH1: With regard to the Estates and Facilities Operational Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to the overall management of the E&F function and how specific technical areas (covered by separate SAQs) are managed, reported, escalated and reviewed in a consistent way	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; 2. CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation. • The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used. • There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures. • Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration. 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. Health Building Note 00-08: The efficient management of healthcare estates and facilities 5. Health Building Note 00-08: Land and Property Appraisal - Available on the NHS Estates Collaboration Hub 6 A Risk-Based Methodology for establishing and Managing Backlog (NHS Estates 2004) 7. Monitor: The asset register and disposal of assets: guidance for providers of commissioner requested services 8. BS ISO 55000, 55001 & 55002: 2014 Asset Management 9 Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148143/Backlog_costing.pdf https://www.england.nhs.uk/licensing-and-oversight-of-independent-providers/guidance-and-support/ https://www.iso.org/standard/55088.Health Technical Memorandum https://www.iso.org/iso-9001-quality-management.Health Technical Memorandum Government Property Standard Launch 7th September 2022 Government Property Strategy 2022-2030 - GOV.UK (www.gov.uk) Government Asset Data Standard Launched Jan 2022 Government Function: Property - FMS 002: Asset Data (publishing.service.gov.uk) Government Facilities Management Standard Launched April 2022 Facilities Management Standard 001: Management and Services - GOV.UK (www.gov.uk)	
SH1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:		
SH1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SH1	**4: Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	4. Requires moderate improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/inspection records		
SH1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH1	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SH1	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH2	**SH2: With regard to the Design, Layout and Use of Premises [Functional suitability/Fitness for Purpose] can the organisation evidence the following in relation to functional suitability/?**	Applicable	Applicable	SH2: With regard to the Design, Layout and Use of Premises in relation to functional suitability can the organisation evidence the following? Critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs	1. Health and Social Care Act 2008 Regulations 14: and CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 2. CQC guidance for providers on meeting the regulations - Regulations 10 and 15 (1) (c, d and f) 3. Land and property appraisal (2007 DH) 4. Equality Act 2010 5. 2010 to 2015 government policy: compassionate care in the NHS 6. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 7. Health Building Note 00-01 General design guidance for healthcare buildings 8. Health Building Note 00-08 Strategic framework for the efficient management of healthcare estates and facilities 9.. Health Building Note 00-02 Designing sanitary spaces 10. Building Regulations Parts M and K 11. Dementia design checklist 12. Health Building Note 08-02 Dementia friendly health and social care environments 13. NHSE Dementia assessment and improvement framework 14. Privacy and dignity report by the CNO into mixed sex accommodation in hospitals 15. Health Building Note 00-09 Infection control in the built environment 16. Secure by design 17. Net Zero Travel & Transport Strategy https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.england.nhs.uk/estates/other-guidance/ https://www.legislation.gov.uk/ukpga/2010/15/contents https://www.gov.uk/government/publications/2010-to-2015-government-policy-compassionate-care-in-the-nhs/2010-to-2015-government-policy-compassionate-care-in-the-nhs https://www.gov.uk/government/publications/nhs-car-parking-management-htm-07-03 https://www.england.nhs.uk/estates/health-building-notes/https://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces https://www.gov.uk/government/publications/consolidation-and-simplification-of-parts-m-k-and-n-of-the-building-regulations https://www.dementiaaction.org.uk/assets/0000/4336/dementia_friendly_environments_checklist.pdf https://www.england.nhs.uk/estates/health-building-notes/ https://improvement.nhs.uk/resources/dementia-assessment-and-improvement-framework/ NEW-Delivering_same_sex_accommodation_sep2019.pdf (england.nhs.uk) https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment https://www.securedbydesign.com/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ For consideration: Protect legislation will be updated and released this year – Trusts should be prepared to self assess against threats of risk of your estate (i.e. minimising threats against the estate - reference 'Martins law' which is due to be released).	
SH2	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Estate strategy setting out current baseline, plans to address deficiencies including organisations risk management process/systems 4. Dementia strategy/policy 5. Privacy and dignity strategy/policy 6. Equality Act accessibility assessment 7. Local Authority approved travel plan 8. Security policy 9. Standard specification		
SH2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. If technical expertise in-house - job descriptions, PDPs, TNA, training plans 5. If technical expertise outsourced - specification, qualifications and references. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandum's and other standards.		
SH2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Six facet survey		
SH2	**4: Maintenance** Are relevant assets, equipment and plant adequately maintained? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place;		
SH2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. If technical expertise outsourced - appointment of qualified consultant or investment in training for staff in functional suitability issues (critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs) 4. If technical expertise in-house - PDPs, TNA, training plans, certificates of attendance/accreditation Purpose is to be able to identify levels of compliance to inform strategy/priority/investment		
SH2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	3. Requires minimal improvement	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Plans in place if ward/unit is closed due to unacceptable levels of compliance - breach of 15 (1) (c, d and f) 6. Test reports/action plans 7. Escalation to relevant committees 8. Peer review outputs		
SH2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Six facet survey; 4. Access audits; 5. Technical reports to cover critical dimensions, distance to key departments and access points, patient observation, mixed sex compliance, security, toilet facilities, storage, provision for people with disabilities, parking, public transport, lifts and stairs 6. Audit plan 7. Audit reports 8. Peer review output		
SH2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH3	**SH3. With regard to Estates and Facilities Document Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the coordination and control of the flow (storage, retrieval, processing, printing, copying, routing, distribution and disposal) of electronic and paper documents for Estates & Facilities documents in a secure and efficient manner.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. Health Technical Memorandum 00: Policies and principles of healthcare engineering 4. BS EN 15221 Facilities Management 5. BS ISO 55000, 55001 & 55002: 2014 Asset Management 6. Quality Management System supported by the International Organisation for Standardisation ISO 9001 Quality Management System, or the current European Foundation for Quality Management (EFQM) Excellence Model criteria or equivalent. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/299276/HTM_00.pdf https://shop.bsigroup.com/ProductDetail?pid=000000000030206404 https://www.iso.org/standard/55088.html "https://www.iso.org/iso-9001-quality-management.html https://efqm.org/efqm-model/	
SH3	**1: Document Management System in Place** Does the Organisation have an effective and efficient document management system in place proportional to the level of complexity, hazards and risks concerned?	3. Requires minimal improvement	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures		
SH3	**2: Approval of documents** Are documents approved for adequacy prior to issue?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SH3	**3: Review of documents** Are documents reviewed and updated as necessary with changes identified?	2. Good	3. Requires minimal improvement	1. Regular of policies and procedures to ensure implementation;		
SH3	**4: Availability of documents** Are all relevant versions of applicable documents available at points of use?	3. Requires minimal improvement	3. Requires minimal improvement	1. Review of document availability both in terms of policies/procedures as well as spot checks on availability;		
SH3	**5. Legibility of Documents** Are all relevant documents legible and readily identifiable?	2. Good	2. Good	1. Review of document availability both in terms of policies/procedures as well as spot checks on legibility;		
SH3	**6: Document Control** Are all internal and external documents identified and their distribution controlled?	3. Requires minimal improvement	2. Good	1. Review of policies and procedures to ensure implementation;		
SH3	**7: Obsolescence** Is there a process to prevent the unintended use of obsolete documents and apply suitable identification to them if they are retained for any purpose?	3. Requires minimal improvement	3. Requires minimal improvement	1. Formal procedures in place to identify and replace obsolete documents; 2. Records of document replacement; 3. Review of documents replacement records to ensure completeness and accuracy;		
SH3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SH4	**SH4: With regard to Health & Safety at Work can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates to overall H&S management. Most of the Safety SAQs will contain aspects of compliance with H&S legislation also e.g. risk assessments and COSHH assessments.	1. The Health and Safety at Work etc. Act 1974: The HSE with local authorities (and other enforcing authorities) is responsible for enforcing the Act and a number of other Acts and Statutory Instruments relevant to the working environment. 2. Management of Health and Safety at Work Regulations 1999 3. Leading health and safety at work: leadership actions for directors and board members INDG417(rev 1) - hse.gov.uk 4. Safety Representatives and Safety Committees Regulations 1977 (as amended) and Health and Safety (Consultation with Employees) Regulations 1996 (as amended): Approved Code of Practice L186 - hse.gov.uk 5. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service. Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased. 7. CQC Provider Handbooks W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? 8.HBN 03-01 Adult mental health units: planning and design: https://www.england.nhs.uk/publication/adult-mental-health-units-planning-and-design-hbn-03-01/ 9.HBN 03-02 Facilities for child and adolescent mental health units: https://www.england.nhs.uk/publication/facilities-for-child-and-adolescent-mental-health-services-hbn-03-02/	
SH4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Evidence that H&S regulations are: - Understood by all teams involved - Applied by all teams involved - Systematically checked for compliance - Reported for exceptions 4. H&S Committee involvement - committee structure chart and terms of reference 5. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities		
SH4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? (Note 1)	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period:1. Adequate welfare facilities 4. COSHH assessments 5. Health and Safety audits / inspections (completed internal and examples of any external agency reports and associated action plans) 6. Plant and equipment are safe including maintenance, service and test reports 7. Safe arrangements for the use, handling, storage and transport of articles, materials and substances, 8. Safe access and egress.		
SH4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Examples of completed risk assessments – including COSHH, DSE, stress etc.		
SH4	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records; 3. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports		
SH4	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. H&S information for staff 6. Copies of permits to work issued and documented procedures and training records for staff responsible for issue of permit to work 7. Copies of insurance and written schemes of inspection certificates 8. Evidence of compliance with all relevant published HBNs, CFPPs and Health technical Memorandum TMs 9. Meeting minutes 6. Documentation and procedures for Safe systems of work		
SH4	**6: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Incident reports and subsequence investigations including root cause analysis investigations 4. The ability to report on the regulatory requirements regarding safer wards (ligature). 5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.		
SH4	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
SH4	Capital cost to achieve compliance	£0	£0			
SH4	Revenue consequences of achieving compliance	£0	£0			
SH5	**SH5: With regard to Asbestos can the organisation evidence the following?**	Applicable	Applicable		1. Control of Asbestos Regulations 2012 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 3. CQC Guidance for providers on meeting the regulations 4. REACH (Registration, Evaluation, Authorisation and Restriction of Chemicals Regulations 2006). 5. HSE equipment and method series (em1 etc.) 6. HSE asbestos essentials task sheets (A1 etc.) https://www.legislation.gov.uk/uksi/2012/632/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.hse.gov.uk/reach/ https://www.hse.gov.uk/pubns/guidance/emseries.htm https://www.hse.gov.uk/pubns/guidance/emseries.htm	
SH5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Permits to work 4. Procedures to undertake work 5. Asbestos management plan 6. Asbestos register		
SH5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period: 4. Procedures to ensure staff and contractors have appropriate competencies, licences, professional indemnities and liability cover, also a record that these have been checked. 5. Permits to work 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
SH5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? (Note 1)	3. Requires minimal improvement	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. A documented record of the location and condition of the asbestos containing materials - or materials which are presumed to contain asbestos. 5. Evidence of risk assessments relating to the potential exposure to fibres from the materials identified. 6. A plan that sets out in detail how the risks from these materials will be managed and how this has been actioned.		
SH5	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SH5	**5: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence that reasonable steps have been taken to find out if there are materials containing asbestos in non-domestic premises, and if so, its amount, where it is and its condition. 6. Evidence that there is a period review of the plan and the arrangements in place to ensure that the plan remains relevant and up-to-date.		

NHS Premises Assurance Model Safety Domain (Combined and Core 24) **H & Estate Interventions**	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide services that supports the delivery of improved clinical outcomes. The ESSA methodology provide assurance that the **design, maintenance and use of facilities, premises and equipment keep people safe.**	Area 1 This answer is considered critical to the delivery of safe Estates & Facilities or an NHS site and therefore, if it is marked 'Inadequate' the whole of the Safety Domain will be marked 'Inadequate'

Ref.	Health Service Standards Click on green shaded cells can be selected/N/A to tick to open control question menus and approval. **Refer to 'prompt guidance sheet' for further guidance**	2022-23 **Rate the prompt question for the area Green where applicable in the wellbeing factors**	2023-24 Evidence (core+) to be in place	Evidence (core+) to be in place Relevant guidance and legislation	Comments The evidence should demonstrate compliance with the requirements in relevant legislation and guidance	Comments
H10	**1) Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	3. Good	1. Annual review s of standards, policies and procedures documented 2. Outputs of reviews and their inclusion in Action Plans. 3. Evidence that information on the location and condition of the estate is kept up to date and that new works is added to work on or asset lists. 4. Audits by Board Members 5. Significant findings from Authorising Engineer reports and action plans		
H10	**1) Control Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires remedial or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAM-1500 and other assessments. 2. Evidence of escalation to Trust Board and relevant committees 3. Inclusion of investment to deliver Actions in future budgets as appropriate 4. Assessment of effect of prior identified investment.		
	Caution!! cost to achieve compliance	£0	£0			
	Revised assessment of achieving compliance					

Ref.	**SAM: NHS-With regard to Medical Gas Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 02-01: Medical gas pipeline systems 2. Health Technical Memorandum 06-01: Piping and Pressures of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. Central Alert System - 'Organisations to familiarise themselves with this alert https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103223	
H42	**1) Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and prescribed guidance?	1. Requires minor improvement	1. Requires minor improvement	1. The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum 02-01 Part A 2. The organisation has used Appendix 4 to the HTM-02-01 part A to undertake a risk assessment of the medical gas pipeline (bulk supply) system 3. The organisation has an accurate and up to date technical library for oxygen supply systems & (in the relevant instruction for use (IFU).	https://www.england.nhs.uk/estates/health-technical-memorandum/ https://www.legislation.gov.uk/ukdsi/2008/9780111705619/contents https://www.cqc.org.uk/guidance-providers/meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_acc_residential_services_provider_handbook_march_15_update_01.pdf	
H42	**2) Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people to fill clear descriptions of their roles and responsibility which are e-all understood?	1. Requires minor improvement	1. Requires minor improvement	1. Trust management structure/organogram for this area 2. The organisation has reviewed the skills and competencies of identified roles within the HTM and has ensured a of resilience for these functions 3. Key relevant Objectives for the period / - Remits e.work 4. Approved persons 5. Job descriptions/roles 6. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards.		
H42	**3) Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	1. Requires minor improvement	2. Good	1. Risks reviewed and included in trust-wide register. 2. Organisation has a risk assessment as per section 6.c.vi of HTM-02-01 3. Organisation has undertaken a risk evaluation of the risk of fire and explosion from the use of medical gases as per HTM-02-01 Part A demonstration G1-01 (please indicated in the organisational evidence column the date of your last review.)		
H42	**4) Maintenance** Are assets, equipment and plant adequately maintained?	1. Requires minor improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w.orks, equipment dow n time etc. 2. Planned procedures maintenance systems in place 3. The organisation has in place an effective Medical Gas Maintenance Committee as described in Health Technical Memorandum 02-01 Part B. 4. The organisation undertakes thorough inspections on a minimum period of annual annually. In relation to the frequency & suitability of the environment of various w.orks in the an are other recommendations in HTM-02-01 are observed herein. for example if the w.orkers have been trained. 5. The organisation demonstrates compliance to G1(3)(4) 6. The organisation has a system for recording incidents/RIDDOR and wrongful intervention 7. The organisation has a maintenance testing methodology, objective environmental sampling, testing and end of w.orkshand over/commissioning procedures in accordance with G1(5)(6)(7) and assurances of three stakeholders. e.g., accreditation or verification		
H42	**5) Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff from levels of safety, technical and quality requirements?	1. Requires minor improvement	2. Good	1. The organisation has revised and the skills and competencies of identified roles within the Health Technical Memorandum and has ensured an of resilience for these functions, including staff from other departments 2. Training needs analysis for all staff and attendance records.		
H42	**6) Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans in ed/s have been formulated and tested with the appropriately trained staff?	1. Requires medical improvement	1. Requires minor improvement	1. The organisation has critical and tested Business Continuity and/or Disaster Recovery plans for medical gases. 2. The organisation has undertaken a risk evaluation/assessment for management of surge in oxygen demand either bulk or cylinder 3. Regular testing of Emergency response, business continuity plans and escalation plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
H42	**7) Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	3. Good	1. Annual review s of standards, policies and procedures documented 2. Outputs of reviews and their inclusion in Action Plans. 3. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Significant findings from Authorising Engineer reports and action plans 5. The organisation demonstrates that it undertakes a process to learn from incidents and near misses and has a robust process for implementing the learning into new or amended organisational policy, procedure or a sys of w.orking.		
H42	**8) Control Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires remedial or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAM-1500 and other assessments. 2. Evidence of escalation to Trust Board and relevant committees 3. Inclusion of investment to deliver Actions in future budgets as appropriate 4. Assessment of effect of prior identified investment.		
	Caution!! cost to achieve compliance	£0	£0			
	Revised assessment of achieving compliance					

Ref.	**SAM: NHS-With regard to Natural Gas and specialist plant systems can the organisation evidence the following?**	Applicable	Applicable	Core SAQ-0-H4 for Medical gas systems. This SAQ covers other gas installations and plant systems with specialist requirements such as high purity, compressed air negative pressure systems.	1. Gas Appliances (Safety) Regulations 1995 2. Pipelines Safety Regulations (Northern Ireland) 1996 3. Health Technical Memorandum 06 - Piping and Principles of Healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 5. CQC Guidance for providers on meeting the regulations https://www.w.legislation.gov.uk/ukdsi/1998/2451/contents/made https://www.w.legislation.gov.uk/ukdsi/1996/2435/contents/made https://www.w.england.nhs.uk/estates/health-technical-memorandum/ https://www.w.legislation.gov.uk/ukdsi/2008/9780111705619/contents https://www.cqc.org.uk/guidance-providers/meeting-regulations	
H51	**1) Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and prescribed guidance?	3. Good	3. Good	1. Policy and procedures relevant for E&F services relevant to the incidence 2. Regular assessment of policies and procedures.		
H51	**2) Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people to fill clear descriptions of their roles and responsibility which are e-all understood?	3. Good	3. Good	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives for the period 4. Evidence of employing appropriately qualified and suitably trained person where appropriate, ie. "Gas Safe Registered" 5. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards. 6. Remits e.work		
H51	**3) Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	3. Good	2. Requires minor improvement	1. Risks reviewed and included in trust-wide register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers.		
H51	**4) Maintenance** Are assets, equipment and plant adequately maintained?	1. Requires minor improvement	1. Requires minor improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w.orks, equipment dow n time etc. 2. Planned procedures maintenance systems in place 3. Quality control/inspection records		
H51	**5) Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff from levels of safety, technical and quality requirements?	3. Good	3. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of their own w.ork and to avoid hazards which control the risks, including safe use of plant, service and test materials. 2. Training needs analysis for all staff and attendance records.		
H51	**6) Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans in ed/s have been formulated and tested with the appropriately trained staff?	1. Requires minor improvement	1. Requires minor improvement	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviews ed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
H51	**7) Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	1. Requires minor improvement	3. Good	1. Annual review s of standards, policies and procedures documented 2. Outputs of reviews and their inclusion in Action Plans. 3. Audits to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Significant findings from Authorising Engineer reports and action plans 5. The organisation demonstrates that it undertakes a process to learn from incidents and near misses and has a robust process for implementing the learning into new or amended organisational policy, procedure or a sys of w.orking.		
H51	**8) Control Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires remedial or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAM-1500 and other assessments. 2. Evidence of escalation to Trust Board and relevant committees 3. Inclusion of investment to deliver Actions in future budgets as appropriate 4. Assessment of effect of prior identified investment.		
	Caution!! cost to achieve compliance	£0	£0			
	Revised assessment of achieving compliance					

Ref.	**SAM: NHS-With regard to Water Safety Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 03: Policies and principles of healthcare engineering 2. Water Supply (Water Fittings) Regulations 1999 3. Defra's guidance to the Water Supply (Water Fittings) Regulations 4. Health Technical Memorandum 04-01: The control of legionella, Parts 1, 2 and 3; Health Technical Memorandum 04-01: the control of legionella, hygiene, safe hot water, cold water and drinking w ater systems. (Scheduled to be replaced in April 2016 by Health Technical Memorandum 04-01: Safe w ater in healthcare premises) 5. Water Supply (Water Quality) (Scotland) Regulations Regulations 1992 6. Health Technical Memorandum 04-01: Addendum Pseudomonas aeruginosa 7. Health Technical Memorandum 04-02: Water management and w ater efficiency 8. Health Technical Memorandum 07-02: Water management and w ater efficiency – best practice advice for the healthcare sector 9. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 10. CQC Guidance for providers on meeting the regulations	
H58	**1) Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and prescribed guidance?	1. Requires minor improvement	1. Requires minor improvement	1. Policy and procedures relevant for E&F services relevant to the incidence 2. Regular assessment of policies and procedures. 3. Procedures to Ensure Staff and Contractors have Appropriate Competencies and Professional Indemnities and Liabilities 4. Water Safety Plans in place, including legionella- or-like risks 5. Action Plans, including their implementation 6. Records of risk assessments, including Control Legionella and Pseudomonas 7. Records of Water Samples taken to meet remits/ w ork to the Private Water Supplies Regulations 2009	https://www.w.england.nhs.uk/estates/health-technical-memorandum/ https://www.legislation.gov.uk/ukdsi/1999/9781851095971/contents/made https://www.w.legislation.gov.uk/ukdsi/1992/0000/contents/made https://www.w.england.nhs.uk/estates/health-technical-memorandum/ https://www.w.legislation.gov.uk/ukdsi/2008/9780111705619/contents https://www.w.gov.uk/government/publications/care-and-cold-w ater-supply-storage-and-distribution-systems-for-healthcare-premises https://www.w.gov.uk/government/publications/water-management-and-water-efficiency-best-practice-advice-for-the-healthcare-sector https://www.w.gov.uk/government/publications/w ater-management-and-w ater-efficiency-best-practice-advice-for-the-healthcare-sector https://www.w.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/guidance-providers/meeting-regulations	
H58	**2) Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people to fill clear descriptions of their roles and responsibility which are e-all understood?	3. Good	3. Good	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives for the period 4. Water Safety Group with relevant advice and attenders		
H58	**3) Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	1. Requires minor improvement	2. Good	1. Risks reviewed and included in trust-wide register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers.		
H58	**4) Maintenance** Are assets, equipment and plant adequately maintained? (Note 1)	1. Requires minor improvement	1. Requires minor improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w.orks, equipment dow n time etc. 2. Planned procedures maintenance systems in place 3. Quality control/inspection records 4. Water Safety Plans (WSP) (ACoP L8 (2013); HSG274 Parts 1, 2 and 3; Health Technical Memorandum 04-01: Safe Water in Health Care Premises		
H58	**5) Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff from levels of safety, technical and quality requirements?	3. Good	3. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of their own w.ork and to avoid hazards which control the risks, including safe use of plant, service and test materials. 2. Training needs analysis for all staff and attendance records.		
H58	**6) Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans in ed/s have been formulated and tested with the appropriately trained staff?	1. Requires minor improvement	1. Requires minor improvement	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviews ed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
H58	**7) Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	3. Good	1. Annual review s of standards, policies and procedures documented 2. Outputs of reviews and their inclusion in Action Plans. 3. Reports to Estates Committee or other groups e.tcfor the Governance Structure 4. Significant findings from Authorising Engineer reports and action plans 5. The organisation demonstrates that it undertakes a process to learn from incidents and near misses and has a robust process for implementing the learning into new or amended organisational policy, procedure or a sys of w.orking.		
H58	**8) Control Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires remedial or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAM-1500 and other assessments. 2. Evidence of escalation to Trust Board and relevant committees 3. Inclusion of investment to deliver Actions in future budgets as appropriate 4. Assessment of effect of prior identified investment.		
	Caution!! cost to achieve compliance	£0	£0			
	Revised assessment of achieving compliance					

Ref.	**SAM: NHS-With regard to Electrical Systems can the organisation evidence the following?**	Applicable	Applicable	The SAQ covers all aspects of electrical safety, such as: high and low voltage, w.orkplace, RMS, fire detection, communication, security, lightening protection, PAT testing etc.	1. Electricity at Work Regulations 1989 (EAWR) 2. Electrical Equipment (safety) Regulations 1994 3. Electromagnetic Compatibility regulations 1992 4. The Low Voltage Electrical Equipment (safety) Order 1989 5. Health Technical Memorandum 06-01: Electrical Services Safety 6. Health Technical Memorandum 06 - Piping and Principles of Healthcare Engineering 7. Health Technical Memorandum 06-01: Electrical Services Safety 8. Health Technical Memorandum 06-02: Electrical safety guidance for low voltage systems in healthcare premises 9. Health Technical Memorandum 06-03: Electrical safety guidance for high voltage systems in healthcare premises 10. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 11. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations	
H66	**1) Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and prescribed guidance?	1. Requires minor improvement	1. Requires minor improvement	1. Policy and procedures relevant for E&F services relevant to the incidence 2. Regular assessment of the policies and procedures through the EWG or sub-capcular build plan/ for the EWG	https://www.w.legislation.gov.uk/ukdsi/1989/9780110809220/contents/made https://www.w.legislation.gov.uk/ukdsi/1994/2373/contents/made https://www.w.legislation.gov.uk/ukdsi/1992/3031/contents/made https://www.w.england.nhs.uk/estates/health-technical-memorandum/ https://www.w.legislation.gov.uk/ukdsi/2008/9780111705619/contents https://www.w.cqc.org.uk/guidance-providers/meeting-regulations	
H66	**2) Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people to fill clear descriptions of their roles and responsibility which are e-all understood?	1. Requires medical improvement	1. Requires minor improvement	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives for the period 4. Evidence of employing appropriately qualified experienced people in key roles as identified in the Health Technical Memorandums and other standards and Authorised Persons requested as recommended by Authorising Engineer.		
H66	**3) Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	1. Requires minor improvement	2. Good	1. Risks reviewed and included in trust-wide register. 2. Mitigation strategies for areas of risk identified by the EWG as per Health Technical Memorandum 06-01 3. Review and inclusion of risks into Trust risk registers.		
H66	**4) Maintenance** Are assets, equipment and plant adequately maintained?	1. Requires medical improvement	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w.orks, equipment dow n time etc. 2. Planned procedures maintenance systems in place 3. Quality control/inspection records 4. Testing and Commissioning Certificates (all Commiss) 5. Records of inspections/thorough examinations 7. Written schemes of examination 8. Up to date and have verified/audited/formal documentation (non-conformities		
H66	**5) Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff from levels of safety, technical and quality requirements?	3. Good	1. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of their own w.ork and to avoid hazards which control the risks, including safe use of plant, service and test materials. 2. Training needs analysis for all staff and attendance records.		
H66	**6) Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans in ed/s have been formulated and tested with the appropriately trained staff?	1. Requires minor improvement	1. Requires minor improvement	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviews ed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
H66	**7) Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	3. Good	3. Good	1. Annual review s of standards, policies and procedures documented 2. Outputs of reviews and their inclusion in Action Plans. 3. Significant findings from Authorising Engineer reports.		
H66	**8) Control Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires remedial or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAM-1500 and other assessments. 2. Evidence of escalation to Trust Board and relevant committees 3. Inclusion of investment to deliver Actions in future budgets as appropriate 4. Assessment of effect of prior identified investment.		
	Caution!! cost to achieve compliance	£0	£0			
	Revised assessment of achieving compliance					

Ref.	**SAM: NHS-With regard to Mechanical Systems and Equipment can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers work systems on industrial/low level (not tower hoists). Equipment with a residual use is assessed? Core SAQ-0-H5 for Lifting operations and lifting equipment (work under 10.5m and 5 tonne). Please see the guidance for further information. (TUUER) and CLG/IS) but some examples, but all are Powered hoppers and pallet trucks, temporary platforms, fixed, free standing, mast platforms, work cradles, vehicle mounted, scissor lifts, mobile towers, work cradles, vehicle mounted, scissor lifts, cranes, diggers, tractors, cranes/cranes e.tcteracrs.	1. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) 2. Provision and Use of Work Equipment Regulations 1998 (PUWER) 3. Health Technical Memorandum 03: Policies and principles of healthcare Engineering 4. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 5. CQC Guidance for providers on meeting the regulations https://www.w.hse.gov.uk/work-equipment-machines/index.htm https://www.w.hse.gov.uk/pubns/books/puwer.htm https://www.w.england.nhs.uk/estates/health-technical-memorandum/ https://www.w.legislation.gov.uk/ukdsi/2008/9780111705619/contents https://www.w.cqc.org.uk/guidance-providers/meeting-regulations	
H72	**1) Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and prescribed guidance?	3. Good	3. Good	1. Policy and procedures relevant for E&F services relevant to the incidence 2. Regular assessment of policies and procedures.		
H72	**2) Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people to fill clear descriptions of their roles and responsibility which are e-all understood?	1. Requires minor improvement	3. Good	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives for the period		

NHS Premises Assurance Model Safety Domain (Combined and Core PAM) **v1.0 Basic Instructions**	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide services that supports the delivery of improved clinical outcomes. The ESQs individually provide assurance that the **design, maintenance and use of facilities, premises and equipment keep people safe.**	Aim 1 This answer is considered critical to the delivery of safe Estate & Facilities or an NHS site and therefore, if it is marked 'Inadequate' the whole of the Safety Domain will be marked 'Inadequate'

Ref.	Question/Statement/Standards Click in green shaded cells can be used/ticks to a tick cross/ current question marks any ignored. **Refer to 'general guidance sheet' for further guidance**	2022-23 **Rate the general question for the area these relate to in the subtexts below**	2023-24 Evidence /examples /benchmarks Guidance to operational teams, should demonstrate the approach (procedures etc.) is understood, appropriately applied, adequately recorded, inspection, audited and reviewed.	Relevant guidance and legislation The evidence should demonstrate compliance with the requirements in relevant legislation and guidance	Comments
Ref.1	1) Risk Assessment Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed? (Note 1)	1. Requires minor improvement	1. Requires minor improvement	1. Risks reviewed and included in local risk register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers.	
Ref.2	2) Maintenance Are estate, equipment and plant adequately maintained? (Note 1)	1. Requires minor improvement	1. Requires minor improvement	1. Reviewed/actioned corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w orks, equipment dow n time etc. 2. Planned preventative maintenance systems in place. 3. Quality control/inspection records. 4. Records of Inspections/Declarations of Conformity. 5. Records of inspections through quarantations. 6. Copies of insurance certificates/formal dec orientation from inspections. 7. Written schemes of examination.	
Ref.3	3) Training and Development Does the Organisation have an up to date training and development plan in place ensuring all relevant roles and responsibilities of staff have levels of safety, technical and quality requirements?	1. Requires minor improvement	1. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of the premises and its activities and to avoid hazards and control the risks, including safe use of plant, service and lad ders. 2. Training needs analysis for all staff and attendance records.	
Ref.4	4) Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and evaluation plans in hich have been formulated and tested with the appropriately trained staff?	1. Requires minor improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	
Ref.5	5) Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual review s of standards, policies and procedures undertaken. 2. Outputs of reviews and their inclusion in Action Plans. 3. Outputs of reviews and their inclusion in Action Plans.	
Ref.6	6) Control Action Plans If any ratings in this SQ are 'Inadequate' or 'requires restricted or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non-compliance identified in the SKR Fund and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Inclusion of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.	
	Capital amount to achieve compliance	£0	£0		
	Revenue annual amount to achieve compliance	£0	£0		
Ref.7	**SKR1: With regard to Ventilation, Air Conditioning and Ventilation Systems can the organisation evidence the following?**	Applicable	Applicable		1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises 2. Health Technical Memorandum 03: Policy and Principles of Healthcare Engineering 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Ref.8	1) Policy & Procedures Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Requires minor improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the evidence. 2. Regular assessment of policies and procedures.	1. Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises https://w ww .england.nhs.uk/wp -content/uploads/2021/05/PRL-20.pdf https://w ww .gov.uk/guidance/the-building-regulations-2010-approved-documents https://w ww .cqc.org.uk/files/guidance-providers/meeting-regulations
Ref.9	2) Roles and Responsibilities Does the Organisation have appropriately qualified, competent and suitably appointed people with clear descriptions of their roles and responsibility and is/are s ed understood?	2. Good	2. Good	1. Trust management structure/organogram for this area. 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives. for the period.	
Ref.10	3) Risk Assessment Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed? (Note 1)	1. Requires minor improvement	1. Requires minor improvement	1. Risks reviewed and included in local risk register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers.	
Ref.11	4) Maintenance Are estate, equipment and plant adequately maintained?	1. Requires minor improvement	2. Good	1. Reviewed/actioned corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w orks, equipment dow n time etc. 2. All ventilation plant should meet a minimum requirement of 4 air changes per hour of fresh air supply (unless otherwise stated in respective ventilation) 3. The maintenance of ventilation plant should be inspected annually. 4. The certification of ventilation plant (including ductwork (such as those servicing operating suites) should be certified annually	
Ref.12	5) Training and Development Does the Organisation have an up to date training and development plan in place ensuring all relevant roles and responsibilities of staff have levels of safety, technical and quality requirements?	2. Good	1. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of the premises and its activities and to avoid hazards and control the risks, including safe use of plant, service and lad ders. 2. Training needs analysis for all staff and attendance records.	
Ref.13	6) Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and evaluation plans in hich have been formulated and tested with the appropriately trained staff?	1. Requires minor improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	
Ref.14	7) Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual review s of standards, policies and procedures undertaken. 2. Outputs of reviews and their inclusion in Action Plans. 3. Significant findings from Authorising Engineer reports.	
Ref.15	8) Control Action Plans If any ratings in this SQ are 'Inadequate' or 'requires restricted or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non-compliance identified in the SKR Fund and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Inclusion of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.	
	Capital amount to achieve compliance	£0	£0		
	Revenue annual amount to achieve compliance	£0	£0		
Ref.16	**SKR2: With regard to Pressure Systems can the organisation evidence the following?**	Applicable	Applicable	Users can assess the specific requirements around Pressure Systems in the SKRs or in other relevant ESQs as the pressure systems e.g. medical gases. The approach used should be explained in the mass number.	1. Simple Pressure Vessels (Safety) Regulations 1991 2. Pressure Systems Safety Regulations 2000 (PSSR) 3. Pressure Equipment Regulations 1999 4. Health Technical Memorandum 02-01: Medical Compressed Air Systems Kent Refers HS HSG176 2021
Ref.17	1) Policy & Procedures Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Requires minor improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the evidence. 2. Regular assessment of policies and procedures.	1. Health Technical Memorandum 03: Policy and Principles of Healthcare Engineering 2. Health Technical Memorandum 02-01: Medical Compressed Air Systems: Parts 1 and 2 3. CQC Guidance for providers on meeting the regulations
Ref.18	2) Roles and Responsibilities Does the Organisation have appropriately qualified, competent and suitably appointed people with clear descriptions of their roles and responsibility and is/are s ed understood?	2. Good	1. Requires minor improvement	1. Trust management structure/organogram for this area. 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives. for the period.	https://w ww .legislation.gov.uk/ukdsi/1989/9780110809657/contents/made https://w ww .england.nhs.uk/wp -content/uploads/2021/05/PRL-20.pdf https://w ww .legislation.gov.uk/ukdsi/2000/9780110858116/contents/made https://w ww .legislation.gov.uk/ukdsi/2016/9780111151760/contents https://w ww .hse.gov.uk/pubns/books/l122.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/282276/HSG176.pdf https://w ww .gov.uk/guidance/the-building-regulations-2010-approved-documents https://w ww .legislation.gov.uk/ukdsi/2014/9780111117613/contents https://w ww .cqc.org.uk/files/guidance-providers/meeting-regulations
Ref.19	3) Risk Assessment Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed? (Note 1)	1. Requires minor improvement	1. Requires minor improvement	1. Risks reviewed and included in local risk register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers.	
Ref.20	4) Maintenance Are estate, equipment and plant adequately maintained? (Note 1)	1. Requires minor improvement	2. Good	1. Reviewed/actioned corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w orks, equipment dow n time etc. 2. Planned preventative maintenance systems in place. 3. Quality control/inspection records.	
Ref.21	5) Training and Development Does the Organisation have an up to date training and development plan in place ensuring all relevant roles and responsibilities of staff have levels of safety, technical and quality requirements? (Note 1)	2. Good	1. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of the premises and its activities and to avoid hazards and control the risks, including safe use of plant, service and lad ders. 2. Training needs analysis for all staff and attendance records.	
Ref.22	6) Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and evaluation plans in hich have been formulated and tested with the appropriately trained staff?	1. Requires minor improvement	1. Requires minor improvement	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed and tested. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	
Ref.23	7) Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual review s of standards, policies and procedures undertaken. 2. Outputs of reviews and their inclusion in Action Plans.	
Ref.24	8) Control Action Plans If any ratings in this SQ are 'Inadequate' or 'requires restricted or minor improvement' are there risk assessed control action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non-compliance identified in the SKR Fund and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Inclusion of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.	
	Capital amount to achieve compliance	£0	£0		
	Revenue annual amount to achieve compliance	£0	£0		
Ref.25	**SKR3: With regard to Fire Safety can the organisation evidence the following?**	Applicable	Applicable	Fire Risk Assessors/ Fire Safety to be actively reviewing detection and alarm systems, sprinklers & other risk systems, fire damper inspections, fire doors, compartmentation, etc. Refer to SKR 3.26 and 3.51 - there can be cross referral to social distancing	1. Regulatory Reform (Fire Safety) Order 2005 2. The Management of Health and Safety at Work and Fire Precautions (Workplace) (Amendment) Regulations 2003 3. The Fire and Rescue Services Act 2004 4. Health and Safety (Training for Employment) Regulations 1990 5. Health and Safety at Work etc Act 1974 6. Management of Health and Safety at Work Regulations 1999 7. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 8. Control of Substances Hazardous to Health Regulations 1977 9. Building Regulations 2010 10. Fire Safety Act 2021
Ref.26	1) Policy & Procedures Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Requires minor improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the evidence. 2. Regular assessment of policies and procedures. 3. Fire Risk Assessments including fire compartmentation, fire doors, fire contractors working on fire compartments	1. Health Technical Memorandum 05-01: Managing Healthcare Fire Safety 2. Health Technical Memorandum 05-02: Fire Safety Engineering Principles for Healthcare Premises 3. Health Technical Memorandum 05-03 Part A/Part B: Fire safety - Operational Provisions 4. HM Government – fire safety risk assessment: Means of Escape for Disabled People 5. Fire Safety (England) Regulations 2022 (Regulation 38) 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Ref.27	2) Roles and Responsibilities Does the Organisation have appropriately qualified, competent and suitably appointed people with clear descriptions of their roles and responsibility and is/are s ed understood?	2. Good	1. Requires minor improvement	1. Trust management structure/organogram for this area. 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives. for the period.	1. CQC Guidance for providers on meeting the regulations 2. Health and Safety Executive: Fire Safety 3. Equality Act 2010 4. Fire Safety Act 2021 – Guidance for those building and Fire Safety 5. Building Control Bulletin - Fires of electrical batteries for the NHS estate 6. Building safety Act 2022 - https://w ww .legislation.gov.uk/ukpga/2022/30/contents/enacted
Ref.28	3) Governance Is there regular meetings of the fire safety committee, is there an external annual report by the authorising engineer (fire) is there an annual internal report to the Board	2. Good	2. Good	1. Minutes of committee meetings 2. Annual AS report 3. Annual internal report	https://w ww .legislation.gov.uk/ukdsi/2005/9780110848670/contents/made https://w ww .legislation.gov.uk/ukdsi/2003/9780110438638/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/282276/HSG176.pdf https://w ww .legislation.gov.uk/ukpga/2004/21/contents https://w ww .legislation.gov.uk/ukpga/1974/37/contents https://w ww .legislation.gov.uk/ukdsi/1999/9780110855574/contents/made https://w ww .legislation.gov.uk/ukdsi/1999/3242/contents/made https://w ww .legislation.gov.uk/ukdsi/1977/500/contents/made https://w ww .legislation.gov.uk/ukdsi/1995/9780110430015/contents https://w ww .legislation.gov.uk/ukdsi/2006/9780110439051/contents https://w ww .england.nhs.uk/estates/health-technical-memorandums/
Ref.29	4) Achievement Has there been a self assessment of the fire safety order, either under articles 22, 32 and 31 of the fire safety order (alterations, extensions, change of use) or under the fire safety order (new construction), is there a enforcement notices have been received, if so what are the dates	2. Good	1. Requires minor improvement	1. Copies of PEE notices. 2. Copies of rectification of deficiencies	https://w ww .legislation.gov.uk/ukdsi/2005/9780110848670/contents/made https://w ww .legislation.gov.uk/ukdsi/2003/9780110438638/contents/made https://w ww .legislation.gov.uk/ukpga/2004/21/contents https://w ww .legislation.gov.uk/ukpga/1974/37/contents https://w ww .legislation.gov.uk/ukdsi/1999/9780110855574/contents/made https://w ww .legislation.gov.uk/ukdsi/1999/3242/contents/made https://w ww .legislation.gov.uk/ukdsi/1977/500/contents/made https://w ww .legislation.gov.uk/ukdsi/1995/9780110430015/contents https://w ww .legislation.gov.uk/ukdsi/2006/9780110439051/contents https://w ww .england.nhs.uk/estates/health-technical-memorandums/
Ref.30	5) Risk Assessment Seen all areas of the premises had a fire risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed? (Note 1)	1. Requires minor improvement	1. Requires minor improvement	1. Risks reviewed and included in local risk register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers at boa rd level.	https://w ww .gov.uk/government/publications/fire-safety-risk-assessment-healthcare-premises https://w ww .gov.uk/government/publications/fire-safety-risk-assessment-means-of-escape-for-disabled-people https://w ww .cqc.org.uk/files/guidance-providers/meeting-regulations
Ref.31	6) Maintenance Are estate, equipment and plant necessary for fire safety maintained, are all doors close, adhere a delay order and gasket seals? (Note 1)	1. Requires moderate improvement	1. Requires moderate improvement	1. Reviewed/actioned corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w orks, equipment dow n time etc. 2. Risk based evidence based planned preventative maintenance systems in place for fire doors, fire dampers, fire compartmentation, fire dampers, fire extinguishers. 3. Risk based methodology - quality control/inspection records	
Ref.32	7) Training and Development Does the Organisation have an up to date training and development plan in place ensuring all relevant roles and responsibilities of staff have levels of safety, technical and quality requirements? (Note 1)	1. Requires moderate improvement	1. Requires moderate improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety and quality of the premises and its activities and to avoid hazards and control the risks, including safe use of plant, service and lad ders. 2. Training needs analysis for all staff and attendance records.	
Ref.33	8) Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and evaluation plans in hich have been formulated and tested with the appropriately trained staff?	1. Requires moderate improvement	1. Requires moderate improvement	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed and tested. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels. 4. Plans for fire alarm mitigation in cases of system failure. 5. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	
Ref.34	9) Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures? (Note 1) Is the annual audit of fire safety and fire safety management undertaken by competent persons and presented to the Trust Board as outlined in HSG65 (6) section 1.1.21	1. Requires minor improvement	2. Good	1. Annual review s of standards, policies and procedures undertaken. 2. Outputs of reviews and their inclusion in Action Plans. 3. Significant findings from Authorising Engineer reports. 4. Fire service liaison. 5. Enunciation tests. 6. Fire evacuation exercise- frequency aligned to legislative requirements and risk	
Ref.35	10) Control Action Plans If any ratings in this SQ are 'Inadequate' or 'requires restricted or minor improvement' are there risk assessed control action plans in place to achieve compliance? Costs can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non-compliance identified in the SKR Fund and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Inclusion of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.	
	Capital amount to achieve compliance	£0	£0		
	Revenue annual amount to achieve compliance	£0	£0		
Ref.36	**SKR4: With regard to Medical Devices and Equipment can the organisation evidence the following?**	Applicable	Applicable	Decontamination is covered under SKA2/SK3	1. Provision and Use of Work Equipment Regulations 1998 2. ICNIRP ICS Safe Use of work Equipment
Ref.37	1) Policy & Procedures Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Requires minor improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the evidence. 2. Regular assessment of policies and procedures.	1. Health Technical Memorandum 03: Policies and principles of healthcare engineering 2. Health Technical Memorandum 02-01: Medical Compressed Air Systems: Parts 1 and 2 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 4. CQC Guidance for providers on meeting the regulations
Ref.38	2) Roles and Responsibilities Does the Organisation have appropriately qualified, competent and suitably appointed people with clear descriptions of their roles and responsibility and is/are s ed understood?	2. Good	2. Good	1. Trust management structure/organogram for this area. 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives. for the period.	https://w ww .hse.gov.uk/pubns/books/l22.htm https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/282276/HSG176.pdf https://w ww .gov.uk/government/publications/managing-risks-to-patients-from-medical-devices-and-products-regulatory-agency https://w ww .legislation.gov.uk/ukdsi/2000/9780111117735/contents https://w ww .cqc.org.uk/files/guidance-providers/meeting-regulations
Ref.39	3) Risk Assessment Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	1. Requires minor improvement	2. Good	1. Risks reviewed and included in local risk register. 2. Mitigation strategies for areas of risk identified. 3. Review and inclusion of risks into Trust risk registers.	

NHS Provisions Assurance (Hotel Safety Domain (Combined and Hard FM) **v1.0 Desk Instructions**	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide services that supports the delivery of improved clinical outcomes. The SOGs individually provide assurance that the **design, maintenance and use of facilities, premises and equipment** keep people safe.	Note 1: The answer is considered critical to the delivery of safe Estates & Facilities or an NHS site and therefore, if it is marked as 'Inadequate' the whole of the Safety Domain will be marked as 'Inadequate'.

Ref.	Standard/Questions	2022-23	2023-24	Evidence, examples to be listed below:	Relevant guidance and legislation	Comments
Ref.	SOGs to given shaded cells can be used/click to re-lock cell / correct question marks are required. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question for using the drop down menus in the evidence below**		Evidence to operational teams should demonstrate the approach (procedures etc.) is understood, appropriately applied, adequately recorded, inspected on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance	
SH1.1	**1. Maintenance** Are estate, equipment and plant adequately maintained?	3. Requires minor improvement	3. Inadequate	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w/orks, equipment down time etc. 2. Planned preventative maintenance systems/ plans. 3. Quality control/inspection records.		
SH1.2	**2. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff / volunteers of safety, technical and quality requirements?	2. Good	3. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to the safety, technical and quality of the service delivered and to avoid the risks, including safe use of plant, service and test objects. 2. Training needs analysis for all staff and attendance records.		
SH1.3	**3. Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and evacuation plans in list/t have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH1.4	**4. Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual review s of standards, policies and procedures 2. Outputs of reviews and their inclusion in Action Plans.		
SH1.5	**5. Control Action Plans** If any ratings in this SOG are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessments and/or action plans in place to achieve compliance? **Costs** can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAR, PAR and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Evidence of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of actions to achieve compliance	£0	£0			
SH2	**SH2: SOG regard to Resilience, Emergency and Business Continuity Planning (are the organisation resilience like fitness?)**	Applicable	Applicable	This SOG looks at the overall approach to resilience, emergency, business continuity planning. This is in relation to estates and Facilities.	1. Civil Contingencies Act 2004 2. NHS Standard Contract 3. Health Building note 00-01 Resilience planning for NHS Facilities 30 April 2018. Guidance 4. ISO 22301:2019 Security and resilience – Business continuity management systems (BCMS) Purpose and scope and Associated Guidance 5. ISO 22301:2019, Business Continuity Management Systems 6. ISO 22313:2020, Business Continuity Management Systems Guidance 7. CQC Provider Handbooks	
SH2.1	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minor improvement	2. Good	1. The organisation has in place a policy or/s that includes a statement of intent to undertake business continuity. The policy has been reviewed in the last 12 months and a Business System (BCMS) in alignment to the ISO standard 22301). 2. The organisation's BCMS is monitored, measured and reported upon internally. The BCMS is externally audited. Reports on these and the outcomes of any exercises, and actions to rectify any issues identified are formally reported to the board.	https://www.legislation.gov.uk/ukpga/2004/36/contents https://www.england.nhs.uk/nhs-standard-contract/ https://www.england.nhs.uk/publication/health-building-note-00-01-planning-for-nhs-facilities/ https://www.england.nhs.uk/wp-content/uploads/2017/12/ward-guidance-chart-v3.pdf https://www.cqc.org.uk/guidance-providers/all-services/how-we-inspect-services https://w ww .iso.org/standard/75107.html https://w ww .cqc.org.uk/sites/default/files/20160229_soc_residential_services_provider_handbook_march_15_update_01.pdf	
SH2.2	**2. Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people in/ith clear descriptions of their roles and responsibility, which are/s well understood?	1. Outstanding	2. Good	1. The organisation's Estates and Facilities team is appropriately resourced at the right (direct, contributory or both) number and with the right competencies to meet its BCMS requirements. 2. Job descriptions including roles and responsibilities. 3. Key relevant Objectives for the period.		
SH2.3	**3. Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	2. Good	3. Requires minor improvement	1. The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management approach of the BCMS. It is documented. 2. Mitigation strategies for areas of risk identified. 3. Review and evolution of risks via Trust risk registers.		
SH2.4	**4. Maintenance** Are estate, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w/orks, equipment down time etc. 2. Planned preventative maintenance systems/ plans. 3. Quality control/inspection records.		
SH2.5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff / volunteers of safety, technical and quality requirements?	3. Requires minor improvement	3. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and the risks, including safe use of plant, service and test objects. 2. Training needs analysis for all staff and attendance records.		
SH2.6	**6. Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis. 2. Outputs of reviews and their inclusion in Action Plans.		
SH2.7	**7. Control Action Plans** If any ratings in this SOG are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessments and/or action plans in place to achieve compliance? **Costs** can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAR, PAR and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Evidence of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of actions to achieve compliance	£0	£0			
SH3	**SH3: What is the reporting of safety-related incidents, near misses and hazards? Does the organisation have a robust reporting system and are lessons learned? Does the organisation evidence like following?**	Applicable	Applicable	This SOG relates to: 1. Reporting of safety-related incidents and accidents, 2. Recording corrective actions is taken where notified in E&F safety alert systems and similar	1. National Frontiers ert for Reporting and Learning from Serious Incidents Requiring Investigation 2. Regulation 13 and 20 of the Care Quality Commission (Registration) Regulations 2009 3. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 4. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 5. CQC Guidance for providers on meeting the regulations 6. Health and Care Act 2022	
SH3.1	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	3. Requires minor improvement	1. Policy and procedures relevant to E&F services rolevant to the Institute. 2. Regular assessment of policies and procedures;	https://www.legislation.gov.uk/uksi/2013/1471/contents/made https://www.england.nhs.uk/patient-safety/incident-reveal-events-policy-and-frames-ref/ https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/uksi/2014/2936/contents https://www.cqc.org.uk/guidance-providers/all-services/how-we-inspect-services https://w ww .cqc.org.uk/guidance-providers/meeting-regulations	
SH3.2	**2. Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their roles and responsibility, which are/s well understood?	3. Requires minor improvement	3. Requires minor improvement	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period 4. Bidesking bulletins /ets practice		
SH3.3	**3. Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	3. Requires minor improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and evolution of risks via Trust risk registers;		
SH3.4	**4. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff / volunteers of safety, technical and quality requirements?	3. Requires minor improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and the risks, including safe use of plant, service and test objects. 2. Training needs analysis for all staff and attendance records.		
SH3.5	**5. Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and evacuation plans in list/t have been formulated and tested with the appropriately trained staff?	3. Requires minor improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH3.6	**6. Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual review s of standards, policies and procedures 2. Outputs of reviews and their inclusion in Action Plans. 3. Reviewing, checking and authorising invoices for payment for Estates & Facilities services 4. Investigations		
SH3.7	**7. Control Action Plans** If any ratings in this SOG are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessments and/or action plans in place to achieve compliance? **Costs** can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAR, PAR and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Evidence of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of actions to achieve compliance	£0	£0			
SH4	**SH4: With regard to ensuring estates and facilities services are safe and suitable when the organisation is not directly responsible for providing these services (are the organisation's contractors like fitness?)**	Applicable	Applicable	This SOG mainly refers to ensuring rented (or similar) premises are safe and suitable for their purpose. Where E&F services are/g generally be considered under the relevant SOG and Contractor management SH10. See the NHS RAM guidance for details on the PAR assessment for multiple sited estates.	1. Health and Safety at Work Act 1974; 2. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 4. CQC Provider Handbooks	
SH4.1	**1. Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Outstanding	2. Outstanding	1. Policy and procedures relevant to E&F services rolevant to the Institute. 2. Regular assessment of policies and procedures;	https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/2014/2936/111/116/3/contents https://www.legislation.gov.uk/uksi/2014/2936/contents/made https://w ww .cqc.org.uk/sites/default/files/20160229_soc_residential_services_provider_handbook_march_15_update_01.pdf	
SH4.2	**2. Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their roles and responsibility, which are/s well understood? (Note 1)	2. Outstanding	2. Outstanding	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period		
SH4.3	**3. Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly review ed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and evolution of risks via Trust risk registers; 4. If the safety risk assessment has been undertaken and has a priority it is evacuation of the building has been undertaken		
SH4.4	**4. Maintenance** Are estate, equipment and plant adequately maintained?	3. Requires minor improvement	3. Requires minor improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w/orks, equipment down time etc. 2. Planned preventative maintenance systems/ plans. 3. Quality control/inspection records.		
SH4.5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff / volunteers of safety, technical and quality requirements?	3. Good	3. Requires minor improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and the risks, including safe use of plant, service and test objects. 2. Training needs analysis for all staff and attendance records.		
SH4.6	**6. Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and evacuation plans in list/t have been formulated and tested with the appropriately trained staff?	3. Requires minor improvement	2. Good	1. Assessment undertaken of resilience risks both direct and indirect. 2. Emergency response and business continuity plans developed and reviewed. 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk/events. 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SH4.7	**7. Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual review s of standards, policies and procedures 2. Outputs of reviews and their inclusion in Action Plans. 3. Reviewing, checking and authorising invoices for payment for Estates & Facilities services 4. Fire safety risk assessor's/ers system for storage of all waste 5. All staff are aware of their roles and responsibilities in the event of an emergency		
SH4.8	**8. Control Action Plans** If any ratings in this SOG are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessments and/or action plans in place to achieve compliance? **Costs** can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAR, PAR and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Evidence of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of actions to achieve compliance	£0	£0			
SH5	**SH5: With regard to Contractor Management for Self-certified FM services (are the organisation evidence like following?**	Applicable	Applicable	This SOG covers, using E&F contractors for a full range of services. **Contractors for Self-certified FM services (Soft Services such like and Soft FM)** It is about ensuring: competent contractors are appointed, adequately informed, instructed and trained, managed and supervised, co-ordinated and co-operated	1. Health and Safety at Work etc. Act 1974; 2. Construction (Design and Management) Regulations 3. Health Act 2006 4. Management of Health and Safety at Work Regulations 5. Health and Safety Executive guidance documents related to relevant SOGs 6. Building Regulations 7. Approved Documents covering listed building consents 8. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 9. CQC Guidance for providers on meeting the regulations 10. CQC Provider Handbooks	
SH5.1	**1. Policy** Does the Organisation have a current and approved policy and if applicable, a set of underpinning set of procedures relating to contractor management.	2. Good	3. Requires minor improvement	1. Policy and procedures relevant to E&F services rolevant to the Institute. 2. Regular assessment of policies and procedures; 3. Procedures/contractor strategies, demonstrative of incorporated process and procedure w hereby risk compliance is identified and remediation strategies are developed and delivered.	https://www.legislation.gov.uk/ukpga/1974/37/contents https://w ww .hse.gov.uk/services/construction/index.htm https://www.hse.gov.uk/legislation/hswa.htm https://w ww .legislation.gov.uk/uksi/1999/3242/contents/made Planning (Listed Buildings and Conservation Areas) Act 1990 (legislation.gov.uk) https://w ww .cqc.org.uk/guidance-providers/all-services/how-we-inspect-services https://w ww .cqc.org.uk/guidance-providers/meeting-regulations https://w ww .cqc.org.uk/sites/default/files/20160229_soc_residential_services_provider_handbook_march_15_update_01.pdf	
SH5.2	**2. Roles and Responsibilities** Does the Organisation have appropriately qualified and appropriately qualified, competent and formally appointed people with clear descriptions of their roles and responsibility which are well understood w ho are responsible for managing these services (see SOGs and Trust representative for major contracts including PFI)?	2. Good	3. Requires minor improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives, for the period.		
SH5.3	**3. Criminal registry** Have the Trust complied with legal requirements and notice periods in respect of the Trust's ability of direct contractors (early on projects and in certain contract period of 6/24 or over) record any PFI and Estates Soft Services to manage these and the transition of services	Not applicable	Not applicable	1. Documented and dates for contracts and contractual requirements		
SH5.4	**4. Risk Assessment** Are contractors risk assessments and if applicable, method statements (for relevant activities) satisfactory and reviewed on a timely, commencing and review ed for their appropriateness?	2. Good	2. Good	1. Agreed allocation of risk is monitored; 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and evolution of risks via Trust risk registers;		
SH5.5	**5. Maintenance** Does the Organisation hold the necessary proof to demonstrate competent contractor maintenance activities , for its contracted services.	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding w/orks, equipment down time etc. 2. Planned preventative maintenance systems/ plans. 3. Quality control/inspection records. 4. Trust's internal evidence of audits and monitors to support compliance. 5. Auditing and inspecting the Contractors' work, ensuring that the Contractor is aware of and complies with all Health, Safety and Safety, environmental and legislative requirements. 6. Fire safety risk assessor/ers take lan the Contracting Body and the Risk Contractors.		
SH5.6	**6. Contractor Competence** Is there a robust procurement of the contractors , has the organisation checked that contractors are using suitably competent persons to carry out the contracted services?	2. Good	2. Good	1. Adequate insurance 2. Performance monitoring against agreed Key Performance indicators 3. Evidence of professional qualifications and experience		
SH5.7	**7. Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and evacuation plans in list/t have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Supplier Business Continuity and Disaster Recovery Plan		
SH5.8	**8. Review Process** Is there a robust annual review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	2. Good	3. Requires minor improvement	1. Annual review s of standards, policies and procedures 2. Outputs of reviews and their inclusion in Action Plans. 3. Reviewing, checking and authorising invoices for payment for Estates & Facilities services 4. Monitoring Contractors' approach to rectifying defects, 5. Problem solving and dispute /prevention and resolution 6. Investigations 7. Suspect and maintain appropriate records and information to enable the Trust to record and manage the performance of the Soft Contractors		
SH5.9	**9. Control Action Plans** If any ratings in this SOG are 'Inadequate' or 'requires moderate or minor improvement' are there risk assessments and/or action plans in place to achieve compliance? **Costs** can be entered below.	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of noncompliance identified in the SAR, PAR and other assessments. 2. Evidence of escalation to Trust Board and relevant committees. 3. Evidence of investment to deliver Actions in future budgets as appropriate. 4. Assessment of effect of prior identified investment.		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of actions to achieve compliance	£0	£0			
SH6	**SH6: The built environment: Reducing harm by ligature is paramount**	Not applicable	Applicable	The standard is notable to Mental health service users being cared for in the Trust's premises and/or those who may be cared for in the future that will have risks in relation to the built environment that may present ligature risks. Ligature risk assessments are required. It is for the Trust to have oversight of how Contractors have undertaken ligature risk assessments and the Trust should also have risks in relation to this. The SOG falls if any themes of risk must be considered when answering these questions.	1. The Health and Safety at Work etc. Act 1974 The HSE will expect workers (and other relevant persons) to be responsible for enhancing the standard of health, safety and welfare (and therefore) the behaviour of the working environment. 2. Management of Health and Safety at Work Regulations 1999 3. Leading health and safety at work: Leadership actions for directors and board members, HSG(65)(rev 1) - first gov.uk 4. Health and Safety (Consultation with Employees) Regulations 1996 (legislation.gov.uk) Health and Safety (Consultation with Employees) Regulations 1996 (as amended) Approved Code of Practice (ACP) - first gov.uk 5. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 6. Health and Safety (Consultation with Employees) Regulations 2024 and CQC Guidance for providers on meeting the regulations HSG(65) premises and equipment used by the service provider must be – HSG(65) properly used, HSG(65) properly maintained, and HSG(65) properly examined; and • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay? Improvements are required. • There must be adequate arrangements in place for ensuring the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. HSG(65) assess, monitor and mitigate the risk risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Providers must have systems and processes in place that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service	
SH6.1	**1. Policy** Has Trust has a policy in place to tert specifically relates to ligature risk and guidance it is being followed in line with the CQC guidance?	Not applicable	Not applicable	1. Policy and procedures for E&F services rolevant to the Institute. 2. Regular assessment of policies and procedures; 3. Procedures/contractor strategies, demonstrative of incorporated process and procedure w hereby risk compliance is identified and remediation strategies are developed and delivered.		
SH6.2	**2. Roles and Responsibilities** The trust has roles and and specified the key roles, responsibilities and competencies for those who are accountable for safety, covering ligature assessment?	Not applicable	Not applicable	1. Trust management structure/organogram for this area 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives, for the period.		

NHS Premises Assurance Model Safety Domain (Combined and Core (PA) **H & Build Installations**	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide services that supports the delivery of improved clinical outcomes. The ESQs collectively provide assurance that the **design, maintenance and use of facilities, premises and equipment keep people safe.**	Key 1: This answer is considered critical to the delivery of safe Estates & Facilities or an NHS site and therefore, if it is marked as 'Inadequate', the whole of the Safety Domain will be rated as 'Inadequate'

Ref.	Health Service Standards	2020-21	2021-22	Evidence / examples to be submitted	Relevant guidance and legislation	Comments
Ref.	ESQs to given shaded cells can be used N/A in a tick n/a) Initial question marks are ignored. **Refer to 'general guidance sheet' for further guidance**	**Rate the principal question for each of the three theme indexes in the adjacent boxes**		Guidance to operational teams should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, inspected on, audited and improved.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance	
SQ1	1. **Risk Assessment** Have a full risk assessment been completed	Not applicable	4 - Good	1. Agreed allocation of risk is mentioned 2. Risk assessment process and methodology in place 3. Mitigation strategies for areas of risk identified 4. Review and inclusion of risks into Trust risk registers 5. Risk assessments should consider the needs of those who may have VIP patients such as VIP, the CQC generally require higher protection considerations across Ethernet/Local Area Networks (LAN) and Wide Area Networks (WAN) 6. Risk assessments should consider the needs of people, for example community services as significant changes to the environment should be considered although this is not a comprehensive list - Dementia Friendly - Survivors Network (tornadoes) - Wheelchair Refresher - Disability Discrimination Act - Ceiling Height - Air Locks - Fire Doors/Fire - Slip and Trip Hazards - Risk of Violence/Violence and Exposure - Lone Working 7. Reduced lockable glass/plastic/Fabric 8. Risk assessments should include Management of Consolidation - procedures for securing and using tools of trim or Mental Health Wards (For example - wood tools or use of tools in secure environments) Ligature risks should be identified and prepare or for mitigation and have to be lockable tool bags in the property 9. Risk of violence, safety/Reducing harm. Consider the two questions, to learn reducing Things, and to utilise - restrictions - planning and visitors that may, have previous issues and identify	Aims for the health, safety and/or welfare of people who use services should be evaluated within the organisation or by a relevant external body as appropriate Identified risks to people who use services and others must be eventually mentioned and appropriate actions taken before a risk has increased. Providers must have processes, to minimise the likelihood of risks and to minimise the impact of risks on people who use services. Aims for the health, safety and/or welfare of people who use services must be evaluated within the organisation or by a relevant external body as appropriate Identified risks to people who use services and others must be eventually mentioned and appropriate actions taken before a risk has increased. SQ1.1 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? SI-NHS-23.02 Adult mental health units: planning and design https://www.england.nhs.uk/publication/adult-mental-health-units-planning-and-design/ SI-NHS-23.03 Facilities for child and adolescent mental health units https://www.england.nhs.uk/publication/facilities-for-child-and-adolescent-mental-health-services-hbn-23-02/ https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00824-hbn-02-03-risk-to-and-tracking-v3.0.pdf HS https://www.rcpsych.ac/docs/default-source/improving-care/ward-design/ligature-risk-minimisation-guidance	
SQ2	2. **Maintenance** Does the organisation hold the necessary proof to demonstrate every-item/contractor maintenance activities - for its contractor services.	Not applicable	4 - Good	1. Preventative/corrective maintenance strategies, together with external analysis of requirements and forecasting, to minimise risks, outstanding w.orks, equipment stand-s time etc. 2. Quality control/service maintenance systems in place 3. Quality control checks 4. Documented evidence of audits and reviews to support improvement 5. Auditing and inspecting the Contractors' work, ensuring that they comply with the contractual requirements on quality, Health and Safety and environmental issues and standards 6. Managing communication between the Contracting Body and the Contractor 7. Risk assessing the impact of any backlogs in maintenance work	
SQ3	3. **Contractor Compliance** Where contractors are used for fixture and fittings they should be adequately qualified to ensure the specific ligature risks have been identified if applicable.	Not applicable	Not applicable	1. Adequate insurance 2. Contractor performance monitoring against agreed Key Performance Indicators 3. Evidence of professional qualifications and experience 4. Contractors' compliance with relevant health and safety legislation 5. Contractors' work-s-ending on-site, to inform/check any risk assessments, maintenance and arrangements	
SQ4	4. **Service Process** Is there a documented review process in place to manage the performance of contractors ensuring compliance to the agreed contract, relevant standards, policies and procedures?	Not applicable	Not applicable	1. Annual review s of standards, policies and procedures 2. Outputs of reviews and their inclusion in Action Plans 3. Benchmarking and addressing processes for unachieved additional services 4. Monitoring Contractors' approach to rectifying defects 5. Contractual and dispute (prevention act) mandates • time issues exist 6. Establish and maintain appropriate records and information 7. Ensuring that there is a clear process for communication with the Key Contractors 8. Ensuring that there is a clear process for all organisation providers to identify lessons from events and incidents, so that relevant information is shared with the relevant people in the relevant organisational policy, procedure or a out of control 9. The ability to report on the regulatory requirements regarding, Health facilities and ASEA units. 10. Demonstrate clear ability to report on-incre events relating to estates and facilities items (e.g.bloc - restrictor/non-collapsible curtain rails) and ensure appropriate actions are in relation to Mental Health facilities and ASEA units.	
SQ5	5. **Planned Action Plans** Are there planned actions to ensure any non-f-ncompliant or requires reminder in terms improvement are there risk assessed rocked action plans in place to achieve compliance? If not have reasons been recorded?	Not applicable	Not applicable			
Total	Number of 'applicable' questions	4	4			
Total	Number of 'Not applicable' questions	0	0			

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS1	**SS1: With regard to Catering Services can the organisation evidence the following?**	Applicable	Applicable	This SAQ covers the safety aspects of catering and food with SAQ PE4 looking at patient feedback on food. Note: This applies to all food sources on-site including commercial and charitable outlets.		
SS1	**1: Policy & Procedures** Does the Organisation have a current, approved Policy, Food Safety Management System and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	1. Outstanding	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS1	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS1	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has the organisation documented all processes and procedures in an approved HACCP document?	3. Requires minimal improvement	3. Requires minimal improvement	1. Food Standards Agency ratings and Nonmental Health Officer reports. 2. Risks reviewed and included in local risk register; 3. Mitigation strategies for areas of risk identified; 4. Review and inclusion of risks into Trust risk registers; 5. Nutritional screening programme identifying patients at risk from malnutrition and dehydration. 6. Allergens screening		
SS1	**4: Maintenance** Are assets, equipment and plant adequately maintained, regularly and monitored to ensure equipment relating to temperature control is functioning correctly?	3. Requires minimal improvement	3. Requires minimal improvement	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS1	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements including level 2 hygiene for all food handlers and HACCP at the appropriate level for supervisors and Managers?	3. Requires minimal improvement	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS1	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.	1. Food Hygiene (England) Regulations 2006. 2. Control of Substances Hazardous to Health 2002 3.Food Safety Act 1990.(Amended Regulations 2004) 4. HSG (96) 20 -Management of Food Hygiene & Food Services in the National Health Service. 5. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related products. 6. Regulation EC 852/2004 on the hygiene of foodstuffs. 7. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2007 8. Compliance with Healthcare Commission Core Standard 14 (Food) 9. Health Act 2006 Code of Practice for Prevention and Control of Health Care Associated Infections (Department of Health 2006) revised January 2008 10. Food Safety(England) Regulations 2005 11. Food Safety (Temperature Control) Regulations 1995 12..CQC Guidance for providers on meeting the regulations 13. Fire Hazards have been considered for any catering service 14. NHS 10 Key Characteristics of Good Nutrition and Hydration 15. British Dietetic Association's Nutrition and Hydration Digest 16. British Dietetic Association guidelines 17. The MUST Toolkit (Malnutrition Universal Screening Tool) 18. National standards for healthcare food and drink 19. Food Review .https://www.legislation.gov.uk/uksi/2006/14/contents/made https://www.hse.gov.uk/coshh/ https://www.legislation.gov.uk/uksi/2004/2990/contents/made https://www.legislation.gov.uk/eur/2004/852/contents https://www.cqc.org.uk/guidance-providers/regulationsenforcement/regulation-14-meeting-nutritional-hydration-needs https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance https://www.legislation.gov.uk/uksi/2005/2059/contents/made https://www.legislation.gov.uk/uksi/1995/2200/contents/made https://www.cqc.org.uk/guidance-providers/regulations https://www.england.nhs.uk/estates/health-technical-memoranda/	
SS1	**7: Review Process** Is there a robust regular review process to assure compliance and effectiveness of relevant standards, policies and procedures which includes sampling and testing where required?	2. Good	1. Outstanding	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS1	8. **Food Standards (No.1)** Organisations should have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.	Not applicable	3. Requires minimal improvement	1. Documented and readily available		
SS1	9. **Food Standards (No.2)** Organisations should have a food and drink strategy.	Not applicable	2. Good	1. Documented and readily available		Guidance for Food Standard no 8. - If patient/staff/visitors are not present 24/7, approach this question as having a food provision for 100% of the time they are on site. If the type of food service is not present within your trust, put not applicable, however you cannot put not applicable for all 7 Food Standard No. 8 questions as you should be working to provide a 24/7 offering for your staff of one of these types of food service If your trust operates 24/7 services but the food provision operates only daytime hours, the maximum score should be requires minimal improvement
SS1	10. **Food Standards (No.3)** Organisations should consider the level of input from a named food service dietitian to ensure choices are appropriate.	Not applicable	2. Good	1. Documented and readily available 2. Minutes of nutritional steering group available 3. Name and details of dietitian from contacts page 4. Documented evidence of dietitian involvement in menu engineering		
SS1	11. **Food standards (No. 4)** Organisations should nominate a food safety specialist and this person should chair a food safety group	Not applicable	2. Good	1. Documented and readily available 2. Minutes of food safety group available 3. Evidence of food safety audit management and safety system		

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Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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SS1	12. **Food Standards (No.5)** Organisations invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services, including training report, matrices or other evidence of chef, catering and nurse training including L2 food safety.	Not applicable	2. Good	1. Documented and readily available training matrices' and training programme 2. available on ESR	https://www.england.nhs.uk/estates/health-technical-memorandal/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ https://www.bda.uk.com/specialist-groups-and-branches/food-services-specialist-group/nutrition-and-hydration-digest.html https://www.bda.uk.com/professional/practice/practice_guidance/home https://www.bapen.org.uk/screening-and-must/must/must-toolkit/the-must-itself https://www.bapen.org.uk/must-and-self-screening/must-toolkit/ https://www.england.nhs.uk/long-read/national-standards-for-healthcare-food-and-drink/ https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food	
SS1	13 **Food Standards (No.6)** Organisations are able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.	Not applicable	2. Good	1. Documented and readily available training matrices' and training programme 2. available on ESR		
SS1	14.**Food Standards (No. 7)** Organisations are able to monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals, a full waste strategy including food waste	Not applicable	2. Good	1. Documented and readily available 2. Evidence provided of involvement of waste management measurements and systems 3. Evidence food is included within waste management strategy 4. Completed ERIC return inline with this		
SS1	15.**Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour restaurant.	Not applicable	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**16.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a 24 hour café	Not applicable	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**17.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have a hot vending services.	Not applicable	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**18.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have retail services	Not applicable	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**19.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have cold vending	Not applicable	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**20.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have smart fridges	Not applicable	3. Requires minimal improvement	1. Documented and readily available with analysis of why this is appropriate		
SS1	**21.Food Standards (no. 8)** NHS organisations are able to demonstrate that they have nutritional, healthy 24/7 food service provision, which is appropriate for their demographic. You have staff provision for storage and heating of food brought from home.	Not applicable	2. Good	1. Documented and readily available with analysis of why this is appropriate		
SS1	**22: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS2	**SS2: With regard to Decontamination Processes can the organisation evidence the following?**	Applicable	Applicable	Management, operation and maintenance of decontamination equipment and processes covering the decontamination of surgical equipment, linen, dental equipment and flexible endoscopes. As set out in the HTM 01 Suite 01-06		
SS2	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Quality manual and supporting processes.		

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SS2	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Trust management structure for decontamination 5. Appointment letter for AE, job descriptions e.g. decontamination lead, SSD manager, Endoscopy Unit decontamination team 6. Appointment letter for AP(D) 7. Evidence of employing appropriately qualified experienced people in key roles as identified in the HTMs and other standards.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained 2. CQC Guidance for providers on meeting the regulations15(1) All premises and equipment used by the service provider must be—15(1)(d) properly used,15(1)(e) properly maintained, and 3. Health Technical Memorandum01-01A, B, C, D, E 4. Health Technical Memorandum01-04A 5. Health Technical Memorandum01-05 6. Health Technical Memorandum01-06A, B, C, D, E; 7. ISO 9001 8. ISO13485 9. Estate/MHRA alerts 10. Medical Devices Directive. 11. Revision to the Medical Devices Directive. 12. CQC Guidance about compliance. - Guidance about compliance Essential standards of quality and safety 13. GS1 coding. 14. NHS Operating Framework 15. Medical Devices Regulations (MDR) 2002. 16. BS EN ISO 13485. 17. Executive Letter EL(98)5. 18. Decontamination Services Agreement. 19. In-vitro Diagnostic Devices Directive. 20. Kirby, E., Dickinson, J., Vassey, M., Dennis, M., Cornwall, M., Mcleod N. et al. (2012). Bioassay stunnex L. 21. IHEEM AE(D) register. 22. Institute of Decontamination Sciences (IDSc). 23. Institute of Healthcare Engineering and Estate Management (IHEEM). 24. ESAC-Pr report. 25. MHRA's 'Managing medical devices: guidance for healthcare and social services organisations' 26. MHRA 'Medical devices: conformity assessment and the CE mark'. 27. BSG Guidance for flexible endoscopy 28. JAG Guidance for endoscopy 29. BS EN ISO 15883 (washers – surgical and endo) 30. BS EN ISO 285 (sterilizers) 31. BS EN ISO 14662 (drying cabinets endo) https://www.legislation.gov.uk/ukdsi/2014/97801111176l3/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda NHS England » Health technical memoranda ISO - ISO 9000 family — Quality management https://shop.bsigroup.com/ProductDetail?pid=00000000000303531 96&creative=435401337506&keyword=&matchtype=b&network=g &device=c&gclid=Cj0KCQjwhb36BRCfARIsAKcXh6GMNUjeSJR KxBsGuwxpkqp_2sQxy7VOg8DODJbCx0VtftiaOupLFzQaAoDME ALw_wcB https://www.cas.mhra.gov.uk/Home.aspx https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom https://services.cqc.org.uk/sites/default/files/gac_-_dec_2011_update.pdf https://www.gs1.org/standards/barcodes https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13 https://www.legislation.gov.uk/uksi/2002/618/contents/made https://shop.bsigroup.com/products/medical-devices-quality-management-systems-requirements-for-regulatory-purposes/tracked-changes https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376918/Guidance_on_the_In_Vitro_Diagnostic_Medical_Devices_Directive.pdf http://eprints.gla.ac.uk/75539/1/75539.pdf https://www.iheem.org.uk/IHEEM-Authorising-Engineer	
SS2	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS2	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Validation reports for washer disinfectors and drying cabinets. 5. Permits to work for service engineers. Service contracts. PPM dockets and maintenance instructions 6. Permit to work system		
SS2	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training needs analysis, staff training matrix for SSD/Endoscopy and Estates Teams. Specialist training with external providers. Scope cleaning training 4. Competency documents for endoscopy technicians 5. Competency documents for contractors required to work on decontamination equipment 6. Agency staff - if used include matrix of assessment of competency etc?		
SS2	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business Continuity plans for SSD and Endoscopy Unit. 6. Test reports for efficacy of plans. 7. Training records for staff following testing		

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS2	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	1. Outstanding	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Internal and external audit reports 4. Use of ISO 9001 and ISO13485 can be incorporated into evidence 5. AE audit of Trust policy and processes 6. IHEEM JAG audit report and certificate 7. Significant findings from Authorising Engineer reports and action plans.	https://www.iheem.org.uk/IHEEM Authorising Engineer Decontamination-Register https://www.idsc-uk.co.uk/ https://www.iheem.org.uk/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271414/Frequently_asked_questions.pdf https://www.gov.uk/government/publications/managing-medical-devices https://www.gov.uk/guidance/medical-devices-conformity-assessment-and-the-ce-mark https://www.bsg.org.uk/clinical-resource/guidance-on-decontamination-of-equipment-for-gastrointestinal-endoscopy-2017-edition/ https://www.thejag.org.uk/ https://shop.bsigroup.com/ProductDetail?pid=000000000303531 96&creative=386044230705&keyword=iso13485&matchtype=b&network=g&device=c&gclid=Cj0KCQjw-uH6BRDQARIsAI3I-UebTMtTTunz4BVFa_wZGh4Z4faiqjOB6iywmYHF2wdiVHKQL0EPDNkaAseTEALw_wcB https://shop.bsigroup.com/ProductDetail/?pid=000000000030278 677#:~:text=It%20specifies%20requirements%20and%20the,of%20at%20least%2060%20l. https://www.iso.org/standard/55290.html	
SS2	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS3	**SS3: With regard to Waste and Recycling Management can the organisation evidence the following?**	Applicable	Applicable	The scope of this SAQ may gross over into Effectiveness Question E4 (SDMP)		
SS3	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS3	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS3	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS3	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Waste Electrical and Electronic Equipment Regulations 2006 2. Pollution Prevention and Control (England and Wales) Regulations 2000 3. Environment Act 1995 4. Environmental Protection Act 1990 5. Health Technical Memorandum 07-01; Safe Management of Healthcare Waste 6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 7. CQC Guidance for providers on meeting the regulations 8. CQC Provider Handbooks https://www.legislation.gov.uk/uksi/2006/3289/contents/made https://www.legislation.gov.uk/uksi/2000/1973/contents/made https://www.legislation.gov.uk/ukpga/1995/25/contents https://www.legislation.gov.uk/ukpga/1990/43/contents https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
SS3	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	3. Requires minimal improvement	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS3	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		

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Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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SS3	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS3	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS4	**SS4: With regard to Cleanliness and Infection Control applying to Premises and Facilities can the organisation evidence the following ?**	Applicable	Applicable	This SAQ covers the safety aspects of cleaning and infection control. SAQ PE3 looks at patient feedback relating to cleanliness.		
SS4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS4	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	1. Outstanding	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. 4. Framework of responsibility at trust level, linking into departmental responsibilities.		
SS4	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	3. Requires minimal improvement	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS4	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS4	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	3. Requires minimal improvement	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Use of NHS England Cleaning Manual	1. Health and Care Act 2022 2. (Health Building Note 00-09) Infection control in the built environment 3. Association of Healthcare Cleaning Professionals (AHCP) (2009) Colour Coding Hospital Cleaning Materials and Equipment: Safer Practice Notice 15 4.National infection prevention and control manual (NIPCM) for England 5. Health Building Note 04-01) Adult in-patient facilities: planning and design 6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8. National Standards of Healthcare Cleanliness 2021 9. NHS Cleaning Manual (on the E+F hub since 2021, to be published on web March 2024) 1. https://www.legislation.gov.uk/ukpga/2022/31/contents 2.. https://www.england.nhs.uk/publication/infection-control-in-the-built-environment-hbn-00-09/ 3.. https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-clea-ng-manual-2009-06-v1.pdf 4. https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/ 5.. https://www.england.nhs.uk/publication/adult-in-patient-facilities-planning-and-design-hbn-04-01/ 6&7. https://www.cqc.org.uk/guidance-providers/regulations 8.. https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/ 9. Hub not yet published	(For SS8 and 9 - Although the mandatory requirement is to display in patient facing areas, a Trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff - it is best prac tice to share this information wider)
SS4	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS4	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	1. Outstanding	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS4	**8. Cleaning Standards 2021** Can you evidence that Star ratings are Displayed in patient facing areas?	Not applicable	1. Outstanding	1. Audit evidence 2. Publicly displayed and available		

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SS4	**9. Cleaning Standards 2021** **As a minimum has 95% of the estate achieved a star rating of 4* or above, following their technical audits, in FR categories 1 – 4?**	Not applicable	2. Good	1. Documented and readily available 2. Publicly displayed and available 3. Reviewed annually		
SS4	**10. Cleaning Standards 2021** **Have you undertaken efficacy audits in a minimum of 95% in each FR categories 1 – 4?**	Not applicable	2. Good	1. Audit evidence 2. Reported to Board quarterly		
SS4	**11. Cleaning Standards 2021** **Do you have evidence that audits scoring 3* stars or below are following an escalation and review process?**	Not applicable	2. Good	1. Audit evidence 2. Reported to Board quarterly		
SS4	**12: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS5	**SS5: With regard to Laundry and Linen Services can the organisation evidence the following?**	Applicable	Applicable	There may be some cross over with this SAQ and SS4.		
SS5	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS5	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS5	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS5	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. (HTM 01-04) Decontamination of linen for health and social care 2. Department of Health Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers 2020 3. Immunisation against infectious disease: 'The Green Book' 4. HSE (1999) Management of Health and Safety at Work Regulations. London: Stationery Office 5.. HSE (2002) Control of Substances Hazardous to Health Regulations. London: Stationery Office- Health and Care Act 2022 6.. CQC Guidance for providers on meeting the regulations 7. CQC Provider Handbooks 8.. The Textile Services Association 1 .https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04/ 2. https://www.england.nhs.uk/publication/uniforms-and-workwear-guidance-for-nhs-employers/ 3. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book 4.. https://www.hse.gov.uk/pubns/hsc13.pdf 5. https://www.hse.gov.uk/coshh/ 6https://www.legislation.gov.uk/ukpga/2022/31/contents 7. https://www.cqc.org.uk/guidance-providers/regulations 8. https://tsa-uk.org/healthcare/	
SS5	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	1. Outstanding	1. Outstanding	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Training matrix available		
SS5	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans;		

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SS5	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS5	**8. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS6	**SS6: With regard to Security Management can the organisation evidence the following?**	Applicable	Applicable	This SAQ relates only to the Physical Security infrastructure and labour related to the security of NHS facilities and not fraud or cybersecurity.		
SS6	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Identified and allocated resources are stipulated in the policy 4. The organisation has in place a security management strategy as a standalone document or as part of a policy statement. 5. Evidence of a Security Policy, Violence and Aggression Policy, 6. Procedure for the dissemination of key and vital information e.g. security alerts. The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.		
SS6	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period; 4. Board nominated executive with the responsibility for overseeing security management 5. Nominated Qualified and Accredited Security Management Specialist to oversee and undertake the delivery of the full range of security management work - external/internal. 6. Evidence of internal (including capital development) and external liaison and involvement in local and national groups and with agency partners also to be included in job descriptions.	1. Counter-Terrorism and Border Security Act 2019 2. National Counter Terrorism Security Office guidance 3.Human Rights Act 1998 4. Criminal Procedure and Investigations Act 1996 5.. Guidance from the Surveillance Commissioners Office 6.. General Data Protection Regulations 2018 7.. Criminal Justice and Immigration Act 2008 8.. Criminal Law Act 1967 9.. Following the principle of NHS Protect - Standards for providers 2017-18 Fraud, bribery and corruption 10. Health and Safety at work act 19741. 11. Updated - NHSE National Contract 22/23 Service condition 24 – counter fraud (previously 'Protect')- NHS Requirements | Government Functional Standards | NHS Counter Fraud Authority (cfa.nhs.uk) -12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and CQC Guidance for providers on meeting the regulations 13. CQC Provider Handbooks 14. Martyn's Law (currently under consultation - it is important to be aware of updates) https://www.legislation.gov.uk/ukpga/1996/25/contents https://www.legislation.gov.uk/ukpga/2019/3/contents/enacted https://www.gov.uk/government/latest?departments%5B%5D=national-counter-terrorism-security-office https://www.npcc.police.uk/ https://www.legislation.gov.uk/ukpga/1998/42/contents	
SS6	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risks identified include those related to; -Violent and aggressive individuals - Premises suitability - Lone working arrangements. - Evidence of Security assessment programme		
SS6	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Evidence of security involvement in new builds. 5. Evidence of a managed and maintained security access control system		

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SS6	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Evidence of the promotion of security awareness via multiple mediums 4. Evidence of tiered security training commensurate with duties based on a training needs analysis which is monitored, evaluated and reviewed as needed. 5. Demonstration of staff training in relation to incident reporting	https://www.legislation.gov.uk/ukpga/1996/25/contents https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786444/Guide_to_the_Regulation_of_Surveillance.pdf https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted https://www.legislation.gov.uk/ukpga/2008/4/contents https://www.legislation.gov.uk/ukpga/1967/58/contents https://cfa.nhs.uk/resources/downloads/standards/Fraud_Standards_for_providers_2017-18.pdf https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcfa.nhs.uk%2Fgovernment-functional-standard%2FNHS-requirements&data=05%7C02%7Chayley.morris10%40nhs.net%7C8a406c7e22d942e9aabc08dc1bec2ccc%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638415948376320929%7CUnknown%7CTWFpbGZsb3dBeyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=0wnDVJjTpnmL0RVCYIj1eczCmOtHPHDkLtQm5T1jQQE%3D&reserved=0 https://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.protectuk.police.uk/martyns-law/martyns-law-overview-and-what-you-need-know	
SS6	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Evidence of plans as required by the security standards; - Planning for Lockdowns; - Planning for child abductions;		
SS6	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Demonstration that risks identified through assessment are sufficiently funded to enable mitigation and response 4. Annual report to board in relation to security management 5. Evidence of work plan and ongoing review and update of plan 6. Evidence that incidents where harm or injury occur or had the potential to occur are sufficiently followed up and investigated including where appropriate support being provided to victims.		
SS6	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify capital and revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS7	**SS7: With regard to Transport Services and access arrangements can the organisation evidence the following?**	Applicable	Applicable	SAQ covers fleet management and transport of goods and services on and between sites. It excludes patient transport apart from the management of taxi services. Related patient experience is covered in SAQ P5. Access arrangements may also be covered under SH2. This includes car parking.		
SS7	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	1. Outstanding	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS7	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	3. Requires minimal improvement	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS7	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored. **Refer to 'prompt guidance sheet' for further guidance**	**Rate the prompt question by using the drop down menus in the columns below**		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
SS7	**4: Maintenance** Are assets, equipment and plant adequately maintained?	1. Outstanding	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1. Health Technical Memorandum 07-03: Transport Management and Car Parking 2. Building Research Establishment BRE - BREEAM Travel Plan documentation. 3. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/estates/health-technical-memoranda/ https://kb.breeam.com/knowledgebase/transport-assessments-and-transport-statements/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-Procurement-Guide.pdf	
SS7	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	1. Outstanding	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:		
SS7	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	1. Outstanding	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS7	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans;		
SS7	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS8	**SS8: With regard to Pest Control can the organisation evidence the following?**	Applicable	Applicable			
SS8	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;. 3. Preventative/corrective strategies; demonstration of documented process and procedure whereby non-compliance is identified and remediation strategies are developed and delivered.		
SS8	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS8	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;		
SS8	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records	1.Public Health Act 1961 2.Control of Pollution Act 1974 3. Health and Safety at Work Act 1974	

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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SS8	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records:	4. The Poisons Act 1972 5. The Control of Substances Hazardous to Health Regulation 1988 6. Control of Pesticides Regulations 1986 7. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 8. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/ukpga/1972/66 https://www.legislation.gov.uk/uksi/1988/1657/contents/made https://www.legislation.gov.uk/uksi/1986/1510/contents/made https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS8	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS8	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Records of pest infestation, COSHH data sheets for pesticides, records of bait placement etc. 4. Documented evidence of audits and reviews to support compliance.		
SS8	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
SS9	**SS9: with regard Portering Services can the organisation evidence the following?**	Applicable	Applicable	In line with local organisational portfolio for this area.		
SS9	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Patient transfer policy. 4. Infection control procedures and training.		
SS9	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	2. Good	2. Good	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		
SS9	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	2. Good	2. Good	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers; 4. Risk assessments for injury from needles and exposure to harmful substances and bodily fluids		
SS9	**4: Maintenance** Are assets, equipment and plant adequately maintained?	2. Good	2. Good	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records 4. Training matrix available	1. Health & Safety at Work Act 1974 2. Management of Health & Safety at Work Regulations 1988 3. CQC Provider Handbooks https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1988/1222/contents/made	

NHS Premises Assurance Model: Safety Domain (Soft FM)	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical outcomes. The SAQs collectively provide assurance that the ***design, maintenance and use of facilities, premises and equipment keep people safe.***
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SS9	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	2. Good	2. Good	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Manual handling training	https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf To note we are working on guidance for portering which will be available for reference next year, covering: - Service strategy (workforce) - Technology and equipment - Policy - Working with clinical teams	
SS9	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	2. Good	2. Good	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans.		
SS9	**7: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Evidence of patient involvement and feedback. 4. Patient Feedback considered and actioned		
SS9	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
S10+A	**SS10:Estates IT and Building Information Management (BIM) systems** **Please confirm you have a plan for your trusts to engage with their current providers of telecoms services who will be able to assist them in identifying their Public Switch Telephone Network services. Once this has been completed, trusts need decide how best these services should be replaced or removed.** **The systems that need to be considered include:** **• Plant alarms;** **• Staff Attack Systems;** **• Security Alarms;** **• Lockdown/Access Control intercoms;** **• Car Park Barriers;** **• Catering freezers & fridges;** **• Pathology & Blood freezers and fridges;** **• Fire alarm auto dial;** **• Lift emergency calls;** **• Building Management Systems (BMS) alarms (oxygen, gas shut out, fuel alarms (leak and level), ventilation, generator etc);** **• Fax machines;** **• Credit card terminals.** **The PSTN situation is discussed at your Local Resilience Forums (LRF) and therefore we suggest you link with your Trust EPRR lead who will be able to assist with the wider work being undertaken by LRF partners, to identify any potential interdependencies within your Trust.**	Not applicable	Applicable			
SS10	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	Not applicable	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
SS10	**2: Roles and Responsibilities** Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?	Not applicable	3. Requires minimal improvement	1. Trust management structure/organogram for this area; 2. Job descriptions including roles and responsibilities; 3. Key relevant Objectives for the period;		

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SS10	**3: Risk Assessment** Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	3. Requires minimal improvement	1. Risks reviewed and included in local risk register; 2. Mitigation strategies for areas of risk identified; 3. Review and inclusion of risks into Trust risk registers;	1 .Public Health Act 1961 2. Health and Safety at Work Act 1974 3. CQC Guidance for providers on meeting the regulations https://www.legislation.gov.uk/ukpga/Eliz2/9-10/64/contents https://www.legislation.gov.uk/ukpga/1974/40 https://www.cqc.org.uk/files/guidance-providers-meeting-regulations	
SS10	**4: Maintenance** Are assets, equipment and plant adequately maintained?	Not applicable	Not applicable	1. Preventative/corrective maintenance strategies, together with statistical analysis of departmental performance e.g. response times, outstanding works, equipment down-time etc. 2. Planned preventative maintenance system in place; 3. Quality control/Inspection records		
SS10	**5. Training and Development** Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?	Not applicable	Not applicable	1. Provision of sufficient training, instruction, supervision and information to enable all employees to contribute positively to their own safety and health at work and to avoid hazards and control the risks, including safe use of plant, service and test reports; 2. Training needs analysis for all staff and attendance records: 3. Process for monitoring operators handling of calls for quality purposes		
SS10	**6: Resilience, Emergency & Business Continuity Planning** Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?	Not applicable	3. Requires minimal improvement	1. Assessment undertaken of resilience risks both direct and indirect; 2. Emergency response and business continuity plans developed and reviewed; 3. Regular testing of Emergency response and business continuity plans appropriate to identified risk levels; 4. Records of testing and responses of actual incidents collated, assessed and used to update risk and plans. 5. Business continuity procedures in place in case of fire or other emergency to maintain service including standby operating facilities located on individual sites 6. Loss of service plans including bleeps and mobile phones. 7. Robust call out procedures tested over all sites monthly with table top exercises.		
	7. Technology replacement plan & Review process Is there a technology migration plan in place for removal of service/infrastructure reliance on PSTN and ISDN by December 2025? When answering this sub-question, "Not Applicable" should only apply where no PSTN connections have ever existed within your organisation. If you have completed migration, please use "Outstanding". Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	3. Requires minimal improvement	1. Identified services reliant on PSTN within your organisation? 2. Have an appropriate replacement solution identified with your provider that ensures continuity of service? 3. Is there a plan in place with your provider to migrate services away from PSTN? 4. Has the identified plan been executed to migrate services to replacement solution? 5 Annual reviews of standards, policies and procedures documented; 6 Outputs of reviews and their inclusion in Action Plans; 7. KPIs on performance including call pick up times		
SS10	**8: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P1	**P1: With regards to ensuring engagement and involvement on estates and facilities services from people who use the services, public and staff can your organisation evidence the following?**	Applicable	Applicable	P1 replicates the CQC Provider handbooks KLOE R4 and assesses your processes for patient involvement, compliments and complaints		
P1	**1. Views and Experiences** Are people's views and experiences gathered and acted on to shape and improve the services and culture?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Review of the Patient Led Assessment of the Care Environment (PLACE) results and implementation of the outcomes;		
P1	**2. Engagement** Are people who use services, those close to them and their representatives actively engaged and involved in decision making?	2. Good	2. Good	1. Engagement process and methodology 2. Friends and Family Test 3. Patient Advice and Liaison Service (PALS)	1. Data Protection Act 1998 2. Freedom of Information Act 2000 3. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: 4. CQC Guidance for providers on meeting the regulations 5. CQC Provider Handbooks 6. NHS England Transforming Participation in Health and Care – September 2013 7. The Kings Fund Research Paper; Patient Engagement and Involvement 8. The Kings Fund Research Paper; The Quality of Patient Engagement and Involvement in Primary Care 2010 https://www.legislation.gov.uk/ukpga/1998/29/contents https://www.legislation.gov.uk/ukpga/2000/36/contents https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf https://www.england.nhs.uk/2013/09/trans-part/ https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement https://www.kingsfund.org.uk/projects/gp-inquiry/patient-engagement-involvement	
P1	**3. Staff Engagement** Do staff feel actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?	2. Good	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Engagement feedback influencing services developments and improvements		
P1	**4. Prioritisation** Do leaders prioritise the participation and involvement of people who use services and staff?	2. Good	2. Good	1. Governance and process for dealing with feedback		
P1	**5. Value** Do both leaders and staff understand the value of staff raising concerns? Is appropriate action taken as a result of concerns raised?	2. Good	2. Good	1. Adherence to confidentiality policy 2. Feedback to stakeholders and patients		
P1	**6: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P2	**P2: With regard to ensuring patients, staff and visitors perceive the condition, appearance, maintenance and privacy and dignity of the estate is satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on condition, appearance, maintenance and P&D. Safety aspects are dealt with in the safety domain.		
P2	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to the care environment (estate) and estates related privacy and dignity issues, for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services 7evelopments and improvements 8. Adherence to confidentiality policy 9. Feedback to stakeholders and patients 10. Complaints Procedure 11. Diversity considerations	1. NHS England: Delivering same sex accommodation guidance. Responsibility transferred to NHSE/I in 2017 .The DHSC guidance was revised and published in 2019. 2. Patient Led Assessments of the Care Environment (PLACE). 3. Health Ombudsman 'Care and Compassion' report 4. National In-patient survey 5. Commission for dignity in Care for older people 'delivering dignity' report 6. Patient Association guidance and advice 7. Joint Committee on Human Rights 'The Human Rights of Older People in healthcare' 8. CQC Provider Handbooks https://improvement.nhs.uk/resources/delivering-same-sex-accommodation/ https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://www.ombudsman.org.uk/publications/care-and-compassion https://www.cqc.org.uk/publications/surveys/surveys https://www.nhsconfed.org/resources/2012/06/delivering-dignity-securing-dignity-in-care-for-older-people-in-hospitals-and-care#:~:text=hospitals%20and%20care-,Delivering%20Dignity%3A%20Securing%20dignity%20in%20care%20for,people%20in%20hospitals%20and%20care&text=Delivering%20Dignity%20is%20the%20final,underlying%20causes%20of%20poor%20care. https://publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf https://www.patients-association.org.uk/Pages/FAQs/Category/policy https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
P2	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction with the estate and related privacy and dignity issues and is action taken on the results?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements		
P2	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P3	**P3: With regard to ensuring that patients, staff and visitors perceive cleanliness of the estate and facilities to be satisfactory can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues on cleanliness. Safety aspects of cleanliness are covered in the safety domain.		

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P3	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to cleanliness for all relevant sites and published a local improvement plan.	1. Outstanding	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 9. Diversity considerations	1. Health and Social Care Information Centre: Patient Led Assessments of the Care Environment (PLACE) https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/	
P3	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the cleanliness and is action taken on the results?	2. Good	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements		
P3	**3. Cleaning Schedules** Are Cleaning Schedules publicly available?	3. Requires minimal improvement	2. Good	1. Reviews of policy stating where schedules are available compared with actual checking of availability.		
P3	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
P4	**P4: with regard to ensuring that access and car parking arrangements meet the reasonable needs of patients, staff and visitors can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements		
P4	**1. PLACE Assessment** The organisation has completed the PLACE assessment relating to access and car parking for all relevant sites and published a local improvement plan.	Not applicable	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations	1.. NHS patient visitor and staff car parking principles 2022 2. Health Technical Memorandum 07-03 (2006): NHS car parking management 3. Car Parking Code of Practice 4. Healthcare Travel Cost Scheme https://www.gov.uk/government/publications/nhs-patient-visitor-and-staff-car-parking-principles https://www.england.nhs.uk/estates/health-technical-memoranda/Private Parking Code of Practice - GOV.UK (www.gov.uk) https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/	
P4	**2. Other Assessments** Is there a system/process, additional to PLACE assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	1. Outstanding	2. Good	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Meetings and dialogue with CQC identifying improvements		
P4	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Patient Experience Domain	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
P5	**P5: With regard to providing a high quality and supportive environment for patients, visitors and staff in relation to Grounds and Gardens can your organisation evidence the following?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with access and car parking. Safety SAQ SS7 covers car park management and access arrangements	1. The Occupiers Liability Act 1957 (amended 1984) 2. The Health and Safety at Work Act 1974 3. The Management of health and safety at Work Regulations 1999 4. Provision and Use of Work Equipment Regulations 1998 5. Control of Substances Hazardous to Health (COSHH) Regulations 2002 6. Personnel Protective Equipment at Work Regulations 1992 7. Management of Health and Safety at Work Regulation 1999 approved code of practice 8. Workplace, Health, Safety and Welfare Regulations 1992 approved code of practice and guidance 9. Work Equipment Provision and use of Work Equipment Regulations 1998 10. First Aid at Work, Health and Safety Regulations 1981 11. Hand-Arm Vibration 12. Corporate Manslaughter and Corporate Homicide Act 2007 13. RIDDOR 2013 RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 14. Working at Height Regulations 2005 15. BS ISO 15799:2003 Soil quality - guidance on eco-toxicological characterization ofsoils and soil materials 16. BS 3882:1994 Specification for topsoil 17. BS 6031:1981 Code of practice for earthworks 18. BS 7562-4:1992 Planning, design and installation of irrigation schemes guide to water resources 19. BS 4428:1989 guide of practice for general landscape operations (excluding hard surfaces) AMD 6784 20. BS 3882:1994 specification for topsoil and AMD 9938 21. BS 3936-1:1992 Nursery stock specification for trees and shrubs 22. BS 3936-5:1985 nursery stock specification for poplars and willows 23. BS 3936-10:1990 nursery stock specification for ground cover plants 24.BS 7370-3:1991 grounds maintenance recommendations for maintenance • 25. BS 3998:1989 recommendations for tree work and AMD 6549 Horticulture 26. BS EN 12579:2000 Soil improvers and growing media - sampling 27. BS EN 13037:2000 Soil improvers and growing media - determination of pH Turf 28. BS 3969:1998 Recommendations for turf for general purposes 39. BS 4428:1989 Code of practice for general landscape operations14 (excluding hard surfaces). 30. Horticultural Trades Association guidelines on plant handling and establishment 31. BS 1129 Specification for portable timber ladders, steps, trestles and lightweight stagings British Standards Institution •BS 2037 Specification for portable aluminium ladders, steps, trestles and lightweight stagings British Standards Institution 32. BS EN 131 Ladders (Specification for terms, types, functional sizes; Specification for requirements, testing, marking; User instructions; Single or multiple hinge-joint ladders) British Standards Institute https://www.legislation.gov.uk/ukpga/1984/3 https://www.legislation.gov.uk/ukpga/1974/37/contents https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/2002/2677/regulation/7/made https://www.legislation.gov.uk/uksi/1992/2966/contents/made https://www.legislation.gov.uk/uksi/1999/3242/contents/made https://www.legislation.gov.uk/uksi/1992/3004/contents/made https://www.legislation.gov.uk/uksi/1998/2306/contents/made https://www.legislation.gov.uk/uksi/1981/917/regulation/3/made https://www.hse.gov.uk/vibration/hav/ https://www.legislation.gov.uk/ukpga/2007/19/contents https://www.hse.gov.uk/riddor/ https://www.legislation.gov.uk/uksi/2005/735/contents/made https://www.iso.org/standard/29085.html https://shop.bsigroup.com/ProductDetail?pid=000000000001382025#:~:text=BS%203882%3A1994%20specifies%20requirements,in%20situ%20topsoil%20or%20subsoil. https://shop.bsigroup.com/ProductDetail?pid=00000000000078031 https://shop.bsigroup.com/ProductDetail?pid=00000000000285806 https://shop.bsigroup.com/ProductDetail?pid=00000000000198326 https://shop.bsigroup.com/ProductDetail?pid=00000000001382025 https://shop.bsigroup.com/ProductDetail?pid=00000000000262241 https://shop.bsigroup.com/ProductDetail?pid=00000000000151386 https://shop.bsigroup.com/ProductDetail?pid=00000000000209042 https://shop.bsigroup.com/ProductDetail?pid=00000000000238150 https://shop.bsigroup.com/ProductDetail?pid=00000000000194564 https://shop.bsigroup.com/ProductDetail?pid=00000000030006469 https://standardsdevelopment.bsigroup.com/projects/1992-06005#/section https://shop.bsigroup.com/ProductDetail?pid=00000000030260283 https://shop.bsigroup.com/ProductDetail?pid=00000000000198326 https://hta.org.uk/ https://shop.bsigroup.com/ProductDetail?pid=00000000001635045 https://landingpage.bsigroup.com/LandingPage/Series?UPI=BS%20EN%20131	
P5	**1. PLACE Assessment** The organisation has completed the PLACE External areas assessment relating to Grounds and Gardens for all relevant sites and published a local improvement plan.	Not applicable	Not applicable	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Engagement process and methodology 4. PLACE training and trust results 5. Internal structure to consider and action feedback 6. Engagement feedback influencing services developments and improvements 7. Adherence to confidentiality policy 8. Feedback to stakeholders and patients 9. Complaints Procedure 10. Diversity considerations 11. The local improvement plan is included within the Green Plan.		
P5	**2. Other Assessments** Is there a system/process, additional to PLACE External areas assessments, to measure patients and visitors satisfaction of the service provided and is action taken on the results?	3. Requires minimal improvement	3. Requires minimal improvement	1. Surveys and questionnaires 2. Focus Groups 3. Benchmarking, KPIs and peer comparison process 4. Patient, visitor and staff charter 5. Monthly reporting of breaches of mixed-sex accommodation guidance 6. Meetings and dialogue with CQC identifying improvements		
P5	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
P5	Capital cost to achieve compliance	£0	£0			
P5	Revenue consequences of achieving compliance	£0	£0			
P6	**P6: How does your organisation/site ensure that NHS catering standards are provided effectively and efficiently?**	Applicable	Applicable	P1 covers the organisations processes whilst this SAQ identifies any specific feedback issues with Catering Services and also complying with Regulation 14. Safety aspects of food and catering are dealt with in the safety domain.		
P6	**1. Policy & Procedures** Does the organisation have in place a policy for healthcare catering which is aligned to current National Standards for Healthcare Catering which has been reviewed via an MDT process within the last 3 years?	3. Requires minimal improvement	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Internal structure to consider and action feedback 4. Adherence to confidentiality policy 5. Feedback to stakeholders and patients 6. Complaints Procedure 7. Benchmarking, KPIs and peer comparison process 8. Meetings and dialogue with CQC identifying improvements 9. Public/patient information e.g. handbooks, pre visit information	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 2. CQC Guidance for providers on meeting the regulations 3. National Specifications for healthcare cleanliness 2007 4. PAS:5748 5. NHS Estates (2000) Reducing food Waste in the NHS Department of Health. Better Hospital Food 6. Hospital Catering Association – Protected Mealtimes 7. Council of Europe Resolution food and nutritional Care in hospitals NHS England – 10 Key Characteristics of Good Nutritional Care in Hospitals 2006 8. Food Service at Ward Level with Healthcare food and Beverage Service Standards – a guide to ward level services – 2009 9. Water for Health – Hydration Best Practice Toolkit for Hospitals and Healthcare 10. NHS Executive 'Hospital catering delivering a quality service.' 11. NHS Code of Practice for the manufacture, distribution and supply of food, ingredients and food related	

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◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
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P6	**2. Regulation** Does the organisation have a food and drink strategy as defined in the NHS Standard Contract	3. Requires minimal improvement	2. Good	1. Review of relevant Policies and Procedures. 2. Nutritional screening programme identifying patient at risk from malnutrition and dehydration	products. 12. Improving Nutritional Care – a joint action plan from the department of health and nutrition summit stakeholders 13. HCA Ward Service guide 14. British Dialectic Association Improving Outcomes through Food and Beverage Services Nutritional & Hydration digest "15. Sustainable procurement: the GBS for food and catering services Official Government Buying Standards (GBS) for food and catering services" 16. NHS Standards Contract 17.The NHS Hospital Food Review 2020 18. British Association for Parenteral and Enteral Nutrition - Malnutrition Screening Tool 19. Public Health England - Healthier and More Sustainable Catering Nutrition Principles 20. A Toolkit to Support the Development of a Hospital Food and Drink Strategy 21. CQC Provider Handbooks https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/news/hospital-cleaning-revised-specification-published https://www.bsigroup.com/en-GB/about-bsi/media-centre/press-releases/2014/december/Standard-for-providing-a-clean-and-safe-hospital-environment-is-revised/ Reducing waste in the NHS: an overview of the literature and challenges for the nursing profession - PubMed (nih.gov) http://www.hospitalcaterers.org/publications/ https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/ http://www.hospitalcaterers.org/publications/ https://www.choiceforum.org/docs/dohplan.pdf http://www.hospitalcaterers.org/publications/ https://www.bda.uk.com/uploads/assets/c24296fe-8b4d-4626-aeebb6cf2d92fccb/NutritionHydrationDigest.pdf https://www.gov.uk/government/publications/sustainable-procurement-the-gbs-for-food-and-catering-services https://www.england.nhs.uk/nhs-standard-contract/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/929234/independent-review-of-nhs-hospital-food-report.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523049/Hospital_Food_Panel_May_2016.pdf https://www.malnutritionselfscreening.org/self-screening.html https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499745/Toolkit_Feb_16.pdf https://www.cqc.org.uk/sites/default/files/20150325_asc_residential_services_provider_handbook_march_15_update_01.pdf	
P6	**3. Choice** The organisation provides a choice of nutritious and appetising food and hydration, in sufficient quantities to meet patients needs	3. Requires minimal improvement	2. Good	1. Review of relevant Policies and Procedures.		
P6	**4. Equality issues** Food and hydration meets any reasonable requirements arising from Equality issues e.g. from a patients religious or cultural background	2. Good	2. Good	1. Diversity considerations as set out in Policies and Procedures.		
P6	**5. Information** Patients have accessible information about meals and the arrangements for mealtimes, access to snacks and drinks throughout the day and night and to have mealtimes that are reasonably spaced and at appropriate times.	2. Good	2. Good	1. Patient, visitor and staff charter		
P6	**6. Patient Led Assessment of the Care Environment (PLACE) Assessment** The organisation has completed the PLACE assessment relating to catering services for all relevant sites and published a local improvement plan.	2. Good	2. Good	1. Completed PLACE assessments reviewed and actioned; 2. PLACE training records		
P6	**7. Other Assessments** Is there a system/process in place, additional to PLACE assessments, to measure patients satisfaction with the service provided and is action taken on the results?	2. Good	2. Good	1. Engagement process and methodology 2. Surveys and questionnaires 3. Focus Groups 4. Engagement feedback influencing services developments and improvements		
P6	**8. Legal Standards** Has the organisation complied with the estates related legally binding standards as detailed in the NHS Standard Contract	Not applicable	Not applicable	1. Review of policies and procedures to ensures compliance.		
P6	**9: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
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Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F1	**F1: With regard to having a well-managed approach to performance management of the estate and facilities operations can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 2	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 3. Developing an Estate Strategy 4. Estates Return Information Collection 5. Patient Lead Assessments of the Care Environment (PLACE) 6. In patient Survey 7. NHS Premises Assurance Model Metrics Dashboard - RICS Real Estate 8. ISO 55000/01/02 Asset Management 2004 ISO 55000:2014 Asset management — Overview, principles and terminology" Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/patient-led-assessments-care-environment-place/ https://nhssurveys.org/surveys/survey/02-adults-inpatients/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.iso.org/standard/55088.html	
F1	**1: Analysing Performance** A process in place to analyse estates and facilities services and costs and if these continue to meet clinical and organisational needs?	2. Good	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F1	**2: Benchmarking** A process in place to regularly benchmark estates and facilities costs?	2. Good	2. Good	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position 2. Benchmarking including the use of metrics and KPIs from suitable sources including: - Estates Return Information Collection (ERIC) - Contract/Service Level agreement KPIs - Estate Strategy KPIs - Energy and sustainability targets - Cost Improvement Plan targets - NHS Model Hospital		
F1	**3: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F2	**F2: With regard to having a well-managed approach to improved efficiency in running estates and facilities services can the organisation evidence the following and is this in line with the ICS infrastructure strategy?**	Applicable	Applicable	HBN 00-08 Part A Section 3	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 - The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Premises Assurance Model Metrics 6. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.england.nhs.uk/estates/health-building-notes/ https://www.gov.uk/government/publications/developing-an-estate-strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://improvement.nhs.uk/resources/model-hospital/ https://www.iso.org/standard/55088.html	
F2	**1: Business Planning** An effective and efficient estate and facilities business planning process in place?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Business plans.		
F2	**2: Estate Optimisation** An effective and efficient process in place to ensure estate optimisation and space utilisation?	2. Good	4. Requires moderate improvement	1. Space utilisation studies and monitoring of usage. 2. Response to NHS Long Term Plan of reduction to 30% non clinical space.		
F2	**3: Commercial Opportunities** An effective and efficient process in place to identify and maximise benefits from commercial opportunities from land and property that support the main business of the NHS ?	2. Good	2. Good	1. Market testing and cost benchmarking of contracts. 2. Land and property sale receipts. 3. Commercial Strategy or agreements such as letting of space for retail use.		
F2	**4: Partnership working** An effective and efficient process in place to investigate and implement improvements through partnership working?	2. Good	2. Good	1. Partnership Working, i.e. One Public Estate		
F2	**5: New Technology** An effective and efficient process in place to maximise the benefits from new technologies?	3. Requires minimal improvement	4. Requires moderate improvement	1. New Technology and Innovation - examples of product design or system implementation 2. IT strategy.		
F2	**6: PFI and LIFT contracts** An effective and efficient process in place to achieve value for money from existing PFI and LIFT contracts?	Not applicable	Not applicable	1. Date and outcome of PFI/PPP reviews and next steps.		
F2	**7: Other contracts** An effective and efficient process in place to achieve value for money from existing other contracts?	2. Good	3. Requires minimal improvement	1. Market testing and cost benchmarking of contracts.		
F2	**8. Property** An effective and efficient process in place to record and managing property interest and leases held	2. Good	2. Good	1. Asset/Estate Terrier		

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F2	**9. Cost Improvement plans** A robust methodology for identifying the delivery and implications of cost improvement plans	4. Requires moderate improvement	2. Good	1. Regular and accurate submission of CIPs 2. Monitoring of progress of delivery		
F2	**10. Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F3	**F3: With regard to improved efficiencies in capital procurement, refurbishments and land management can the organisation evidence the following?**	Applicable	Applicable	HBN 00-08 Part A Section 4.0		
F3	**1. Capital Procurement** Capital procurement and refurbishment projects progressed in line with local standing orders and financial instructions and relevant procurement guidance, HM Treasury and DHSC and NHSE guidance.	1. Outstanding	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
F3	**2. Capital project management** Processes and procedures that ensure there are robust processes for the management of projects during construction including change control and lessons learnt/benefits realisation once projects are completed.	Not applicable	4. Requires moderate improvement	1. Project governance documentation in line with capital management 2. Track how many projects are delivered on time or late and track that these were delivered within budget 3. Lessons learnt/benefits realisation and evidence of applying learning to subsequent projects		
F3	**3.. Capital Procurement Efficiencies** Capital procurement and refurbishment projects that actively seek efficiency such as through cost benchmarking, Building Information Modelling and repeatable designs?	3. Requires minimal improvement	3. Requires minimal improvement	1. Ongoing review of costs on a consistent basis that measures progress against established baseline position	1. Health Building Note 00-08, The efficient management of healthcare estates and facilities Health Building Note 00-08 Part B: Supplementary information for Part A 2. NHS Model Health System 3. Estates Return Information Collection (ERIC) 4. Building Cost information Service 5. Government Construction Strategy 6. ProCure22/ProCure23 guidance 7. Naylor Review: 8. Lord Carter Review: 9. NHS Long Term Plan: 10. NHS Net Zero Building Standard 11. Estates Net Zero Carbon Delivery Plan (NZCDP)	
F3	**4. Flexibility** Capital procurement and refurbishment projects that actively seek flexible designs to accommodate changes in services?	2. Good	2. Good	1. Consideration of innovative design and building options e.g. "New for Old".		
F3	**5. Identification and disposal of surplus land** An effective and efficient process for the identification and disposal of surplus land?	2. Good	2. Good	1. Benchmarking including the use of metrics and KPIs from suitable sources 2. Surplus land identified in Annual Surplus Land Return, STP/ICS Estate Strategy, and EPIMS and shared through One Public Estate.	1. https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 2. https://model.nhs.uk/ 3. https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection 4. https://www.rics.org/uk/products/data-products/bcis-construction/ 5. https://www.gov.uk/government/publications/government-construction-strategy 6. https://procure22.nhs.uk/ and https://procure22.nhs.uk/p23/ 7. https://www.gov.uk/government/publications/naylor-review-government-response#:~:text=The%20Naylor%20review%20was%20a,response%20capitalises%20on%20those%20opportunities. 8. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals 9. https://www.longtermplan.nhs.uk/ 10. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/ 11. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117	
F3	**6.Net Zero Carbon** Do the Capital Procurement Capital procurement and refurbishment projects include plans to meet national NHS net zero carbon targets?	3. Requires minimal improvement	3. Requires minimal improvement	1. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance) 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects.		
F3	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			

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	Revenue consequences of achieving compliance	£0	£0			
F4	**F4: With regard to having well-managed and robust financial controls, procedures and reporting relating to estates and facilities services can the organisation evidence the following?**	Applicable	Applicable			
F4	**1: Policy & Procedures** Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. NHS Standing Financial Instructions -These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by us. 3. Audit Commission Report 2004 - Achieving first-class financial management in the NHS 4. The Public Contracts Regulations 2015 5. The Bribery Act 2010 - Guidance (publishing.service.gov.uk) 6. Leading the fight against NHS Fraud, organisational strategy 2017-2020 -Standards for NHS Providers 2020-21 Fraud, bribery and corruption January 2020 7. HFMA Finance training modules https://www.england.nhs.uk/estates/health-building-notes/https://www.england.nhs.uk/publication/standing-financial-instructions/ http://www.wales.nhs.uk/documents/FinanceinNHS_Report.pdf https://www.legislation.gov.uk/uksi/2015/102/contents/made https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832011/bribery-act-2010-guidance.pdf https://cfa.nhs.uk/resources/downloads/standards/NHS_Fraud_Standards_for_Providers_2020_v1.3.pdf https://www.hfma.org.uk/online-learning/bitesize-courses/detail/nhs-finance	
F4	**2: Review Process** Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	2. Good	2. Good	1. Internal Audits 2. Financial controls and scheme of delegation 3. Business Case procedure and Capital regime		
F4	**3. Board reporting and contracting** Is there comprehensive and regular reporting relating to estates and facilities services to the trust board highlighting performance, risks and issues. Are contracts in place for all estates and facilities services, documenting requirements with appropriate ability to terminate or manage poor performance and defined change control arrangements.		2. Good	1. Board reports 2. Do you have robust change control and review of costs 3. Contracts in place for all services with appropriate provisions for cost control and service incentivisation		
F4	**4: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
F5	**F5: With regard to ensuring Estates and Facilities services are continuously improved and sustainability ensured can the organisation evidence the following?**	Applicable	Applicable	SAQ taken from CQC KLOE W5. Prompt 6 can be cross referred to SAQ F1 and Patient Experience SAQs		
F5	**1. Quality and Sustainability** When considering developments to estates and facilities services or efficiency changes (including derogations from standards and guidance), is the impact on quality and sustainability and net zero carbon targets assessed, understood and monitored, before, during and after the development?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Action from surveys and feedback. 4. Backlog Risk Assessment, impact assessment and mitigation and action plan.	1. CQC Guidance For Providers KLOE 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Developing an Estate Strategy 4. Estates Return Information Collection (ERIC) 5. NHS Model Health System 6. Department of Health Built Environment Key Performance Indicators (KPIs) 7. ISO 55000/01/02 Asset Management 2004 Assessment framework for healthcare services showing changes from 2015 (cqc.org.uk) https://www.gov.uk/government/publications/the-efficient-management-of-healthcare-estates-and-facilities-health-building-note-00-08 https://www.gov.uk/government/publications/developing-an-estate-strategy	
F5	**2. Financial Pressure** Are there examples of where financial pressures have negatively affected estates and facilities services?	3. Requires minimal improvement	3. Requires minimal improvement	1. Estates Incidents impacting on clinical care- ERIC returns, & feedback to EFM Division to NHS England and NHS Improvement.		
F5	**3. Continuous Improvement** Do leaders and staff strive for continuous learning, improvement and innovation?	2. Good	3. Requires minimal improvement	1. Risk Assessments and Registers 2. Derogations documented with clinical impact assessment and clinical sign-off. 3. Training and Development plans and records.		
F5	**4. Quality Improvements** Are staff focused on continually improving the quality of estates and facilities services?	2. Good	3. Requires minimal improvement	1. Regular assessments of quality outputs e.g. PLACE scores; 2. Inclusion of quality assessments in Costed Action Plans.		

NHS Premises Assurance Model: Efficiency Domain	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
F5	**5. Recognition** Are improvements to quality and innovation recognised and rewarded?	2. Good	2. Good	1. Staff suggestion scheme. 2. Staff awards and recognition.	https://www.gov.uk/government/publications/developing-an-estate strategy https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection https://model.nhs.uk/ https://improvement.nhs.uk/resources/model-hospital/ https://www.gov.uk/government/statistics/key-performance-indicators https://www.iso.org/standard/55088.html	
F5	**6. Use of Information** Is information used proactively to improve estates and facilities services?	2. Good	3. Requires minimal improvement	1. Use of design evaluation tools.		
F5	**7: Costed Action Plans** If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? **Costs can be entered below.**	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E1	**E1: With regard to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this inline with the ICS infrastructure strategy?**	Applicable	Applicable	SAQ is taken from CQC KLOE W1 and covers the estates and other related strategies as described in HBN 00-08 Part B section 2. Prompt 3 can be linked to SAQ PE1. Operational management is covered in SAQ S01		
E1	**1. Vision and Values** A clear vision and a set of values, with quality and safety the top priority?	2. Good	2. Good	1. Estates Strategy and related documents;	1. Developing an Estate Strategy document 2. Health Building Note 00-08 The efficient management of healthcare estates and facilities 3. Health building Note 00-08The efficient management of healthcare estates and facilities (part A): Land and Property Appraisal 4. Strategic Health Asset Planning & Evaluation (SHAPE) tool 5. RICS UK Commercial Real Estate Agency Standards. 6. RICS Guidance Notes- Real Estate disposal and acquisition. 7. Assets in Action 8. Healthcare providers: asset register and disposal of asset 9. Strategy development: a toolkit for NHS providers 10. Developing strategy What every trust board member should know 11. Energy guidance section (how to produce an SDMP) to the current guidance for green plans: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf https://www.gov.uk/government/publications/developing-an-estate-strategy https://www.england.nhs.uk/estates/health-building-notes/ https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards	
E1	**2. Strategy** A robust, realistic strategy for achieving the priorities and delivering good quality estates and facilities services?	2. Good	3. Requires minimal improvement	1. Documentary evidence relevant to the prompt questions e.g. document articulating the vision such as mission statement		
E1	**3. Development** The vision, values and strategy has been developed with staff and other stakeholders?	1. Outstanding	2. Good	1. Regular discussions/meetings/exchanges with interested parties; 2. Integration of these discussions into Strategies and Visions/Values;		
E1	**4. Vision and Values Understood** Staff know and understand what the vision and values are?	2. Good	2. Good	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;		
E1	**5. Strategy Understood** Staff know and understand the strategy and their role in achieving it?	2. Good	3. Requires minimal improvement	1. Feedback from staff to quantify their understanding of visions, values and strategy e.g. staff survey results;		
E1	**6. Progress** Progress against delivering the strategy is monitored and reviewed?	2. Good	2. Good	2. Staff, Patient and stakeholder engagement and feedback 2. Analysis of relevant complaints;		
E1	**7: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E2	**E2: With regard to having a well-managed approach to town planning can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 3.0.		
E2	**1. Local Planning** An effective and efficient process to participate in Local Planning matters?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
E2	**2. Neighbourhood Planning** An effective and efficient process to participate in Neighbourhood planning matter?	2. Good	2. Good	1. Involvement in town planning issues		
E2	**3. Planning Control** An effective and efficient process to participate in planning control process?	2. Good	2. Good	3. Involvement in town planning issues		
E2	**4. Special Interests** **A**n effective and efficient process to manage special interests (e.g. conservation areas, listed buildings etc.) ?	1. Outstanding	2. Good	1. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 2. Preventing third parties gaining inappropriate rights over land and property 3. Management of easement agreements 4. Management of tenancy and other contractual arrangements 5. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented	1. Health Building Note 00-08: The efficient management of healthcare estates and facilities 2. Health building Note 00-08:The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. Health Technical Memorandum 05 Fire code 4. Estates Net Zero Carbon Delivery Plan 5.Health Technical Memorandum 07-02 6. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/estates/health-building-notes https://www.england.nhs.uk/estates/health-building-notes/ https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/	
E2	**5. Enforcement** **A**n effective and efficient process to deal with any enforcement procedures served on the organisation?	1. Outstanding	2. Good	1. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green		
E2	**6: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E3	**E3: with regard to having a well-managed robust approach to management of land and property can the organisation evidence the following?**	Applicable	Applicable	SAQ measures compliance with HBN 00-08 Part B Section 4.0 to 8.0		

NHS Premises Assurance Model: Effectiveness Domain	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E3	**1: Disposal of land and property** An effective and efficient process for the disposal of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Demonstration of re-investment of income. 8. Maintenance of an up-to-date and accurate property asset register 9. All statutory obligations to be identified and met 10. Preventing third parties gaining inappropriate rights over land and property 11. Management of easement agreements 12. Appropriate action when land and/or property is subject to compulsory purchase powers or potential or actual applications for registering as a town or village green 13. Where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented 14. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings	1. Health Building Note 00-08 - The efficient management of healthcare estates and facilities 2. Health Building Note 00-08: The efficient management of healthcare estates and facilities - Part A Land and Property Appraisal 3. RICS UK Commercial Real Estate Agency Standards. 4. RICS Guidance Notes- Real Estate disposal and acquisition. 5. Assets in Action 6. Real estate management - 3rd edition, October 2016" 7. Healthcare providers: asset register and disposal of asset 8. Estates Net Zero Carbon Delivery Plan https://www.england.nhs.uk/estates/health-technical-memoranda/ https://www.england.nhs.uk/estates/health-building-notes/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency-1st-edition-rics.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/144216/Assets_in_Action.pdf https://shapeatlas.net/ https://www.rics.org/uk/upholding-professional-standards/sector-standards/real-estate/uk-commercial-real-estate-agency/ https://www.rics.org/globalassets/rics-website/media/upholding-professional-standards/sector-standards/real-estate/real-estate-management-3rd-edition-rics.pdf https://www.gov.uk/government/publications/healthcare-providers-asset-register-and-disposal-of-assets	
E3	**2: Granting of Leases** An effective and efficient process for the granting of leases?	2. Good	2. Good	1. Management of leases, tenancy and other contractual arrangements		
E3	**3: Acquisition of land and property** An effective and efficient process for the acquisition of freehold/leasehold land and property?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3 Evidence of a short and long term estate strategy supporting clinical, financial and investment objectives. 4. Evidence of optimising utilisation of accommodation across the estate, the Sustainability and Transformation Partnership and Integrated Care Organisation footprint and with One Public Estate partners. 5. Evidence of masterplans for large sites which identify areas for retention, development and disposal 6. Involvement of District Valuer 7. Maintenance of an up-to-date and accurate property asset register 8. All statutory obligations to be identified and met 9. Preventing third parties retaining inappropriate rights over land and property 10. Management of easement agreements 11. The identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings 12. Consideration of mandatory energy efficiency ratings.	
E3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
E4	**E4: With regard to having a suitable Sustainability approach in place and being actioned.**	Applicable	Applicable			
E4	**1: Green Plan / Sustainability Strategy** Has your Green Plan been approved by Board and submitted to the ICS / ICB	1. Outstanding	2. Good	1. The Green Plan / Sustainability Strategies published on the Trust's website and has been updated within the last 3 years 2. The organisation tracks its progress using the Green Plan Support Tool 3. The Green Plan / Sustainability Strategy names an executive lead for sustainability 4. The Green Plan / Sustainability Strategy states progress against carbon emission reduction targets in line with the 'Delivering a net zero NHS report' 5. Alignment with STP/ICS estates strategy; 6. Green Plan is published on the Trust's website & has been updated within the last 3 years 7. Green plan states progress against carbon emission reduction targets in line with national NHS net zero targets.	1. How to produce a Green Plan 2. Green Plan Support Tool 3. Delivering a net zero NHS report 4. Estates Net Zero Carbon Delivery Plan 5. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 1. https://improvement.nhs.uk/resources/how-produce-sustainable-development-management-plan-sdmp/ 2. https://future.nhs.uk/sustainabilitynetwork/view?objectID=40820880 3. https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/ 4. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117	

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E4	**2: Energy** Is your energy usage, including heat, managed to fully deliver sustainability and effectiveness, and includes plans to meet national NHS net zero carbon targets?	4. Requires moderate improvement	2. Good	1. The organisation has evidence of TM44 Air Conditioning System Assessments 2. Organisations which qualify for the EU Emissions Trading Scheme (EUETS) have an EUETS assessor and can demonstrate relevant annual reporting systems 3. Organisations with Combined (Cooling) Heat and Power Plant (CHP/CCHP) have a CHP Quality Assurance (CHPQA) Certificate for Climate Change Levy (CCL) exemption for each unit installed 4. The organisation has a current energy efficiency policy 6. Evidence that utility bills are checked and validated before payment 7. The organisation has rolled out smart metering across the estate, or has a programme to roll out within the next 3 years 9. Monthly meter readings are taken and recorded, and automated readings validated physically 10. The organisation employs a dedicated (spends > 50% of their time working on energy management activities) energy manager / responsible person for energy 11. The Organisation is compliant to HTM 07-02; Making Energy work in Healthcare 12. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex. 13. Site Level Heat decarbonisation plans (targets in Delivering a Net Zero NHS report and heat decarbonisation requirement within Green Plan Guidance)	1. CIBSE TM44 : Inspection of Air Conditioning Systems 2. EU Emissions Trading System 3. Combined Heat and Power Quality Assurance Programme 4. Making energy work in healthcare (Health Technical Memorandum 07-02) 5. ISO 50001 Energy Management 6. Estates Net Zero Carbon Delivery Plan (NZCDP) 7. NZCDP Technical annex 1. https://www.cibse.org/AirConditioning_1 2. https://ec.europa.eu/clima/policies/ets_en 3. https://www.gov.uk/guidance/chpqa-guidance-notes 4. https://www.england.nhs.uk/estates/health-technical-memoranda/ 5. https://www.iso.org/iso-50001-energy-management.html 6. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 7. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557#	
E4	**3: Waste** Are effective systems in place to minimise waste production and effectively dispose of it?	3. Requires minimal improvement	2. Good	1.The organisation has a current waste management and minimisation policy 2.The organisation's Dangerous Goods Safety Advisor (DGSA) has reported within the last 12 months 3.The organisation can evidence completion of Pre-acceptance Audits? 4.The Trust can demonstrate processes to fulfil their Duty of Care for waste 5.The organisation holds regular contract review meetings 6.The organisation can evidence record receipt and review of monthly progress reports 7.The organisation holds regular operational meetings 8.The organisation conducts monthly independent audits of the service 9.The organisation maintains statutory waste records (disposal notes, destruction certificates) and compliance audits 10.The organisation can evidence staff waste 11.The organisation employs a dedicated (spends > 50% of their time working on waste management activities) waste manager / responsible person for waste 12.The organisation is compliant with HTM 07-01; Safe Management of Healthcare Waste 13. The organisation is compliant with the Clinical Waste Strategy 14. The organisation is compliant with the 20:20:60 split of Alternative Treatment, Incineration (clinical waste) and Offensive Waste volume	1. HTM 07-01; Safe Management of Healthcare Waste 2. NHS Clinical Waste Strategy 1. https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ 2. https://www.england.nhs.uk/publication/nhs-clinical-waste-strategy/	
E4	**4: Air Pollution** Does your Trust have policies and procedures in place to control air pollution and an overview of these procedures is included within the Green Plan?	3. Requires minimal improvement	3. Requires minimal improvement	1.The organisation has completed the Clean Air Hospitals Framework Tool 2.The organisation has a Clean Air policy including anti-idling 3.The organisation has an action plan for tackling air pollution from its buildings 4. The organisation has an action plan for tackling air pollution from its own vehicles and those that visit the organisation's site(s) 5.The organisation keeps an FGAS register 6.The organisation has a plan for migrating to Zero Emission Vehicles 7. The organisation has an action plan to meet air pollution targets in the Long Term Plan	1. Clean Air Hospital Framework 2. Fluorinated gas (F gas): guidance for users, producers and traders 3. NHS Long Term Plan https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/air-pollution/ https://www.globalactionplan.org.uk/clean-air-hospital-framework/ https://www.gov.uk/government/collections/fluorinated-gas-f-gas-guidance-for-users-producers-and-traders	
E4	**5.: Travel & Transport** Can the organisation evidence an effective and efficient process to ensure staff commuting, patient & visitor travel, and the organisation's own fleet are sustainable and meet the relevant guidance?	Not applicable	3. Requires minimal improvement	1. The organisation has a sustainable travel plan. 2. Zero emissions vehicles are integrated into procurement practices - in-line with Net Zero Travel & Transport strategy. 3. A staff travel survey is completed at least every 24 months. 4. The organisation has a parking policy covering staff, patient & visitor travel. 5. The organisation provides secure bike storage, changing facilities and good quality on and off-site walking and cycling routes. 6. The organisation considers sustainable transport, flexible working and route planning/optimisation in its business travel (or similar) policy. 7. The organisation reports to the Greener NHS Fleet Data Collection	1. Net Zero Travel & Transport Strategy https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/ 2. Health Technical Memorandum 07-03 NHS Car parking management, environment and sustainability 3. Delivering a Net Zero NHS https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/ https://energysavingtrust.org.uk/wp-content/uploads/2020/10/EST0018-001-EV-Guide-for-Fleet-Manager-WEB.pdf https://www.r-e-a.net/wp-content/uploads/2020/03/Updated-UK-EVSE-Procurement-Guide.pdf	
E4	**6.: Water** Are water services efficiently and effectively delivered?	3. Requires minimal improvement	Not applicable	1.The organisation has a water efficiency policy 2.Monthly meter readings are taken and recorded, and automated readings validated physically 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. NZCDP Technical annex 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=151919557	
E4	**7.: Climate Change Adaptation** Are risk assessments of the effects of climate change risk assessment and mitigation action implemented and include references to overheating, flooding and extreme weather events?	3. Requires minimal improvement	4. Requires moderate improvement	1.The organisation has a climate change adaptation risk assessment on the Trust risk register 2.The organisation reports on estate related events, such as extreme weather events including flooding, heatwave and cold winter events 3. The organisation has plans in place to implement the actions outlined in the Estates Net Zero Carbon Delivery Plan Technical Annex.	1. Estates Net Zero Carbon Delivery Plan (NZCDP) 2. HBN 00-07 Resilience planning for the healthcare estate 3. Flood Risk Toolkit 1. https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectId=155202117 2. https://www.england.nhs.uk/publication/resilience-planning-for-nhs-facilities-hbn-00-07/ 3. https://tabanalytics.data.england.nhs.uk/#/views/FloodRiskToolkit/TitlePage?=null&:iid=3	

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
E4	**8.: Procurement** Is all relevant procurement consistent with NHS England's net zero and sustainable procurement policies?	4. Requires moderate improvement	3. Requires minimal improvement	1.The organisation takes account of the NHS Net Zero Supplier Roadmap and reports against compliance with this through the quarterly Greener NHS data collection. 2.The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects.	1. NHS Net Zero Supplier Roadmap 2. Greener NHS quarterly data collection 3. Applying net zero and social value in the procurement of NHS goods and services (building on PPN06/20) 4. Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works (aligning to PPN06/21) 5. Evergreen Sustainable Supplier Assessment 6. NHS Net Zero Building Standard 1. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/ 2. https://future.nhs.uk/sustainabilitynetwork/view?objectID=40822960 3. https://www.england.nhs.uk/greenernhs/publication/applying-net-zero-and-social-value-in-the-procurement-of-nhs-goods-and-services/ 4. https://www.england.nhs.uk/long-read/carbon-reduction-plan-requirements-for-the-procurement-of-nhs-goods-services-and-works/ 5. https://www.england.nhs.uk/nhs-commercial/central-commercial-function-ccf/evergreen/ 6. https://www.england.nhs.uk/publication/nhs-net-zero-building-standard/	
E4	**9: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
E4	Capital cost to achieve compliance	£0	£0			
E4	Revenue consequences of achieving compliance	£0	£0			

NHS Premises Assurance Model: Governance Domain	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.
◄◄ Back to instructions	

Ref.	SAQ/Prompt Questions	2022-23	2023-24	Evidence (examples listed below)	Relevant guidance and legislation	Comments
	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	
G1	**G1. With regard to ensuring the Estates and Facilities governance framework has clear responsibilities and that quality, performance and risks are understood and managed, can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W2.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 2. NHS Constitution and Handbook to the NHS Constitution 3. NHS Long Term Plan 4. Quality Governance in the NHS 5. Gov.uk - Quality governance in the NHS - A guide for provider boards 6. Monitor Code of Governance for Foundation Trusts 7. NHS TDA Delivering High Quality Care 8. NHS Good Corporate Citizen 9. Monitor: Risk Assessment Framework for NHS Foundation Trusts 10. HSE five steps to risk assessment - INDG163 (rev 4) 06/11 11. Developing strategy What every trust board member should know 12. Modern Slavery Act 2015 13. Public Services (Social Value) Act 2012 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.longtermplan.nhs.uk/ https://www.gov.uk/government/publications/quality-governance-in-the-nhs-a-guide-for-provider-boards https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance Foreword: https://www.england.nhs.uk/wp-content/uploads/2013/10/keogh-qual-ltr.pdf https://healthbusinessuk.net/features/good-corporate-citizenship-nhs https://www.gov.uk/government/publications/risk-assessment-framework-raf https://www.hse.gov.uk/pubns/INDG163.pdf https://www.gov.uk/government/publications/strategy-development-a-guide-for-nhs-foundation-trust-boards https://www.legislation.gov.uk/ukpga/2015/30/contents/enacted https://www.legislation.gov.uk/ukpga/2012/3/enacted	
G1	**1. Framework** There is an effective governance framework to support the delivery of the Estates and Facilities strategy and good quality services?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G1	**2. Roles** Staff are clear about their roles and understand what they are accountable for?	2. Good	2. Good	1. Governance Structure 2. Annual Plan/Programme Board 3. Structure chart 4. Committee terms of reference and minutes		
G1	**3. Partners** Working arrangements with partners and third party providers, e.g. PFI, are effectively managed?	2. Good	2. Good	1. Local sustainability and transformation partnership plans		
G1	**4. Framework** The governance framework and management systems are regularly reviewed and improved?	2. Good	2. Good	1.Estate Strategy 2 Standing Orders		
G1	**5: Assurance** There are comprehensive assurance system and service performance measures, which are reported and monitored, and action taken to improve performance	2. Good	2. Good	1. Evidence of walkarounds 2. Signed-of processes and procedures documentation, including risk register. 3. Signed-off roles and responsibilities documentation.		
G1	**6. Monitoring** There are effective arrangements in place to ensure that the information used to monitor, report (including regional and national data collections) and manage quality and performance is accurate, valid, reliable, timely and relevant (including PFI and non PFI costs).	2. Good	2. Good	1. Audit reports, peer and external reviews.		
G1	**7. Audit** There is a systematic programme of internal audit, which is used to monitor quality and systems to identify where action should be taken?	2. Good	2. Good	1. Surveillance Programme 2. Audit Programme		
G1	**8. Mitigation** There are robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	2. Good	2. Good	1. Job descriptions and training records for risk management. 2. Corporate, current risk register in place, with an identifiable owner. 3. Signed-off risk management strategy by the Board		
G1	**9. Alignment** There is alignment between the recorded risks and what people say is 'on their worry list'?	2. Good	2. Good	4. Evidence risks are passed into corporate risk register and actions taken, do not simply disappear without action		
G1	**10: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
G2	**G2: With regard to ensuring the Estates and Facilities leadership and culture reflects the vision and values, encourages openness and transparency and promoting good quality estates and facilities services can the organisation evidence the following?**	Applicable	Applicable	SAQ is taken from CQC KLOE W3.	1. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: and CQC Guidance for providers on meeting the regulations 2. CQC Guidance for providers on meeting the regulations 3. CQC Regulation 20: Duty of candour (FS) 4. NHS Long Term Plan 5. Conduct for NHS Managers	
G2	**1. Effectiveness** Leaders have the skills, knowledge, experience and integrity that they need and have the capacity, capability, and experience to lead effectively – both when they are appointed and on an ongoing basis.	2. Good	3. Requires minimal improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies		
G2	**2. Challenges** Leaders understand the challenges to good quality estates and facilities services and can identify the actions needed to improve.	2. Good	2. Good	1. Local and national staff surveys and feedback		
G2	**3. Visibility** Leaders are visible and approachable.	2. Good	3. Requires minimal improvement	1. Organograms and structure charts		
G2	**4. Relationships** Leaders encourage appreciative, supportive relationships among staff.	2. Good	2. Good	1. Local and national staff surveys and feedback		
G2	**5. Respect** Staff feel respected and valued.	2. Good	3. Requires minimal improvement	1. Local and national staff surveys and feedback		
G2	**6. Behaviours** Action is taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority.	2. Good	3. Requires minimal improvement	1. Performance reviews 2. Local and national staff surveys and feedback		

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◄◄ Back to instructions	

Ref.	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence (examples listed below) Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	Relevant guidance and legislation The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.	Comments
G2	**7. Culture** Is the culture centred on the needs and experience of people who use services?	2. Good	2. Good	1. Local and national staff surveys and feedback 2.The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working	6. NHS Constitution and Handbook to the NHS Constitution 7. NHS complaints procedure in England SN / SP / 5401 24.01.14 "8. ISO 10002:2004 Quality management — Customer satisfaction — Guidelines for complaints handling in organizations" 9. NHS whistleblowing procedures in England SN06490 13.12.13 10. Public Interest Disclosure Act 1998 https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents https://www.cqc.org.uk/files/guidance-providers-meeting-regulations https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour https://www.longtermplan.nhs.uk/ https://www.nhsemployers.org/~/media/Employers/Documents/Recruit/Code_of_conduct_for_NHS_managers_2002.pdf https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england https://www.england.nhs.uk/contact-us/complaint/ https://www.iso.org/standard/35539.html https://www.england.nhs.uk/ourwork/whistleblowing/ https://www.gov.uk/government/publications/the-public-interest-disclosure-act	
G2	**8. Honesty** The culture encourages candour, openness and honesty.	2. Good	2. Good	1. Local and national staff surveys and feedback		
G2	**9. Safety & Wellbeing** There is a strong emphasis on promoting the safety, health and wellbeing of staff.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures; 3. Job specification and competencies		
G2	**10. Healthier workplace** Promoting a healthier NHS workplace through cutting access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff.	3. Requires minimal improvement	4. Requires moderate improvement	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G2	**11. Collaboration** Staff and teams work collaboratively, resolve conflict quickly and constructively and share responsibility to deliver good quality estates and facilities services.	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G2	**12: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
	Capital cost to achieve compliance	£0	£0			
	Revenue consequences of achieving compliance	£0	£0			
G3	**G3: With regard to ensuring that the Organisations Board has access to professional advice on all matters relating to Estates and Facilities services can the organisation evidence the following?**	Applicable	Applicable			
G3	**1. Professional advice** The organisation has adequately identified its requirements for Estates and Facilities related professional advice?	2. Good	2. Good	1. Policy and procedures relevant to E&F services relevant to the trust/site; 2. Regular assessment of policies and procedures;		
G3	**2. In-house advisors** Where Estates and Facilities related professional advice is provided in house mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate pre-employment checks?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors		
G3	**3. External advisors** Where Estates and Facilities related professional advice is provided externally mechanisms are in place to ensure the appointment of suitably qualified staff with the appropriate skills and knowledge?	2. Good	2. Good	1. Documented list of advisors 2. Transparent process to appoint suitable advisors 3. Suitable qualifications and experience of advisors		
G3	**4: Costed Action Plans** If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?	Not applicable	Not applicable	1. Action plans to identify Capital and Revenue investment should address areas of non compliance identified in the NHS PAM and other assessments; 2. Evidence of escalation to Trust Board and relevant committees; 3. Inclusion of investment to deliver Actions in future budgets as appropriate; 4. Assessment of effect of prior identified investment;		
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◄◄ Back to instructions	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

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	SAQs in green shaded cells can be rated N/A in which case prompt question scores are ignored.	Rate the prompt question by using the drop down menus in the columns below		Evidence in operational systems should demonstrate the approach (procedures etc.) is understood, operationally applied, adequately recorded, reported on, audited and reviewed.	The evidence should demonstrate compliance with the requirements in relevant legislation and guidance.
H1	**H1. Confirmation of Safe Helipad Operations and Evidencing Planning and Implementation Practices: Can the organisation confirm they have processes in place to safely maintain the operation of their helipad?** **The Trust must demonstrate that it has established processes to ensure the safe and efficient operation of its helipad.** **This includes evidencing the planning and implementation of the helipad, with clearly defined responsibilities about quality, performance, and risk management.** **The organisation should also be able to evidence the planning and implementation of a helipad with clear responsibilities for quality, performance and risks, can the organisation evidence the following?**	Not applicable	Not applicable	**•Documented Safety Protocols and Procedures** These documents should detail safety protocols for helipad operations, including emergency procedures, maintenance schedules, and guidelines for safe landings and take-offs. **•Maintenance Records** Regular helipad maintenance is essential. Logs and records must show consistent inspections and upkeep to required standards. **•Training Records of Personnel** Ensure all helipad personnel, ground staff, and emergency teams, are trained and qualified. Training records must confirm staff adherence to current safety practices and procedures. **•Risk Assessment Documentation** Evidence must show regular risk assessments for helipad operations, identifying and mitigating potential hazards. **•Quality and Performance Monitoring Records** Documentation should demonstrate the monitoring and evaluation of helipad operations, including incident logs, response times, and corrective actions taken. **•Certifications and Compliance Reports** Any relevant certifications or compliance reports that show the helipad meets national and international safety standards. **•Operational Guidelines and Manuals** Comprehensive operational manuals outlining procedures and responsibilities for safe helipad operation. **•Emergency Response Plans** Documentation of emergency response plans, including coordination with local emergency services and contingency plans for various emergency scenarios. **•Feedback and Incident Reports** Records of user feedback and incident reports for the helipad, including follow-up actions taken. **• hsurance and Liability Documents** Proof of appropriate insurance coverage and liability protections related to helipad operations. **CAA training should be undertaken Hospital Helipad – Aviation Awareness | Training Course by the UK CAA (caainternational.com)**	
H1	1. Compliance Assessment and Policy Review: Adherence to CAP1264 and Downwash Helipad Considerations in the Trust: Policy, Procedures and Compliance: Is the organisation compliant and does the organisation have a current, approved policy and an underpinning set of procedures that comply with CAP1264? The Trust should have a responsible person able to demonstrate and a documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.	Not applicable	Not applicable	CAP1264 Compliance and Operations: The Trust must have documentation proving its helipad design and operations comply with CAP1264 standards. This includes assessing the helipad's layout, safety features, and protocols. Approved Helipad Policy: A regularly reviewed helipad policy, in line with CAP1264 guidelines, should be established. It should encompass emergency procedures, maintenance, and staff training. Documented Evidence/Policy for Downwash Considerations: Downwash Factors Records and analyses are needed to manage helicopter downwash, a key safety concern in helipad design and operations, in accordance with CAP1264. Responsibility and Documentation Appoint a responsible person or team knowledgeable in CAP1264 to oversee helipad operations. Their role includes managing documentation related to downwash, including risk assessments, mitigation strategies, and staff training. Regular Audits and Reviews Conduct frequent audits to ensure the Trust's helipad policies and procedures remain compliant with CAP1264. These should review downwash management and adapt to changes in helicopter technology or operational practices.	
H1	2. Roles and Responsibilities Ensuring Qualified Personnel and Clear Governance Does the Organisation have appropriately qualified, trained, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood? When developing the policy and procedures have you consulted with internal and external stakeholders? The Trust should have a responsible person and a documented evidence/policy in relation to general helipad factors and considerations within the Trust.	Not applicable	Not applicable	Governance Structure Documentation This should outline the overarching framework within which helipad operations are conducted. It includes details on decision making processes, accountability and how different roles within the organisation contribute to helipad management. Organisational Structure Chart This chart should visually represent the hierarchy and reporting lines relevant to helipad operations. It clarifies who is responsible for what, ensuring that roles and responsibilities are clearly defined and understood. Post Profiles and Training Records Detailed job descriptions for each role involved in helipad operations, along with records of individual training, are crucial. These profiles should include specific qualifications, competencies, and experience required for each position. Training records prove that staff members have been adequately trained for their roles. Evidence of Training and Development Documentation should be provided to show that all staff involved in helipad operations have received proper training. This includes training that meets safety, technical, and quality requirements. Evidence may include certificates, course completion records, and ongoing professional development logs. Specific Training Certifications For instance, the CAA training for Hospital Helipad - Aviation Awareness. This specialised training, offered by the UK Civil Aviation Authority (CAA), ensures that staff is aware of aviation-specific considerations and safety practices related to helipad operations. To ensure comprehensive compliance, the Trust should have a designated responsible person who can present and manage these documents. This individual should be well-versed in the operational aspects of the helipad and the regulatory environment. They should also be capable of liaising with both internal and external stakeholders to ensure that all policies and procedures are up-to-date, effective, and widely understood. Regular consultations with stakeholders, including emergency services, aviation experts, and hospital staff, are vital for maintaining a safe and efficient helipad operation.	

H1	3. Risk Assessment and Mitigation Strategies for Helipad and Estates In relation to this, has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?	Not applicable	Not applicable	Documented Risk Assessment Report This should include a comprehensive risk assessment of the helipad and surrounding estate. The report should detail identified risks, the likelihood of occurrence, potential impact, and the scoring methodology used to prioritise risks. Mitigation Strategies and Implementation Evidence Documentation should be provided showing the specific risk mitigation strategies that have been applied. This could include engineering controls, procedural changes, training programs, or any other relevant measures. Evidence of implementation might include records of changes made, training completed, or equipment installed. Regular Review and Update Records Compliance requires not just a one-time assessment but ongoing monitoring and reassessment of risks. Documentation should show how often the risk assessment is reviewed and updated and how new risks or changes in the environment are incorporated. Alignment with Civil Aviation Authority Standards Evidence should be presented that the organisation's risk assessment and mitigation strategies are in line with the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, as detailed in CAP 1264. This might include a comparative analysis or a compliance checklist. Audit and Inspection Reports Regular audits or inspections of the helipad and related facilities can provide evidence of compliance. These reports should detail the findings of the audits, any non-compliances identified, and how these were addressed. Incident and Accident Records Records of any incidents or accidents related to the helipad should be maintained. This includes how these incidents were investigated and what measures were taken to prevent recurrence. Stakeholder Consultation Records Documentation of consultations with stakeholders, including hospital staff, emergency services, and aviation experts, can provide evidence of a thorough and inclusive risk assessment process. Training Record Evidence of training provided to relevant staff in helipad operations and safety can demonstrate commitment to risk mitigation. Emergency Response Plan A documented emergency response plan specific to helipad operations should be available, detailing procedures for various potential emergencies.	
	4. Risk assessment - Regulatory Differences between Ground-Based and Elevated Helipads When conducting fire risk assessments and ensuring compliance with relevant guidelines for NHS helipads, please confirm the Trust understands the distinct regulatory considerations for ground-based and elevated helipads.		Not applicable	Ground-Based Helipads Accessibility: Ground-based helipads typically offer easier access to emergency services and fire-fighting equipment. This accessibility needs to be factored into the risk assessment and mitigation strategies. Surrounding Environment The assessment must consider the immediate environment around the helipad, including the types of surfaces (grass, concrete, etc.) and nearby structures or natural features that might influence fire risk. Elevated Helipads (such as on rooftops) Structural Integrity Elevated helipads require careful assessment of the building's structural integrity to support the helipad's weight, especially during fire emergencies. Evacuation Routes Special attention must be given to evacuation routes and emergency access, as elevated helipads may present more challenges in these areas compared to ground-based helipads. Wind and Weather Conditions Elevated helipads are more exposed to wind and other weather elements, which can impact fire behaviour. This must be considered in the fire risk assessment. Fire Suppression System Due to their location, elevated helipads may require specialised fire suppression systems that are effective at higher elevations and in potentially limited spaces. In both cases, the NHS Trust should ensure compliance with the Civil Aviation Authority's standards (CAP 1264) and incorporate specific guidelines for each type of helipad into their overall fire risk management strategy. Regular training, emergency drills, and clear documentation are crucial components of this strategy, regardless of the helipad type.	Possible updates to follow 2023/24
H1	5. NHS Helipad Fire Risk Assessment and Compliance Guidelines Has there been a specific fire risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed? Has this assessment taken into account the helipad and the potential healthcare buildings in its curtilage In addition the Trust should have a responsible person and a documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.	Not applicable	Not applicable	Specific Fire Risk Assessment for the Helipad Area The NHS Trust should conduct a thorough fire risk assessment specifically for the helipad area. This assessment should consider all potential fire hazards associated with helicopter operations, including fuel, electrical systems, and potential ignition sources. The assessment should also consider the unique characteristics of the helipad, such as its location, size, and proximity to healthcare buildings and other infrastructure. Regular Review and Update of the Fire Risk Assessment The fire risk assessment should not be a one-time activity. It needs to be regularly reviewed and updated to reflect any changes in the operating environment, new helicopter models, or changes in surrounding infrastructure. Regular reviews ensure that any new risks are identified and mitigated promptly. Risk Mitigation Strategies Based on the findings of the fire risk assessment, the Trust should implement appropriate risk mitigation strategies. These might include fire suppression systems, emergency response plans, and safety protocols for fuel handling and storage. The effectiveness of these mitigation strategies should be regularly tested and evaluated. Documentation and Policy The Trust should maintain comprehensive documentation of the fire risk assessment process, including the findings, decisions made, and actions taken. This documentation serves as evidence of compliance with relevant guidelines and legislation. There should also be a clear policy outlining the responsibilities and procedures related to fire risk management at the helipad. Responsibility and Training The Trust should designate a responsible person or team to oversee fire safety at the helipad. This individual or team should have the necessary training and expertise in fire risk management and helicopter operations. Regular training and drills should be conducted for all staff involved in helipad operations to ensure they are aware of fire risks and know how to respond in an emergency. Compliance with Civil Aviation Authority Standards The Trust's risk assessment and mitigation strategies should take into account the relevant sections of the Civil Aviation Authority's Standards for helicopter landing areas at hospitals, outlined in CAP 1264. This includes ensuring that the design, operation, and maintenance of the helipad meet the safety standards set by the Civil Aviation Authority.	

H1	6. Resilience, Emergency & Business Continuity Planning Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff in relation to helipad and the estate.	Not applicable	Not applicable	Business Continuity Audit Reports for Helipads: These reports analyse an organization's capacity to maintain operations amidst major disruptions like natural disasters or cyber attacks, with a focus on helipad operations and continuity measures. Trust's Incident Response Plan for Helipads: A detailed plan outlining response procedures for incidents impacting the helipad, including emergency medical situations and natural disasters. Committee/Group Terms of Reference: Document detailing the responsibilities of the committee overseeing the helipad's emergency and business continuity plans, including test frequency, scope, and review processes. Corporate Risk Register for Helipad Operations: A comprehensive list of risks related to helipad operations, detailing the nature, likelihood, impact, and mitigation measures for each risk, regularly updated and maintained by an assigned owner. Board-Approved Risk Management Strategy: A strategy document outlining the approach to managing helipad risks, aligning with the organization's broader risk management policies, and subject to periodic review. Board-Signed Incident Response and Business Continuity Plans: Documents detailing emergency response and continuity strategies for the helipad, indicating organizational commitment to preparedness and safety. Stakeholder Collaboration in Risk Assessment and Meeting Records: Documentation evidencing collaboration with stakeholders, including helipad users, emergency services, and staff, in risk assessment processes, and minutes from meetings discussing safety, security, and operational procedures. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement.	
H1	7: Review Process Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?	Not applicable	Not applicable	1. Annual reviews of standards, policies and procedures documented; 2. Outputs of reviews and their inclusion in Action Plans; 3. Receiving, checking and authorising invoices for payment for additional services; 4. Monitoring Contractors' approach to rectifying defects; 5. Problem solving and dispute (prevention and) resolution where issues exist. 6. Establish and maintain appropriate records and information management systems to record and manage the performance of the Sub-Contractors; 7. The organisation demonstrates that it undertakes a process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working' 8. The ability to report on the regulatory requirements regarding safer wards (ligature). 9. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.	
H1	8. Collaboration Has the organisation in undertaking the risk assessment processes collaborated with helipad users, fire and rescue services re pre-determined site attendance and police with regard to safety & security (in particular terrorism threat) and staff members whose role includes receiving patients from/transferring a patient to, a helicopter	Not applicable	Not applicable	1. Working with relevant organisations to ensure best practice is followed. 2. Consider external sites being used	
H1	9. Costed Action Plans If any ratings in this SAQ are 'inadequate' or 'requires moderate or minor improvement' are there risk assessed costed action plans in place to achieve compliance? Costs can be entered below.	Not applicable	Not applicable	Detailed Action Plans: Outlining investments needed for compliance with the NHS Premises Assurance Model (PAM), including specific steps, timelines, and responsible parties. Financial Documentation and Risk Assessments: Detailed cost estimates and risk assessments for areas needing improvement. Board and Committee Escalation Evidence: Documentation showing board-level awareness and action plan discussions. Budget Inclusion Proof and Prior Investment Assessment: Evidence of budgetary allocation for actions and analysis of the impact of previous investments. Compliance Tracking and Stakeholder Communication: Systems for monitoring action plan progress and evidence of stakeholder engagement. Legal and Regulatory Compliance Documents: References to documents guiding NHS helipad operations and safety standards.	
H1	Capital cost to achieve desired improvements/outcomes	£0	£0	Capital Cost Analysis and Legislative Alignment Detailed Cost-Benefit Analysis: Breakdown of costs and benefits of helipad improvements, including patient care and operational efficiency. Post-Implementation Review Plan: Outline for evaluating helipad performance and impact after implementation. Revenue Implications of NHS Helipad Improvements	
Ref.	Revenue consequences of achieving desired improvements/outcomes	£0	£0	Cost-Benefit Analysis and Comparative Case Studies: Financial analysis of improvements and case studies from similar healthcare facilities. Regulatory Compliance and Projected Revenue Impact Reports: Documentation on compliance with laws and projected revenue changes. Stakeholder Feedback and Performance Metrics: Input from various stakeholders and clear metrics for evaluating improvement outcomes. Risk Analysis and Sustainability Assessments: Financial risk identification and assessments of long term sustainability.	

This one!

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

			Scoring	**1**	**2**	**3+**		
Integrated	**Integrated Leadership**	Q1 How integrated is facilities management - Soft Services?	**3+**	Soft services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Soft services is integrated with a clear centre of expertise with delivery coordinated centrally		
			Scoring	1	2	3+		
		Q2. How integrated is facilities management - Hard Services?	**2**	Hard services is devolved around the organisation without a central "controlling mind".	A central team exists that manage a range of core buildings directly but are not fully integrated	Hard services is integrated with a clear centre of expertise with delivery coordinated		
			Scoring	1	2	3+		
		Q3. How integrated is Property Leadership?	**2**	FM works in a silo, reactive to demand with little engagement with wider property leadership	FM links in some what with construction, design and asset management teams, but gaps remain.	leadership across the wider property function is integrated and aligned. Total cost of ownership is considered and understood across all aspects of asset lifecycle.		
	CAFM		**Scoring**	1	2	3	4	5
		Q4. How integrated are your FM Management IT Systems?	**2**	No CAFM, basic spreadsheets or similar used to monitor and manage FM.	Several systems in use, e.g. asset management system, CAFM, finance system, supplier system. Limited or no integration. Multiple versions of the truth.	A combination of systems are used between departments and suppliers, but a recognised master system is in place, showing one version of	An integrated CAFM is in use holding all but financial data, which is held in corporate finance system.	Organisation has a single, integrated CAFM system holding a single version of the truth, with other key systems feeding into a master system.
			Scoring	1	2	3	4	5
Collaborative	**Partnership & Transparency**	Q5 - How closely does FM management work with the FM delivery organisation(s)?	**2**	Minimal, adversarial relationship	Weekly or monthly meeti	Regular, joint meetings held taking both a backwards look at performance and a forward look at opportunity for improvement and upcoming changes	Genuine partnership, both sides work in an open and honest way to improve service delivery, built on trust. Very little discussion on poor performance or penalties.	A fully open and trusting relationship, working both ways to improve performance and value
			Scoring	1	2	3+		
		Q6 - How strategic and effective are supplier relationships?	**1**	Supplier relationships are transactional only.	A supplier relationship model (SRM) is in place (See CCS)	Open and honest conversations about what can be done both sides to improve outcomes. Service plans are jointly developed with each party inputting to one another. Topics such as profit, overheads, investment and supplier sustainability are openly discussed. An effective		
			Scoring	1	2	3+		
		Q7 - How transparent is FM delivery between the management organisation and delivery organisation?	**1**	No transparency regarding performance or cost.	Data held by supplier but	Organisation has real time access to key data in a transparent and open way and is regularly audited.		
			Scoring	1	2	3+		
		Q8 - Does the FM team collaborate outside of the management organisation?	**1**	Little engagement with wider government departments, occasional attendance at events or key meetings.	Actively involved in cross	In addition to formal cross gov groups, work closely with equals and leadership in other government departments to share best practice and go develop solutions, driving continuous improvement and innovation.		
			Scoring	1	2	3	4+	
	Compliance	Q9 - How effective is your hard compliance management approach?	**3**	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (Asbestos, Water, Fixed Wiring, Fire, Gas, Lifts). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated	
			Scoring	1	2	3	4+	5

		Q10 - How effective is your soft compliance management approach?	2	Limited compliance monitoring. Majority of compliance sits supplier side with little departmental oversight. Different approaches used in different buildings or parts of the organisation. No agreed, defined specification or policy.	Most compliance activity is done supplier side and suppliers retain key info. Key risk items are held by department for oversight. Compliance data is regularly validated.	Able to evidence compliance on high risk items (security, risk assessments, data). Wider compliance held client side but regularly validated with robust QA.	Able to prove compliance. Compliance reporting and monitoring is done in a regular basis, data is complete. Governance in place to ensure continued compliance and spot potential risks. Department has full visibility of compliance data and is validated through robust QA.	
			Scoring	1	2	3+		
	Standards and Best Practice	Q11 - How well standardised is FM management in line with industry best practice? (E.g. ISO)	**1**	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, but less maturity on other aspects	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
Delivery Excellence			**Scoring**	1	2	3+		
		Q12 - How well standardised is FM delivery in line with industry best practice? (E.g. SFG20, CCS)	**1**	No use or monitoring of standards and industry best practice. No feedback mechanism in place for service users, demand organisation or service provider to gauge user satisfaction. Outdated or inflexible specifications used, requiring complex and slow change control.	Use of some industry standards, such as SFG20 but less maturity on other aspects.	Full awareness of standards and industry best practice. Strong understanding of how to meet standards within scope of service agreement. Incentivisation and robust monitoring in place to ensure standards are met.		
			Scoring	1	2	3+		
	Defined Roles	Q13 - How well defined are FM roles and responsibilities within Hard Services?	**2**	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3+		
		Q14 - How well defined are FM roles and responsibilities within Soft Services?	**3+**	Duplication of services or gaps through unclear supplier responsibilities. Siloed, focused on single function etc. Poorly trained staff (undertaking tasks outside of their service scope).	Suppliers work in clearly defined roles, understand their responsibilities. Well trained staff, multi-skilled staff understand their scope and deliver to high standard. Quality monitoring in place, monitoring of performance metrics.	Clearly defined roles and responsibilities. KPI's used to track performance. Customer feedback captured. "business as usual" to drive continuous improvement in service delivery.		
			Scoring	1	2	3	4+	
	Enabling	Q15 - How flexible is FM to changing business needs?	**2**	FM works on fixed price o	Part fixed, part variable a	Work in partnership with suppliers to continually improve support for changing business objectives.	Supplier is engaged in the organisations service and strategy planning and understands their role. They work in partnership to proactively deliver change.	
			Scoring	1	2	3	4+	

Strategic	**FM Strategy**	Q16 -How strategic is FM?	**2**	No FM strategy or service plan. FM is delivered in a reactive way.	Basic FM strategy and ser	FM Strategy in place, cons	Long-term vision of what good FM looks like and how to get there. Consideration for external impact (e.g. sustainability) fully embedded into delivery model with robust monitoring and reporting in place. Horizon scanning undertaken including strategic risk management. Strategy fully aligned with aims and values of department/	
			Scoring	1	2	3		
	Governance	Q17 -Do you have effective FM governance in place?	**2**	No management/minimal management. Risk poorly allocated.	Following recognised governance, for example RICS Public sector asset management guide or functional standard on governance.	Clear, best in class and effective governance arrangements in place. Understood by organisation with clear roles and responsibilities.		
			Scoring	1		3	4+	
	Intelligent Client	Q18 -Do you have a clear definition and recognised Intelligent client function?		The ICF is dispersed without a clear, recognised function.		A recognised intelligent client function is in place, with defined roles and responsibilities, recognised by the wider organisation and has the capabilities and capacity required to be effective.	A highly effective ICF is in place with it's value recognised at an organisational level.	
			Scoring	1	2	3+		
Intelligent		Q19 - Is an effective client department in place?	**1**	No recognisable client department, a number of individuals within the organisation may be responsible for various aspects	An identifiable client department is in place, acting as a conduit between the wider organisation and the delivery organisations to maximise value.	A strong and effective client department is in place, with centralised oversight of all aspects of FM.		
				1	2	3+		
	Control Levers	Q20 -How well do you understand the levers to improve performance?	**2**	A basic understanding of levers available in the contract, primarily performance failure driven	A good understanding of commercial, financial and quality control levers and their impact of performance	Regular, demonstrable use of all types of control levers to drive continuous improvement		
			Scoring	1	2	3+		
	Management structure	Q21 - Is there sufficient management, capability and capacity to be effective? Are roles clear?	**2**	Unclear roles and responsibilities, disjoined management with FM and property spread over multiple departments, devolved FM model - no "corporate landlord".	A defined, central FM team undertaking most FM duties, but with some aspects still devolved.	Clearly defined roles and responsibilities, appropriate capacity and capability to effectively discharge duties in a timely manner. Centralised "Centre of expertise" and an effective corporate landlord in place.		
			Scoring	1	2	3+		
	Forward Planning	Q22 - How proactive is FM service delivery in your organisation?	**1**	Reactive works only, failure driven.	Short term planning - next financial year only.	Accurate condition data driving an FMR based on risk and asset criticality, long term view and whole life costing.		

Facilities Management (FM) Maturity

This section has been added as part of a wider Government estate process, NHSE Trusts are asked to support the wider property function across government

Data Structure	**Hierarchy**		**Scoring**	1	2	3+		
		Q1 - What level of location hierarchy is asset data captured against?	**2**	Asset level data is captured against the site and building it is in.	Asset level data is captured against the site, building, floor and location it is in.	Asset level data is captured against the site, building, floor, location and system it is in.		
	Data Specification		**Scoring**	1	2	3	4	5
		Q2 - Is there a consistent data specification aligned to the FM asset data standards (4.2)?	**2**	No defined data specification for FM asset data.	Defined data specification for FM asset data is not aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard (4.2.1).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and inconsistently aligned to 'non-core' fields (4.2.2).	Defined data specification for FM asset data is consistently aligned to the data standard for 'core' (4.2.1) and 'non-core' fields (4.2.2).
			Scoring	1	2	3+		
		Q3 - How consistently is the data specification applied across the estate?	**2**	No defined data specification for FM asset data.	The data specification is inconsistently applied across the estate.	The data specification is consistently applied across the estate.		
Data Assurance & Quality	**Coverage and Completeness**		**Scoring**	1	2	3+		
		Q4 - What is the level of coverage of assets in the asset register data?	**2**	The asset data covers some assets in some estates.	The asset data covers all assets in some estates but only some assets in other estates.	The asset data covers all assets in all estates.		
			Scoring	1	2	3	4	5
		Q5 - How complete is the data captured against assets in the asset register?	**2**	Data is not captured against assets for the 'core fields' in the data standard (4.2.1).	Data is captured against some assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and some assets for the 'non-core fields' in the data standard (4.2.2).	Data is captured against all assets for the 'core fields' in the data standard (4.2.1) and all assets for the 'non-core fields' in the data standard (4.2.2).
	Audit		**Scoring**	1	2	3+		
		Q6 - Is a full asset verification exercise required to update the asset register (5.1)?	**2**	Data is out of date or incomplete and requires a full asset verification exercise.	Data is out of date or incomplete for parts of the estate and requires a targeted asset verification exercise.	Data is up to date and complete. An asset verification exercise is not currently required.		
			Scoring	1	2	3	4	5
		Q7 - What regular sample surveys exist for on-going asset verification (5.2)?	**1**	No / limited sample surveys.	Inconsistent and ad-hoc sample surveys for some of the estates.	Consistent and regular sample surveys for all estates. There is a defined methodology to logically work through the all estates over time.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in some parts of the estate.	Sample surveys with verifications utilising digital enablers to increase the speed and coverage of surveys in all estates.
	Data Quality Control		**Scoring**	1	2	3	4	5
		Q8 - What processes are in place for change control/approvals for adding, removing or changing an asset (5.3)?	**1**	No / limited processes in place.	Inconsistent processes exist covering some parts of the estate.	Consistent processes exist covering all estates with clear responsibilities for approvals and tracking of changes.	Partially automated processes with frequent updates to change log.	Automated processes across all estates with close to real-time updates to change log.
			Scoring	1	2	3	4	5
		Q9 - What processes are in place for data quality checks (5.4)?	**1**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using basic checks covering some parts of the estate.	Consistent and regular processes exist using checks based on business rules covering all estates.	Partially automated processes using data quality check algorithms and data quality dashboards.	Automated processes using real-time data quality check algorithms, business rules, quality control dashboards and user feedback.
			Scoring	1	2	3	4	5

		Q10 - What processes are in place for data update assurance (5.5)?	**2**	No / limited processes in place.	Inconsistent and ad-hoc processes exist using minimal data quality checks covering some parts of the estate.	Consistent and regular processes exist using verification tools and update logs covering all estates.	Partially automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering parts of the estate.	Automated processes using controls for flagging erroneous records, identifying data and high-quality update logs covering all estates.
	Governance		**Scoring**	1	2	3	4	5
		Q11 - What governance is in place to support data assurance and quality (5.)?	1	No / limited governance / informal group for asset data quality.	A dedicated asset data-quality governance group/board exists but meets on an irregular basis or without the required attendees.	A dedicated asset data-quality governance group/board exists, which meets regularly with all the relevant attendees.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with the suppliers.	Along with the dedicated asset data quality governance group/board, there are additional sub-working groups with suppliers and cross-organisational governance board/group.
			Scoring	1	2	3+		
		Q12 - What level of documentation exists for the these data quality processes and governance (5.6)?	**1**	No / limited documented items for processes and governance.	Some documentation exists related to processes and governance which are applied on an ad-hoc basis across some parts of the estate.	Consistent documentation exists which the organisation applies for these processes and the governance across all estates. This documentation is reviewed and updated on a regular basis.		
Data Ownership and Access	**Ownership**		**Scoring**	1	2	3+		
		Q13 - Is the data contractually owned by the organisation (6.1)?	**3+**	The organisation does not contractually own the data.	The organisation contractually owns the data for some data stores/parts of estate.	The organisation contractually owns the data for all estates.		
	Accessibility		**Scoring**	1	2	3	4	5
		Q14 - What level of access does the organisation have to the data in the asset management systems (6.2)?	**3**	No / limited access to the data (e.g. data extracts requested via email to FM provider).	Access to some data tables/extracts across some data stores/parts of the estate.	Access to all data tables/extracts across all data stores/all estates and manually extract the required data.	The ability to access data in via desktop tool or automated APIs for some data stores/parts of estate.	The ability to access data in data in via desktop tool or automated APIs for all data stores/all estates.
			Scoring	1	2	3+		
		Q15 - What level of access management exists for controlling user privileges (6.3)?	**3+**	No / limited access management privileges.	Some access management privileges exist across some data stores/parts of the estate. These are inconsistently applied.	Access management privileges exist across all data stores/all estates. These are consistently applied and tightly controlled.		
	Flexibility		**Scoring**	1	2	3+		
		Q16 - Do the asset management systems provide the flexibility to accommodate the data standards (7.1)?	**1**	Systems with limited flexibility to accommodate the data standards.	Systems with some flexibility to partially accommodate the data standards for some data stores/parts of the estate.	Systems with flexibility to fully accommodate the data standards for all data stores/all estates.		
			Scoring	1	2	3+		
		Q17 - Do the asset management systems allow interoperability of asset data (7.2)?	**1**	Systems with limited interoperability between systems.	Systems with some interoperability between some systems and data is not transferable in COBie format.	Systems with interoperability between all systems and data is transferable in COBie format.		
			Scoring	1	2	3	4	5

Data Systems	**Interoperability**	Q18 - Does the asset management systems sync to a common data platform (7.3)?	**1**	No common data platform exist.	Common data platform exists but data from some data stores/parts of the estate are stored. Data sources are updated on an ad-hoc basis.	Common data platform exists where data from all data stores/all estates are stored. Data sources are updated on a regular basis.	Common data platform exists where data from all data stores/all estates are aggregated using desktop tools and databases. Data sources are updated frequently.	Common data platform exists where data from all data stores/all estates are aggregated using automated APIs (applications). Data sources are updated in real-time.
	Management		**Scoring**	1	2	3+		
		Q19 - Do the systems meet data security requirements (7.4)?	**2**	No systems meet minimum requirements across any estate.	Some of the systems meet data security requirements across some data stores/parts of the estate.	All systems meet data security requirements across all estates.		
			Scoring	1	2	3+		
		Q20 - Do the systems meet data backup management requirements (7.5)?	**1**	No systems meet minimum requirements across any estate.	Some of the systems meet data backup management requirements across some data stores/parts of the estate. Backup processes are ad-hoc.	All systems meet data backup management requirements. Backup processes are on a regular basis.		
Data Usage	**Management Information**		**Scoring**	1	2	3	4	5
		Q21 - What types of management information reports and dashboards are used for FM asset data (8.1)?	**1**	No / ad hoc reporting and dashboarding to support the use of FM asset data.	Inaccurate reports generated from data gathered point in time.	Standard reporting and interactive dashboards generated regularly with reliable processing and calculations.	Standard reporting and interactive dashboards generated from frequently updated data via robust data pipelines.	Ability to create bespoke customisable reports to answer the latest business questions.
	Insights		**Scoring**	1	2	3	4	5
		Q22 - How does asset data inform decisions relating to contract management (8.2)?	**2**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q23 - How does asset data inform decisions relating to mandatory and statutory compliance (8.3)?	**2**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q24 - How does asset data inform decisions relating to Planned Preventative Maintenance (8.4)?	**2**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5
		Q25 - How does asset data inform decisions relating to Investment Prioritisation (8.5)?	**2**	None / limited insights available to inform decision making.	Some insights generated but with limitations that impact decision making.	Data insights are generated and used to make informed decisions.	Robust and repeatable processes for generating insights and acting upon these.	Predictive and prescriptive analytical techniques used to create forward-looking insights to inform decisions.
			Scoring	1	2	3	4	5

Team Capacity and Capability	**Capacity**	Q26 - What is the capacity of the teams working with asset data (9.1, 9.2)?	**2**	No dedicated teams/informal teams.	Dedicated team exists within the organisation covering some parts of the estate. Individuals do not have assigned responsibilities and accountabilities.	Dedicated team exists within the organisation covering some parts of the estate. Individuals have clear with responsibilities and accountabilities. Identified individuals with responsibilities and accountabilities to manage, monitor and generate required reports/insights from FM asset data.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers.	Along with the dedicated team, there are additional sub-teams consisting individuals from the suppliers and cross-organisational data team.
			Scoring	1	2	3	4	5
	Capability	Q27 - What is the capability of the teams working with asset data (9.3)?	**2**	No dedicated personnel/informal teams.	Team with some FM and data/technical understanding.	Team with good FM and data/technical understanding. Ability to extract, transform, load and report data to generate required reports and insights.	Team with the ability to create robust and repeatable data processes along interactive dashboard to support in generating insights.	Team with the ability to use predictive and prescriptive analytical techniques used to create forward-looking insights.
			Scoring	1	2	3	4	5
	Training	Q28 - What training is provided for teams working with asset data (9.4)?	**1**	No / limited training provided.	Inconsistent and ad-hoc pieces of training exist focusing on basic understanding and only the necessary parts of the processes. They are partially in line with the Government Property Profession career framework.	Consistent and regular pieces of training exist focusing on all the necessary processes. They are in line with the Government Property Profession career framework.	Frequent pieces of training focusing on better understanding and upskilling in extended processes and tools used within the organisation.	Frequent pieces of training focusing on upskilling in advanced analytical and automation skills.
			Scoring	1	2	3+		
		Q29 - What training materials exists relating to asset data (9.5)?	**1**	No training and guidance material for asset data and processes.	Some training and guidance material exist related to asset data and processes covering some parts of the estate. These are reviewed and referred to on an ad-hoc basis.	Consistent training and guidance material exist covering onboarding, quality and audit processes, etc. for all estates. These are reviewed and referred to on regular basis.		
			Scoring	1	2	3	4	5
		Q30 - What knowledge sharing exists relating to asset data (9.6)?	**1**	No / limited knowledge sharing in place.	Some knowledge sharing exists within the organisation and some irregular knowledge sharing exists between organisations.	Consistent knowledge sharing exists between different organisations on a regular basis.	Consistent knowledge sharing exists between different organisations on a regular basis. Some knowledge sharing with suppliers on an irregular basis.	Consistent knowledge sharing exists between different organisations. Consistent knowledge sharing with suppliers on a regular basis.

Section	Area	Question	Add Details
All	Contact details	1. **Identify Lead for:** Insert name for board representative	Lee Bond, Chief Finance Officer
		1.a Insert contact details	lee.bond2@nhs.net
Food	Contact details	2. **Identify Lead for:** Insert name of catering dietitian	Kay Burns
		2a. Contact details of the dietitian	kay.quirke@nhs.net
		2b Indicate if this is in house in-house, from an FM provider or an external contract (including NHS Supply Chain)	In-house
Food	Contact details	3. **Identify Lead for:** Organisations must nominate a food safety specialist. Provide details of person or company supplying service	Keith Fowler keithfowler@nhs.net
Medical Gas	Contact details	4. Medical gas committee: Board Executive responsible for medical gasses	Simon Priestley simon.priestley@nhs.net
Medical Gas	Contact details	5. Authorised Engineer	Mark Milnemark.milne@hactraining.com
Medical Gas	Contact details	6. Authorised Person	Gareth Scott gareth.scott1@nhs.net

NHS PAM Safety Prompt Question Guidance Sheets	◄◄ Back to instructions

Introduction

This sheet supplements the 'generic' prompt questions contained within NHS PAM safety domain. It provides key references from the following documents that users should consider when undertaking their assessment of the relevant prompts:
1. Health and Safety Executive publication HSG 65 'Managing for health and safety'
2. The Care Quality Commission Provider Handbooks Appendix A 'Key Lines of Enquiry'
3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Associated CQC guidance

Extracts from HSG 65 primarily relate to H&S regulations so may not be strictly relevant in all instance. However the advice may still be useful. HSG 65 'Managing for health and safety' is available from: http://www.hse.gov.uk/pubns/priced/hsg65.pdf.
Similarly some references from the regulations and CQC guidance, particularly around training and development, may relate primarily to clinical and clinical support staff but again they still may be useful.

1: Policy & Procedures
Does the Organisation have a current, approved Policy and an underpinning set of procedures that comply with relevant legislation and published guidance?

1.1 HSG 65 page 21:

Policies should be designed to meet legal requirements, prevent health and safety problems, and enable you to respond quickly where difficulties arise or new risks are introduced.

1.2 Regulations and CQC Guidance

15(1)d
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.

15(1)d&e
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.

1.3 Regulations and CQC Guidance	CQC KLOE
15(1)d • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).

2: Roles and Responsibilities
Does the Organisation have appropriately qualified, competent and formally appointed people with clear descriptions of their role and responsibility which are well understood?

2.1 HSG 65

HSG 65 page 11)
The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including:
■ ensuring there is adequate and appropriate supervision in place;
■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;

HSG 65 page 17:
The competence of individuals is vital, whether they are employers, managers, supervisors, employees or contractors, especially those with safety-critical roles (such as plant maintenance engineers). It ensures they recognise the risks in their activities and can apply the right measures to control and manage those risks.

2.2 Regulations and CQC Guidance

15(1)d&e
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.

18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

2.4 Regulations and CQC Guidance	CQC KLOE
18(1) Guidance: Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).	E3.1. Do staff have the right qualifications, skills, knowledge and experience to do their job when they start their employment, take on new responsibilities and on a continual basis?

3: Risk Assessment
Has there been a risk assessment undertaken and any necessary risk mitigation strategies applied and regularly reviewed?

3.1 HSG

HSG 65 Page 27)
What the law says on assessing risks
The law states that a risk assessment must be 'suitable and sufficient', i.e. it should show that:
■ a proper check was made;
■ you asked who might be affected;
■ you dealt with all the obvious significant risks, taking into account the number of people who could be involved;
■ the precautions are reasonable, and the remaining risk is low;
■ you involved your workers or their representatives in the process.
The level of detail in a risk assessment should be proportionate to the risk and appropriate to the nature of the work. Insignificant risks can usually be ignored, as can risks arising from routine activities associated with life in general, unless the work activity compounds or significantly alters those risks.
Your risk assessment should only include what you could reasonably be expected to know – you are not expected to anticipate unforeseeable risks.

HSG 65 page 14)
Leaders, at all levels, need to understand the range of health and safety risks in their part of the organisation and to give proportionate attention to each of them. This applies to the level of detail and effort put into assessing the risks, implementing controls, supervising and monitoring.

HSG 65 page 13)
The risk profile of an organisation informs all aspects of the approach to leading and managing its health and safety risks.

HSG 65 page 13)
Every organisation will have its own risk profile. This is the starting point for determining the greatest health and safety issues for the organisation. In some businesses the risks will be tangible and immediate safety hazards, whereas in other organisations the risks may be health-related and it may be a long time before the illness becomes apparent.

3.2 Regulations and CQC Guidance

15(1)c: • Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.

17(2)(b)
Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.

17(2)(b)
Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.

17(2)(b)
Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.

17(2)(b)
Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate.
Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.

17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
3.3 Regulations and CQC Guidance	**CQC KLOE**
15(1)d&e • There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required. 17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively? S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing? W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?
4: Maintenance **Are assets, equipment and plant adequately maintained?**	
4.1 Regulations and CQC Guidance	
15(1)d • Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	
15(1)d&e • All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	
5. Training and Development **Does the Organisation have an up to date training and development plan in place covering all relevant roles and responsibilities of staff, that meets all safety, technical and quality requirements?**	
5.1 HSG 65	
HSG 65 page 11) The Management of Health and Safety at Work Regulations 1999 require employers to put in place arrangements to control health and safety risks. As a minimum, you should have the processes and procedures required to meet the legal requirements, including: ■ ensuring there is adequate and appropriate supervision in place; ■ access to competent health and safety advice, for example see the Occupational Safety and Health Consultants Register (OSHCR) at www.hse.gov.uk/oshcr;	
3.2 Regulations and CQC Guidance	
18(2) Persons employed by the service provider in the provision of a regulated activity must 18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,	
Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.	
Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised.	
Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.	
Other mandatory training, as defined by the provider for their role.	
Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.	
Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.	
All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.	
Other mandatory training, as defined by the provider for their role.	
Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support.	
Other learning and development opportunities required to enable them to fulfil their role. This includes first aid training for people working in the adult social care sector.	
All learning and development and required training completed should be monitored and appropriate action taken quickly when training requirements are not being met.	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.	
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
Providers must support staff to obtain appropriate further qualifications that would enable them to continue to perform their role.	
Providers must not act in a way that prevents or limits staff from obtaining further qualifications that are appropriate to their role.	
4.3 Regulations and CQC Guidance	**CQC KLOE**
Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role.	E3.2. How are the learning needs of staff identified? E3.3. Do staff have appropriate training to meet their learning needs? E3.4. Are staff encouraged and given opportunities to develop?
Staff should be supported to make sure they are can participate in: Statutory training.	S3.2. Do staff receive effective mandatory training in the safety systems, processes and practices?
Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.	E3.5. What are the arrangements for supporting and managing staff? (This includes one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.) E3.6. How is poor or variable staff performance identified and managed? How are staff supported to improve?
6: Resilience, Emergency & Business Continuity Planning **Does the Organisation have resilience, emergency, business continuity and escalation plans which have been formulated and tested with the appropriately trained staff?**	
6.1 CQC KLOE	
S5.2. What arrangements are in place to respond to emergencies and major incidents? How often are these practised and reviewed?	
S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?	
7: Review Process **Is there a robust annual review process to assure compliance and effectiveness of relevant standards, policies and procedures?**	
7.1 Regulations and CQC Guidance	
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
7.2 Regulations and CQC Guidance	**CQC KLOE**
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).
8: Costed Action Plans **If the organisation/site has any inadequate or requires (moderate or minor) improvement ratings in this SAQ, are there risk assessed costed action plans in place to achieve compliance?**	
References to risk assessment and management are details under prompt 3 above	
8: Scoring	
Scoring should be based on the following:	

	Self-assessment rating	% to score in given area
	Not applicable: This prompt question does not apply to the trust e.g. Mental Health trusts do not use Medical Gases;	
	Outstanding: Compliant with no action required, plus evidence of high-quality services and innovation. This Score is likely to be rarely applied.	100%
	Good: compliant no action required.	85% or above
	Requires minimal improvement: The impact on people who use services, visitors or staff is low.	66% to 85%
	Requires moderate improvement: The impact on people who use services, visitors or staff is medium.	45% to 65%
	Inadequate	45% or less

NHS Premises Assurance Model 2016

◄◄ Back to instructions	
This sheet shows the relationship and link between the NHS PAM SAQs and: 1. Relevant parts of the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' 2. Associated CQC guidance to providers on meeting the Regulations 3. CQC provider Handbooks Annex A: Key Lines of Enquiry	
Regulations (bold text) **CQC Guidance** (non-bold text), **CQC KLOE** (bold italics)	**PAM Ref.**
Regulation 14: Meeting nutritional and hydration needs (FS)	
CQC KLOE: E1.4. How are people's nutrition and hydration needs assessed and met?	
14(1) The nutritional and hydration needs of service users must be met.	
Providers must include people's nutrition and hydration needs when they make an initial assessment of their care, treatment and support needs and in the ongoing review of these. The assessment and review should include risks related to people's nutritional and hydration needs. Providers should have a food and drink strategy that addresses the nutritional needs of people using the service.	SS1
14(2) Paragraph 1 applies where— **(a) care or treatment involves—** **the provision of accommodation by the service provider, or** **an overnight stay for the service user on premises used by the service for the purposes of carrying on a regulated activity, or** **(b) the meeting of the nutritional or hydration needs of service users is part of the arrangements made for the provision of care or treatment by the service provider.**	SS1
Providers must meet people's nutrition or hydration needs wherever an overnight stay is provided as part of the regulated activity or where nutrition or hydration are provided as part of the arrangements made for the person using the service.	
14(3) But paragraph (1) does not apply to the extent that the meeting of such nutritional or hydration needs would— **(a) result in a breach of regulation 11, or** **(b) not be in the service user's best interests**	NA
14(4)(a) receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health,	
Nutrition and hydration assessments must be carried out by people with the required skills and knowledge. The assessments should follow nationally recognised guidance and identify, as a minimum: requirements to sustain life, support the agreed care and treatment, and support ongoing good health dietary intolerances, allergies, medication contraindications how to support people's good health including the level of support needed, timing of meals, and the provision of appropriate and sufficient quantities of food and drink.	SS1 should demonstrate following the Nutrition & hydration assessment but assessment is not part of PAM
Nutrition and hydration needs should be regularly reviewed during the course of care and treatment and any changes in people's needs should be responded to in good time. A variety of nutritious, appetising food should be available to meet people's needs and be served at an appropriate temperature. When the person lacks capacity, they must have prompts, encouragement and help to eat as appropriate.	SS1
Where a person is assessed as needing a specific diet, this must be provided in line with that assessment. Nutritional and hydration intake should be monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Action must be taken without delay to address any concerns. Staff must follow the most up-to-date nutrition and hydration assessment for each person and take appropriate action if people are not eating and drinking in line with their assessed needs. Staff should know how to determine whether specialist nutritional advice is required and how to access and follow it.	NA
Water must be available and accessible to people at all times. Other drinks should be made available periodically throughout the day and night and people should be encouraged and supported to drink. Arrangements should be made for people to receive their meals at a different time if they are absent or asleep when their meals are served. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.	SS1

14(4)(b) receipt by a service user of parenteral nutrition and dietary supplements when prescribed by a health care professional,	NA
14(4)(c) the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background, and	
People should be able to make choices about their diet. People's religious and cultural needs must be identified in their nutrition and hydration assessment, and these needs must be met. If there are any clinical contraindications or risks posed because of any of these requirements, these should be discussed with the person, to allow them to make informed choices about their requirements. When a person has specific dietary requirements relating to moral or ethical beliefs, such as vegetarianism, these requirements must be fully considered and met. Every effort should be made to meet people's preferences, including preference about what time meals are served, where they are served and the quantity.	SS1
14(4)(d) if necessary, support for a service user to eat or drink	NA
Regulation 15: Premises and equipment (FS)	
15(1) All premises and equipment used by the service provider must be— 15(1)(a) clean,	
CQC KLOE S3.5. How are standards of cleanliness and hygiene maintained?	
• Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance.	
• Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant.	
• Providers should: o Use appropriate cleaning methods and agents. o Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. o Monitor the level of cleanliness. o Take action without delay when any shortfalls are identified. o Make sure that staff with responsibility for cleaning have appropriate training.	Safety SAQ SS4
• Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance.	
CQC KLOE S3.9. Do the arrangements for managing waste and clinical specimens keep people safe? (This includes classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.)	Safety SAQ SS3
15(1) All premises and equipment used by the service provider must be— 15(1)(b) secure,	Safety SAQ SS6
• Security arrangements must make sure that people are safe while receiving care, including:	
CQC KLOES3.4. Are there arrangements in place to safeguard adults and children from abuse that reflect relevant legislation and local requirements? Do staff understand their responsibilities and adhere to safeguarding policies and procedures?	Safety SAQ SS6
o Protecting personal safety, which includes restrictive protection required in relation to the Mental Capacity Act 2005 and Mental Health Act 1983. This includes the use of window restrictors or locks on doors, which are used in a way that protects people using the service when lawful and necessary, but which does not restrict the liberty of other people using the service.	Safety SAQ SS6
CQC KLOE E1.7. Are the rights of people subject to the Mental Health Act (MHA) protected and do staff have regard to the MHA Code of Practice?	
o Protecting personal property and/or money.	
o Providing appropriate access to and exit from protected or controlled areas.	
o Not inadvertently restricting people's movements.	
o Providing appropriate information about access and entry when people who use the service are unable to come and go freely and when people using a service move from the premises as part of their care and treatment.	
o Using the appropriate level of security needed in relation to the services being delivered. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Guidance for providers on meeting the regulations March 2015 57	Safety SAQ SS6

• If any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service, while remaining mindful of their responsibilities for the safety of their staff. Any surveillance should be operated in line with current guidance. Detailed guidance on the use of surveillance is available on CQC's website.	
15(1) All premises and equipment used by the service provider must be— 15(1)(c) suitable for the purpose for which they are being used,	Safety SAQ SH2
Premises must be fit for purpose in line with statutory requirements and should take account of national best practice.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe?	
• Premises must be suitable for the service provided, including the layout, and be big enough to accommodate the potential number of people using the service at any one time. There must be sufficient equipment to provide the service.	Safety SAQ SH2 & SH15
• Adequate support facilities and amenities must be provided where relevant to the service being provided. This includes sufficient toilets and bathrooms for the number of people using the service, adequate storage space, adequate seating and waiting space.	Safety SAQ SH2
• People's needs must be taken into account when premises are designed, built, maintained, renovated or adapted. Their views should also be taken into account when possible.	Patient Experience SAQ P1
• People should be able to easily enter and exit premises and find their way around easily and independently. If they can't, providers must make reasonable adjustments in accordance with the Equality Act 2010 and other current legislation and guidance.	Safety SAQ SH2 & Patient Experience SAQ P6
• Any alterations to the premises or the equipment that is used to deliver care and treatment must be made in line with current legislation and guidance. Where the guidance cannot be met, the provider should have appropriate contingency plans and arrangements to mitigate the risks to people using the service.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
The premises and equipment used to deliver care and treatment must meet people's needs and, where possible, their preferences. This includes making sure that privacy, dignity and confidentiality are not compromised.	Safety SAQ SH2
• Reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with requirements of the Equality Act 2010.	Safety SAQ SH15
15(1) All premises and equipment used by the service provider must be— 15(1)(d) properly used, 15(1)(e) properly maintained, and	Safety prompt questions 1,4 & 7 for each technical area e.g. electrical safety
• Providers must make sure that they meet the requirements of relevant legislation so that premises and equipment are properly used and maintained. See Annex A for relevant legislation.	
CQC KLOE S3.7. Does the design, maintenance and use of facilities and premises keep people safe? S3.8. Does the maintenance and use of equipment keep people safe?	
• The provider's Statement of Purpose and operational policies and procedures for the delivery of care and treatment should specify how the premises and equipment will be used.	Safety SAQ SH2 & SH15
• Any change of use of premises and/or equipment should be informed by a risk assessment and providers must make appropriate alterations to premises and equipment where reasonably practical. Where this is not possible, providers should have appropriate contingency plans and arrangements to mitigate the risks to people using the service. Alterations must be in line with current legislation and guidance.	Safety SAQ SH2
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be regular health and safety risk assessments of the premises (including grounds) and equipment. The findings of the assessments must be acted on without delay if improvements are required.	SH4 & safety SAQ prompt 3
CQC KLOE W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• There should be suitable arrangements for the purchase, service, maintenance, renewal and replacement of premises (including grounds) and equipment. These arrangements must make sure that they meet the requirements of current legislation and guidance, manufacturers' instructions and the provider's policies or procedures.	Safety SAQ SH1 & Safety SAQ prompt 4

• Providers must have operational policies and procedures and maintenance budgets to maintain their equipment, buildings and mechanical engineering and electrical systems so that they are sound, operationally safe and exhibiting only minor deterioration.	Safety SAQ SH1 & Safety SAQ prompt 4
S3.8. Does the maintenance and use of equipment keep people safe?	
• All equipment must be used, stored and maintained in line with manufacturers' instructions. It should only be used for its intended purpose and by the person for whom is it provided.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
• Providers must make sure that staff and others who operate the equipment are trained to use it appropriately.	Safety SAQ SH15 & Safety SAQ prompt 2&5
15(1) All premises and equipment used by the service provider must be— 15(1)(f) appropriately located for the purpose for which they are being used.	
• When planning the location of premises, providers must take into account the anticipated needs of the people who will use the service and they should ensure easy access to other relevant facilities and the local community.	Patient Experience SAQ P1
• Facilities should be appropriately located to suit the accommodation that is being used. This includes short distances between linked facilities, sufficient car parking that is clearly marked and reasonably close, and good access to public transport.	Safety SAQ SH2
Equipment must be accessible at all times to meet the needs of people using the service. This means it must be available when needed, or obtained in a reasonable time so as not to pose a risk to the person using the service. Equipment includes chairs, beds, clinical equipment, and moving and handling equipment.	Safety SAQ SH15
S3.8. Does the maintenance and use of equipment keep people safe?	
15(2) The registered person must, in relation to such premises and equipment, maintain standards of hygiene appropriate for the purposes for which they are being used.	
• Providers must comply with guidance from the Department of Health about the prevention and control of infections: Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance.	Safety SAQ SS4
S3.6. Are reliable systems in place to prevent and protect people from a healthcare-associated infection?	
• Where applicable, premises must be cleaned or decontaminated in line with current legislation and guidance, and equipment must be cleaned, decontaminated and/or sterilised in line with current legislation and guidance and manufacturers' instructions. Equipment must be cleaned or decontaminated after each use and between use by different people who use the service.	Safety SAQ SS4
• Ancillary services belonging to the provider, such as kitchens and laundry rooms, which are used for or by people who use the service, must be used and maintained in line with current legislation and guidance. People using the service and staff using the equipment should be trained to use it or supervised/risk assessed as necessary.	Safety SAQ SS1, SS4 & SH10
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
• Multiple use equipment and devices must be cleaned or decontaminated between use. Single use and single person devices must not be re-used or shared. All staff must understand the risk to people who use services if they do not adhere to this.	Safety SAQ SS2 & SS4
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Regulation 16: Receiving and acting on complaints (FS)	Patient Exp SAQ P1
R4. How are people's concerns and complaints listened and responded to and used to improve the quality of care?	
16(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.	P1

People must be able to make a complaint to any member of staff, either verbally or in writing. All staff must know how to respond when they receive a complaint. Unless they are anonymous, all complaints should be acknowledged whether they are written or verbal. Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf. Appropriate action must be taken without delay to respond to any failures identified by a complaint or the investigation of a complaint. Information must be available to a complainant about how to take action if they are not satisfied with how the provider manages and/or responds to their complaint. Information should include the internal procedures that the provider must follow and should explain when complaints should/will be escalated to other appropriate bodies. Where complainants escalate their complaint externally because they are dissatisfied with the local outcome, the provider should cooperate with any independent review or process.	P1
16(2) The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.	P1
Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service. Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested. When complainants do not wish to identify themselves, the provider must still follow its complaints process as far as possible. Providers must have effective systems to make sure that all complaints are investigated without delay. This includes: Undertaking a review to establish the level of investigation and immediate action required, including referral to appropriate authorities for investigation. This may include professional regulators or local authority safeguarding teams. Making sure appropriate investigations are carried out to identify what might have caused the complaint and the actions required to prevent similar complaints. When the complainant has identified themselves, investigating and responding to them and where relevant their family and carers without delay.	P1
Providers should monitor complaints over time, looking for trends and areas of risk that may be addressed. Staff and others who are involved in the assessment and investigation of complaints must have the right level of knowledge and skill. They should understand the provider's complaints process and be knowledgeable about current related guidance. Consent and confidentiality must not be compromised during the complaints process unless there are professional or statutory obligations that make this necessary, such as safeguarding. Complainants, and those about whom complaints are made, must be kept informed of the status of their complaint and its investigation, and be advised of any changes made as a result. Providers must maintain a record of all complaints, outcomes and actions taken in response to complaints. Where no action is taken, the reasons for this should be recorded. Providers must act in accordance with Regulation 20: Duty of Candour in respect of complaints about care and treatment that have resulted in a notifiable safety incident.	P1
16(3) The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of— **(a) complaints made under such complaints system,** **(b) responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and** **(c) any other relevant information in relation to such complaints as the Commission may request.**	P1

CQC can ask providers for information about a complaint; if this is not provided within 28 days of our request, it may be seen as preventing CQC from taking appropriate action in relation to a complaint or putting people who use the service at risk of harm, or of receiving care and treatment that has, or is, causing harm. The 28-day period starts the day after the request is received.	P1
Regulation 17: Good governance (FS)	
W2.6. Are there comprehensive assurance system and service performance measures, which are reported and monitored, and is action taken to improve performance ***S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff?*** ***W2. Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?***	The NHS PAM is designed to be used as a system that meets this requirement
17(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.	
Providers must operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service.	
The system must include scrutiny and overall responsibility at board level or equivalent.	Governance domain
17(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—	
17(2)(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);	The NHS PAM is designed to be used as a system that meets this requirement
S3.3. Is implementation of safety systems, processes and practices monitored and improved when required?	
1. Providers must have systems and processes such as regular audits of the service provided and must assess, monitor and improve the quality and safety of the service. The audits should be baselined against Regulations 4 to 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and should, where possible, include the experiences people who use the service. The systems and processes should be continually reviewed to make sure they remain fit for purpose. Fit for purpose means that: systems and processes enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. providers have access to all necessary information.	
17(2)(a) 2. Information should be up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. When required, results should be escalated and appropriate action taken.	G1.7
W2.7. Are there effective arrangements in place to ensure that the information used to monitor and manage quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified? ***W5.6. How is information used proactively to improve care?***	
17(2)(a) 3. Providers should have effective communication systems to ensure that people who use the service, those who need to know within the service and, where appropriate, those external to the service, know the results of reviews about the quality and safety of the service and any actions required following the review.	NA
17(2)(a) 4. Providers should actively seek the views of a wide range of stakeholders, including people who use the service, staff, visiting professionals, professional bodies, commissioners, local groups, members of the public and other bodies, about their experience of, and the quality of care and treatment delivered by the service. Providers must be able to show how they have: analysed and responded to the information gathered, including taking action to address issues where they are raised, and used the information to make improvements and demonstrate that they have been made	Patient Experience SAQ P1
W4. How are people who use the service, the public and staff engaged and involved?	
Providers must seek professional/expert advice as needed and without delay to help them to identify and make improvements.	Governance SAQ G3

17(2)a Providers must monitor progress against plans to improve the quality and safety of services, and take appropriate action without delay where progress is not achieved as expected.	PE domain and action plan prompt under each SAQ
Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay.	Safety SAQ SH17
17(2)a Providers should read and implement relevant nationally recognised guidance and be aware that quality and safety standards change over time when new practices are introduced, or because of technological development or other factors.	Safety SAQ prompt Question 1
E1.1. How are relevant and current evidence-based guidance, standards, best practice and legislation identified and used to develop how services, care and treatment are delivered? (This includes from NICE and other expert and professional bodies).	
17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;	
S3.1. Are the systems, processes and practices that are essential to keep people safe identified, put in place and communicated to staff? ***S4.4. Are comprehensive risk assessments carried out for people who use services and risk management plans developed in line with national guidance? Are risks managed positively?*** ***S5.1. How are potential risks taken into account when planning services, for example, seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing?***	
17(2)(b) Providers must have systems and processes that enable them to identify and assess risks to the health, safety and/or welfare of people who use the service.	Safety SAQ prompt question 3 & G1.9 & G1.10
17(2)(b) Where risks are identified, providers must introduce measures to reduce or remove the risks within a timescale that reflects the level of risk and impact on people using the service.	
17(2)(b) Providers must have processes to minimise the likelihood of risks and to minimise the impact of risks on people who use services.	
17(2)(b) Risks to the health, safety and/or welfare of people who use services must be escalated within the organisation or to a relevant external body as appropriate. Identified risks to people who use services and others must be continually monitored and appropriate action taken where a risk has increased.	
17(2)(b) Note: In this regulation, 'others' includes anyone who may be put at risk through the carrying on of a regulated activity, such as staff, visitors, tradespeople or students.	
17(2)(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;	NA
17(2)(d) maintain securely such other records as are necessary to be kept in relation to— **(i) persons employed in the carrying on of the regulated activity, and** **(ii) the management of the regulated activity;**	
Records relating to people employed and the management of regulated activities must be created, amended, stored and destroyed in accordance with current legislation and guidance.	
Records relating to people employed must include information relevant to their employment in the role including information relating to the requirements under Regulations 4 to 7 and Regulation 19 of this part (part 3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This applies to all staff, not just newly appointed staff. Providers must observe data protection legislation about the retention of confidential personal information.	

Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents.	Safety SAQ SH3
W2.9. Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions?	
Records must be kept secure at all times and only accessed, amended or destroyed by people who are authorised to do so.	
Information in all formats must be managed in line with current legislation and guidance.	
Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 1998.	
17(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;	Patient Experience SAQ P1
17(2)(e) Providers should actively encourage feedback about the quality of care and overall involvement with them. The feedback may be informal or formal, written or verbal. It may be from people using the service, those lawfully acting on their behalf, their carers and others such as staff or other relevant bodies.	
17(2)(e) All feedback should be listened to, recorded and responded to as appropriate. It should be analysed and used to drive improvements to the quality and safety of services and the experience of engaging with the provider.	
17(2)(e) Improvements should be made without delay once they are identified, and the provider should have systems in place to communicate how feedback has led to improvements.	
17(2)(e) Where relevant, the provider should also seek and act on the views of external bodies such as fire, environmental health, royal colleges and other bodies who provide best practice guidance relevant to the service provided.	
17(2)(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).	Safety SAQ prompt question 7, SAQ G1.8 & G1.4
17(2)(f) Providers must ensure that their audit and governance systems remain effective.	
17(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—-	NA
Regulation 18: Staffing (FS)	see also 'prompt guidance sheet'
18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.	Safety SAQ prompt question 2: See 'prompt guidance sheet'
S4.1. How are staffing levels and skill mix planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance, where available?	
18(2)(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,	Safety SAQ prompt question 5: See 'prompt guidance sheet'
S3.2. Do staff receive effective mandatory training in the safety systems, processes	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and	
18(2)(b) be enabled where appropriate to obtain further qualifications appropriate to	
Regulation 19: Fit and proper persons employed (FS)	NA
Regulation 20: Duty of candour (FS)	**G2.9**