focused Listening events in areas across the Trust. Data will be collected to track progress and this will be included in future reports.

7. Peer support

7.1 The local Guardian network, broadly in line with the Cambridgeshire and Peterborough Integrated Care System footprint, continues to meet regularly to share best practice and ideas. The East of England regional FTSUG network meets on a quarterly basis. The CUH FTSUG is a member of both networks.

8. Governance

8.1 In line with national recommendations, the Board of Directors has previously agreed to receive a six-monthly report on Freedom to Speak Up. An annual report is also presented to the Audit Committee. The next Audit Committee report is due in October 2022, with the next Board report scheduled for January 2023.

8.2 The CUH Raising Concerns procedure is currently under review against the National Guardian's Office framework. Following review, it will be presented to the Board of Directors for approval.

9. Recommendations

9.1 The Board of Directors is asked to receive and discuss the six-monthly report from the Trust's Freedom to Speak Up Guardian.

Appendix A: Analysis of Freedom to Speak Up concerns raised
Table 1a: Concerns raised with the CUH Speaking Up service by occupational group

	October 2021 – March 2022		April 2021 – September 2021		2020/21 (April – March)		2019/20 (April – March)	
Occupational group	**Number**	**% of group workforce** (CHEQS Mar 2022)	**Number**	**% of group workforce** (CHEQS Sep 2021)	**Number**	**% of group workforce** (CHEQS Mar 2021)	**Number**	**% of group workforce** (CHEQS Mar 2020)
Admin & Clerical; Maintenance/Ancillary	10	0.4	15	0.6	64	2.4	30	1.2
Nursing & Midwifery	16	0.4	17	0.5	67	1.8	35	1.0
Health Care Assistant/ Nursing Associates	5	0.3	3	0.2	19	1.0	7	0.4
Ancillary and Technical	Data now included in Admin & Clerical/Maintenance/Ancillary above							
Add Prof, Tech and Scientific, Healthcare Scientist	Data now included in Allied Health Professionals below							
Medical and Dental	0	0	3	0.2	14	0.9	4	0.3
Allied Health Professionals	8	0.5	5	0.3	25	1.7	15	1.6
Other	2		4		9		2	
TOTAL	**41**	**0.3**	**47**	**0.4**	**198**	1.7	**93**	**0.8**

A.1 Table 1a also shows the number of staff within each occupational group raising concerns as a percentage of the total workforce for that occupational group. In the October 2021 to March 2022 period, the following points stand out:

- Compared to the Trust average, staff in the Admin & Clerical/Maintenance and Ancillary, Nursing & Midwifery and Allied Health Professionals groups are more likely to raise concerns.

- Compared to the Trust average, staff in the Medical and Dental group are much less likely to raise concerns.

Work continues to seek to better understand the drivers of these differences. There are likely to be a number of factors at play including awareness of the FTSU service, access to other channels for raising concerns and varying levels of staff engagement across occupational groups.

Table 1b: Concerns raised with the CUH Speaking Up Service by category

	October 2021 – March 2022		April – September 2021		2020/21 (April – March)		2019/20 (April - March)	
Concern category	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Behaviour/ relationships	19	19	23	25	-	-	-	
Behaviour/attitude	-	-	-	-	75	27	43	29
Trust processes in practice	20	20	18	19	107	31	38	26
Management support	24	25	21	23	49	20	32	22
Patient safety and quality	10	10	12	11	-	-	-	-
Patient related	-	-	-	-	34	17	24	16
Capacity/workload/training	10	10	4	4	22	5	9	6
Bullying and harassment	10	10	12	14	-	-	-	-
Worker safety	5	5	4	4	-	-	-	
TOTAL	**98**		**94**		**287**		**146**	

A.2 Some concerns cover more than one theme, i.e. in this period (October 2021 to March 2022) 41 individuals raised concerns across 98 themes. The main theme raised in concerns for this reporting period was management support, being part of 25% of all concerns raised in this six month period. Trust processes and practices and behavior and relationships both also featured regularly in concerns being brought to the FTSUG, both in around 20% of cases.

Table 1c: Concerns raised with the CUH Speaking Up service by division from October 2021 to March 2022

Job Role	Behaviour/ relationship	trust proc in practice	Mgmt support	Capacity workload training	Patient Safety & Quality	Bullying & Harassment	Worker Safety	Total Themes	Total Cases	Total Workforce	% Total workforce
A	2	4	5	5	4		1	21	6	2239	0.3
B	5	6	5	1	2	3		22	12	3043	0.4
C	3	4	4			1	1	13	6	1643	0.4
D		3	3				3	9	3	1473	0.2
E	6	2	5	3	3	4		23	8	1399	0.6
Corporate	2	1	2	1	1	1		8	4	1470	0.3
R&D	0	0	0	0	0	0	0	0	0	465	0
Not Known	1					1		2	2	n/a	n/a
Grand Total	**19**	**20**	**24**	**10**	**10**	**10**	**5**	**98**	**41**	**11732**	**0.3**

A.3 Over the last 6 month period Division E accessed the service more than other areas and both Division D and Research and Development accessed the service less than average. However, there is no evidence of a consistent pattern in the Divisional breakdown over time.

Table 1d: Shelford Group FTSU comparisons, 2021/22 Q1-Q3

Trust	Q1 total cases	Q1 Patient safety and quality cases	Q1 Bullying and harassment cases	Q2 total cases	Q2 Patient safety and quality cases	Q2 Bullying and harassment cases	Q3 total cases	Q3 Patient safety and quality cases	Q3 Bullying and harassment cases
CUH	25	5	6	22	7	6	19	8	2
GSTT	67	1	11	38	0	6	78	5	25
Imperial	No data	No data	No data	No data	No data	No data	No data	No data	No data
King's	29	10	14	40	7	24	62	11	20
Manchester	24	6	7	32	6	10	37	11	12
Newcastle	11	0	6	16	1	6	15	2	5
Oxford	21	6	18	17	8	10	43	12	22
Sheffield	6	1	1	10	1	3	10	2	3
UCLH	40	0	2	30	0	10	16	0	2
Birmingham	23	1	9	No data	No data	No data	28	4	7
Average	**27**	**3**	**8**	**26**	**4**	**9**	**37**	**6**	**12**

A.4 Comparisons between CUH data and Shelford Group comparisons (from NGO data) are provided in Table 1d. Nationally there is a wide disparity between the number of cases and resources allocated to speaking up services in Trusts which makes direct comparisons difficult.

Table 1e: NHS National Staff Survey

Staff Survey Question		% of staff selecting 'Agree'/'Strongly Agree'				
		2017	**2018**	**2019**	**2020**	**2021**
Q17a I would feel secure raising concerns about unsafe clinical practice	CUH	73.1	73.8	76.1	75.3	75.9
	Benchmark Median	69.4	69.8	70.8	71.8	73.9
Q17b I am confident that my organisation would address my concern	CUH	61.4	63.7	65.8	64.8	62.3
	Benchmark Median	57.4	57.3	59.1	59.1	57.6
Q21e I feel safe to speak up about anything that concerns me in this organisation	CUH	-	-	-	69.5	67.5
	Benchmark Median	-	-	-	65.0	60.7
Q21f If I spoke up about something that concerned me I am confident my organisation would address my concern	CUH	-	-	-	-	55.5
	Benchmark Median	-	-	-	-	47.9

Table 1f: National Staff Survey results for Q21e (I feel safe to speak up about anything that concerns me in this organisation) broken down by protected characteristic

Disability	2020	2021	Diff
Disabled	63%	61%	-2%
Non- Disabled	71%	69%	-2%
Ethnicity	2020	2021	Diff
BAME	67%	64%	-3%
White	71%	69%	-2%
Sexuality	2020	2021	Diff
Gay, Lesbian, Bisexual and Other	67%	66%	-1%
Heterosexual or Straight	71%	68%	-3%
I would prefer not to say	58%	55%	-3%

NHS
Cambridge University Hospitals
NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Quality Committee	**DATE OF MEETING:**	6 July 2022
CHAIR:	Sharon Peacock	**LEAD EXECUTIVE DIRECTOR:**	Chief Nurse / Medical Director
RECEIVING BOARD / COMMITTEE:	Board of Directors, 13 July 2022		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5. 5.1	**Lead Executives' Report and Patient Safety and Experience Overview** <u>Lead Executives' Report</u> 1. The Chief Nurse and Medical Director presented the report to the committee. 2. The Trust had received the Joint Advisory Group (JAG) accreditation award for Gastrointestinal (GI) endoscopy services, demonstrating that best practice quality standards had been met. 3. The Quality Account had been successfully published on time per national requirement. 4. Covid numbers had increased within the community and the hospital, infection control and prevention measures remained under review. Compulsory mask wearing across patient facing clinical areas had been reinstated.	Information/ Assurance	BAF 001/002	N

	5. Staffing remains a concern with a full establishment review completed. The recommended changes had been supported and will be presented to the Board of Directors. 6. The Care Quality Commission (CQC) conducted an unannounced inspection on the 21 March 2022. The inspection focused on urgent and emergency care and medical services, forming part of a wider system review of urgent care. Three domains were reviewed; safe, responsive and well led. Critical care, infection prevention and control, patient flow, workforce and leadership and culture were the five key lines of enquiry focused on. The report highlighted examples of excellent care, good evidence of infection prevention and control and effective multi-professional working, as well as staff treating patients with compassion and kindness. However, the rating for urgent and emergency cares safe domain was reduced from good to require improvement and four must dos and three should dos were raised, these concerns are already under the scrutiny of the Quality Committee.			
5.2	<u>Patient Safety and Experience Overview</u> 1. The report covered the period up until the end of May 2022. 2. Normal variance in the amount of patient safety incidents had been reported.			
6.	**Maternity** <u>Maternity Update</u> 1. The core competency framework was in year one roll-out and currently includes all core requirements for MDT training. Following updated Covid guidance the number of staff able to attend face to face training can be increased. The trajectory of overall compliance is 80% by end of June. 2. CNST year 4 relaunched in May 2022 with a deadline for board declaration by 5 January 2023. There are significant changes to	Information/ Assurance		N

	reporting requirements for safety actions two, five and seven. The maternity service is on track to deliver six of the 10 safety actions for year four, plans are in place to address gaps. 3. The registered midwife vacancy rate was 32.14 WTE (15%), mitigation with bank and agency staff continues. Recruitment campaigns have been successful with international and newly qualified midwives due to start by the end of October 2022. 4. Work on the Ockenden action plan continued with 15 of the 81 actions (19%) overdue, 12 of the 15 have plans in place to complete within a 12 week period and 3 of the 15 are at risk due to an organisational IT build pause.			
7.	**Safeguarding Annual Report** 1. The safeguarding team have seen an increase in safeguarding referrals across children's, adult and maternity safeguarding throughout the past year. The highest increase in referrals has been within the adult (29%) and learning disabilities services (123%). 2. The children's safeguarding team have continued to adapt and implement new ways of working within the trust and with partner agencies. The team have embraced holding meetings over a social platform which has improved time efficiency and attendance at patient centred meetings at short notice due to there not being a requirement to travel to various different locations.	Information/ Assurance		N
8.	**Health and Safety Annual Report** 1. The annual report covers the period 1 April 2021 to 31 March 2022 and provides summary information on: • Health and safety risks and significant issues • Significant health and safety incidents • Health and safety incidents and RIDDORs • Health and safety audits • Health and safety culture survey results	Information/ Assurance		N

	• Work of the health and safety committee and its sub-committees • Key performance indicators • Key priorities for the health and safety team in 2022/23 3. The health and safety team have continued to support the Trust's response to COVID-19 during 2021/22. 4. A new health and safety strategy has been developed to set the direction for effective health and safety at CUH over the next five years. 5. The health and safety team carried out 170 COVID-19 spot checks during 2021/22 in place of the monthly health and safety audit programme which was paused during the pandemic.			
9.	**Pharmacy Clinical Audit** 1. The Pharmacy Clinical Audit covers the period between November 2021 and May 2022 and provides an update on related improvement projects, provides a summary of pharmacy and medicines optimisation audits and service evaluations. 2. Routine audits of compliance with medicines storage and security policy had been carried out, with a sustained improvement across many audit results following a series of improvement projects noted by the committee. 3. Implementation of changes to the fridge monitoring process had produced a sustained reduction in the number of reported temperature excursions. 4. Audits were completed on a digital platform which had resulted in a reduction in audit time taken and enhanced completion rate.	Information/ Assurance		N
10.	**Quality Account update and quality priorities for 2022/23** 1. The committee noted the 2022/23 Quality Account which was prepared in accordance with national guidance and was submitted	Information/ Assurance		N

	on 30 June 2022 as required by legislation, and published on the Trust website.			
11.	**Board Assurance Framework (BAF) and Corporate Risk Register**. 1. The committee received and noted the current version of the Board Assurance Framework and Corporate Risk Register.	Information/ Assurance		N

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 July 2022

Agenda item	15.2
Title	Safeguarding Annual Report 2021/22
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Tracy Brown, Safeguarding Adults Lead; Cheryl Exley, Learning Disability Specialist Nurse; Gillian Harrington, Named Midwife for Safeguarding; Sian Forman, Named Nurse for Safeguarding Children; Amanda Small, Deputy Chief Nurse
Purpose	To receive the annual report.
Previously considered by	Quality Committee, 6 July 2022

Executive Summary

The Safeguarding Annual Report for 2021/22 is attached. It was received and endorsed by the Quality Committee at its meeting on 6 July 2022.

Related Trust objectives	Improving patient care
Risk and Assurance	The paper provides assurance on CUH processes and procedures for safeguarding.
Related Assurance Framework Entries	n/a

Legal / Regulatory / Equality, Diversity & Dignity implications	▪ Care Quality Commission National Standards of Quality and Safety – Outcomes 7-11; Essential Standards of Quality and Safety. ▪ Care Quality Commission registration standards. ▪ Counter terrorism and Security Bill 2015 (Health Element: PREVENT) ▪ Equality Act 2010 ▪ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 ▪ Homelessness Reduction Act (2017) ▪ Intercollegiate Document Looked after Children: roles and competencies of ▪ healthcare staff (2019) ▪ Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) ▪ Safeguarding Adults: Roles and Competences for Health Care Staff – Intercollegiate Document (2018) ▪ Safeguarding Children and Young People: Roles and Competences for Health Care Staff ▪ Safeguarding Vulnerable People in the NHS – Accountability and Assurances Framework (2015) ▪ Section 11 The Children's Act 2004 ▪ The Care Act (2014) ▪ The Sexual Offences Act (2003) ▪ Working Together (2018) ▪ Equality Act (201) ▪ NHSI National Learning Disability Improvement Standards for NHS Trusts (2018)
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent	Yes

Actions required by the Board of Directors
The Board is asked to receive the Safeguarding annual report for 2021/22.

Cambridge University Hospitals NHS Foundation Trust

Annual Safeguarding Report 2021/22

Contents

1.0 Introduction

This report gives an oversight of the safeguarding agenda at Cambridge University Hospitals NHS foundation trust (CUH) over the past year and provides assurance that the Trust continues to fulfil its legislated safeguarding responsibilities through robust processes, delivered in line with the Trust values.

2.0 Executive Summary

Healthcare organisations must ensure that those who use their services are safeguarded and that staff are suitably skilled and supported to manage safeguarding responsibilities well. All health care organisations have a duty outlined in legislation to make arrangements to safeguard and to co-operate with other agencies to protect individuals who are at risk from harm, abuse or neglect.

The intercollegiate documents 'Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)' and 'Looked after Children: roles and competencies of healthcare staff (2019)' provides a clear framework for all organisations that provide or commission health care. This report intends to provide assurance to the Trust, its patients and their families and our partner agencies that Cambridge University Hospitals NHS foundation trust (CUH) regard safeguarding as a key priority and ensure that all our staff are aware that 'safeguarding is everyone's business' whilst also providing evidence of compliance with the intercollegiate documents.

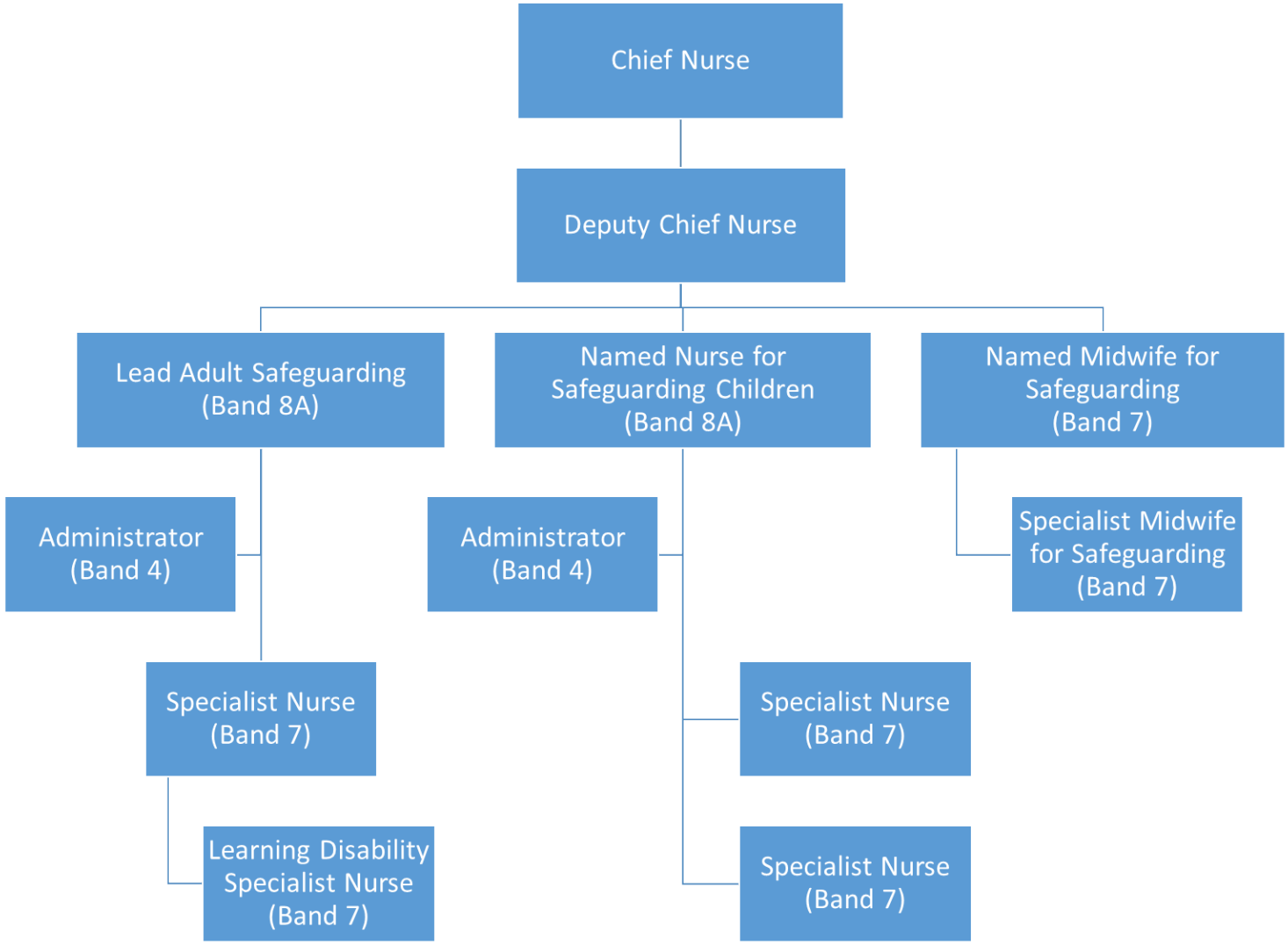
The safeguarding team have seen an increase in safeguarding referrals across children's, adult and maternity safeguarding throughout the past year. The highest increase in referrals has been within the adult (29%) and learning disabilities services (123%). The report presents in more detail the referrals received and the activity undertaken within each of the specialist safeguarding teams. Additionally, the report looks back and summarises the key achievements over the past year as well as outlining the planned developments for the year ahead.

3.0 Background

Collectively, the safeguarding team consists of three specialist teams who are responsible for children (including the unborn baby), adults and women at risk of abuse in maternity services. These teams report via the deputy chief nurse to the chief nurse who is the executive lead for safeguarding. The teams work jointly with partner agencies to develop and promote safe systems and practise for all groups in challenging and ever changing landscapes. In order to ensure oversight and assurance of safeguarding activity within the trust, the teams report to trust board via the joint safeguarding committee. This is illustrated in Appendix 1.

The organogram on the following page provides an overview of the team structure.

CUH safeguarding structure



4.0 Strategic Context

4.1 CUH strategic safeguarding aims

In line with CUH's strategy, values and priorities the safeguarding team aims are to:

1. Improving patient journeys by:
    - making safeguarding personal to the individual patient.
    - working with our partner agencies e.g. social care, care quality commission (CQC) and local safeguarding boards to ensure we are constantly seeking ways to improve how we work together to ensure best outcomes for all those who use or come into contact with our services.
    - contributing to initiatives to reduce health inequalities and improve health outcomes for people with socially complex lives.

2. Supporting our staff through:
    - ensuring staff are equipped with safeguarding knowledge and skills through the delivery of education and training that is aligned to national policy.
    - ensuring that the safeguarding teams are accessible and available to support staff with complex cases and offer supervision for staff involved in safeguarding cases.

3. Building for the future through:
    - contributing nationally and internationally by sharing expertise through safeguarding conferences and publishing work and experiences.

4.2 National Agenda

The intercollegiate documents 'Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)' and 'Looked after Children: roles and competencies of healthcare staff (2019)' provides a clear framework for all organisations that provide or commission health care. The documents identify the competencies required for all healthcare staff to support safeguarding, focusing on the knowledge and skills needed to undertake this core professional role.

Healthcare organisations must ensure that those who use their services are safeguarded and that staff are suitably skilled and supported. All health care organisations have a duty outlined in legislation to make arrangements to safeguard and to co-operate with other agencies to protect individuals who are at risk from harm, abuse or neglect. The trust ensures that all staff remain compliant within the framework outlined within the intercollegiate documents.

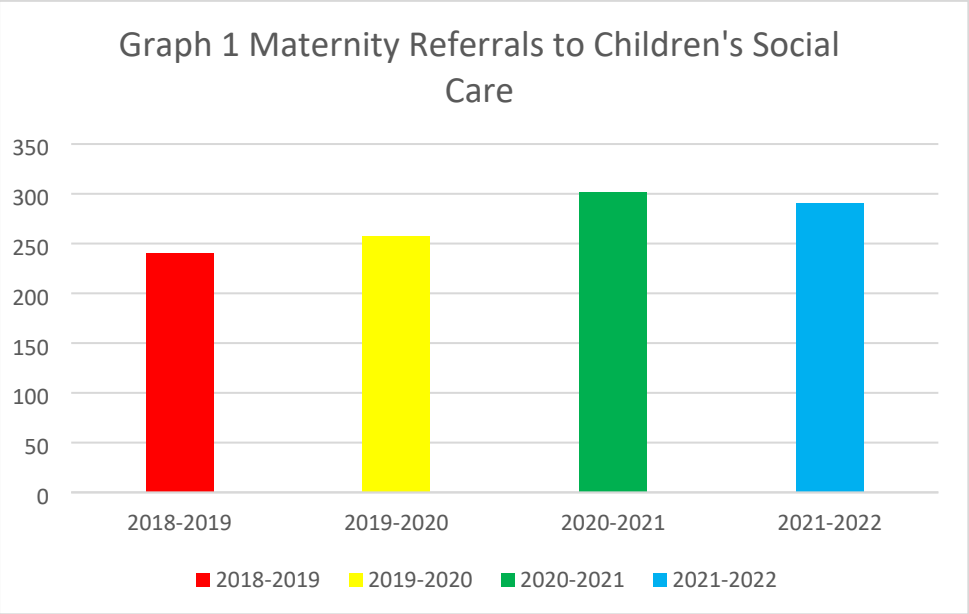
In addition to safeguarding training it is also essential that staff have training on confidentiality, data protection and mental capacity legislation in order to effectively respond to the safeguarding needs of patients.

5.0 Maternity and Women's Services

Lifting of restrictions of visitors to health care environments has facilitated a gradual return to National Institute for Health and Care Excellence (NICE) guidance on antenatal assessments in pregnancy (these were reduced in the Covid-19 pandemic). Partners are now able to be present for antenatal, birth and postnatal encounters so clinicians have reduced opportunities to ask about domestic violence. Challenges on maternity staffing levels have necessitated reduced postnatal visiting at home- offering alternative telephone support and clinic attendance for post birth checks (including new born blood spot testing and weight assessments). This reduces opportunity to assess families in their home environment and is also reliant on attendance- hence impacting on our assessment of family functioning and whether there are unmet needs for support. Specialist midwives have maintained bespoke antenatal care to meet the needs of vulnerable mothers and babies in our care.

5.1 Maternity and Women's Services Referral Activity

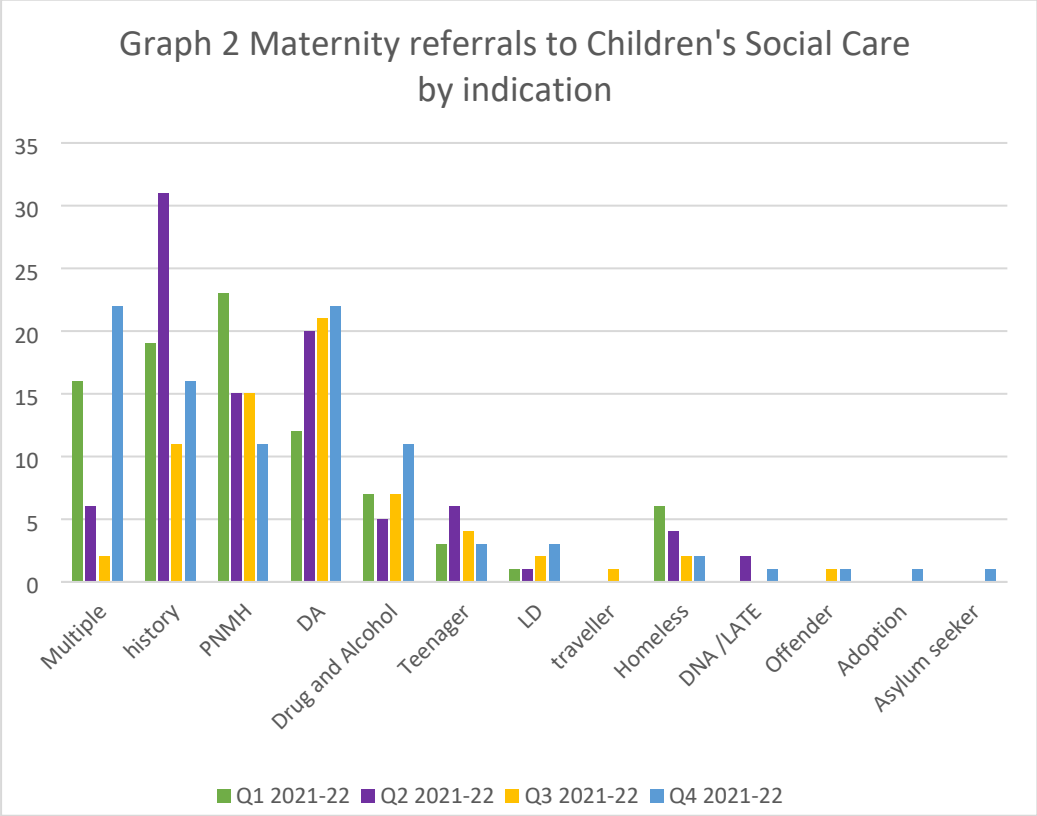
Maternity services have had fairly consistent levels of referrals to children's social care in 2021-2022 with 291 referrals this year compared to 302 in the last financial year as illustrated in graph 1.



Analysis of the maternity booking data identifies that 4.9% of women booked for maternity episodes have disclosed safeguarding concerns.

As illustrated in graph 2, domestic abuse remains the highest reason for referral to children's services. National and local data demonstrates

increasing rates with Cambridgeshire Police reporting a 2% rise in the percentage of all crimes that were domestic abuse related to 20.4% (Office of National statistics published Nov 2021). Domestic abuse increases the risk of child maltreatment 5-fold, with the risk of harm being greatest in infants under 1 year; hence the drive to identify families where this behaviour is prevalent. Routine questioning in the antenatal and postnatal period is embedded in maternity care at CUH, with prompts and documentation in the electronic records. The domestic abuse audit completed by the specialist midwife in March 2022 highlighted a need to maintain education of staff to increase women being consistently asked 3 times in their maternity episode and to support staff when a disclosure was made. The Pathfinder document (Safe Lives 2021) informs the health response to domestic abuse. As outlined in the document, training for multi-disciplinary team (MDT) staff to become domestic abuse champions begins in April 2022. This, alongside a newly appointed Health independent domestic violence advisors (IDVA) in the Trust will raise the profile to ensure domestic abuse is recognised as core business at CUH.



Key:

PNMH:	Perinatal Mental health (either parent)
DA:	Domestic Abuse
LD:	Learning Disability
DNA/LATE	Did Not Attend greater than 3 occasions/late booker (>12 weeks gestation of pregnancy)

Maternal suicide is the leading cause of direct (pregnancy-related) death in the first year after pregnancy. Sadly, there has been one incident of a mother committing suicide on day 78 after the birth of her baby (outside the scope of midwifery practice). Local review highlighted the need for staff to have increased awareness of pathways for mothers with deteriorating mental health, and patient information posters have been put up in parent facilities on wards.

Specialist midwives have taken on the triaging of all referrals to the well-being clinics. Nationally and locally approximately 10% of pregnant women will have a pre-existing diagnosis of impaired mental health. Initially driven by reductions in Obstetric sessions, triaging has reduced unnecessary appointments and given opportunity for caseload analysis and tailoring of service provision. Impact of this will be apparent by May 2022; audit of outcomes and patient experience will test the validity of this measure.

5.2 Pregnancy amongst under 19's

Pregnancies in adolescents under 19 continue to decrease in line with national trends. A new specialist midwife was appointed in November 2021; she has built good relationships with the mothers, family nurse partnership workers, Romsey Mill and Social Care. The team are observing good levels of engagement in antenatal care and good outcomes in birth weight, breastfeeding and contraception uptake after the birth.

5.3 Mothers with learning disabilities

CUH have a relatively low number of mothers with learning disabilities booking within maternity services; however there is still a consistent requirement for social care input for these families. One mother requested a home birth, which was facilitated, recognising her right to choice over place of birth. This patient story is being presented to the executive board as an example of supportive health care enabling actualisation in life events for mothers with a learning disability.

5.4 Female Genital Mutilation (FGM)

In line with CUH policy, all women are asked about FGM at their maternity booking appointment, regardless of ethnicity, and the response is documented. Women who disclose a history of undergoing FGM are asked about the family history of FGM and familial attitudes towards the FGM are assessed. Women are informed of the illegality of FGM, and also asked about their intentions regarding FGM if the baby is a girl.

Where there is a perceived risk to the child, a referral to Children's Social Care is made. Although there were 8 cases where the mother disclosed this year, there were no concerns that the parents would perpetrate FGM of their child, and hence no referrals made. All mothers had discussion with the

safeguarding team to clarify their beliefs and intentions regarding this practice, and had awareness of the illegality of this practice in the UK.

The Named Midwife for Safeguarding is the Trust Lead with responsibility for contributing to quarterly national audit data and FGM monitoring; cases from other specialties are notified to this post holder, in order to submit as full a dataset as possible to the Clinical Audit Platform. However, data is disregarded for any area submitting fewer than 6 cases per quarter; CUH regularly falls into this category, and is therefore classified as a low prevalence area.

In order to ensure ongoing monitoring of female children in families where there is a history of FGM, Maternity staff contribute to the FGM-RIS system linked to the NHS 'Spine'. An alert is created in the NHS record, to alert Health professionals to any FGM risk.

5.5 Service Delivery

Table 1 illustrates the maternity safeguarding team key achievements and table 2 details the areas of focus for the next financial year.

Table 1 Key Achievements
▪ Domestic abuse audit, staff survey and initiation of Domestic Abuse Champions as per the Pathfinder Toolkit. ▪ Continuation of proactive awareness of domestic abuse through poster campaigns in patient facilities. ▪ Changes in staffing: appointment of a substantive Band 7 safeguarding, midwife for vulnerable families and midwife for maternal mental health ▪ Introduction of swipe out access in all clinical areas to slow down any attempted abduction. ▪ Completion of MDT abduction scenario drill performed on delivery unit 11/03/2022. Staff responded promptly and appropriately after identification of the abduction. Learning from this raises questions regarding reasonable actions to reduce risk, and clear action cards with stepped escalations. Abduction drills and policies are a key line of enquiry for the CQC so compliance and learning is now embedded as core business for the maternity safeguarding team.

Table 2 Areas of Focus in the Coming Year	Key Milestones / Targets
• Adherence to Cambridgeshire and Peterborough Safeguarding Partnership's priorities. Incorporating key priorities into training to impact on practice- death of a 12 week old baby born within the system where domestic abuse was a key factor in the home environment	Increased awareness and referrals to IDVA's. Introduction of DA champions and health IDVA Impact on practice assessed through DA audits. Making each encounter count to reach out and offer support which reduces risk of harm for infants

• Embedding the ICON programme (aimed at helping parents and carers with young babies to cope with infant crying) in the antenatal and postnatal period. This involves collaborative working with health visitors and is a focus of Cambridgeshire and Peterborough Safeguarding Partnership to reduce abusive head trauma in babies.	Patient information videos being accessible on Rosie website and postnatal discharge video. ICON key messages discussed in the antenatal period with mothers and fathers.
• Continuation work to improve cross boundary working with neighbouring maternity services. • Working groups to improve and standardise safeguarding communication amongst different Trusts and GPs	Liaison with Named professionals and social workers from neighbouring LA's by establishing monthly meetings. Purposely discussing plans to increase clarity of case management and reduce avoidable delays to discharge.

6.0 Safeguarding Children

6.1 Activity

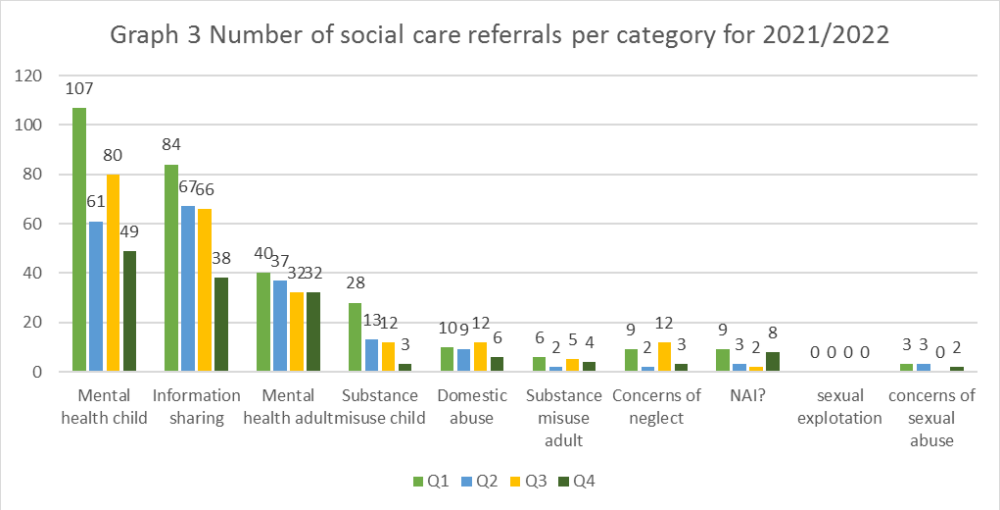
There has been a 17% increase in the number of social care referrals that the childrens safeguarding team have made to social care in 2021/22. Table 3 illustrates the number of social care referrals each year from 2017 – 2022.

Table 3 Number of child social care referrals 2021/22

2017/18	2018/19	2019/20	2020/21	2021/22
948	953	852	952	1120

The number of referrals per quarter has been fairly consistent with the exception of quarter 4 where the number of referrals to childrens social care reduced. This is illustrated in Graph 11, Appendix 2.

The main reasons for referring to social care relates to mental health referrals or for information sharing purposes. Graph 3 illustrates the reasons for onward referral to social per quarter.



When considering these referrals per quarter, in Q1, children and young people had just returned to school after the coronavirus restrictions had been lifted and there remained a large need for mental health support for this group. The number of mental health referrals was the highest of all quarters for both children (107) and parents (40). This accounts for 42.8% of the total referrals in Q1, and is an increase of 59% on the previous quarter of the last financial year. Graph 12 in appendix 2 illustrates this trend in referrals.

Young people expressed anxiety about returning to school in a new world with the pressures of returning to education and support bubbles. Following the third lockdown, the number of child protection conferences increased. This is likely attributed to families being seen face to face by multi agencies in the home or school where any concerns would have become more apparent compared to concerns observed via remote communication during the pandemic.

In Q2, children were again out of school due to the summer holidays, and in line with previous years referrals decreased as children were less visible. The majority of referrals were completed for information sharing purposes only, which does not reflect there necessarily being any safeguarding concerns around the patient's presentation to CUH.

In Q3 which covered Christmas and the New Year, domestic abuse had the highest amount of referrals out of all quarters (12). This is consistent with previous years. Refuge UK report that this quarter often reflects an increase in the incidence of domestic abuse, with people spending more time with abusive partners, higher alcohol consumption, financial worries, and extra difficulty in accessing services. However, this year in particular there were further financial pressures to families brought about by the pandemic exacerbating the impact on those who are at risk.

Out of the 1120 referrals, an overwhelming majority were completed by staff in the Emergency department (ED). This demonstrates that ED are acting as an effective 'front door' and recognising safeguarding concerns and managing them appropriately. The safeguarding team will complete a service review/

audit to monitor this and provide assurances that we are compliant in achieving this. In addition, the safeguarding team will continue to work with Adult ED to provide education, advice and support on completing referrals.

As in 2020/21 neglect in children was one of the children's partnerships main priorities with a simplified version of The Graded Care Profile Tool being embedded to assist professionals at identifying the early signs of neglect. There has been a reduction in 2021/22 of children identified and referred to social care (27 compared to 51 in 2020/21). The trust has moved to and continues to deliver safeguarding children training virtually due to the pandemic, this has made it difficult to provide a comprehensive overview of the tool and ensure practitioners feel confident to use it. However, the safeguarding team have developed and submitted an online evaluation form that all staff will be asked to complete. This will allow us to audit and therefore assess the 'real time' knowledge of staff in relation to key partnership board tools and look at how training can be focused to address any knowledge deficit. In addition, face to face training will be recommenced.

Cambridge and Peterborough now have an online portal which goes directly to the Multi-agency Safeguarding hub (MASH). This has enabled the timeliness of referrals to improve however, it is still a new system and therefore some staff are unfamiliar with it which has led to some issues being identified which have been raised to the safeguarding team. The safeguarding team have provided support to address these issues.

6.2 Did not attend (DNA) of Children (under 18s)

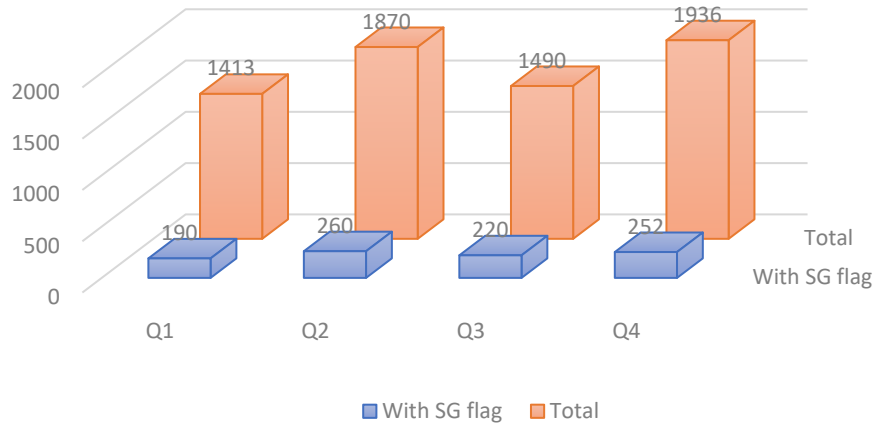
Over the past year, the total number of DNA's or was not brought (WNB) has increased to 7009. Table 4 illustrates the number of DNA's per year from 2017 – 2022.

Table 4 Number of DNA's of children per year from 2017-2022

2017/18	2018/19	2019/20	2020/21	2021/22
6,118	6,484	6,666	5,419	7009

Of the total number of children who did not attend, 922 had a safeguarding alert on record (13%) compared to 719 in 2020/21. Graph 4 illustrates the total number of DNA's per quarter along with those patients who had a safeguarding flag on record.

Graph 4 DNA totals per quarter for 2021/2022



This demonstrates that throughout the pandemic, DNA's have remained relatively consistent for children with a safeguarding flag however DNA's are significantly higher (29%) this year in the general patient cohort. Adapting the ways that patients were offered appointments throughout the pandemic last year has allowed patients and families to access a hybrid of virtual and face to face appointments which has allowed for increased flexibility. However, over time this approach can also lead to technical and usability challenges, alongside 'digital amnesia' – virtual appointments often require frequent reminders to be sent which can be difficult with continually changing demographics. This may account in part for the increase in the DNA rate. It should be noted that a benchmarking project for outpatient services and activity within Specialist Children's Hospitals outpatients, showed CUH to be 3rd out of 17 trusts with lowest DNA/WNB rate.

Each division continue to receive a monthly breakdown of their specific DNAs with a safeguarding alert and are tasked with providing assurance that those DNAs have been followed up and actioned appropriately by the relevant team. In order to provide more robust oversight and assurance, a working group has been established to review how this is actioned throughout the trust and to recommend any changes require in order to capture children who are at risk. The DNA policy will be updated to reflect any changes and the findings reported to the Joint Safeguarding Committee.

6.3 Child Sexual Exploitation (CSE)

The Children's partnership exploitation checklist which was part of the Epic safeguarding checklist build is not available on the portal, however, the safeguarding team have been utilising the CSE/Exploitation risk and management tool with staff who have concerns and either want to make a referral or are unsure whether they should make a referral to children's social care. This is in addition to adhoc training that the team have delivered to both nursing and medical staff. This supports the governments Tackling Child Sexual Abuse Strategy (2021) which identifies that CSE is more widespread

than the data highlights. Moreover, Epic alerts remain active to notify staff that the child or young person is vulnerable to exploitation. In 2021/22, there have been no cases of child sexual exploitation.

6.4 Independent Inquiry into Child Sexual Abuse (IICSA)

The Independent Inquiry into Child Sexual Abuse was set up to review serious high profile instances of non-recent child sexual abuse where there was a failure to protect children. Part of this inquiry related to the 'truth project' which closed in October 2021. The Truth project has offered opportunities for victims and survivors to share their experiences and be respectfully heard and acknowledged. 32549 participants provided information for the project. The work of the inquiry is ongoing with 15 investigations into historic institutional child sexual abuse being conducted.

6.5 Mental Health - Referrals to Children and adolescent mental health (CAMH) and Social Care

As illustrated in table 5, the number of children and adolescent mental health referrals has steadily risen over the previous four years although they have decreased by 15% in 2021/22.

Table 5 Number of mental health referrals per year from 2017 -2022.

2017/18	2018/19	2019/20	2020/21	2021/22
236	206	361	385	326

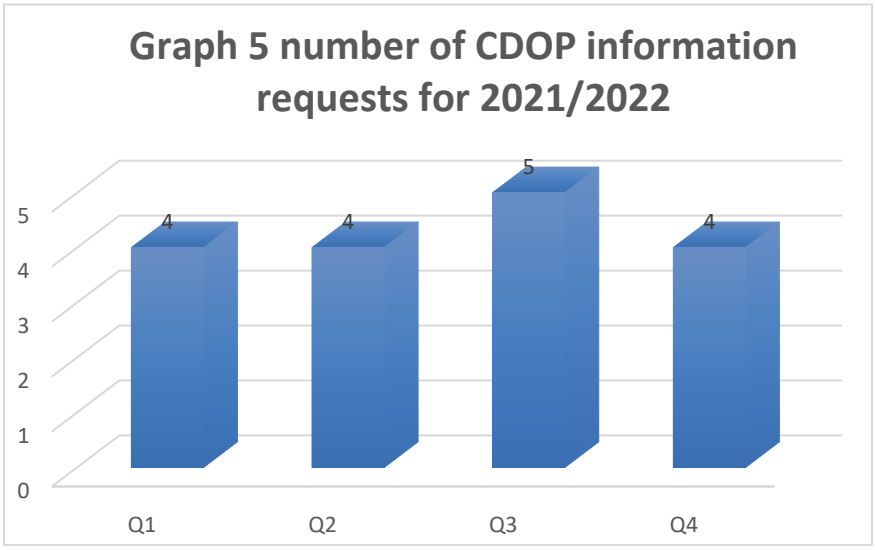
This trend reflects the national picture with no statistically significant change identified by sex. It has been noticed that even after lockdown 2 and the lifting of many restrictions, Covid has adversely impacted young people. This was highlighted in Wave 2 of the 'Mental Health of Children and Young People 2021', report which showed negative changes to household circumstances since 2020 such as reductions in household income (24.8%) leading to problems paying bills and buying food (4.1%). This has put increased stress and pressure on young people which in turn is reflected in mental health issues.

CUH has continued to see an increase in admissions for children and young people with an eating disorder. This is in line with the national picture with NHSEI reporting that nationally, there are 81 children and young people with an eating disorder waiting over 12 weeks to start treatment or be admitted to a mental health bed compared to 13 at the end of 2021. This waiting time is reflected in the number of children who are cared for at CUH whilst awaiting a suitable placement.

6.5 Child death overview panel (CDOP)

The key functions of a child death overview panel (CDOP) is to review all child deaths, excluding those babies who are stillborn and planned terminations of pregnancy to determine whether the death was preventable or if there were modifiable factors which may have contributed to the death. The panel will identify whether there are any relevant factors that impact on the welfare of children in the area or to public health and safety, and will consider whether action should be taken in relation to any matters identified.

The children's safeguarding team have provided information for 17 CDOP reviews in 2021/22 as illustrated in graph 5 compared to 35 reviews in 2020/21 (48.5% reduction).



6.6 Service Delivery

This year, the children's safeguarding team have continued to adapt and implement new ways of working within the trust and with partner agencies. The team have embraced holding meetings over a social platform which has improved time efficiency and attendance at patient centred meetings at short notice due to there not being a requirement to travel to various different locations. Table 6 illustrates the teams' key achievements and table 7 details the areas of focus for the next financial year.

Table 6 Key Achievements
• Ad hoc training around Sexual abuse and CSE tools to meet specific team needs has started to be offered • The appointment of a new Named Nurse who started in March. • The appointment of a specialist nurse from ED/ outpatients who is due to commence employment in July. • Improvement to safeguarding referral pathways and triage of referrals to social care. • Improvements to referral data recording. • Regular presence at a range of CCG and partnership board subgroup meetings to enhance professional networks. • Regular outcome meetings to obtain feedback and referral outcomes from children's social care.

Table 7 Areas of Focus in the Coming Year	Key Milestones / Targets
Compliance with the Partnership board priorities of the lived experience of the child, alongside exploitation, CSE and neglect.	Will be reflected in SI reporting and safeguarding statistics/quarterly reporting.
Continued education for staff to make social care referrals ensuring quality and consent are captured.	Feedback from social care and the children's partnership.
Re-implementing a hybrid of face to face and virtual contacts and training to maintain core business post peak pandemic.	Families continue to receive support in multiagency framework.
Audit and Service review	
Implementation of SI/Practice Reviews recommendations.	
Clinical safeguarding supervision for paediatric areas to be rolled out.	

7 Safeguarding Adults

There are six key principles to safeguarding adults, these are summarised in table 8.

Table 8 key principles of safeguarding adults.

Empowerment:	People being supported and encouraged to make their own decisions and informed consent.
Prevention:	It is better to take action before harm occurs.
Proportionality:	The least intrusive response appropriate to the risk presented.
Protection:	Support and representation for those in greatest need.
Partnership:	Local solutions through services working with their Communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability:	Accountability and transparency in safeguarding practice.

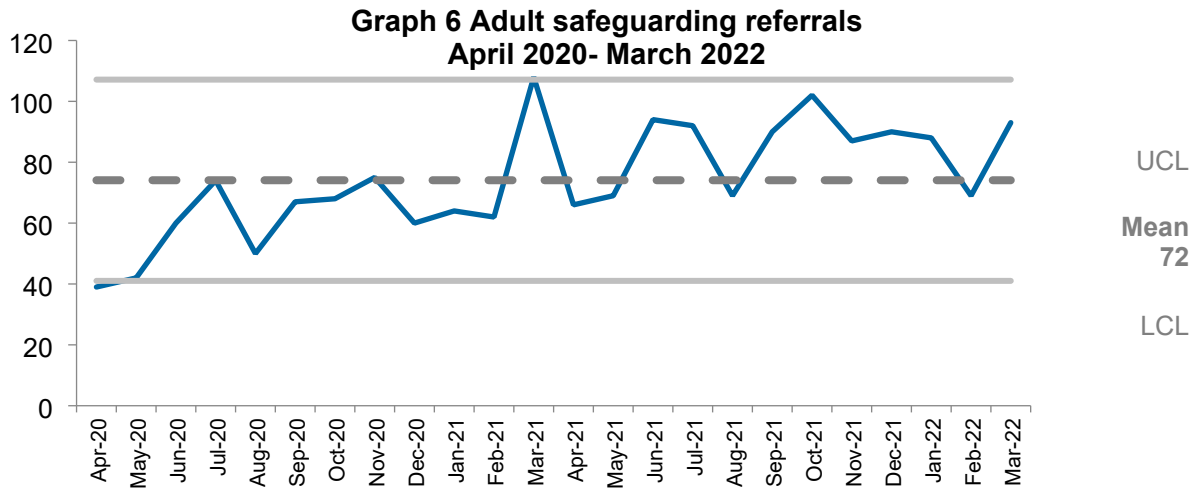
7.1 Activity

There continues to be a year on year increase in referrals to the Adult Safeguarding team as illustrated in Table 9.

Table 9 Adult safeguarding referrals 2017 - 2022

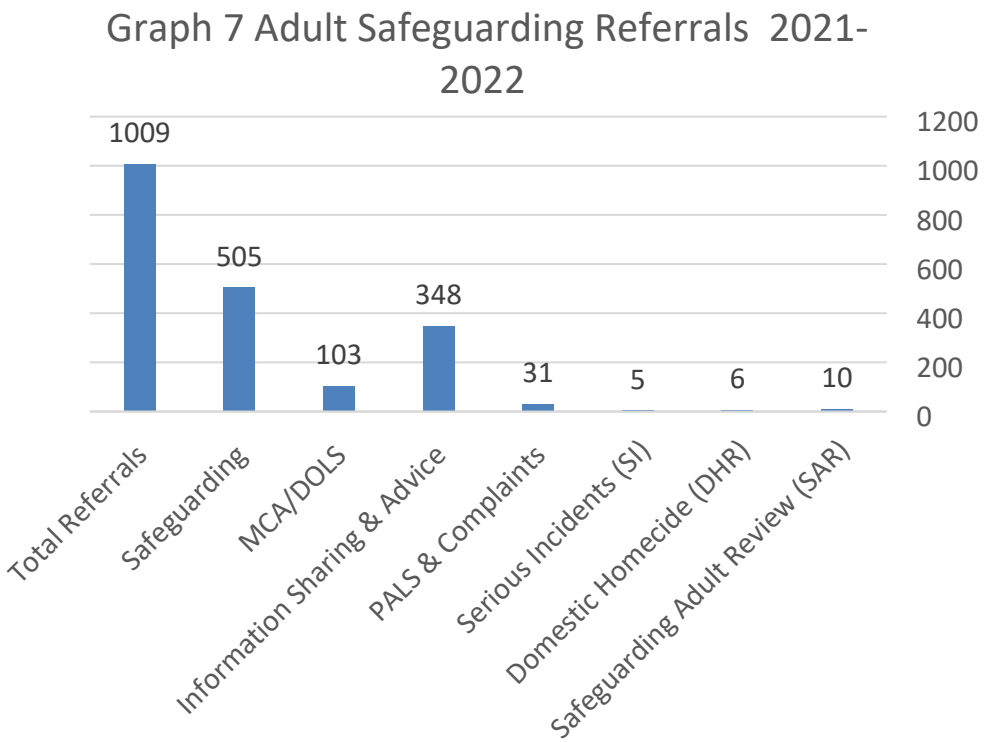
2017/18	2018/19	2019/20	2020/21	2021/22
375	421	395	785	1009

In 2021/2022, there has been a 29% increase in referrals to the team compared to 2020/2021 as illustrated in graph 6, this does not include referrals to request a Deprivation of liberty safeguards (DOLS) authorisation which are reported separately. Ethnicity data related to these referrals can be found in graph 13 in appendix 3.



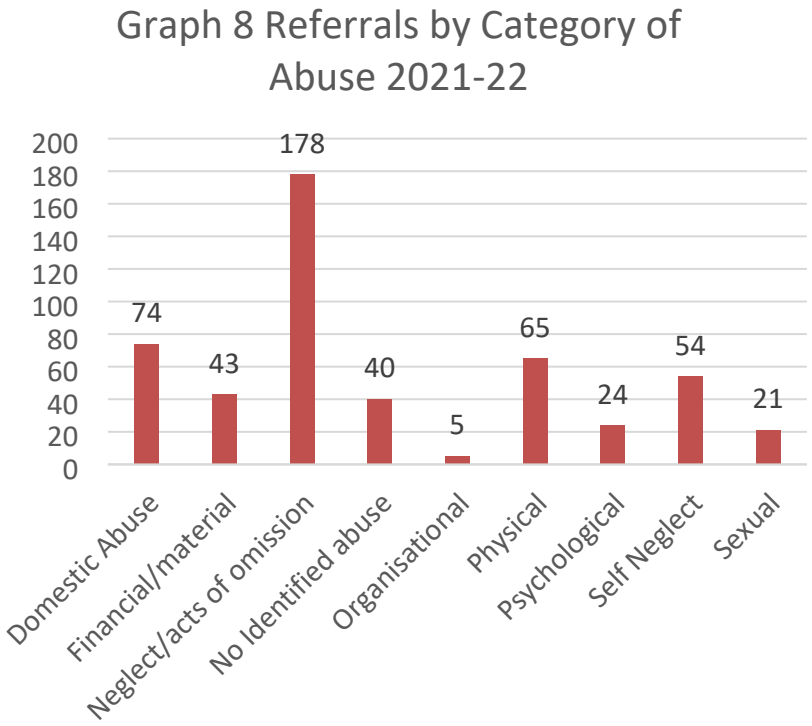
The Emergency Department (ED) have been responsible for 23% (116) of the referrals received in the last year which is significantly less than in previous years. Conversely, a 109% increase in referrals from EAU4/5 and N2 has been observed in 21/22. This change in referral patterns is thought to be attributed to the change in emergency department admission pathways to medical assessment pathways thus resulting in some patients being assessed in other areas (EAU4/5 and N2) rather than ED. Graph 14 in appendix 3 illustrates the number of safeguarding referrals by ward, department or team.

The reasons for a referral to the safeguarding team is illustrated in graph 7.



There has been a significant increase in the number of referrals for concerns relating to financial abuse this year with an overall increase of 138% compared to 20/21. 51% of these concerns were shared with the patients local authority (LA) for further investigation; this will continue to be monitored in 22/23.

The largest number of referrals (34%) forwarded to the local authority for further safeguarding investigations relate to neglect, this presents a similar pattern as in 2018/19, 2019/20 and 20/21. This is reflected in graph 8.



78% of all referrals requiring a community safeguarding investigation were directed to Cambridgeshire Adult Social Care. Graph 15 in appendix 3 illustrates the safeguarding referrals by local authority.

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so if it believes an adult is experiencing or at risk of abuse or neglect .Safeguarding concerns relating to the care and treatment received by patients during an in-patient admission or out-patient visit are investigated by the ward or department responsible for their care supported by the safeguarding team. This is monitored by Cambridgeshire local authority who have responsibility for ensuring the investigation is completed and agreeing appropriate actions with the Trust.

A total of 47 concerns have been raised this year, compared to 54 in 2020/21. After initial fact finding, 13 cases did not proceed to an investigation as the facts concluded that no abuse or neglect had taken place. A summary of these concerns are below:

- 10 concerns were fully investigated and found to be unsubstantiated by the local authority.

- 3 concerns were discussed at the trust Serious Incident Review Panel (SIERP), 1 was declared as a serious incident (SI) and 2 were managed via the internal investigation process with involvement of the safeguarding team including discussion with the local authority.
- 5 investigations led by the police, have been closed with no further action required by the Trust.
- 3 Concerns are being addressed via the NHS formal complaints process, with input from the Safeguarding Lead.
- 1 concern following an investigation was found to be inconclusive by the local authority.
- 2 Cases are currently under investigation by the police.
- We are awaiting the outcome of 2 investigations.

Following investigation, 4 concerns were partially substantiated by the local authority, all of which relate to patients discharge. A number of common themes have been identified.

- Lack of referrals to District Nursing.
- Poor or absent nursing handover to care providers and family carers.
- Poor communication and handover of pressure ulcer and wound care.

Details of the concerns and themes have been escalated to the Discharge Assurance Panel and reported to the Discharge Assurance Steering Group.

A total of 4 concerns were substantiated by the local authority in 2021/22 one less than in the previous year. These concerns were:

- J2 – patient with mitts in place that had been secured with tape.
- J2 – inappropriate use of restraint by nursing staff.
- D8 - patient discharged to care home unable to weight bear, was re-admitted with a fractured ankle - Missed fracture.
- F4 – patient discharged to care home, skin condition poor, patient did not look well cared for, reported weight loss.

All safeguarding investigation reports and action plans are shared with the local authority, monitored at divisional level with completed actions plans reviewed by the Joint Safeguarding Committee.

During 2021/22 the Adult Safeguarding Team have contributed to 11 Multi Agency Adult Safeguarding Reviews (SAR) and 6 Domestic Homicide Reviews (DHR) including submission of chronologies and reports.

7.2 Mental Capacity Act / Deprivation of Liberty Safeguards

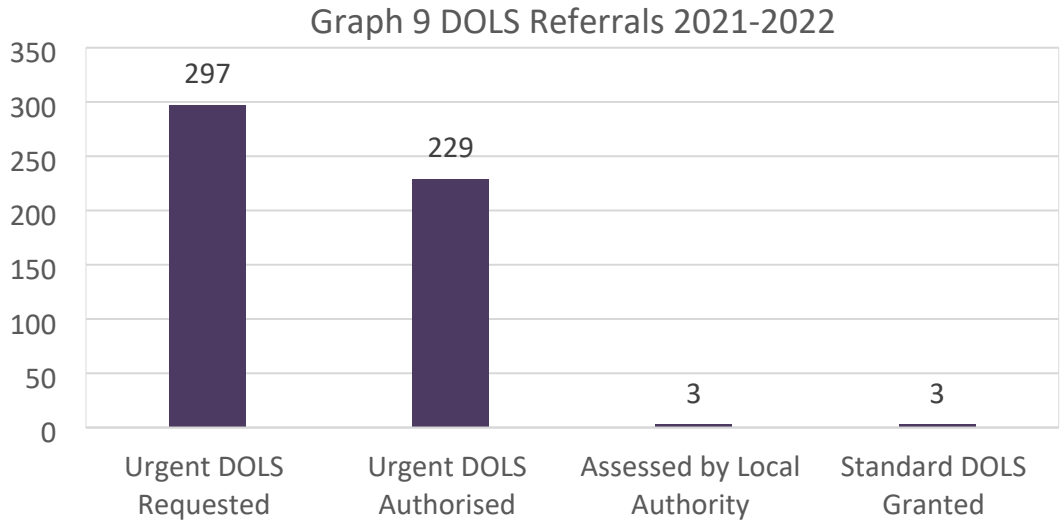
Table 10 illustrates that there has been a total of 297 requests for Urgent Deprivation of Liberty Safeguards (DoLs) authorisations in 2021/2022. Whilst this is a significant increase of 112% when compared to 2020/2021, it is comparable to the numbers of requests pre-pandemic. All supervisory bodies

suspended face to face DOLS assessments during the pandemic and recently we have seen areas returning to face to face assessments.

Table 10 Number of requests for urgent DOLS authorisations

2017/18	2018/19	2019/20	2020/21	2021/22
304	360	301	140	297

Of the 297 urgent requests that were received, 229 were authorised, 3 were assessed by the local authority and a further 3 patients were granted standard DOLS. This is illustrated in graph 9.



The majority of patients who required a DOLS had an acquired brain injury or stroke (135 patients) and 97 patients had dementia or delirium. Chart 16 in appendix 4 illustrates the other conditions or vulnerabilities which led to a DOLS authorisation. A5 (neurology ward) and J2 (neurology rehabilitation ward) request the highest number of urgent DOLS authorisations which correlates with this patient group due to the speciality of the wards. A further breakdown of the number of DOLS requests per ward can be found in graph 17 in appendix 4 along with the DOLS requests by ethnicity (graph 18, Appendix 4).

Authorisations for patients who live in Cambridgeshire continues to remain the highest which is to be expected as it reflects our patient population. Graph 19 in appendix 4 illustrates the other local authorities in which those patients who had a DOLS authorised reside.

The legislative framework of the Mental Capacity Act (MCA) 2005 occupies a central role in the pathways and practices of acute hospital care, and efforts continue at CUH to embed capacity assessment and the best interests' process into all aspects of care and treatment. MCA and DOLS training is included in adult safeguarding training at Trust Induction for identified staff groups and this is supplemented by bespoke training delivered to identified

staff groups. The electronic patient record allows CUH to record assessments and report on them collectively. The care and treatment given to those who are unable to provide consent through our DoLS referrals is also monitored.

The Mental Capacity (Amendment) Act 2019 received Royal Assent on 16th May 2019. The purpose of the Act is to abolish the Deprivation of Liberty Safeguards (DoLS) and to replace them with a completely new system, the Liberty Protection Safeguards (LPS). This system will apply to England and Wales only. The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

In 2020 the Government announced that the original implementation date for LPS (1 October 2020) would be postponed until April 2022. In autumn 2021 The Department of Health and Social Care (DHSC) formally announced that the Liberty Protection Safeguards (LPS) would be delayed beyond the planned start date of April 2022.

In March 2022, the Department of Health and Social Care published the draft regulations and Code of Practice for the Mental Capacity Act (MCA) and the Liberty Protection Safeguards (LPS) for public review. The extended 16 week public consultation will run until 7 July 2022. A revised implementation date will not be released until after the consultation responses have been considered. It is likely that there will be at least 6 months between the Government's response to the consultation and the start date of LPS. This is to allow for the health and social care bodies to prepare for the changes and to recruit and train staff.

7.3 Prevent

The NHS needs to ensure that staff can identify early signs of an individual being drawn into radicalisation and to be confident in referring individuals to their organisational safeguarding lead or the police. There are two training packages available to CUH staff dependent on their role. From April 2019 the collection of Prevent training data became a contractual matter and CUH are measured against these contractual requirements. The compliance with Prevent training has remained above the required 85% this year.

The aim of the data collection is to demonstrate how all NHS commissioned providers are delivering the key elements of the duty. These include identified Prevent leads, delivery of awareness training, the level of referrals made and the engagement with relevant partnership forums that coordinate the Prevent strategy at local and regional level.

All NHS Trusts and Foundation Trusts are required to submit Prevent data quarterly to NHS England using the Strategic Data Collection Service (SDCS) portal provided by NHS Digital. CUH did not make any referrals to Prevent in 2021/22 however we have responded to 25 requests for information to assist in the assessment or management by the Chanel Panel.

7.4 Domestic Abuse

Victims of domestic abuse who have care and support needs are referred with their consent to the relevant local authority safeguarding team. Many patients who are in an abusive relationship and are seeking support do not have care and support needs and can receive advice and support from the Independent Domestic Advice (IDVA) service. Cambridgeshire IDVA service will offer support to patients during an in-patient stay and can provide on-going support in the community

The Adult Safeguarding team have made 11 referrals to IDVA in the last year and have supported the patient to liaise with the IDVA and other agencies with their consent.

The increase in domestic abuse referrals that was reported during 2020/21 has reduced by 16% and represents 15 % of referrals received by the team.

7.5 Service Delivery

Table 11 lists the key achievements of the adult safeguarding team in 2021/22 and table 12 lists the areas of focus for the next financial year.

Table 11 Key Achievements

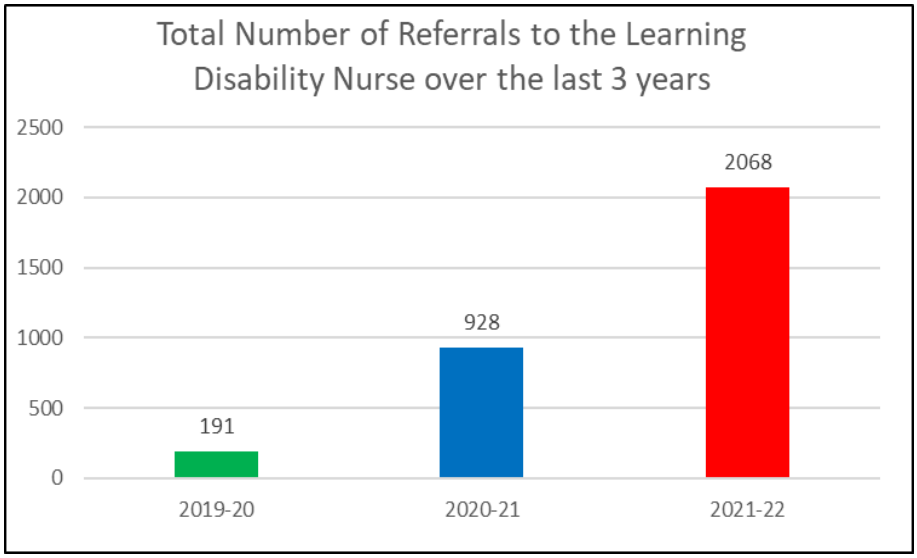
- Approved investment to enable recruitment of a substantive MCA/LPS practitioner (Band 7 WTE)
- Appointment of substantive Adult Safeguarding Administrator
- Introduction of MCA/DOLs monthly divisional spot checks
- Bespoke Training
    - MCA Master Class – Senior Nursing/AHP team
    - Discharge Planning Team MCA /DOLS joint training with local authority Trainer
    - LPS presentation to Management Executive
    - MCA LPA & Deputyship Communication Aid Service East of England (CASEE)
    - J2 MCA Learning from safeguarding incident – 4 x Sessions
    - Clinical Psychology – Safeguarding and MCA
- CUH physiotherapy department focused project improving confidence and competence with capacity assessments and documentation.
    - Department teaching to ensure all staff members have access to up to date MCA and DOLS information to best support their practice.
    - Development of regular training, to support the physiotherapy team to identify resources as well as documentation templates to support best patient care

Table 12 Areas of Focus in the Coming Year	Key Milestones / Targets
Review of Internal safeguarding reporting	Aligned to QSIS
The implementation of Level 3 Adult Safeguarding Training	Roll -out, recording and reporting of Compliance.
Review and Development of Virtual Training Packages	Training available via DOT
Review of Adult Safeguarding Electronic Referral Form	Aligned to Safeguarding adult board on-line form.
*Development of MCA/LPS advisory group to lead on implementation and review of procedures, and documentation.	Group members identified TOR agreed.
Liberty Protection Safeguards Policy and Procedure **Carried over due to delay in LPS implementation*	Ratified and in place for LPS Launch

8 Learning Disability

The referrals to the learning Disability Specialist Nurse has increased year on year for the last 3 years. This is illustrated in graph 10. Compared to 2020/21, there has been an increase in referrals of 123% during 2021-22. It should be noted that this does not reflect the work associated with each referral as the amount of involvement from the learning disability specialist nurse will be dependent on the patients' length of stay or support needs.

Graph 10 Total number of referrals to the Learning disability Specialist Nurse over the last 3 years



A more detailed breakdown of the number of referrals per month in 2021-22 can be found in graph 20 in appendix 5.

The increase in referrals is likely to be multifactorial and may relate to the Learning disability flag that has been developed on epic, an increase in admissions of patients with a learning disability, an increased awareness of the Learning Disability Specialist Nurse and close collaboration with community Learning Disability Teams.

8.1 The Trust Learning Disability Strategy

The Learning Disability 3 year strategy was approved in June 2018. This strategy recognises that people with learning Disability and Autism will often require adjustments to their care and treatment pathways in order to: support access (in adherence to the Equality Act 2010); improve the patient experience and improve health outcomes.

In order to achieve the objectives outlined within the strategy, a learning disability and autism working group was convened in September 2018. Additionally, the group aims to improve and build on collaborative working between CUH, patients with a learning disability, local authority partners, families and carers whilst also supporting and monitoring progress against regional and national improvement programmes that relate to the care of learning disability patients in acute hospital Trusts. Unfortunately three meetings were paused during 2021 due to the pandemic and trust capacity however these meetings have now recommenced.

The group undertook a gap analysis in 2021 against key requirements of the service. The main themes and priorities identified from this gap analysis were:

- To identify clear Trust outcome measures which identify how effective CUH services are for people with a learning disability
- Identification of people with a learning disability on the waiting list

- The need for clear guidance for staff to monitor rates of did not attend appointments for people with learning disability/Autism and the process for follow up
- To develop process for highlighting harm from waiting list delays
- Requirement to develop an equality, diversity and inclusion (EDI) strategy to include the learning disability procedure
- To implement reasonable adjustments to Trust wide care pathways to ensure people with learning disabilities can access highly personalised care and achieve equality of outcomes
- To ensure patient experience and engagement of this patient group Utilising the results from this gap analysis an improvement plan was developed which is monitored and reported at the Joint Safeguarding Committee.

8.2 Improving Patient Journeys

Despite the COVID 19 pandemic during 2021/22, it was important to keep pace with the changing landscape and ensure patients with a learning disability continued to receive an equitable service across the organisation. This was achieved through:

- Providing specialist advice and consultation, including:

  - Ensuring that people with learning disabilities could be exempt from masks if they were unable to tolerate.
  - Enabling visitors to continue to support people with learning disabilities during their stay.
  - Identifying alternative pathways for patients who lacked capacity and could not tolerate covid swabbing.
  - Ensuring national guidance was circulated and distributed throughout the organisation ie communication around do not attempt cardio pulmonary resuscitation DNACPR or use of frailty scores.
  - Circulation of easy read information regarding government advice/guidance.
  - Consulting on documents to ensure that people with learning disabilities can appropriately access outpatient/virtual consultations were appropriate.
  - Highlighting any people on waiting lists where their needs may have changed as elective services and outpatient services were dealing with backlogs.

- Maintaining close links with families/providers/local authority, this was achieved through:

  - Discussion with community learning disability teams and providers about ensuring hospital passport information was updated, many also brought in the National Covid 19 passports that were produced.
  - The learning disability specialist nurse ensured close links were maintained for those patients with a learning disability who were not

supported on wards by their carers/families to ensure the wards had information required to care and treat individual patients successfully and to ensure that families/providers were kept informed.
  - Reintroduction of family/support providers for these patients within green clinical areas and supporting flow of patients into these areas as a priority.
  - Supporting individual risk assessments in cases where family support was able to be provided in amber/red areas in individual side rooms.

- Supporting timely discharge of patients with a learning disability or autism, this was achieved through:

  - The learning Disability Partnership establishing a link worker scheme jointly with the Learning Disability Nurse at CUH to ensure smooth transitions into and out of hospital.
  - The learning Disability Nurse linking with the discharge planning and inpatient areas ensuring that COVID testing for people with learning disabilities was robust and timely for discharge.

8.3 Learning Disability Improvement Standards for NHS Trusts 2018

There are four standards that trusts need to meet (3 relevant to acute Trusts); meeting these identifies Trusts as delivering high quality services for people with learning disabilities, autism, or both.

The three standards for acute trusts concern:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce

Trusts are expected to publish their performance against these standards in their annual quality accounts: to demonstrate to the population they serve how they measure quality of services and whether quality is improving.

The most recent report from NHSI (2019/20) was delayed due to the pandemic and was published in December 2021. 131 acute NHS trusts participated in the data collection. On average trusts providing services identified 0.3% of people with an electronic patient record as having a learning disability. This remains lower than the number of people registered as having a learning disability in primary care. The main national themes highlighted from the benchmarking report were:

- 59% of organisations do not intermittently contact people with a learning Disability or Autism on waiting lists to see if their situation has become more urgent.
- 69% do not monitor waiting times and report concerns to the board.
- 75% do not monitor and compare emergency readmission rates

- 46% of staff feel they did not feel they had the necessary resources to meet the needs of people with a learning Disability and Autism.

When considering CUH specific results, table 13 below summarises the staff and patient survey highlights.

Table 13 NHSI Learning Disability Standards Report 2019/2020, CUH staff and patient survey highlights.

Survey Question	Staff survey %	Patient survey %
Only included strongly agree and agree scores and omitted neither agree nor disagree in the data calculation (combined data collected from staff working with adults and Children and young people). Some questions are not asked in both surveys.		
Able to identify what reasonable adjustments are needed	78	-
Have the necessary resources to meet the needs	59	79
Always able to deliver safe care	76	89
In trust feel people are always treated with dignity and respect	82	93
Routinely involved in planning of trust services	31	-
Have received LD/Autism training	72	-
Access to LD/Autism Nurse	75	-
Recommend trust to family/friends	73	84

In general, CUH Staff report positive feedback however 69% felt that the Trust could improve in relation to involving people with a learning disability/autism in planning new services. The learning disability action plan that has already been developed identifies the trust improvement plan over the next 3 years and this is included.

8.4 Learning Disability Mortality Review (LeDeR) Programme

2017/18 saw the launch of the Learning Disability Mortality Review (LeDeR) Programme provided by Bristol University and funded by NHS England.

Key activities related to the programme:

- Acts as a central point for the notification of deaths of people with learning disabilities.
- Supports local areas to review the deaths of people with learning disabilities, identify learning and take forward lessons learnt into service improvements.
- Collates and shares anonymised information so that common themes, learning points and recommendations can be identified and taken forward.

Any death in the Trust concerning a patient with a learning disability is notified to the LeDeR programme. Under the Trust's mortality programme, patients with a learning disability receive a Structured Judgement Review with oversight provided by the Learning from Deaths Oversight Committee.

Cambridgeshire and Peterborough CCG have had a key role in supporting local areas to review deaths of people with a learning disability, however there have been difficulties locally in allocating and undertaking reviews of deaths (initially also a national issue). Additionally, Cambridgeshire paused reviews other than COVID 19 related deaths in the pandemic. All these factors have hindered the full extent of themed learning countywide. At time of this report, the CCG local area contact annual report has not been finalised but it is likely that respiratory remains the leading cause of death in this patient group. The emphasis will move from CCG to integrated care boards (ICBs) moving forwards and a system wide approach to inequality in health.

Between April 2021- March 2022, 10 adult deaths of patients with a learning disability have been reported within CUH compared to 11 deaths reported in 2020 - 2021. 1 of these was a COVID 19 related death in a patient who was unvaccinated compared to 5 COVID 19 related deaths in 2020-2021. Additionally, CUH has received 15 LeDeR information requests for medical records. When benchmarking against other organisations, the 2019/20 NHSI learning disability improvement standards for NHS trusts report demonstrated that LeDeR was embedded within the organisation and that the number of deaths is below the mean average of the other trusts.

8.5 CUH Training Numbers for 2021/22

During the pandemic face to face training was paused and only essential training continued. This has resulted in a reduction in the number of staff who have received learning disability or autism training. Table 14 illustrates the number of staff who have received learning disability training within 2021 – 2022.

Table 14 Number of staff who have received learning disability training in 2021 - 2022

Training	Participant Numbers
Health Care support worker development days (induction)	392
Preceptorship Division A (October- March)	37
Palliative and bereavement care study day	22
Nurse Associate training/shadowing	12
Ward bespoke training as learning from action plan (C7)	25

During 2021 – 2022, 488 members of staff have received learning disability training. The number of staff trained is lower than previous years as additional training that would normally be delivered has been paused during the pandemic. This training includes:

- Qualified practitioner orientation – all new registered Nurses and Midwives commencing employment would normally have a session on learning disabilities as part of their induction programme.
- Be Disability Confident – 3 courses usually delivered per year.
- Learning Disability/Autism Awareness – This is a full study day which is usually held twice per year.

Despite relatively low training numbers, the staff survey results from the NHSI benchmarking report highlighted that:

- 72% of staff say they receive up to date training covering learning Disability/Autism.
- 75% said they had access to the specialist Learning Disability staff.

This is due in part to funding that was secured from the Mencap 'Treat me well' campaign by voiceability to produce an additional three videos raising awareness for staff and the public which has meant that staff are still able to access educational resources even though the face to face training sessions have been disrupted. The learning disability specialist nurse at CUH has jointly produced the videos. The title of the videos include:

- Learning disability nurse's and how they can help you
- Communication and reasonable adjustments
- Hospital passports

Further promotion of these videos will occur during learning Disability Week 2022.

The National mandating of learning disability training has also been delayed due to the pandemic. Recently, Royal assent has been given and the mandating of learning disability training is included within the Health and Social Care Act 2022. This states that all CQC registered service providers are to ensure their employees receive learning disability and autism training appropriate to their role.

Over the last year, the National Development Team for Inclusion (NDTI) in collaboration with Bemix and my life choice organisations have continued to independently evaluate the proposed National training packages from the Bristish Institute of Learning Disabilities (BILD), Royal Mencap Association, Gloucestershire Health and Care NHS Foundation Trust and Pathways Associates Community Interest Company.

Following this review, the Secretary of State is required to publish a Code of Practice, which will make provisions about the nature of the training including the content, delivery and the ongoing evaluation of the training. This code of practice

will be subject to public consultation, the timings of which are currently being considered. Once the national consultation has been completed, CUH will identify an implementation plan working with the Mandatory training advisory group (MTAG).

8.6 Workforce

Recognition of the NHSI standards to strengthen the Learning Disability specialist workforce across the organisation and the increase in referrals to the current Learning Disability Nurse resulted in fixed term investment in this area during 2021. This investment was:

- a second adult Learning Disability Practitioner on a 6 month fixed term contract. This contract has now ended and currently there is no investment available to reappoint although it should be noted that the referrals continue to rise.
- a 12 month paediatric post currently jointly funded with external organisations.

During 2021 NHS England have been analysing data in a new study from submissions of the Learning Disability standards 2018/19 comparing trusts with and without Learning Disability Nurses. This demonstrates that there are benefits for both patients with a Learning Disability and for organisations when a learning disability specialist nurse is employed. Table 15 provides a high level summary of the NHS England analysis of learning disability standards 2018/19.
Table 15 NHS England analysis of Learning Disability Standards 2018/19 in relation to acute learning disability specialist nurses.

Mortality	% Total trust deaths (2018/19) by people identified as having a learning Disability	% People known by trust to have a learning Disability who died in 2018-19
No Specialist Nurse	1.05%	1.15%
Specialist LD Nurse	0.85%	0.75%
Potential deaths prevented if all trusts had specialist nurses	Approximately 105-175	
Impact of LD specialist nurses	**IMPACT** Reduce Mortality Increase patient safety, better risk management Increased recognition (flagging) and raising awareness of people with learning Disability More reasonable adjustments Improved staff confidence/support Improved patient experience, valued by families and wider organisations More accessible complaints process	

	Inform policy, strategy, commissioning and service Improvement Close attention to MCA issues Promotion of information sharing Improved discharge planning

This will complement the future work planned by the Royal College of Nursing (RCN) regarding Learning Disability acute nurse competencies and the Care Quality Commission (CQC) Independent voice review of acute care of people with a learning disability or autism.

8.7 Quality Commission (CQC) Independent voice review of acute care of people with a learning disability or autism (LeDeR).

The CQC identified eight NHS acute trusts to participate in a national Independent voice product review which focused on the acute care of people with a learning disability or autism. Cambridge University Hospitals NHS Foundation trust (CUH) were identified as one of the eight trusts to be invited to participate in the review.

The CQC team visiting CUH had a background in working with people with learning disabilities in social care settings. The review focussed on 4 key lines of enquiry to obtain a better understanding of how it feels to receive services in an acute hospital trust for this patient cohort and what makes that positive, negative or otherwise. The publication in September 2022 of the national review will identify common themes and contain a collection of findings and reflections of the experiences of people who use services who have a learning disability or who are autistic. As this was not an inspection, formal negative judgements were not made in relation to the findings.

The review included a number of elements over two stages:
Stage 1: Virtual element - interviews, focus groups with CUH staff and case tracking of 2 patient volunteers to share their experiences.
Stage 2: A one day visit to CUH on 17th March 2022, including ward visits, discussion with patients, and their carer's, housekeeping, security, and ward staff.

The immediate feedback at the end of the on site visit was that all CUH staff were very polite, enthusiastic, eager, open, honest, and passionate in wanting to support patients with learning disabilities and autism. The team recognised staff wanted to do the 'right thing' although sometimes finding the resource and time to do it was challenging. The team fed back that staff demonstrated excellent examples of reasonable adjustments that had been made for this patient group.

The initial feedback was reviewed against the existing learning disability and autism improvement action plan to ensure learning/action points were included. The feedback was shared in committees, forums and communication networks across the organisation.

8.8 Patient/service user feedback

Table 16 illustrates the feedback received from patients and service users within the last NHSI report and also demonstrates areas where service users have been involved in developing services.

Table 16 Patient/User Feedback and service user involvement
• The NHSI benchmarking bespoke CUH report 2020/21 highlighted good compliance with engagement relating to views of people with learning disabilities and their carers. They felt safe, cared for, listened to, were provided with choice and had things explained in a way they understood. 61% of people surveyed reported they had family/support stay with them during their admission and pandemic. • Hospital passports were refreshed in consultation with people with learning disabilities • Patients were consulted over an easy read leaflet for an EEG produced by clinical psychology • Voiceability have Consulted on our easy read friends and family feedback survey • Patients supported engagement/feedback with CUH in the CQC review during the trust visit and individual interviews

8.9 Service Delivery for 2022 – 2023

Table 17 outlines the key areas of focus for the next financial year for the learning disability specialist nurse and the key milestones. It should be noted that there is a more detailed Learning Disability and autism improvement plan with deliverables for the next 3 years.

Table 17 Areas of focus in the coming year	Key milestones/targets
Development of Learning Disability Guidance/Procedure	September 22
Facilitation of the 3 year LD action plan with the relevant divisions/departments across the organisation	Refresh plan across organisation including CQC review July 22
Development of patient feedback in alternative formats	July 22 (previously delayed by the pandemic)
Align the organisation in preparation for delivery of Learning Disability training	Awaiting code of practice - no timescale currently
Gap analysis of learning Disability specialist and Autism Specialist	March 2023

workforce across the organisation in line with NHSI recommendations	

9.0 Working and Learning Together

The Trust continues to be a member of both the local safeguarding children and adult boards (LSCB/LSAB). The boards seek how to test effectiveness of multiagency arrangements and find ways of improving children's and adults journeys in key local priority areas, including "getting child protection right".

The safeguarding teams continue to work proactively with the LSCB and LSAB to take forward health responses and input to these important agenda items e.g. revision of the domestic abuse policy.

In addition to the partnership boards, the safeguarding teams contribute to a number of internal and external forums, ensuring our safeguarding expertise is informing agenda and contributing to decision making. Table 18 lists the external meetings attended and table 19 lists the internal meetings/forums attended.

Table 18 External forums

- Acute Trust Named Nurse Forum
- Cambridgeshire and Peterborough Safeguarding Adults Board (SAB)
- Cambridgeshire and Peterborough Multi-Agency Risk Assessment conferences (MARAC)
- Cambridgeshire and Peterborough Information Sharing in maternity/Health care professionals - CCG
- Child Death Overview Panel (CDOP)
- Child Safeguarding Practice Review subgroup (CSPRs) - CCG
- East of England Safeguarding Midwives Lead Forums
- Haverhill safeguarding meeting (Multiagency with West Suffolk Hospital, Suffolk children's services and Health Visitors)
- Health Safeguarding Group – CCG
- Health Heads of Safeguarding – CCG
- Health Training Group – CCG
- Hertfordshire (North and East) safeguarding meeting (Multiagency with East and North Herts NHS trust, Hertfordshire children's services and Health Visitors)
- Learning from deaths of people with a learning disability (LeDeR) Quality Assurance Group - CCG
- LeDer Steering Group, Cambridgeshire and Peterborough Safeguarding Adults Board
- Learning Disability Summit
- Local safeguarding childrens board (LSCB) Business meeting
- LSCB Delivery Group meeting
- LSCB Health Safeguarding Group
- LSCB Serious Case Review subgroup

- Quality and Effectiveness Group, Cambridgeshire and Peterborough Safeguarding Adults Board
- Quality and Effectiveness Group, Cambridgeshire and Peterborough Safeguarding Childrens Board
- Safeguarding Adult Review Panel and Sub-Group Meetings – Cambridgeshire & Peterborough SAB
- Safeguarding Children assessment and analysis framework (SAAF) – NHSIE
- Safeguarding Adults national network (SANN) - NHSIE
- Safeguarding meeting with Granta Medical Practice (Multiagency with GP's, Health Visitors and Midwives- once a month)
- Staff safeguarding supervision maternity services
- The East of England Regional Safeguarding Forum
- Unborn Baby Panel (City and South Cambridgeshire)
- Unborn Baby Panel (East Fenlands)
- Vulnerable children and health- CCG

Table 19 Internal forums

- Accessible Information Standards Working Group
- Adult Learning Disability and Autism Forum
- Childrens Learning Disability and Autism Forum
- Carers Strategy Group
- Clinical ethics advisory group
- Clinical Nurse Specialist Group
- Consent working group
- Discharge Assurance Panel and Steering Group
- Domestic Abuse Forum
- Education and Training- Subject Matter Expert Forum
- Equality, Diversity and Dignity Steering Committee
- Equality, Diversity and Dignity patient operational group
- Joint Safeguarding Committee (quarterly)
- Monthly multiagency maternity meeting
- Patient Experience Group
- Paediatric Clinical Governance Meeting
- Paediatric Gastro-enter ology psycho-social meeting.
- Paediatric Morbidity and Mortality Meeting (PICU)
- Paediatric Peer Review
- Paediatric Rheumatology Psycho-social meeting.
- Paediatric/Emergency Department Link meeting.
- PICU Clinical Governance Meeting
- Psychosocial meeting for the Paediatric Neurology team
- Psychosocial meeting for the Paediatric Respiratory Team
- Restrictive Interventions Steering Group
- Serious Incident review panel (SIERP) Actions Meeting
- Staff Carers Group

10. Safeguarding Training

Safeguarding training is a priority for the Trust. It is a mandatory requirement that all staff undertake safeguarding awareness training when they start in the organisation, and a detailed training need analysis identifies groups of staff that are required to undertake more in-depth training which is aligned to their role.

The Intercollegiate Documents identify the levels of training required per staff group for both adults and children. These requirements are mapped across the trust using the on line learning management tool (DOT) to ensure all staff are aware of their own mandatory training requirements with regards to safeguarding.

In areas where 16-17 year olds receive their care and treatment (generally adult wards and clinics), the designated senior staff are required to complete level 3 paediatric safeguarding training. These senior staff are then used as a resource for junior staff to signpost them to enhanced advice and support.

As illustrated in table 20 and 21 below, there is good mandatory training compliance in both adult and children level 1 however there is more work required to focus on increasing the training compliance with safeguarding adults level 2, safeguarding children level 2, safeguarding children level 3 and Prevent. During the pandemic, face to face mandatory training was paused which may have impacted upon training compliance, therefore it is expected that compliance is higher across all training in 2022/23.

Table 20 Safeguarding Training Compliance Rates (Divisional %)

Drill down - Division / Business Unit / Specialty / Department	Safeguarding Adults	Safeguarding Children Lvl 1	Safeguarding Children Lvl 2	Safeguarding Children Lvl 3	Safeguarding Adults Lvl 2	Prevent Lvl 3 (WRAP)
Division A	(118) 94.1%	(87) 95.7%	(221) 88.2%	(28) 82.7%	(286) 84.8%	(13) 92.0%
Division B	(130) 95.3%	(103) 96.3%	(194) 88.7%	(23) 82.3%	(259) 84.9%	(14) 89.2%
Division C	(100) 92.9%	(71) 94.9%	(157) 88.5%	(61) 75.0%	(233) 82.9%	(34) 86.1%
Division D	(73) 94.5%	(54) 95.9%	(119) 89.8%	(28) 79.4%	(138) 88.1%	(18) 86.8%
Division E	(84) 93.1%	(55) 95.5%	(117) 89.6%	(151) 85.1%	(160) 85.7%	(113) 88.9%
Chief Executive Officer	(12) 83.8%	(12) 83.8%	(0) 100.0%	(0) 100.0%	(0) 100.0%	(1) 50.0%
Chief Financial Officer	(13) 93.0%	(10) 94.7%	N/A	N/A	N/A	N/A
Chief Information Officer	(1) 99.6%	(1) 99.6%	(0) 100.0%	N/A	(0) 100.0%	N/A
Chief Nurse	(11) 90.9%	(10) 91.7%	(10) 85.9%	(3) 70.0%	(13) 81.4%	(2) 80.0%
Chief Operating Officer	(4) 94.5%	(3) 95.9%	(2) 91.3%	(1) 0.0%	(2) 91.3%	(0) 100.0%
Director of Improvement And Transformation	(1) 95.5%	(0) 100.0%	N/A	N/A	N/A	N/A
Director of Strategy And Major Projects	(1) 90.9%	(1) 90.9%	N/A	N/A	N/A	N/A
Estates & Facilities	(12) 97.2%	(10) 97.6%	N/A	N/A	N/A	N/A
Medical Director	(4) 86.7%	(4) 86.7%	(6) 50.0%	N/A	(6) 50.0%	N/A
Director of Workforce	(10) 94.4%	(10) 94.4%	(6) 85.4%	N/A	(7) 82.1%	N/A
NIHR R & D Operational	(8) 97.7%	(6) 98.3%	(11) 92.0%	(1) 50.0%	(11) 92.0%	(1) 50.0%
Research Grants Directorate	(6) 92.2%	(6) 92.2%	(6) 88.7%	(0) 100.0%	(5) 90.4%	(0) 100.0%
Total	**(588) 94.4%**	**(443) 95.8%**	**(849) 88.8%**	**(296) 82.6%**	**(1120) 85.2%**	**(196) 88.5%**

Table 21 Safeguarding Training Compliance Rates (Staff Group %)

Staff Group	Safeguarding Adults	Safeguarding Children Lvl 1	Safeguarding Children Lvl 2	Safeguarding Children Lvl 3	Safeguarding Adults Lvl 2	Prevent Lvl 3 (WRAP)
Add Prof Scientific and Technic	(6) 97.4%	(6) 97.4%	(24) 87.6%	(0) 100.0%	(19) 90.2%	(0) 100.0%
Additional Clinical Services	(69) 96.0%	(40) 97.7%	(167) 89.3%	(22) 86.7%	(213) 86.3%	(19) 88.6%
Administrative and Clerical	(109) 95.0%	(92) 95.8%	(20) 83.6%	(3) 57.1%	(17) 85.8%	(2) 71.4%
Allied Health Professionals	(27) 95.9%	(18) 97.3%	(50) 92.6%	(8) 86.7%	(90) 86.6%	(8) 86.7%
Estates and Ancillary	(13) 96.3%	(10) 97.1%	N/A	N/A	N/A	N/A
Healthcare Scientists	(19) 96.8%	(16) 97.3%	(28) 82.8%	(12) 47.8%	(30) 81.6%	(9) 60.9%
Medical and Dental	(212) 85.6%	(175) 88.1%	(264) 83.1%	(89) 75.9%	(327) 79.0%	(74) 80.0%
Nursing and Midwifery Registered	(133) 95.9%	(86) 97.4%	(296) 91.1%	(162) 85.0%	(424) 87.2%	(84) 92.2%
Total	**(588) 94.4%**	**(443) 95.8%**	**(849) 88.8%**	**(296) 82.6%**	**(1120) 85.2%**	**(196) 88.5%**

In addition to the mandatory training identified above, the teams deliver bespoke training to clinical areas and in response to incidents and complaints. Within the intercollegiate document, there is a requirement for organisations to provide level 3 adult safeguarding. This training is currently being developed and will be implemented across the trust in 2022/23.

11.0 Care Quality Commission (CQC)

Regulation 13 – Safeguarding service users from abuse and improper treatment

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, providers must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

In October 2018 the CQC inspected four services at CUH. The inspection team reported that staff were aware of processes and standard procedures to keep people safe from abuse, and received training to assess, recognise and report abuse. They did however recommend that the Trust should ensure medical staff attendance at mental capacity act (MCA) and Deprivation of Liberty Safeguards (DoLS) training is improved to meet the trust target. Attendance at this training has been impacted by the pandemic however the safeguarding lead is working in partnership with the Mandatory training advisory group to utilise the national e-learning packages from Health Education England. This is due to be implemented in the summer of 2022 and will increase the number of medical staff who access this training.

12 Recommendations

The quality committee are asked to note the content of the annual safeguarding report.

Appendix 1 Governance and Accountability

Safeguarding Team

Executive Lead:
Lorraine Szeremeta, Chief Nurse

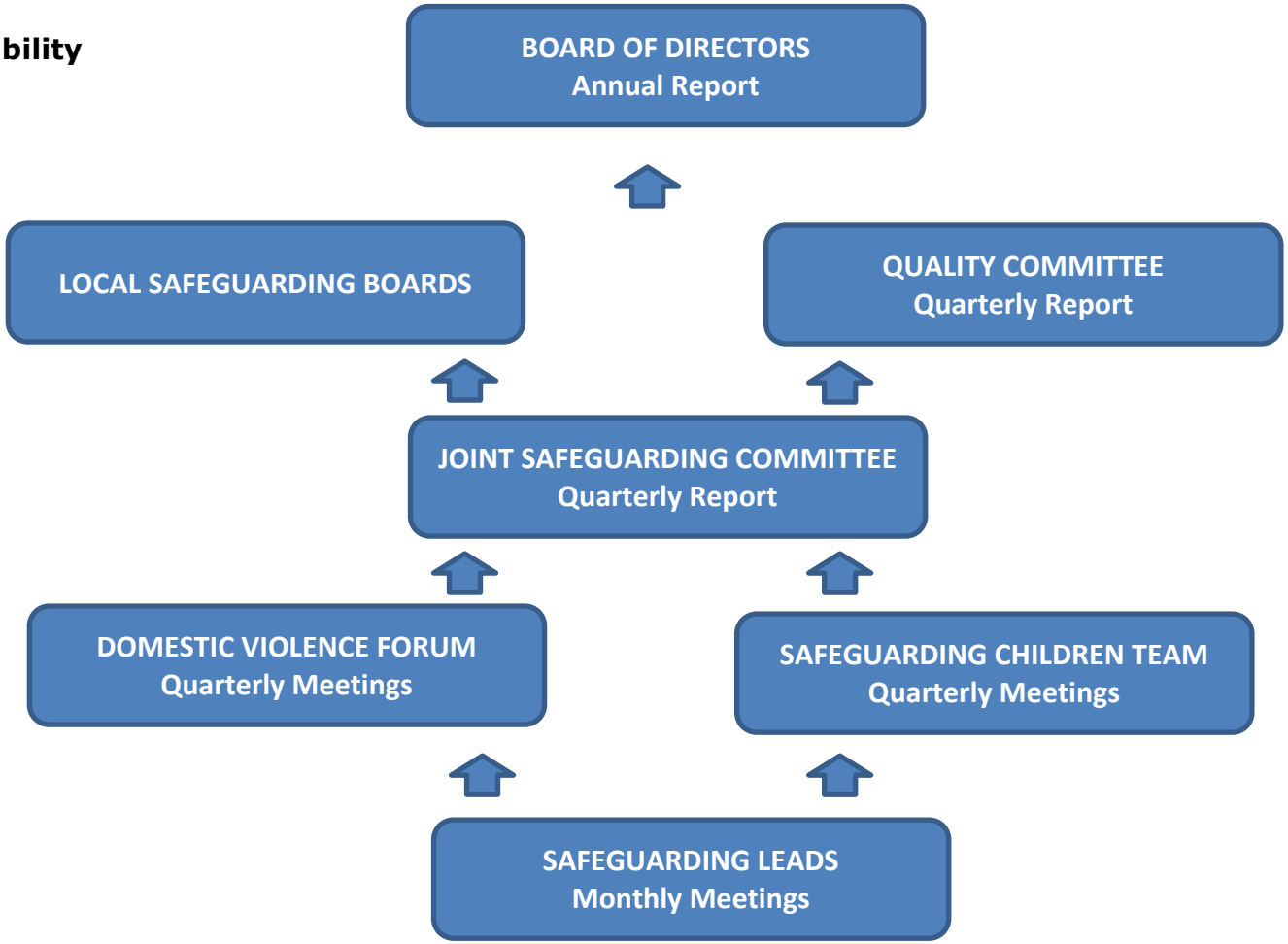
Operational Lead:
Amanda Small, Deputy Chief Nurse

Adult Safeguarding Leads:
Tracy Brown (Named adult safeguarding lead)
Dr Liam Brennan (named doctor)

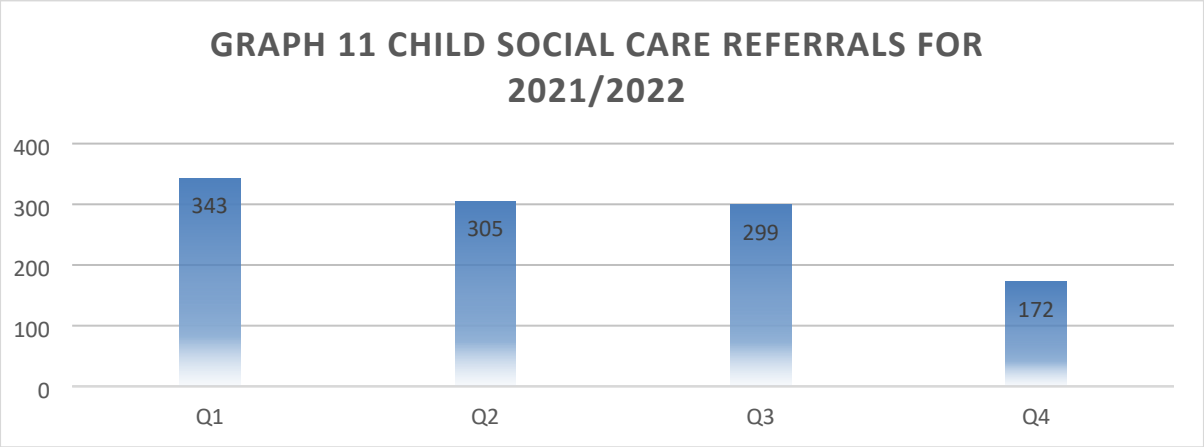
Children Safeguarding Leads:
Sian Forman (named nurse)
Dr Lucy Preston (named doctor)

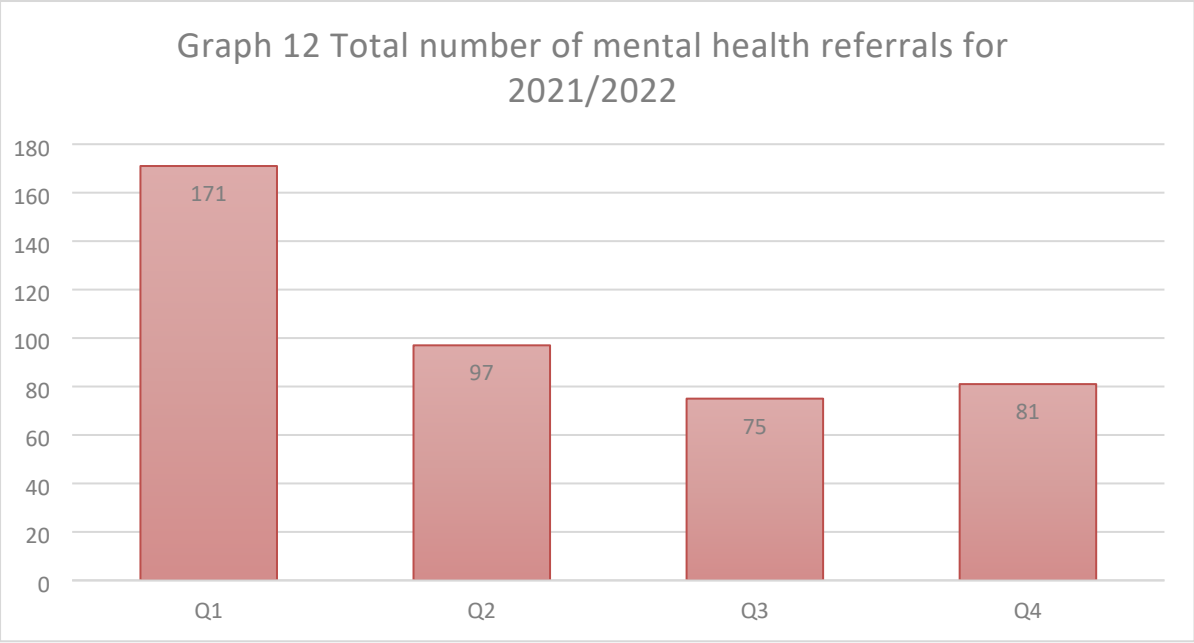
Maternity Safeguarding Leads:
Gillian Harrington (named Midwife)

Workforce Safeguarding Lead:
Richard Lewis, Associate Director of workforce

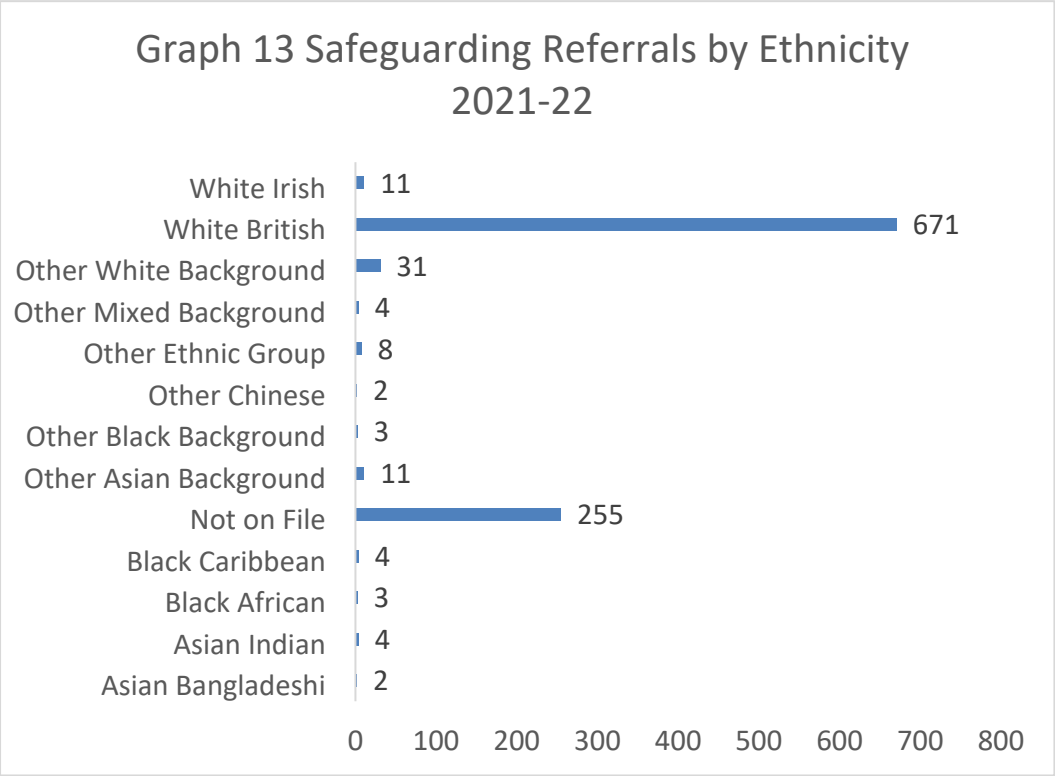


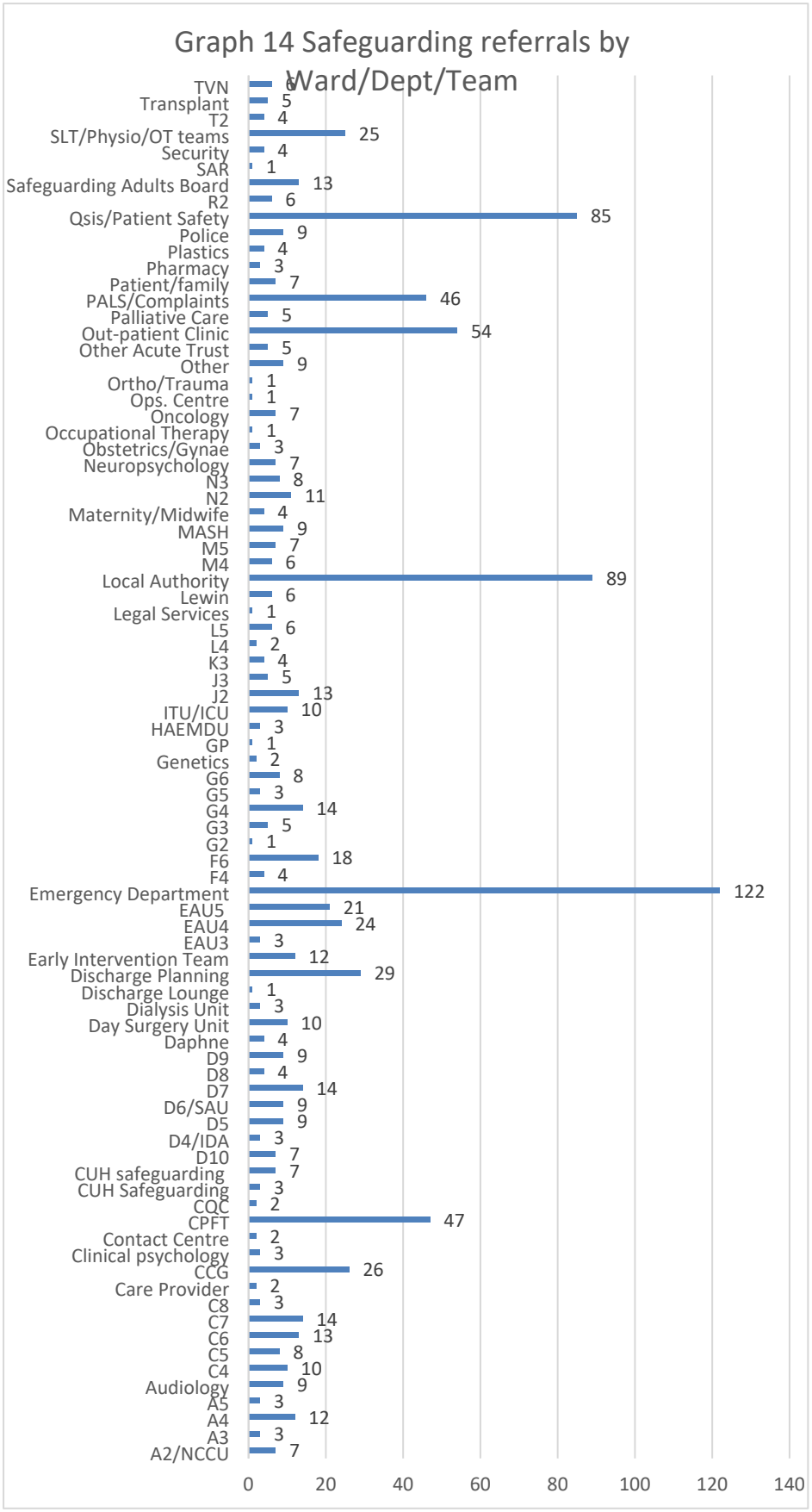
Appendix 2 – Safeguarding Children Activity Data

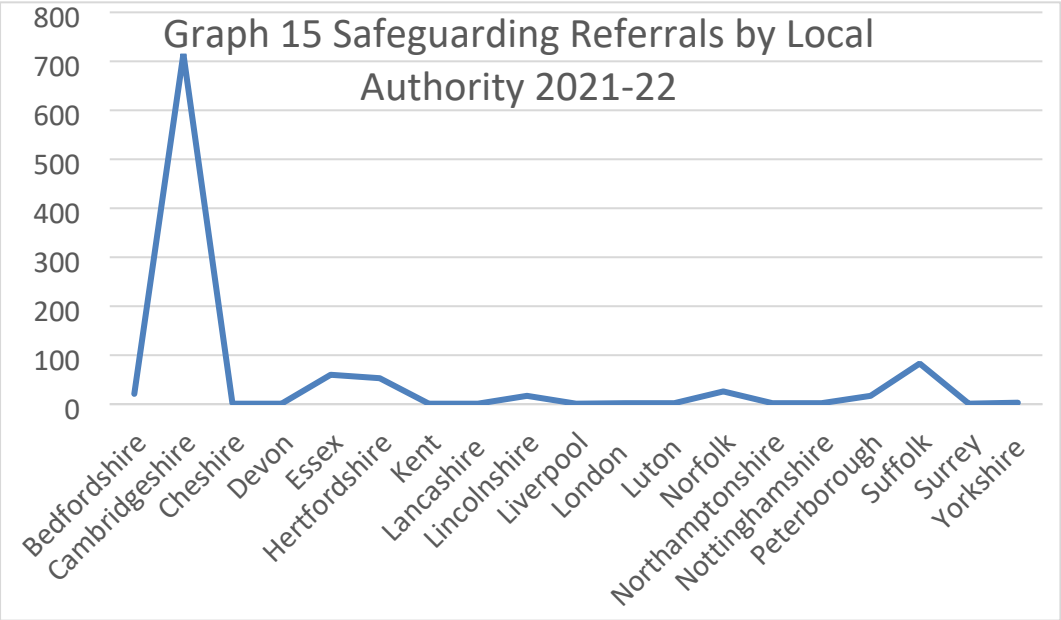




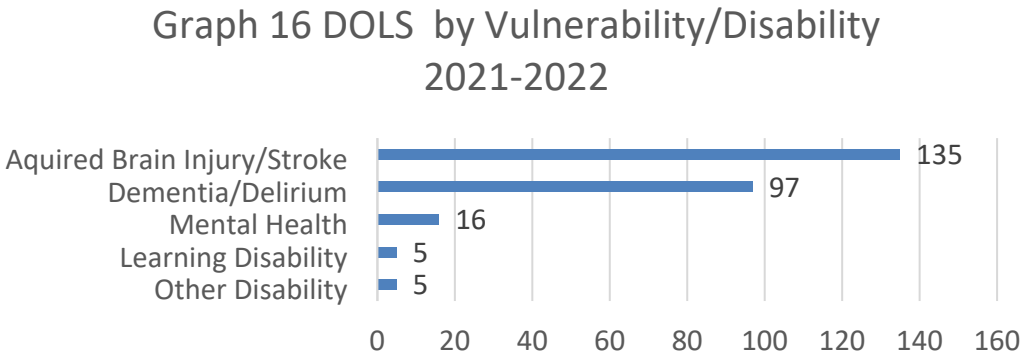
Appendix 2 – Safeguarding adults referral data

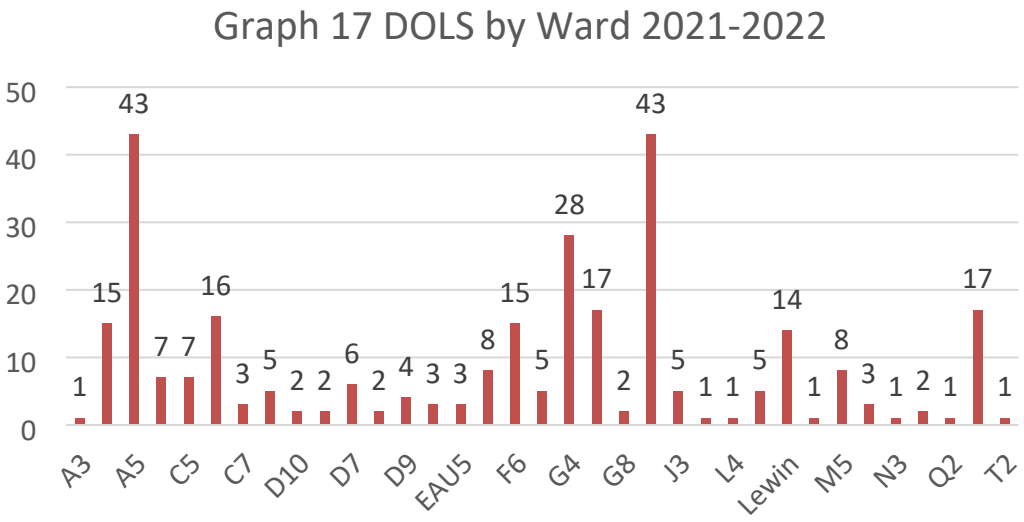


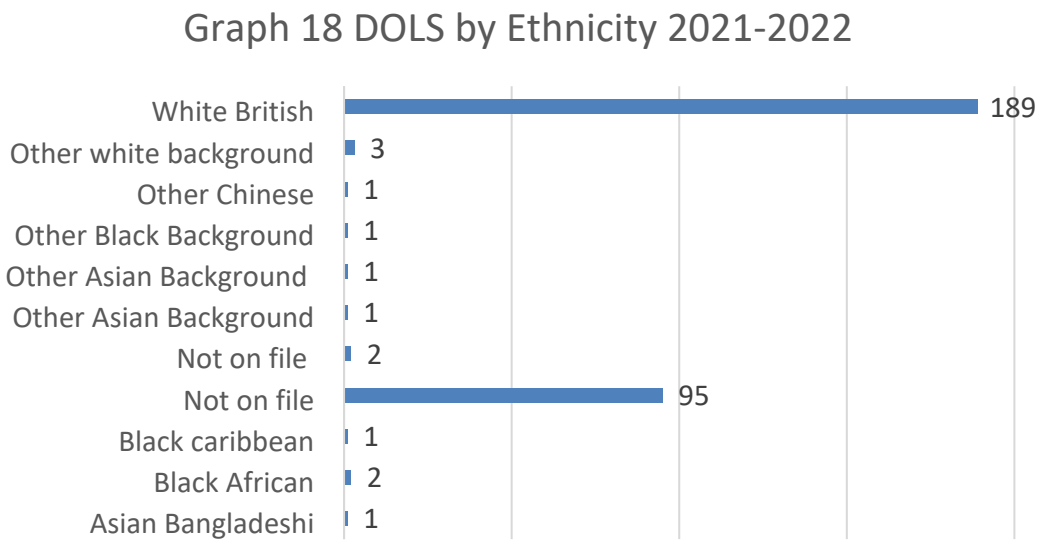

Graph 14 Safeguarding referrals by Ward/Dept/Team
TVN 6
Transplant 5
T2 4
SLT/Physio/OT teams 25
Security 4
SAR 1
Safeguarding Adults Board 13
R2 6
Qsis/Patient Safety 85
Police 9
Plastics 4
Pharmacy 3
Patient/family 7
PALS/Complaints 46
Palliative Care 5
Out-patient Clinic 54
Other Acute Trust 5
Other 9
Ortho/Trauma 1
Ops. Centre 1
Oncology 7
Occupational Therapy 1
Obstetrics/Gynae 3
Neuropsychology 7
N3 8
N2 11
Maternity/Midwife 4
MASH 9
M5 7
M4 6
Local Authority 89
Lewin 6
Legal Services 1
L5 6
L4 2
K3 4
J3 5
J2 13
ITU/ICU 10
HAEMDU 3
GP 1
Genetics 2
G6 8
G5 3
G4 14
G3 5
G2 1
F6 18
F4 4
Emergency Department 122
EAU5 21
EAU4 24
EAU3 3
Early Intervention Team 12
Discharge Planning 29
Discharge Lounge 1
Dialysis Unit 3
Day Surgery Unit 10
Daphne 4
D9 9
D8 4
D7 14
D6/SAU 9
D5 9
D4/IDA 3
D10 7
CUH safeguarding 7
CUH Safeguarding 3
CQC 2
CPFT 47
Contact Centre 2
Clinical psychology 3
CCG 26
Care Provider 2
C8 3
C7 14
C6 13
C5 8
C4 10
Audiology 9
A5 3
A4 12
A3 3
A2/NCCU 7
0 20 40 60 80 100 120 140

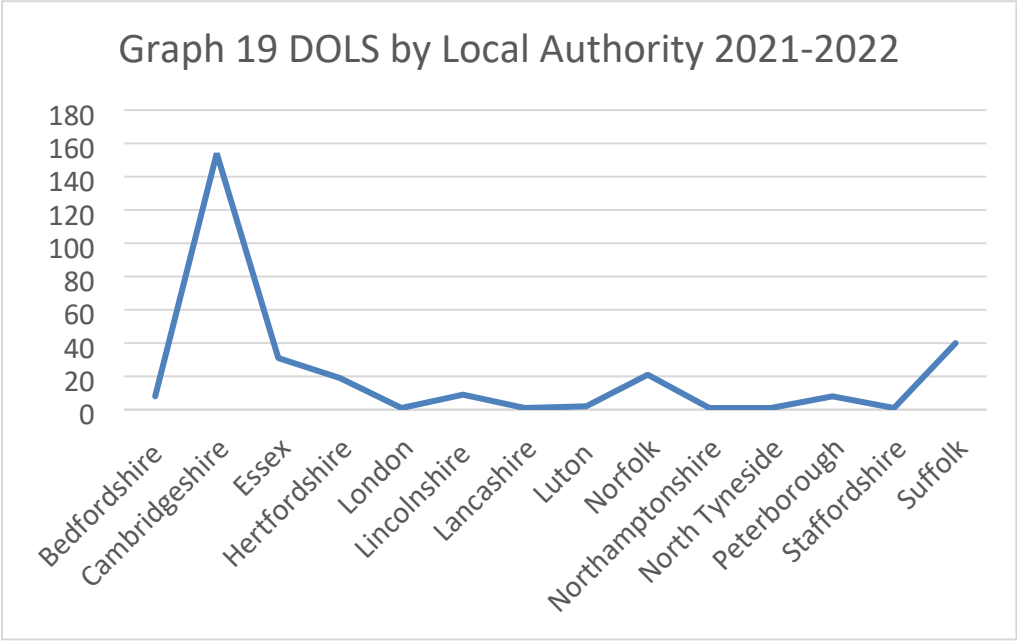


Appendix 4. DOLS activity data



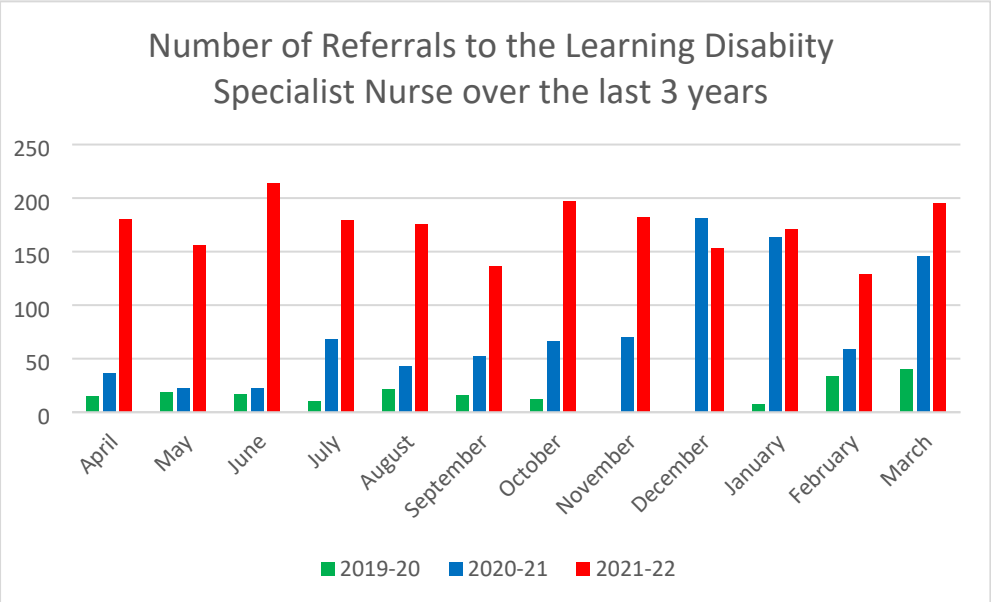



Graph 18 DOLS by Ethnicity 2021-2022
White British
189
Other white background
3
Other Chinese
1
Other Black Background
1
Other Asian Background
1
Other Asian Background
1
Not on file
2
Not on file
95
Black caribbean
1
Black African
2
Asian Bangladeshi
1


Graph 19 DOLS by Local Authority 2021-2022
180
160
140
120
100
80
60
40
20
0
Bedfordshire
Cambridgeshire
Essex
Hertfordshire
London
Lincolnshire
Lancashire
Luton
Norfolk
Northamptonshire
North Tyneside
Peterborough
Staffordshire
Suffolk

Appendix 5 – Adults with Learning Disability and Autism Activity Data

Graph 20 Number of Referrals to the Learning Disability Nurse over the last 3 years by month



NHS
Cambridge University Hospitals
NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Performance Committee	**DATE OF MEETING:**	6 July 2022
CHAIR:	Adrian Chamberlain	**LEAD EXECUTIVE DIRECTOR:**	Chief Operating Officer, Chief Finance Officer
RECEIVING BOARD / COMMITTEE:	Board of Directors, 13 July 2022		

AGENDA ITEM	DETAILS OF ISSUE	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5	**Review of Major Project Business Case** 1. The committee reviewed two business cases: • <u>40 bed theatres</u> ○ The committee discussed the need to place an initial order to the value of £3.9m to secure materials and undertake enabling works ahead of the Board meeting on 13 July 2022. ○ The committee agreed to recommend the proposal to the Board. • <u>Children's hospital – draft OBC</u> ○ The committee was being asked for comment on the draft OBC. ○ Final OBC is due to be submitted in the autumn. ○ The committee was concerned about the significant increase in the cost of the project from SOC stage.	For approval For information	BAF 009	n/a

6	**Improvement update** 1. The committee received an update from the Director of Improvement and Transformation. 2. The committee noted the progress in the implementation of the virtual wards programme and the beneficial effect on recovery. 3. The committee noted progress in the outpatients transformation programme.	For information		n/a
7	**Operational Performance** 1. The committee received and noted the detail of the Integrated Performance Report for month 2. 2. The committee received updates regarding operational performance. 3. The committee noted improvements in waiting times in ED, ambulance handover times and elective activity. 4. The committee discussed the results of the recent system CQC inspection.	For information	BAF 001	n/a
8	**Financial Performance** <u>Financial position Months 1&2</u> 1. The committee received and noted the content of report from the Chief Finance Officer. 2. The committee noted the breakeven is reflected in the budget, had been maintained in Month 2 and is expected to continue in Month 3. 3. The committee acknowledged that it would continue to be difficult to quantify the risk from Covid over the remainder of the year. <u>Month 1 Capital Update</u> 1. The committee received and noted the content of the Month 2 Capital report.	For information	BAF 011	n/a

9	**Workforce Quarterly Update** 1. The committee received and noted the content of the report of the Director of Workforce. 2. The committee noted the risks to the nursing pipeline due to accommodation issues and the need to focus on staff retention. 3. The committee noted the effects of the high cost of living on staff. 4. The committee noted the focus on the 'good work' initiative.	For information	BAF 007, 008, 013,	n/a
10	**Developing a five-year strategic plan for CUH** 1. The committee received and noted the report of the Director of Strategy and Major Projects.			
11	**Board Assurance Framework and Corporate Risk Register** 1. The committee received and noted the current version of the Board Assurance Framework and Corporate Risk Register.	For information	All	n/a